

Client Expectations and Satisfaction with Psychological Treatment

E. J. van der Merwe
MA (Clinical Psychology)

**Thesis submitted for the degree Philosophiae Doctor in Psychology at the
North-West University**

Promotor: Prof. E. van Rensburg

Co-promotor: Dr. S. M. Ellis

November 2016

Potchefstroom Campus



**“... you can’t always get what you want,
but if you try sometimes well you might find,
you get what you need.”**

– The Rolling Stones –

Acknowledgements

First and foremost, I want to thank my Heavenly Father for his love, and for the strength that He granted me to complete this thesis, and for all the wonderful people that He enriched my life with, and who supported me in this venture.

I wish to extend my sincere gratitude to the following individuals and institutions that, in some way or the other, contributed to make this study possible:

To my promotor, Prof. Esmé van Rensburg, and co-promotor, Dr. Suria Ellis, for their insightful guidance, support, and setting examples of what satisfaction means in life.

To the Health Research Ethics Committee of the Faculty of Health Sciences (HREC), North-West University (Potchefstroom Campus) for ethical guidance and approval.

To Dr. Althéa Kotze for superb language editing.

To Deidre Duvenage for outstanding document formatting, and assistance.

To my wife, Elmé, for all her devoted love, support and joyful companionship.

To my mother and father, for their undying support and encouragement, for always being there, caring and helping, and for their unconditional love.

To my sister, Elmarie, for always being there for me, and her ability to make me laugh throughout the tough times.

Table of contents

Acknowledgements	iii
Summary	v
Opsomming	viii
Preface	xi
Proof of language editing	xii
Section A: Introduction and rationale	1
Section B: Article 1: Psychometric properties of scales measuring client expectations and satisfaction with psychological treatment in a South African context	72
2.1 Guidelines for authors: <i>Journal of Psychology in Africa</i>	73
2.2 Manuscript: Psychometric properties of scales measuring client expectations and satisfaction with psychological treatment in a South African context	74
Section B: Article 2: The nature of clients' expectations and satisfaction with psychological treatment in a South African context	116
3.1 Guidelines for authors: <i>South African Journal of Psychology</i>	117
3.2 Manuscript: The nature of clients' expectations and satisfaction with psychological treatment in a South African context	118
Section B: Article 3: The relationship between client psychological treatment expectations and satisfaction in South Africa	148
4.1 Guidelines for authors: <i>Psychology and Practice: Research and</i>	149
4.2 Manuscript: The relationship between client psychological treatment expectations and satisfaction in South Africa	151
Section C: Critical Reflection: Conclusion, implications and recommendations	188
Complete reference list	205

Summary

Client Expectations and Satisfaction with Psychological Treatment

Keywords: client, patient, satisfaction, psychotherapy, psychological treatment, expectations, health care

This study, presented in article format, contributed to the development of the science and practice of psychological treatment, specifically in the South African multicultural context, through (i), a first-phase exploration of the validity of scales, mainly developed in a Western context, for applicability of measurement of facets of clients' expectation and satisfaction with psychological treatment in the South African context (manuscript 1); (ii) an exploration of patterns or the nature of client expectations and satisfaction with psychological treatment in South Africa (manuscript 2), and (iii), the relationship between clients' expectations and satisfaction with psychological treatment in the South African context (manuscript 3). Section C, the critical reflection provides guidelines for use in practice to enhance psychological treatment through the *patient experience* construct.

The aim of the first article was to do a first-phase screening of psychometric properties of two scales measuring facets of client expectations and satisfaction with psychological treatment in a South African context. These scales were developed in a predominantly Western context, and measures facets of cognitive, affective, conative, and social client expectation and satisfaction with psychological treatment. Data gathered included 204 participants from different cultural contexts in the North-West and Gauteng provinces in South Africa. The data comprised a convenience sample of 120 participants from the Gauteng province and 84 participants from North-West. All were adult clients from

independent practicing psychologists in the North-West and Gauteng provinces. Reliability and validity of scales for use in a South African context were reported. Results indicated that the reliability and validity of scales were acceptable for use in specific subgroups. It was concluded that the Milwaukee Psychotherapy Expectations Questionnaire (MPEQ 2011) and the Satisfaction with Therapy and Therapist Scale (STTS-R 1999) are valid and reliable in a South African context.

The second article explored the nature and patterns of clients' expectations of and satisfaction with psychological treatment in the South African context. Secondary factor analyses were conducted on data obtained, comprising 204 participants. Questionnaires measured facets of affective, conative, emotional, and interpersonal client expectation and satisfaction with psychological treatment. Similarities and differences in patterns of client expectations and satisfaction with psychological treatment were found. Implications for models of client expectations and satisfaction with psychological treatment were indicated. Implications for models of client expectations and satisfaction with psychological treatment and interventions to enhance clients' expectation and satisfaction with psychological treatment were indicated.

In the third article, the researchers aimed to determine whether correlations between clients' expectations and their satisfaction were significant. In this article, the researchers found that the correlations of the satisfaction components were high, indicating high correlation between Process and Outcome expectations with the Satisfaction construct. It was surmised that client satisfaction or dissatisfaction is a complex phenomenon linked to patients' expectations and personal traits. Patient or client satisfaction is by nature multidimensional and the study confirms that a relationship exists between clients' expectations and satisfaction with psychological treatment in South Africa.

The critical reflection reviewed and evaluated the practical applicability of scientific knowledge from the domain of client satisfaction and expectations, with specific reference to application of the patient experience construct. It was shown that knowledge in the scientific domain of client satisfaction and expectations has great relevance for, and application possibilities on an individual, organisational, as well as a public policy level. Applications were found in various contexts (such as education, psychotherapy, organisations, and health promotion). Several strategies for enhancement of facets of client expectations and satisfaction with psychological treatment were highlighted.

A central supposition across the different studies reported in this thesis (articles 1 through 3), was that cultural contexts and variables certainly need to be taken into account in research and practice of client expectations and satisfaction. Despite the major developments in the scientific domain of the patient experience construct, its theories and applications have mainly been developed and explored in a Western context, and further research is necessary, specifically in the African context. Several recommendations for future research were made.

Opsomming

Kliënte se verwagtinge van en tevredenheid met psigologiese behandeling

Sleutelwoorde: kliënt, pasiënt, tevredenheid, psigoterapie, psigologiese behandeling, verwagtinge, gesondheidsorg

Die navorsingsuitkomste van hierdie studie, wat in artikelformaat aangebied word, dra by tot die ontwikkeling van die wetenskap en praktyk van psigologiese behandeling, spesifiek in die multikulturele Suid-Afrikaanse verband (konteks), deur:

- (i) 'n eerstefaseverkenning van die geldigheid van skale (meetinstrumente), wat hoofsaaklik in 'n Westerse konteks ontwikkel is, vir die toepaslikheid van meting van aspekte van kliëntverwagtinge van en tevredenheid met psigologiese behandeling in 'n Suid-Afrikaanse konteks (manuskrip 1);
- (ii) 'n verkenning van tendense of die aard van kliënteverwagtinge en hulle tevredenheid met psigologiese behandeling in Suid-Afrika (manuskrip 2), en
- (iii) die verwantskap tussen kliënte se verwagting van en tevredenheid met psigologiese behandeling in die Suid-Afrikaanse konteks (manuskrip 3).
- (iv) Afdeling C is 'n kritiese beskouing vir toepassing in die praktyk gerig op die verbetering van psigologiese behandeling deur die pasiëntbelevingkonstruk (pasiënt-ervaringskonstruk).

Die doel van die eerste artikel is om die psigometriese eienskappe van twee meetinstrumente wat aspekte van kliëntverwagting en -tevredenheid meet met betrekking tot psigologiese behandeling in die Suid-Afrikaanse konteks. Hierdie instrumente is hoofsaaklik ontwikkel binne 'n Westerse konteks, en meet (bepaal) aspekte van kognitiewe, affektiewe,

konatiewe en sosiale kliëntverwagtinge van en kliëntetevredenheid met psigologiese behandeling. Die versamelde data sluit in 204 deelnemers uit diverse kulturele verbintenisse in die Noordwes- en Gauteng-provinsies in Suid Afrika. Die data behels 'n gerieflikheidsteekproef van 120 deelnemers uit Gauteng, en 84 deelnemers uit Noordwes. Almal is volwasse kliënte van onafhanklik praktiserende sielkundiges in Noordwes en Gauteng. Betroubaarheid en geldigheid van die meetinstrumente vir gebruik in die Suid-Afrikaanse konteks is vermeld. Resultate dui daarop dat betroubaarheid en geldigheid van die meetinstrumente aanvaarbaar is vir spesifieke subgroepe. Daar is tot die gevolgtrekking gekom dat die *Milwaukee Psychotherapy Expectations Questionnaire* (MPEQ, 2011), en die *Satisfaction with Therapy and Therapist Scale* (STTS-R, 1999), geldig en betroubaar is in 'n Suid-Afrikaanse konteks.

Die tweede artikel verken die aard en tendense van kliëntverwagtinge van en kliëntetevredenheid met psigologiese behandeling binne die Suid-Afrikaanse konteks. Sekondêre faktoranalise is uitgevoer op die data wat van die 204 deelnemers verkry is. Vraelyste het fasette van affektiewe, konatiewe, emosionele, en interpersoonlike kliëntverwagtinge van en -tevredeheid met psigologiese behandeling gemeet (bepaal). Ooreenkomste en verskille in tendense van kliëntverwagtinge van en -tevredeheid met psigologiese behandeling is bevind. Implikasies vir modelle van kliëntverwagtinge sowel as vir kliëntetevredenheid is aangetoon. Implikasies is uitgewys vir modelle van kliëntverwagtinge van en -tevredeheid met psigologiese behandeling. Voorts is intervensies aangedui om kliëntverwagtinge en -tevredeheid te versterk.

Met die derde artikel het die navorsers ten doel gehad om vas te stel of die verwantskappe (ooreenkomste) tussen kliënte se verwagtinge en hul tevredeheid betekenisvol was. Die navorsers vind in hierdie artikel dat die korrelasies van die komponente van tevredeheid hoog was, en dui op hoë verwantskappe tussen Proses- en

Uitkomsverwagtinge en die tevredenheid-konstruk. Daar is voorspel dat kliënttevredenheid of -ontevredenheid 'n ingewikkelde en merkwaardige verskynsel is, en dat dit verwant is aan pasiënte se verwagtings en karaktereenskappe. Pasiënt- or kliënttevredenheid is uiteraard multidimensioneel en die studie bevestig dat daar 'n verwantskap bestaan tussen kliënte se verwagtinge en hul tevredenheid met psigologiese behandeling in Suid Afrika.

Die kritiese beskouing hersien en evalueer die praktiese toepaslikheid van wetenskaplike kennis uit die domein van kliënteverwagtinge en -tevredenheid, met spesifieke verwysing na die toepassing van die pasiëntervaringskonstruk. Dit toon dat kennis vanuit die wetenskaplike domein van kliënteverwagtinge en -tevredenheid 'n groot mate van verwantskap toon met en toepassingsmoontlikhede het op individuele, organisatoriese, sowel as op openbare beleidsvlak. Toepassings in verskeie kontekste (naamlik opvoeding, psigoterapie, organisasies, en gesondheidsbevordering), is bevind. Verskeie strategieë vir die verbetering (versterking) van fasette van kliënteverwagtinge en -tevredenheid met psigologiese behandeling is beklemtoon (belig).

'n Deurlopende (sentrale) voorveronderstelling oor die spektrum van die verskillende studies wat in hierdie tesis vermeld word, is dat kulturele verbande en verskille bo alle twyfel in aanmerking geneem moet word in die navorsing en toepassing van kliëntverwagtinge en kliënttevredenheid. Ten spyte van belangrike ontwikkelinge in die wetenskaplike domein van die pasiëntervaringskonstruk is die teorieë en toepassings daarvan hoofsaaklik in 'n Westerse konteks ontwikkel en nagevors. Nog meer navorsing word benodig, veral in die Afrika-konteks. Ten slotte word verskeie aanbevelings vir verdere navorsing aanbeveel.

Preface

- The thesis is submitted in article format as described in rules A.14.4.2, and A13.7.3, A13.7.4, A17.7.5 of the North-West University.
- The three manuscripts comprising this thesis will be submitted for review to the *Journal of Psychology in Africa* (JPA; Manuscript 1), the *South African Journal of Psychology* (SAJP; Manuscript 2), and *Professional Psychology: Research and Practice* (PP:RP; Manuscript 3).
- The referencing style and editorial approach for this thesis is in line with the prescriptions of the *Publication Manual* (sixth edition) of the American Psychological Association (APA), except where the requirements of the above-mentioned journals differed in the case of the specific manuscripts. In these instances, recently published articles in the journals were perused for guidance relating to style, headings, numbering, and so forth. The articles are thus compiled according to the guidelines of the journals to which the articles are submitted, which furthermore specifies consulting previously published articles.
- For the purposes of this thesis, the pages of the thesis as a whole are numbered consecutively. However, for submission purposes each individual manuscript was numbered starting from Page 1.

Proof of language editing

I hereby declare that I have language-edited the following thesis by **ERNST J. VAN DER MERWE** (student number **11939222**) submitted in the fulfilment of the requirements for the degree PhD in Clinical Psychology at the Potchefstroom Campus of the North-West University to the approval of the student and his supervisor:

Client Satisfaction with Psychological Treatment

A black rectangular box containing a white handwritten signature that reads "A.D. Kotze". Below the signature is a horizontal line that starts under the 'A' and extends to the right, ending under the 'e'.

.....

Dr. A. D. Kotze

Althéa Kotze • Accredited Language practitioner • APed (South African Translators' Institute)
• PhD Afrikaans and Dutch • MA Afrikaans and Dutch • MA Applied Linguistics • BA Hons • BA • PGCE •
6 Acacia Street • SE3 • Vanderbijlpark • 1911 • South Africa
+27 (0) 823518509 (m)
+27 (0) 16 9324932 (w)
althea.erasmus@gmail.com



Client Expectations and Satisfaction with Psychological Treatment

SECTION A: INTRODUCTION AND RATIONALE

1.1 Introduction and Problem Statement

The South African Constitution considers health care a basic human right (The Bill of Rights of the Constitution of the Republic of South African, 1996). At its most fundamental level, health care requires available, accessible, acceptable, and high-quality health services, goods, and facilities in the country. This is the aim behind the proposed National Health Insurance (NHI), in addition to ensuring that all citizens of South Africa are provided with these essential health-care services. This results not only in an increase in physical services, but also in an expansion of psychological services (National Health Insurance for South Africa, 2015). All over the world, but to a greater extent in South Africa, people are increasingly utilising psychological and mental health services (Lund, Petersen, Kleintjes, & Bhana, 2012).

The reason behind the boom in the increased utilisation of psychological services during the twenty-first century may very well be an increase in psychological ailments. Depression, anxiety, trauma, and substance-use problems are the leading illnesses of our time (South African Depression and Anxiety Group, 2013). Furthermore, the upsurge in the utilisation of said services by previously disadvantaged groups might constitute yet another reason for the amplified use of mental health services in South Africa (World Health Organization, 2001). This phenomenon may also be partly due to a decrease in the stigma associated with mental health services, owing to a more accurate image and precise information being freely available (Bruwer et al., 2011; Ruane, 2010).

With the increasing emphasis on clinical governance in health-care provision, National Health Services in South Africa are trapped in the situation of having to justify their work using standardised outcome measures (National Department of Health, 2013). As stated by Lawrie, McIntosh, and Rao (2000), clinical governance can be referred to as “the means by which health-care organizations ensure the provision of quality care by making individuals accountable for the setting, maintaining and monitoring performance standards” (p. 2). Clinical governance as a framework thus guides health-care organisations in continuously improving service quality, thereby creating an environment in which excellence in clinical care will thrive.

The notion of providing access to essential health-care services to all citizens also constitutes a widely accepted international principle. Thus, the World Health Organization (WHO) requires its member states to endeavour to develop and promote evidence-based policies, including global standards to improve client care (WHO, 2012).

The Health Professions Council of South Africa (HPCSA) also stipulates the emphasis on high quality service. The HPCSA is a statutory body committed to serve and protect the public, and is dedicated towards promoting the health of the population of South Africa. This body was established to determine the standards of professional education and training. It achieves its mandate by regulating professional conduct and ethical behaviour, fostering compliance with health-care standards, and setting and maintaining fair standards of professional practice and competence (HPCSA, 2013). It can thus be surmised that the HPCSA expects registered health-care practitioners to provide a professional and value-adding service. It is the ethical responsibility of the health-care practitioner to provide a service that meets the expectations of clients and satisfies their needs (British Association for Counselling and Psychotherapy, 2010). As health professionals, psychologists are

consequently bound to deliver a service that is empirically and ethically sound and furthermore, professionally satisfying (HPCSA, 2013).

Psychotherapy, like any medical service, is expensive. In 2011 the total spent on health care in South Africa amounted to about 8.3% of the gross domestic product (GDP), exceeding the five percent recommended by the WHO (Leadership Magazine, 2013). The Psychological Society of South Africa (PsySSA) and the Board of Healthcare Funders (BHF) recommend psychologists' fees. While some medical schemes do give partial or full financial support for psychotherapy, it depends on the particular contract the client has with their medical aid scheme. The cost of psychological amenities are further increased by advances in technology, an increased disease burden, shortage of skills, co-payments, a lack of competition, Prescribed Minimum Benefits (PMB) coverage, and clients who do not belong to or have exhausted their medical aid. The high cost of psychological services also necessitates the service of psychologists to be of the highest quality, as well as time-effective.

In recent years, the topic of client¹ satisfaction with clinical service has gained rapid recognition as an outcome of quality of care (American College of Emergency Physicians, 2014). As quoted by Spiegel and Hyman (1998), Avedis Donabedian (1988), a physician and founder of the study of quality in health care and a noted authority in medical outcome research, states, "It is futile to argue about the validity of patient satisfaction as a measure of quality ... information about patient satisfaction should be as indispensable to assessment of quality as to the design and management of health-care systems" (p. 1746).

Trends in business and industry focus on empirical research to validate their economic and business decision-making (Kurti, 2015; Wadhwa, 2002). From a business and marketing perspective, client satisfaction takes on additional significance. In a competitive marketplace, a happy customer leads to an increased market share. Weisman and Koch (1989) as cited in

¹ • Throughout this thesis the terms 'client' and 'patient' will be used interchangeably, due to the fact that most literature on the subject refers to 'patient satisfaction'.

Frattali (1991) proposed, “It stands to reason, then, that providers who actively seek and respond to patient opinion will enjoy not only healthier and more satisfied patients, but a more favourable position in today’s competitive healthcare marketplace. Clearly, good quality is good business” (p. 167).

In recent years, the tendency to validate economic and professional decision-making through focussing on empirical research has been emphasised by numerous professional organisations (APA Presidential Task Force on Evidence-Based Practice, 2006; Association for Behavioral and Cognitive Therapies, 2013, and the Society of Clinical Child and Adolescent Psychology, 2014).

The American Psychological Association (APA, 2006) strongly recommends that their members carry out investigations to provide evidence supporting or rejecting the use of specific interventions. Pressure has also emanated from the public and private health insurance providers, refusing coverage of practices lacking in systematic evidence of usefulness and thus embracing evidence-based practice (EBP). According to Feenstra and Horn (2014), the field of psychological assessment lacks published empirical evidence regarding its clinical utility. Prior to the 1990s, there were no specific guidelines for either practitioners or mental health consumers regarding the selection of treatments for specific conditions. Consequently, the psychotherapy field was plagued by serious quality control problems (Association for Behavioral and Cognitive Therapies, 2003). The need for a way to exclude quack practitioners or nonempirical-based treatments in order to protect the public became clear.

Furthermore, the importance of identifying what actually does work was recognised. Hence, with this study the idea (or awareness) of working more effectively as a practitioner could improve and promote significant practices. Evidence-based treatment (EBT), as such an approach, aims to specify the way in which professionals should make decisions by

identifying specific evidence in place for a practise, and rating it according to plausible scientific soundness. Its goal is to eradicate unreliable or exceptionally risky practices in favour of those with superior outcomes. Evidence-based practices require practitioners to consistently evaluate and utilise the best available research (Berke, Rozell, Hogan, Norcross, & Karpiak, 2011). The latest development in the field stemming from the consumer revolution in health care follows the formal introduction of evidenced-based practice (EBP) in psychology as of 1992 (Buysse & Wesley, 2006). One of the main reasons for successfully incorporating EBPs into treatment services is the numerous studies linking clients' improved health outcomes and the general attitude that treatments should be based in scientific evidence (Sackett, Straus, Richardson, Rosenberg, & Haynes, 2000). This concept embraces client satisfaction and requires practitioners to consistently evaluate and utilise the best available research in order to meet their clients' needs (Berke et al., 2011). This importance of evidence-based empirically validated practices (compare 1.2) in order to meet client satisfaction, motivate this particular study area even further.

Client satisfaction in a psychotherapeutic context is by nature arbitrary. According to Norberg, Wetterneck, Sass, and Kanter (2011), all published reviews on client expectations have acknowledged the problem of inconsistent measurement and identified the need to develop a comprehensive, standardised instrument. No existing instruments of measurement can be directly applied to determine the level of satisfaction that clients experience. Research points to the existence of a relationship between premature termination or psychotherapy dropout and treatment expectations (Sharf & Primavera, 2010). According to Donabedian (1988), four elements constitute assessment of the quality of care, namely, the performance of the health-care practitioner; the amenities of care; the care implemented by the patient and family members; and the care received by the community as a whole. Fortunately, some of the existing research and measurement instruments could be adapted for use in this study.

Most psychologists will agree that the occupation of psychology can at times be a taxing and even ungrateful profession (Roothman, 2009). Clients consult mostly when things are appalling, but often once the crisis is resolved, they do not follow up again. Certain clients may express gratitude during run-of-the-mill sessions with psychologists, while others do not verbalise their experience of satisfaction. It therefore makes sense that, if psychologists were aware of appropriate services that meet the expectations of clients and satisfy their needs, it would most probably improve the work satisfaction experienced by these psychologists. This points to and emphasises the importance of client satisfaction and clients' expectations of satisfaction.

As stated previously, psychotherapy can be an expensive and time-consuming endeavour. Given the fact that no one has unlimited amounts of time and money, empirical evidence of appropriate, satisfactory, and cost-effective practice methods could prove invaluable during the therapy process.

A databases search of EBSCOhost and other catalogues reveals little to none relevant information pertaining to client satisfaction with psychotherapy in the South African context. This rather pronounced lack of empirical evidence in the South African context motivates effective therapeutic methods even further.

It is against this backdrop that the additional advantages and contributions of this thesis are discernible on the following levels:

- It will play an important part in contributing to current knowledge on clients' satisfaction, experience, and expectations of psychological services in the South African context. This vital new information will contribute to the expansion of the existing knowledge of psychology as a subject and science, considering that

relevant data regarding psychological services not previously researched in South Africa will be presented.

It is envisaged that:

- Increased knowledge on the expectations, satisfaction, and experiences of clients will promote high-quality psychological services, since psychologists will gain a heightened and additional understanding of appropriate factors or components contributing to client satisfaction with psychological treatment. In addition and perhaps even more important, factors that do not contribute favourably to client satisfaction can be identified.
- The knowledge gained from the results will assist psychologists – and especially newly qualified, inexperienced psychologists – in avoiding pitfalls concerning therapy.

The objective of this study is to contribute to the development of the science and practice of psychological treatment, specifically in the South African context by means of three articles:

- (i) Manuscript 1: A first-phase exploration of the psychometric properties (validity and reliability) of scales measuring facets of client expectations and satisfaction with psychological treatment mainly developed in a Western context, for applicability in measurement in the South African (multicultural) context.
- (ii) Manuscript 2: An exploration of the nature and patterns of clients' expectations of and satisfaction with psychological treatment in a South African context.
- (iii) Manuscript 3: A review of the relationship between clients' expectations and their satisfaction with psychological treatment in the South African context.

The thesis is presented in article format comprising three manuscripts presented consecutively with supplementary guidelines for authors (where applicable). A literature review provides an overview of the existing research regarding client satisfaction.

The research aim for the first article (Section B1) was to conduct a first-phase screening of the psychometric properties of scales measuring aspects of client expectations and satisfaction with psychological treatment to determine the validity and reliability of the before-mentioned measurement instruments in a South African context.

The aim of the second article (Section B2) was to determine the nature and patterns of clients' expectations of psychological treatment in a South African context, as well as to explore the nature of clients' satisfaction with psychological treatment.

The aim of the third article (Section B3) was to determine the relationship between clients' psychological treatment expectations and their satisfaction with psychological treatment in the South African context.

In the final section (Section C) a critical reflection of the main findings is summarised, implications are indicated, and some recommendations are made for future research with specific reference to the patient experience construct.

1.2 Client Satisfaction

Reeder (1972) anticipated intensifying developments in the medical care and allied health field build toward consumer representation on hospital boards and prepaid medical care plans. His avowal was owing to the development of consumerism in the health field as well as the issue of the changing client-professional relationship. He expected that the client-therapist relationship will be transformed as the health-care professional takes into account the clients' or consumers' desires, requirements, grievances, satisfactions, and dissatisfactions. Forty years down the line his predictions ring true, as indeed most of the

anticipated changes have taken place. Currently consumer satisfaction surveys are a standard part of the practice of many mental health facilities (Lebow, 1982; Thompson, 2003). This development results from the merging of several factors, such as the increasingly frequent use of mental health program evaluation; the movement to a more consumer-oriented society; increased financing of treatment by government and third party payment like medical aids and medical insurance, as well as the broadened make-up of the clientele. This change is evident in the increasing number of papers published that relate to client satisfaction pertaining to the health-care field (Gill & White, 2009; Kravitz, 1998; Rivers & Glover, 2008). Kurti (2015) indicated that the assessment of patient satisfaction was studied extensively over the past decade and cited 3038 publications in PubMed of which 85% were published since 1993. It indicates a growing interest in this category of research (Branson, Buxton, & Fryman, 2014; Williams, Coyle, & Healy, 1998). The significance thereof lies not only in the data presented, but also in the far more important concept of the client partaking in their own health care. Furthermore, it is crucial to accentuate that, as already reiterated, none of the available research was conducted in a South African context.

The consumer revolution in health care has had numerous favourable outcomes (Rivers & Glover, 2008). Patients are nowadays more than ever actively involved in the decision-making process, not only by selecting health-care plans and service providers, but also by participating directly in judgements about their treatment options (Popovic, Milne, & Barrett, 2007). The dawning of the twenty-first century as the information age has equipped clients with knowledge and has positioned them to evaluate and understand previously inconceivable material better (Slywotzky, 2015). Clients are presently better informed than ever before and are therefore routinely asked to evaluate the quality of services they receive (White, 2008). A secondary effect of this revolution in the evaluation of service quality is an

increasing scholarly interest in evaluating and understanding the increased participation of patients regarding their own health care.

A further constructive consequence of the consumer revolution in health care follows the introduction of evidence-based practice in psychology. Evidence-based practices reduce errors in clinical inference by restraining clinical selections to interventions that have research support (Lilienfeld, Ritschel, Lynn, Cautin, & Latzman, 2014). In addition, it increases the chances that clients will receive effective treatments and decreases the chance that clients will be exposed to ineffective interventions, directly harmful interventions (iatrogenic interventions), or indirectly harmful interventions as a result of opportunity costs incurred by the loss of time, effort, or resources that could have otherwise been invested in effective interventions (Lilienfeld et al., 2014). The goal of evidence-based practice is thus not to eliminate all error but to minimise error, and, analogous to all respectable science, it is in principle self-correcting. As improved treatments become available, they will eventually displace less effective interventions (Lilienfeld et al., 2014). Evidence-based, empirically validated treatment requires practitioners to consistently evaluate and utilise the best available research in order to meet client satisfaction (Berke et al., 2011).

Health-care providers and researchers alike have interminably believed that clients would be satisfied with good services and dissatisfied with poor services (Amyx, Mowen, & Hamm, 2000). However, research findings indicate that the actual experience (of satisfaction) represents only one of several factors that determine whether a client is satisfied or dissatisfied with their health care (Jimmieson, 1998). A client's expectations, prospects, personal characteristics, health status, and physician choice subject to managed health-care insurance plans also constitute client satisfaction and play a vital role in clients' appraisal of their satisfaction with health care (Amyx et al., 2000; Kravitz, 2001; Pascoe, 1983). Moreover, certain aspects of a client's health-care experience appear to be more influential

than other aspects (Frattali, 1991). The freedom to choose a physician may not be as important to patients as originally thought (Amyx et al., 2000). Patients who not only had their freedom of choice violated but also received a nonpreferred physician (choice rejected), were least satisfied. Amyx et al. (2000) found that regardless of choice offering, the satisfaction level among “good-outcome subjects” was higher than the satisfaction of “bad” health-related outcome subjects. It would seem as if the process leading to an outcome becomes less important if the outcome is positive, yet the process becomes more important if the outcome is negative (Amyx et al., 2000; Meyer & Zane, 2013).

The consumer’s view as an assessor of treatment has merit and remains indispensable. The client has a unique vision of the treatment process and an imperative conception of the quality of service (Donabedian, 1988; Kurti, 2015). In general, the consumer can be expected to make a reasonable ruling about the suitability of service. Consumer satisfaction is also widely regarded by clients as an important goal of treatment (Hudak, McKeever, & Wright, 2003). Psychological treatment should therefore be judged equally by whether clients obtained what they sought and were satisfied with their experience in the same manner as evaluation of other service areas are determined by such considerations. A strong argument for the importance of satisfaction as a crucial treatment goal can thus also be made (Bovbjerg, et al., 2009; Donabedian, 1988). The appropriate examination of client-treatment interactions in relation to satisfaction should lead to better matching of client and therapist. Despite the widespread use of consumer evaluation in mental health settings, coherent literature has yet to develop (Kurti, 2015; Lebow, 1982).

1.2.1 Defining *Client Satisfaction*

The quest to determine the nature of clients’ satisfaction with psychological treatment, leads one to ponder how clients delineate satisfaction. From the client’s perspective,

satisfaction can be seen as an evaluation of the quality of care, as a conclusion, as well as an outcome variable in its own right (Donabedian, 1980), and furthermore as an indicator of weaknesses in service (Frattali, 1991). Within this framework of patient-centred health care, client satisfaction emerged as an important indicator of the quality of client care (Hush, Cameron, & Mackey, 2011). The significance of this dominant paradigm is further emphasised by the evidence that satisfied clients are more likely to adhere to treatment, benefit from their health care, and have a higher quality of life (Walker, Ristvedt, & Haughey, 2003). By targeting the aspects of psychotherapeutic treatment that clients consider of utmost importance, clinicians may optimise client satisfaction and the quality of care that, in turn, is in keeping with quality assurance, accreditation, and the ethical competency of the practitioner. Satisfying clients in a competitive marketplace, therefore, benefit health-care facilities, shareholders, psychologists, and clients equally (Newsome & Wright, 1999).

Kravitz (1998) sees patient satisfaction not as a single or uniform entity, but rather as a distillation of perceptions and values. Perceptions form the patients' beliefs about occurrences that reflect what happened, whereas values are seen as the weights patients apply to those occurrences and reveal the degree to which patients consider specific occurrences to be desirable, expected or necessary (Kravitz, 1998). Most literature (Frattali, 1991; Gill & White, 2009; Hsieh & Kagle, 1991; Kravitz, 1998) on client satisfaction holds in agreement that client satisfaction is a multifaceted concept. According to Frattali (1991), it relates to *technical* and *interpersonal aspects of care*, as well as the *amenities of care* (such as physical environment, location, and parking). The goals and values of patients diverge and differ extensively (Gill & White, 2009); they are unpredictable when based only on demographics and disease factors, and therefore give cause to undergo change (Frattali, 1991). Thus, the only means to determine what patients want and whether their needs are being met is to enquire about them (Donabedian, 1980). Starting from this standpoint and viewing, care

through the patient's eyes becomes an ethical and professional imperative (Hush et al., 2011; Kravitz, 1998).

By the 1980s, Donabedian, arguably the leading theorist in the area of quality assurance, had already emphasised the fundamental importance of client satisfaction as a measure of the quality of care. He noted that it offers information on the providers' success at meeting those client values and expectations that are essential. Moreover, the client is the ultimate authority on these matters. He also indicated that a client's evaluation of quality, expressed as satisfaction or dissatisfaction, could be extraordinarily meticulous. He stated, "It could pertain to the settings and amenities of care, to aspects of technical management, to features of interpersonal care, and to the physiological, physical, psychological, or social consequences of care. A subjective summing up and balancing of these detailed judgements would represent overall satisfaction" (p. 25).

Over the years, there have been various definitions of patient satisfaction. According to Hawthorne (2006) and Gill and White (2009) the main theories concerning patient or client satisfaction were published in the 1980s. The more recent theories are largely reiterations of those theories. The five key theories as acknowledged by Gill and White are as follows:

- The discrepancy and transgression theory of Fox and Storms (1981) advocated that patients' health-care orientations differ and provider conditions of care differ. They believed that if orientations and conditions were congruent, patients were satisfied; if not, the patients were dissatisfied.
- The expectancy-value theory of Linder-Pelz (1982) postulated that satisfaction was mediated by personal beliefs and values about care, as well as prior expectations about care. Linder-Pelz identified the important relationship between expectations and variance in satisfaction ratings. It offered an operational definition for patient satisfaction as "positive evaluations of distinct dimensions of health care" (p. 578).

The care being evaluated might be a single clinic visit, treatment throughout the course of an illness or episode, a particular health-care setting or plan, or the health-care system in general. The Linder-Pelz model was developed by Pascoe (1983) to take into account the influence of expectations on satisfaction and then further established by Strasser, Aharony, and Greenberger (1993) to create a six-factor psychological model: cognitive and affective perception formation; multidimensional construct; dynamic process; attitudinal response; iterative; and ameliorated by individual difference. This model includes both the emotional and intellectual perceptions of the client who reflects actively or subconsciously upon his or her treatment, whilst acknowledging that it comprises more than one facet of individual consumer motives and needs.

- The determinants and components theory of Ware, Snyder, Wright, and Davies (1983) proposed that patient satisfaction was a function of patients' subjective response to experienced care mediated by their personal preferences and expectations. Such dimensions include "the art of care", which focusses on the personality attributes of the health provider; "technical competence", or patients' perception of the provider's knowledge and expertise; "the physical environment" as perceived by the patient; and "efficacy of care" (p. 670), or the client's perception of outcome (Ware, Davies-Avery, & Stewart, 1977).
- The multiple models theory of Fitzpatrick and Hopkins (1983) argued that expectations were socially mediated, reflecting the health goals of the patient and the extent to which illness and health care violated the patient's personal sense of self.
- Donabedian's healthcare quality theory (1980), proposed that satisfaction was the principal outcome of the interpersonal process of care and a heavy contributor to

the definition of quality from the perspective of clients' values and expectations. He argued that the expression of satisfaction or dissatisfaction signifies the patient's judgement on the quality of care in all its aspects, but particularly in relation to the interpersonal component of care.

The paucity of recent research regarding client satisfaction, in spite of being a very contemporary issue, is noteworthy. The latest theories with regard to satisfaction in health care acknowledge that consumers are no longer considered purely subservient patients. Patients are now regarded as health-care customers, hence recognising that individuals consciously choose to purchase a service. Client satisfaction today recognises providers that best meet their health-care needs; it acknowledges the fact that the health-care delivery system is an extremely competitive market (Barton, 2010), and it accepts health care as driven by the demands of busy clients to provide them with useful information and involves them in decision-making (Wadhwa, 2002). In the context of this research project, it was significant that no current theories could be found.

Davis and Hobbs (1989) defined client satisfaction as the extent to which a program fulfils clients' treatment expectations. They identified *access to care* (e.g. signs and direction to treatment facility, waiting room time, clinic hours); *the physical environment* (e.g. cleanliness of reception area, noise level, and condition of treatment space) as well as *care received* (i.e. human, clinical, and outcome aspects) as three of the most important components or dimensions of client satisfaction that allow an accurate measurement.

Corsini (2002) outlines client satisfaction as follows:

“... the degree to which persons paying for a service are happy with the result. When professional or other personal services are offered in any field, a major criterion of quality of service is satisfaction expressed by clients. Satisfaction is behaviourally demonstrated by the clients returning for additional sessions

and by referrals to other clients. However, satisfaction is not necessarily evidence of quality of service” (p. 5).

Thus, client satisfaction can be defined in more detail as an outcome measure (May, 2002) that in turn can be subdefined as a clients’ satisfaction with outcome and clients’ satisfaction with the care. Outcome satisfaction pertains to the results of the treatment clients had received whereas care satisfaction concentrates on satisfaction with the services that they had received.

However, clients begin to develop their impression while phoning for an appointment, as well as immediately after they step into a counselling centre (Chao, Metcalfe, Lueck, & Petersen, 2004). Thus, clients’ satisfaction is considerably more comprehensive than what is covered by narrow outcome evaluations. The results of a study by Chao et al. (2004) supported the hypothesis that clients’ overall satisfaction would significantly relate to their reactions of counsellors’ interventions, as well as to systematic aspects. Beyond psychological interventions, clients’ satisfaction is also related to their positive or negative perception of the *entire systemic experience* and arises from effective collaboration among all elements in the counselling centre. Thus, some researchers have encouraged adopting a broader definition of client satisfaction (Pascoe, 1983). These findings suggest that counselling centres need to pay an appropriate quantity of attention to paraprofessional personnel as well as the entire system. Psychologists alone are not responsible for clients’ satisfaction, for counselling is a shared cooperative operation with the comprehensive system of the counselling centre. The counselling centre as a whole has a holistic and dynamic impact on clients. Thus, a working definition of client satisfaction needs to conceptualise and address philosophical, empirical, and practical challenges.

The developers of the included scale defined patient satisfaction as an important institutional consideration. This implies essential patient-level outcomes that are influenced

by elements such as expectations, clinical and socioeconomic factors; quality factors such as waiting times, as well as previous experiences.

The following composite definition is proposed and accepted for this study.

Patient satisfaction is

- a multi-dimensional construct, dynamic, continually altering and an iterative process of cognitive, affective and conative perception formation;
- an attitudinal response enhanced by individual difference, which culminates in positive evaluations, ameliorated by prior expectations of distinct dimensions of health care;
- a construct whereby quality, expressed as satisfaction or dissatisfaction, could pertain to settings and amenities of care, to aspects of technical management, to features of interpersonal care, and to the physiological, physical, psychological or social consequences of care.

1.2.2 Factors Influencing Client Satisfaction: Components, Dimensions, and Determinants

Current literature on client satisfaction identifies numerous variables and factors accompanying the present paradigm of client satisfaction. The WHO determined as many as eight aspects of consumer satisfaction pertaining to health care. They are defined as autonomy; choice; communication; confidentiality; dignity; quality of basic amenities; prompt attention; and access to family and community support (Brunero, Lamont, & Fairbrother, 2009). Generally, these variables or factors may be grouped into two classes: factors that affects client satisfaction negatively or cause dissatisfaction; and variables that correlate with fostering positive or constructive satisfaction, thus enhancing or enabling client satisfaction.

Areas frequently identified as the source of client dissatisfaction include lack of communication or explanation by the care provider, the amount of time devoted to the client, and the lack of provision of continuity of care. Client concerns also have a propensity to revolve around the existing facilities, access to health care, and cost. Apprehensions encompassing satisfaction involve administrative aspects or nonclinical issues (such as location, distance, and parking), the quality of client and clinician interaction, empathy, the provider's skills, and receiving adequate information. Another common cause of client dissatisfaction is associated with poor service or receiving inadequate care from the clinician or staff.

A number of enabling variables have been found to correlate with clients' satisfaction. Some of them include adherence to a treatment program, as well as a self-rated improvement program. Boshoff and Gary (2004) found that health providers who are cheerful and demonstrate kindness could earn satisfaction. Courteous, highly skilled, and prompt service providers enhance and satisfy the needs of their clients (Holikatti et al., 2012). A satisfied client is also more likely to return to such a care provider and health-care facilities.

An abundance of literature exists that emphasises the importance of quality in the therapist-client relationship (Habbal, 2007; Holikatti et al., 2012; Kim, Kaplowitz, & Johnson, 2004). Interaction between clinician and client strongly relates to client satisfaction. Therapists who demonstrate concern when listening, having good communication skills, and provide clear explanations on treatments promote clients' satisfaction with the service (Beattie, Pinto, Nelson, & Nelson, 2002).

Clients' perceptions on treatment benefits have also been found to be influenced by their predetermined expectations (Lateef, 2010). The literature further indicates that clients' personal beliefs concerning the efficacy of treatment are significant in determining their treatment compliance (Bowling et al., 2012; Patterson, Anderson, & Wei, 2014). Where

clients believe that their problems are worse than they really are, this perception may reduce their expectations of improvement, which in turn may reduce their motivation to manage their own problems. Furthermore, preconceived client expectations have been shown to influence their needs and satisfaction. The latter topic will be considered in more detail in the section on Client Expectations (1.3).

Donabedian (1988) highlights the decision regarding the definition of quality (of care) with the statement that "... detailed information about the causal linkages among the structural attributes of the setting in which care occurs ... as well as the process of care and the outcomes of care" (p. 1145), are needed when deciding how to define quality. Regarded as such, *quality of care*

- is dependent on the initial assessment of the performance of practitioners;
- takes into account the contributions of patients and of the health-care system;
- considers whether one seeks maximally effective or optimally effective care; and
- considers whether individual or social preferences define the optimum.

According to Donabedian (1988), factors such as the performance of the health-care practitioner and the amenities of care (the desirable attributes of the setting in which care is provided, including amongst others, convenience, comfort, quiet, privacy and so on) constitute elements of the quality of care. As such it encompasses factors like confidentiality (safety), environment (setting), the service quality, therapist-client relationship, trust, professionalism, and humour. Linder-Pelz (1982) also suggested ten constructs that should be used to determine satisfaction, namely, accessibility or convenience, availability of resources, continuity of care, efficacy or outcomes of care, finances, humanness, information gathering, pleasantness of surroundings, and quality or competence.

Most noteworthy literature on client satisfaction also identifies the following significant factors as relating to client satisfaction:

- satisfaction with the therapist (Holikatti et al., 2012);
- therapist intent and confidentiality (Prakash, 2010);
- felt importance, closeness, meeting needs (Hatamizadeh, Jafary, Vameghi, & Kazemnezhad, 2012);
- satisfaction with overall care, outcome (Hatamizadeh et al., 2012);
- satisfaction with problem solving (Chimbindi, Barnighausen, & Newell, 2014);
- clinic service, clinic access (Chimbindi et al., 2014; Hatamizadeh et al. 2012);
- staff responsiveness, staff behaviour (Chimbindi et al., 2014; Hatamizadeh et al. 2012);
- centre accountability (Chimbindi et al., 2014; Hatamizadeh et al. 2012); and
- medicines (Chimbindi et al., 2014; Hatamizadeh et al. 2012).

Along with patient expectation, researchers (Gigantesco, Picardi, Chiaia, Balbi, & Morosini, 2002; Holcomb, Parker, Leong, Thiele, & Higdon, 1998; Mavrogiorgou, Siebers, Juckel, & Kienast, 2013; Tempier, Pawliuk, Perreaut, & Steiner, 2002) have linked the following aspects to patient satisfaction with health care:

- socio-demographic factors (Naidu, 2009);
- health status (Holikatti et al., 2012);
- specific psychiatric diagnosis or diagnostic category (Holikatti et al., 2012);
- informing adequately both clients and their relatives (Prakash, 2010); as well as the
- mode of service delivery.

Furthermore, the components or determinants of client satisfaction as discussed in the following subsection were also identified from the literature and remains vital when assuring better quality and client satisfaction.

1.2.2.1 Patient Choice

The majority of the literature studying patient choice in relation to satisfaction, for instance, clients having the freedom to choose their physician (Amyx et al., 2000; Pifer et al., 2003) indicate a positive relationship between a client's freedom of choice and their satisfaction. Choice of service provider is generally associated with higher client satisfaction. Care provided under the fee-for-service (FFS) arrangements generate greater satisfaction than those delivered with prepaid schemes (Amyx et al., 2000). FFS is a payment model where services are separated and paid for individually. In health care, it gives an incentive for physicians to provide more treatments because payment is dependent on the quantity of care, rather than quality of care. The relationship between patient satisfaction and mode of service delivery, usually fee-for-service (FFS) versus prepaid group practice (PPG) or managed care, has been widely studied. Research findings indicate that patients who receive services under FFS arrangements generally report higher levels of satisfaction than do those who use PPGs (Amyx et al, 2000; Pifer et al., 2003; Reschovsky, Hadley & Landon, 2006). However, when satisfaction is broken down into different aspects of care PPG enrollees report less satisfaction with travel time and the time-lapse between making an appointment and the appointment date. Nevertheless, they report higher satisfaction with health-care costs (Amyx et al., 2000; Pifer et al., 2003; Reschovsky et al., 2006).

Amyx et al. (2000) highlight the following theories to explain this positive relation between choice and satisfaction:

- The effects of individual choice can be traced to Festinger's cognitive dissonance theory (1957). It states that there is a tendency for individuals to seek consistency among their cognitions (i.e., beliefs, opinions). When there is an inconsistency between attitudes or behaviours (dissonance), something must change to eliminate the dissonance. Much of his work hinges on individual volition and personal responsibility to maintain a state of cognitive consistency (McLeod, 2008).
- The reactance theory as proposed by Brehm (1966), states that psychological reactance occurs in response to threats to perceived behavioural freedoms and that individuals respond in a negative manner when important freedoms are threatened or lost.
- Kelley's attribution theory (1967) deals with how the social perceiver uses information to arrive at causal explanations for events. It examines what information is gathered and how it is combined to form a causal judgment (Fiske & Taylor, 1991); in other words, how one attaches meaning to other's behaviour or to one's own (McLeod, 2008).
- Oliver's model of expectancy disconfirmation (1981) and the gap theory (Parasuraman, Zeithaml, & Berry, 1985) may also be used in explaining choice and satisfaction. Both the above theories originate from consumer research. It posits that satisfaction refers to the extent to which a person is pleased or contented with a service or product after having gained direct experience with the service and is influenced by disconfirmation of beliefs and perceived performance. Such an inference implies a discrepancy between what is communicated to the customer and what is delivered (Amyx et al., 2000).

1.2.2.2 Demographic Characteristics

The relation between client characteristics and satisfaction has been examined by a few studies (amongst others, Doran et al., 2007; Goncalves & Sampaio, 2012; O'Neill, 1994). These studies suggest that demographic characteristics are not good predictors of satisfaction, and that age, gender, marital status, income, and education have been found to be unrelated to, or at least inconsistent regarding the degree of satisfaction a client experiences (Alrubaiee & Alkaa'ida, 2011; Naidu, 2009, Robinson, Shaver, & Wrightsman, 1991). In various studies researchers identified only a single demographic variable, namely race, as related to satisfaction. However, no such relation has been detected in several other relevant studies (Barr, 2004). Where race has been found to be important, minority groups have been less satisfied (Meyer & Zane, 2013). This might be because the majority of measurement instruments have been developed in a Western context.

Socio-economic status has also been a topic of some interest. In some studies researchers reported that low-income patients are more cynical and less satisfied with medical care than are other groups (Hulka, Kupper, Daly, Cassel, & Schoen, 1975; Jin, Sklar, Oh, & Li, 2008; Nabbuye-Sekandi et al., 2011; Suchman, 1964). This might be because these low-income groups generally utilise government health services.

Factors such as literacy levels, difficulties with language proficiency or educational status, intellectual and physical or sensory disability, ethnic and cultural diversity, financial status, demographics (urban or rural), and even technological exposure of users should be taken into account when including patient satisfaction mechanisms in health-care systems (Hubbeling & Bertram, 2014; Kishor, Pal, Lodha, & Vishal, 2011; Saha, Beach, & Cooper, 2008). This not only entails the capacity of the user to understand what is being asked of them, but also their ability to communicate their options and feelings effectively and without fearing the consequences of articulating it (Hubbeling & Bertram, 2014; Kishor et al., 2011).

Age was found to be an influencing factor in client satisfaction to the extent that older respondents generally recorded higher satisfaction (Alrubaiee & Alkaa'ida, 2011; Jackson, Chamberlin, & Kroenke, 2001). Although a negative relationship between age and patient satisfaction was reported by Jackson et al. (2001) and Hulka et al. (1975), most researchers established that elderly patients are more likely to indicate a marked satisfaction with their health care than younger groups tend to do (Jackson et al., 2001; Linn, 1975; Linn & Greenfield, 1982).

Evidence about the effects of gender, ethnicity, and socioeconomic status is equivocal due to the small amount of literature available on each theme (Nabbuye-Sekandi et al., 2011). In most studies patient satisfaction are reported to be unrelated to the patient's gender (Hulka, Zynanski, Cassel, & Thompson, 1971; Linn, 1975; Linn & Greenfield, 1982). However, in some studies it is reported that women are more satisfied with their health care than men are (Hasler et al., 2004; Hulka et al., 1975; Ware et al., 1977).

In the 2004 study by Hasler et al., a decrease in symptoms and changes in the interpersonal domain were important results related to patient satisfaction. Initial research showed that coping with specific problems and symptoms is associated with satisfaction among male patients, whereas interpersonal changes seem to produce satisfaction among female patients (Hasler et al., 2004).

1.2.2.3 Diagnosis of the Patient

Psychological, diagnostic, and prognostic client variables in relation to satisfaction appear to be more auspicious. Regarding drug abusers, suicidal clients, psychotic clients, and clients with poor prognoses, satisfaction is often reported to be lower (Holikatti et al., 2012; Mitchell, Garand, Dean, Panzak, & Taylor, 2010; Zhiwei, Gerstein, & Friedmann, 2008).

Diagnosis may very well relate to the expectations held by the client and thus influence general satisfaction.

1.2.2.4 Health Status

The patient's health status has also been found to correlate significantly with ratings of satisfaction. Typically, patients who report poor health also report lower levels of satisfaction (Jin et al., 2008; Linn & Greenfield, 1982; Patrick, Scrivens & Charlton, 1983; Stratmann, Block, Brown, & Rozzi, 1975). Jackson et al. (2001) have linked illness to lower levels of satisfaction, but this might be because it has proven difficult to distinguish between the experience of sickness and the experience of health service treatment, or other factors as causes of dissatisfaction. Satisfaction with the outcome may very well be a determining factor in health status.

1.2.2.5 Interpersonal Relationships

There is reliable proof in literature that throughout multiple settings the most important factor affecting health service satisfaction is the client-practitioner relationship (Garety et al., 2006). Crowe et al. (2002) highlighted that there is consistent evidence across settings that the most important determinants of satisfaction are the interpersonal relationships and their related aspects of care. Patients seem to place significant value on physician empathy when considering satisfaction (Derksen, Bensing & Lagro-Janssen, 2013, Kim, Kaplowitz, & Johnson, 2004). Empathy is a decidedly subjective factor, but is not exclusively personality driven. A few specific actions could make a significant difference between being perceived as sincere and caring, or unsympathetic and callous (Richmond et al., 2012). Examples are if the client feels understood and accepted by the clinician when the practitioner has the ability to comprehend the client's mental state accurately, as well as to

communicate effectively (Kim et al., 2004). If patients feel that one spends an adequate quantity of time listening to all their concerns, they will perceive you as kind and caring. Furthermore, research on physicians' body language in the clinical setting indicates that a seated position with one's torso and legs facing the patient is significant for establishing collaborative interaction and demonstrating active listening (McEwen & Harris, 2010).

1.2.2.6 Waiting Time

Another key factor for patients seems to be waiting time. Clients do not want to wait at any time during the therapeutic experience. It includes registration, room placement and treatment by the physician (Bleustein et al., 2014). Waiting time is mostly beyond one's immediate control, but from a patients' perspective, the only thing worse than waiting is waiting without explanation (Soremekun, Takayesu, & Bohan, 2011).

1.2.2.7 Quality and Quality of Care

Mosadeghrad (2012) reported that various health-care stakeholders all have different perceptions of the important attributes of quality health care. Furthermore, it identified five attributes of quality in health care. These five dimensions, or the five-E model, were: *Effectiveness* (that refers to meeting customer expectations); *Efficacy* deals with the extent to which the provider's objective of providing the service has been achieved; *Efficiency* of health-care services affects the utilisation of resources for providers and service affordability for customers; *Environment* (e.g. amenities), and *Empathy* (e.g. interpersonal relationships). It is also consistent with other research that found different perceptions on essential dimensions of quality in health care (Grimmer, Sheppard, Pitt, Magarey, & Trott, 1999; Kerssens, Groenewegen, Sixma, Boerma, & van der Eijk, 2004). The interpretation of clinicians and clients about quality of care can differ immensely. While clinicians are known

to define quality mainly by their technical skills, clients are inclined to define quality by a clinician's interpersonal skills (Frattali, 1991). Patients' satisfaction also has some limitations as a measure of quality, because clients generally have an incomplete understanding of the science and technology of care, so that their judgments concerning these aspects of care could be faulty (Habbal, 2007). Moreover, clients sometimes expect and demand things that would be wrong for the practitioner to provide because they are forbidden professionally or socially, or they are not in the client's best interest (Habbal, 2007). One could argue, in these instances, that the practitioner has failed to educate the client properly (Kessels, 2003; Prakash, 2010). These limitations do not however lower the validity of patient satisfaction as a measure of quality, but they are the best representation of certain components of the definition of quality, namely those that pertain to client expectations and valuations.

1.2.2.8 Other

Returning to the same program for further treatment has also been linked to reduced satisfaction (Frattali, 1991). This might be linked to the expectations of the client as it pertains to the outcome. Prior experiences of satisfaction with health care, as well as granting clients' desires have also been linked to client satisfaction (Hsieh & Kagle, 1991). Again, client expectations may play a prominent role in contributing to the level of satisfaction experienced.

The above factors suggest that different groups have different expectations and diverse perceptions of the health-care system. According to Hsieh and Kagle (1991), it is doubtful that "... older patients, women, members of higher socioeconomic groups, those who are in good health, and those who select FFS models of service all perceive health care more favourably because they receive better health care. It is more likely that their

satisfaction is linked to different expectations and to having their positive expectations fulfilled” (p. 3).

1.3 Client Expectations

Anthropological literature holds various examples in which the mental representation of humans influenced their feelings and behaviour. Placebo control studies also provide further evidence for the impact of expectations on subsequent therapeutic treatment. Client expectations are therefore an important ingredient of psychotherapeutic change (Kirsch, 1990). The following is a discussion on the nature of clients’ expectations, the types of expectations, empirical findings on expectations, as well as clinical strategies for fostering and responding to client expectations as it pertains to psychological treatment.

The terms *satisfaction* and *quality assessment* are often used interchangeably and while they do correspond on certain levels, satisfaction is largely seen to be the broader concept that can be viewed at the individual or more global level, and encompassing all experiences with an organisation. Perceived quality is just one of a number of antecedent factors driving satisfaction and can occur in the absence of actual experience with an organisation – it is “perceived” quality that is important but this will always be subjective. The disconfirmation theory (Amyx et al., 2000; Oliver, 1981) proposes that the higher expectations are, the less likely it is that the service or product can meet or exceed them, resulting in reduced satisfaction. The higher the perceived level of performance, the more likely those expectations will be exceeded, the result being increased satisfaction. Several studies have found that satisfaction relates to the fulfilment of client expectations (Bjertnaes, Sjetne, & Iversen, 2011; Bowling et al., 2012; Duckro, Beal, & George, 1979; Gladstein, 1969).

As previously stated, client expectations play an important role in the process by which an outcome of care can be said to be satisfactory or unsatisfactory. The research on both health care and mental health care, as well as the literature on the service marketing industry (Gill & White, 2009) indicates that satisfaction is influenced by expectations (Palazzo et al., 2014; Swift & Callahan, 2009). Clients bring to any evaluation process a set of expectations that result from their beliefs about idyllic or anticipated situations (Miller & Turnbull, 1986). Clients have certain positive expectations of the care that they will receive. When experience fulfils these expectations, patients are likely to be satisfied; when experience fails to meet expectations, patients may be dissatisfied (Duckro et al., 1979; Kurti, 2015; Larsen & Rootman, 1976; Noble, Douglas & Newman, 2001).

1.3.1 Defining Client Expectations

According to Palmer, Donabedian, and Povar (1991), *client satisfaction* can be defined as a judgement made by a recipient of care as to whether their expectations for care have been met or not. Whilst in agreement with this description, client expectations regarding psychological treatment refer to the anticipatory beliefs about what is to be encountered or experienced during a consultation or in a health-care system (Lateef, 2010). It can be thought of as attitudes or the visualisation that clients hold concerning the process of interaction with the treatment. These perceived occurrences and authentic interactions during, or because of, therapy produce care-related evaluations (Kravitz, 1998).

Expectations for psychotherapy can be defined as clients' anticipatory beliefs about the contributions of both the therapist and client in therapy (Nock & Kazdin, 2001), and include outcome expectations and treatment expectations. The former concerns the likelihood of treatment success, where the latter relates to the role and process of the therapeutic work (Constantino, Glass, Arnkoff, Ametrano, & Smith, 2011).

The developers of the included scale defined patient expectations as two broad classes of expectations, namely, expectations about the process of therapy and expectations about the outcome of therapy. *Process* referred to patients' beliefs about what will happen during therapy and it includes the behaviours of the therapist and client (role expectations), the procedures that will occur, and the length of treatment. Outcome expectations (prognostic expectations) referred to patients' expectations for improvement and expected helpfulness of therapy.

The following composite definition is proposed and accepted for this study: *Client expectations are judgements and beliefs about experiences during psychological treatment. It encompasses attitudes and conceptions about the process of collaboration between client and therapist, and the culmination of said process.*

According to Patterson et al. (2014), the role of treatment expectations in psychotherapy is important in that

- it has a powerful influence on the perceptions and experiences of individuals;
- it shapes an individual's interpersonal relationships;
- it can be modified with relative ease; and
- it reflects a pan-theoretical construct, encompassing all theories, and thus the implications for research are likely to be relevant for the majority of clinicians and clients, regardless of the specific intervention being delivered.

Clinical significance is another meaningful way of assessing change in therapy.

Clinical effectiveness is determined by the reduction of symptoms, the increase of functionality, as well as whether scores for a treated group are significantly better than scores for a control group (Kazdin, 1999). Unfortunately, repeated measurements are expensive and time-consuming. An inexpensive approach to outcome evaluation can be seen in the Consumer Reports (CR) on mental health service-outcome surveys of over four thousand CR

readers. Seligman (1995) praised this survey as an ideal study of the effectiveness of psychotherapy. A composite of three items were used to assess clinical effectiveness, namely,

- (i) satisfaction (“Overall, how satisfied were you with the therapist’s treatment of your problems?”);
- (ii) specific improvement (“How much the treatment helped with the specific problem that led you to therapy?”); and
- (iii) global improvement (How informants described their “overall emotional state” at the time of the survey compared with the start of treatment).

The two constructs assessed are satisfaction with treatment and perceived improvement. In addition, clinical significance holds social importance in the sense that it has a built-in emphasis on behavioural change. Thus, helping clients develop and maintain appropriate prognostic expectations is an important clinical process that should be a goal of all therapies (Swift & Derthick, 2013).

In order to explain the above-mentioned differences and contradictions more thoroughly, researchers communicate a more comprehensive outlook on the term “expectations”. Comprehending that consumers can and do hold several different types of expectations and that these are characterised by a range of levels, rather than a single level.

1.3.1.1 The Content of Client Expectations

The primary hypothesis that patients’ expectations are the best predictor of satisfaction was supported by the study of Hsieh and Kagle (1991). In several studies, it is reported that satisfaction is related to the fulfilment of client’s expectations, and that this relationship is conceivably affected by numerous additional variables (Anderson, Patterson, McClintock & Song, 2013). According to Newsome and Wright (1999), several studies have also found that the effects of expectations differ under different conditions, between

consumer groups, across different product categories, and between products and services. It can thus be surmised that client satisfaction or dissatisfaction is a complex phenomenon. Research furthermore found that health status, personal characteristics, and health system characteristics were not strong predictors of satisfaction (Hsieh and Kagle, 1991). These findings suggest that patients may construct their evaluations based on sophisticated expectations and that those expectations differ from one client or socio-demographic group to another.

Concerning services, Bitner, Faranda, Hubbert and Zeithaml (1997), distinguish between three types of expectations, namely desired, adequate, and predicted services. The first is defined as the level of service the customer hopes to receive; the *wished-for* level of performance (blending what the customer believes can be and should be). Customers hope to achieve their service desires, but recognise that this is not always possible. For this reason, they hold a second, lower-level adequate service expectation representing the minimum tolerable expectation or bottom level of acceptable performance. *Predicted service* refers to the level of service customers believe they are likely to get and implies some objective calculation of the probability of performance.

Bitner, Faranda, Hubbert and Zeithaml (1997) maintain that customers recognise that service performance may vary and that the extent to which they distinguish and are willing to accept this variation is called the *zone of tolerance*. Predicted service could parallel either adequate or desired service in theory, but it is most likely to fall between the two and hence within the zone of tolerance. The zone of tolerance is seen as the range or space in which the customer does not particularly notice service performance. Once performance falls outside the range, the customer expresses satisfaction (very high) or dissatisfaction (very low). Customer tolerance zones are thought to vary for different service attributes and the more

important the factor (e.g. service outcome – the result of service), the narrower the zone of tolerance is likely to be (Bitner, Faranda, Hubbert, & Zeithaml, 1997).

According to Harper Petersen (1989), the following aspects of care are found in the professional literature as significant components of clients' expectations: being comfortable; being treated as a mature individual; getting information about what will happen; learning how to participate in care; feeling safe; needing reassurance; feeling more in control; decreasing stress, and having staff available to listen. Much of the research in health and mental health fields has studied the relationship between patient satisfaction and the behaviour and manner of the provider (Jackson et al., 2001; Lebow, 1983; Ware et al., 1977).

This effect was clearly demonstrated in a study where Korsch, Gozzi, & Francis (1968) found that mothers who perceived paediatricians to be friendly expressed a higher level of satisfaction with care. Moreover, the mothers who expected to learn the cause and nature of their children's illness but did not, were likely to be dissatisfied. Similarly, Noyes (1974) found that if gynaecology patients' positive expectations of their physicians were fulfilled, they were more likely to be satisfied. Larsen and Rootman (1976) found that the more the physician's role performance met a patient's expectations, the more satisfied the patient was with the physician's services.

Linder-Pelz (1982) found a statistically significant relationship between a patient's expectation of physician's conduct and both general satisfaction, and satisfaction with the physician's conduct. According to the study by Ankuta and Abeles (1993), symptom relief appears to be associated with client satisfaction concerning therapy outcome. In this study, the members of the group that changed moderately to not at all were less satisfied with their therapy. The results suggest that symptom relief is an important factor in the client's evaluation of therapy and satisfaction with outcome.

The above findings indicate that patients, whose positive expectations of the physician's behaviour are met, are more likely to be satisfied with the physician and with their health care in general. Physician characteristics are thus important themes related to clients' expectations. No correlation between expectation of physician's conduct and satisfaction with convenience was evident in this study.

A growing number of researchers, however, are of the opinion that patient satisfaction and consumer satisfaction are not the same thing, and that the marketing-oriented conceptual model does not easily fit, or is simply inappropriate for many medical scenarios (Newsome & Wright, 1999). Thus, the appropriate examination of client interaction with treatment as pertaining to expectations should lead to a more suitable fit of client and therapist.

1.3.2 The Components and Factors of Client Expectations

Clients bring to any evaluation process a set of expectations resultant from their beliefs about idyllic or anticipated situations (Miller & Turnbull, 1986). A client's expectations, prospects, personal characteristics, health status, and physician choice all constitute client satisfaction and play a vital role in clients' appraisal of their satisfaction with health care (Amyx et al., 2000).

Several studies found that satisfaction relates to the fulfilment of client expectations (Bjertnaes et al., 2011; Bowling et al., 2012; Duckro et al., 1979; Gladstein, 1969). Kirsch (1990) referred to client expectations as an important ingredient of psychotherapeutic change. The research in both health and mental health care, as well as the literature of the service marketing industry (Gill & White, 2009) indicates that satisfaction is influenced by expectations (Palazzo et al., 2014; Swift & Callahan, 2009). Clients have certain positive expectations of the care that they will receive. When experience fulfils these expectations, patients are likely to be satisfied; when experience fails to meet expectations, patients may be

dissatisfied (Duckro et al., 1979; Kurti, 2015; Larsen & Rootman, 1976; Noble et al., 2001).

In this context, it would appear that certain aspects of a client's experience with health care appear to be more influential in appraising satisfaction than that of others.

1.3.2.1 Far-reaching and Encompassing Expectations

Research indicates that clients' expectations may convey probabilities or ideals related to a specific visit or to current care. Likewise, the content of clients' expectations is far-reaching, and it does make a difference when expectations are elicited (Kravitz, 1998).

Individual clients who consult a clinician have their own unique expectations. These are based upon their understanding of the condition, their cultural background, health beliefs, attitude, as well as their level of comprehension (Wissing & Van Eeden, 2002). Client demographics and visit characteristics may also contribute toward client expectations. Examples of the general expectations that clients hold include the need to be listened to; to receive a clear explanation and instructions about their condition; to be treated by staff that show care, concern and compassion and who are professional in their work (Lateef, 2010).

1.3.2.2 Client, Clinician, and System Perceptions

The managing of client expectations is an essential part in ensuring the delivery of high quality, cost-effective health care (Rivers & Glover, 2008). Unrealistic client expectations, rigid clinician standards, and unattainable health-care standards may all upset the delicate balance relevant to managed health care (Lateef, 2010). A satisfactory balance should thus be achieved between client expectations and clinicians' perceptions, and priorities set out by health-care planners.

1.3.2.3 The *Expectation Construct*

In a recent study by Dagnan, Jahoda, & Kilbane (2013), it became evident that clients' views and expectations of therapy predict therapeutic outcome. These findings are also consistent with conclusions in other literature on the subject of perceptions and clients' expectations (Ardito & Rabellino, 2011; Ward & Rosen, 2000). Therapy expectancies can be defined as "anticipatory beliefs about what will happen during or because of therapy" (Garfield, 1994), which proposes separating the expectancy construct into three subclassifications as it pertains to outcome, process, and role expectancies. These will be discussed in more detail below.

- *Outcome expectancy*: Client outcome expectations are those beliefs about whether therapy will be beneficial and result in change. Clients' expectations of therapy at the time they become part of the process, might be significantly affected by the way in which therapy is offered (e.g. referred via their general practitioner). Potential clients need to understand why they are being offered therapy, what precisely is offered by means of therapy, and what to expect regarding benevolence and change. Moreover, their beliefs about the potential for change may be quite subtle. In a recent study by Jahoda et al. (2007), it was found that many of the participants thought that change was likely to occur, but that any change was expected to be fragile and unlikely to be maintained in the long run (Jahoda et al., 2007). Obtaining these kinds of insights can help to prepare the client for therapy, perhaps beginning by addressing the clients' belief in their ability to achieve and sustain change. Further, outcome expectations refer also to patients' beliefs about the consequences of receiving treatment (Constantino et al., 2011) and can be seen as a set of procedures that clients believe in as a cure.

A contemporary study by Swift and Derthick (2013) highlighted five interventions designed to foster appropriate outcome expectations. These were

- (i) presenting a convincing treatment rationale;
- (ii) increasing clients' trust in their therapists;
- (iii) expressing faith in clients;
- (iv) providing outcome education; and
- (v) comparing progress with expectations.

- *Role expectations:* Role expectations are described as beliefs about what behaviours the client and therapist will engage in during therapy. Experiences of receiving help from education, health and social care professions, as well as from other psychologists, will shape the participants' beliefs about the potential of therapy to help them achieve change (Jahoda et al., 2007). Exploring clients' views of other past and present involvements may therefore be an important part of the role expectations concerning psychological treatment. For example, Jahoda et al. (2007) found that people with intellectual disabilities are likely to have a limited understanding of the role they will be expected to take during therapy. Similarly, Garzon and Tilley (2009) hypothesised that lay approaches to Christian counselling might affect expectations of conservative Christian clients in lieu of professional psychotherapy, particularly if the clients were to expect similar interventions and roles during professional psychotherapy.
- *Process expectations:* Process expectations refer to those beliefs about procedures, the experience, and the duration of therapy. Clients generally have limited knowledge of the therapeutic process and therefore it might be difficult for clients to imagine or have a sense of what it means to work collaboratively with a therapist (Garfield, 1994). It is important to present an initial explanation of what is likely to

happen during sessions and the type of activities it may involve. Care needs to be taken to ensure that clients understand the limits of the therapeutic relationship, as well as the fact that therapy is a time-limited endeavour. Explaining the process (number and frequency of visits, types of in-session activities) and possible outcomes (reduced distress, increased functioning) of psychotherapy to clients before treatment begins is critical to success (Garfield, 1994). This type of pretreatment explanation increases engagement, reduces misunderstandings, and increases success and satisfaction. Moreover, it addresses the clients' expectations regarding the above and serves to align them with ones that are more appropriate.

1.3.2.4 Pretreatment Expectations

Clients who enter psychotherapy have certain expectations about what will happen in treatment and about the outcome of treatment (Constantino et al., 2011). Clients' pretreatment expectations are important predictors of both process and outcome in psychotherapy, where higher expectations are associated with deeper engagement in treatment and with better outcomes (Constantino et al., 2011). Positive expectations of psychotherapy are related to clients' lower distress at intake (Goldfarb, 2002), higher psychological mindedness (Beitel, et al., 2009), and higher ambiguity tolerance (Craig & Hennessy, 1989).

Assessing expectations and preferences may help psychologists to generate clinical wisdom about clients' pretreatment views. As such, it may help clients utilise treatment that in turn may increase positive psychotherapy outcomes.

1.3.2.5 Client Preferences

Clients entering psychotherapy may also have certain preferences about the therapist and the type of treatment. For example, a client might prefer their therapist to behave in certain ways or role preferences, to be of a particular demographic group (e.g. age, ethnicity, gender, or degree type), or provide a certain type of psychotherapy (cognitive-behavioural or psychodynamic therapy; Glass, Arnkoff, & Shapiro, 2001). Researchers suggest that neither role nor demographic preferences are strong predictors of outcome. However, receiving one's preferred treatment type might have a small positive effect on outcome and significantly reduce dropout (Swift & Callahan, 2009).

Clients' expectations seem to differ extensively and appear to be based upon the individual's perception of what is important for them in a given interaction with the health-care system. Some clients every so often hold expectations of the process in higher regard, whereas outcome expectations are judged as more important in other instances. Generally, clients expect friendliness, efficiency, and timely consultations from their clinicians, but also value the overall outcome. Level of education, motivation and previous interactions with the health-care system contribute to clients' expectations.

The above-discussed literature analysis focused on the nature and constructs related to client expectation and satisfaction with treatment. The constructs were discussed in the context of psychological treatment in order to clarify and define them in more detail for the reader.

1.4 Research Paradigm and Design

In this study, a quantitative research paradigm was followed, whereby the research methodology is directed by deductive measurement, analysis, and interpretation of stipulated hypotheses (Bless, Higson-Smith, & Kagee, 2007). According to Tuli (2010), quantitative

purists articulate assumptions that are consistent with what is commonly called a positivist paradigm. “Positivism sees social science as an organized method for combining deductive logic with precise empirical observations of individual behaviour in order to discover and confirm a set of causal laws that can be used to predict general patterns of human activity” (Neuman, 2000, p. 177). Researchers who utilise this perspective explain in quantitative terms how variables interact, shape and cause outcomes. Research questions guide the investigation and the researcher develops and tests these explanations in experimental studies (Tuli, 2010). Quantitative research is deductive and states a hypothesis; it involves the gathering, analysis, interpretation, and presentation of numerical data (Teddlie & Tashakkori, 2009). A single cross-sectional design will be employed. This means data will be collected at a specific time in a specific population (Saint-Germain, 2001). According to Neuman (2000), the strengths and advantages of using a quantitative style are that systematic and standardised data occurs, objective facts are measured, the focus is on variables, reliability is important, it is value free and independent of context, and the researcher is detached. The procedures are standard and replication is assumed. The advantages of employing a cross-sectional study are that it can estimate prevalence of outcome of interest because the sample is usually taken from the whole population; many outcomes and risk factors can be assessed; it is useful for public health planning, understanding disease aetiology and for the generation of hypotheses, and there is no loss to follow-up (Levin, 2006).

1.5 Procedure

The research was divided into the following phases:

During Phase 1, a thorough, critical literature analysis was conducted that focused on the nature of client satisfaction in the context of psychological treatment.

Phase 2 involved obtaining permission from HREC at the North-West University in Potchefstroom to conduct the research. The identified psychologists, who met the necessary criteria as specified in the next section, were requested to participate in the research. The request was made by e-mail and contained information on the study, such as what would be expected of them, what the benefits may be, and what the application of the findings of this study involves. The researcher then scheduled an appointment with those practitioners that indicated that they would be interested to participate in the study. During this meeting, the practitioners were given the opportunity to clarify with the researcher any questions they might have relating to the study, participation, and so forth. Only once the psychologists were completely satisfied with the process and willing to participate, they were requested to identify potential clients who meet the relevant criteria (see 1.6). They were then asked to obtain permission from the prospective participants to provide the researcher with their e-mail addresses. This allowed the researcher to contact them and explain the opportunity and the study to the likely participants. The researcher subsequently contacted the clients via e-mail to explain the aim of the research and request participation without the treating psychologist's past therapeutic role being affected. This was achieved by assuring clients of the anonymity of their results and emphasising that their former therapist will in no way be involved with or shown their individual responses. Furthermore, this procedure also ensured that the treating psychologist remained unaware of the answers provided by the clients and ensured objectivity on the parts of the researcher, participant, and the practicing psychologist. Psychologists and clients alike were assured that the results of any one specific client would not be made known to any of the psychologists. The participants were then given the opportunity to ask the researcher any questions that they might have had. Only once the participant was comfortable to proceed with participation, the relevant questionnaires were sent to the participant. Once the participant had agreed to participate and consented in writing

to all the relevant possesses, the researcher distributed the Milwaukee Psychotherapy Expectations Questionnaire, the Satisfaction with Therapy and Therapist Scale, and the Biographical Particulars Form, using the provided e-mail address.

During Phase 3, the researcher gathered and scored all the completed questionnaires.

In Phase 4, the data of the questionnaires were subsequently statistically analysed and interpreted.

Phase 5 involved reporting on the results of the study and feedback to the participants was given.

1.6 Participants and Context

The participants consisted of a target sample of 204 post-psychotherapy clients. The clients were obtained from thirteen psychologists from the private sector, practising in Gauteng and the North-West province. The sample size of the data ensured that the most prominent age clusters or groups were included in this research.

A directory listing all psychologists currently registered with the HPCSA was used to identify private practising psychologists in the relevant areas to request their participation in this study. The participating psychologists had to be currently registered with the HPCSA in either one of the before-mentioned registration categories and had to be qualified for more than three years. The number of years qualified as a psychologist was deemed of importance, as this relates to greater experience and is in keeping with the guidelines of the HPCSA regarding supervising and training of intern psychologists.

Because of the availability of the participants, this was a limited population and it was decided on a minimum of 200 participants to be able to conduct factor analysis (S. M. Ellis, personal communication, April 1, 2014).

1.7 Data Collection

The researcher distributed the Milwaukee Psychotherapy Expectations Questionnaire, the Satisfaction with Therapy and Therapist Scale and the Biographical Questionnaire to the participants. This was done using the provided e-mail address, after informed consent was provided by the participants.

1.8 Measurement Instruments

The following measurement instruments were administered:

- Biographical particulars questionnaire

A biographical particulars form was compiled in order to obtain information regarding age, gender, duration of therapy, occupation, socioeconomic status, demographics and source of referral.

- Measurement instrument for psychotherapeutic expectations

Norberg et al. developed the Milwaukee Psychotherapy Expectations Questionnaire (MPEQ) during 2011. It presented initial evidence in assessing both process and outcome expectations in therapy. The questionnaire was also established to measure clients' expectations about the components and effects of therapy. The instrument demonstrated good internal consistency and test-retest reliability, along with support for convergent, discriminant, and predictive validity (Norberg et al., 2011). Conclusions from studies indicate that patients tend to improve more in programs when they have high expectations of independence and open sharing of personal problems in an involving and expressive environment (Cronkite, Moos, & Finney, 1983). The MPEQ is the first psychometrically sound brief measure of both process and outcome of therapy. The MPEQ consists of a list of statements describing expectations about therapy that clients may have. The

statements cover expectations regarding their own behaviour in therapy, their therapist, and the therapy setting. Each statement will be scored by the participant on a scale of 1 to 5, where a score of 1 would indicate that the participant does not agree with the statement at all and a score of 5 would indicate complete agreement. Examples of statements include, “I expect my therapist will provide support”; “My therapist will be sincere”; “I will be able to express my true thoughts and feelings”, and “After therapy I will be a much more optimistic person”.

- Measurement instrument for client satisfaction with psychotherapy

The Satisfaction with Therapy and Therapist Scale (STTS-R) was developed for group psychotherapy by Oei and Shuttlewood during 1999 and designed to assess patients’ levels of satisfaction with their therapeutic endeavour (Oei & Green, 2008). The STTS-R has sound psychometric properties and as such serves as a useful instrument in assessing a patient’s level of satisfaction with both group therapy and therapist in research as well as clinical settings (Oei & Green, 2008). The STTS-R has a factor structure of a 12-item scale that is determined by way of principle components factor analysis. The statements will be scored on a scale of 1 to 5 where 1 represents “strongly disagree” and 5 represents “strongly agree”. In addition, an outcome variable question determines the client’s perception of the efficacy of the treatment. Statements include, “The therapist listened to what I was trying to get across”; “I would recommend the program to a friend”, and “I would return to the clinic if I needed help”.

1.9 Data Analysis

With the purpose of ensuring that statistically correct and appropriate procedures were followed, statistical consultations were scheduled with a statistician, Dr. S. M. Ellis, who was also a co-promotor to this study (S. M. Ellis, personal consultations, April 2016). The IBM

SPSS software package for statistical analysis was utilised to analyse and process the data obtained (SPSS Inc., 2013).

The aim of Article 1 was to determine whether the measurement instruments were valid and reliable in a South African context. In order to determine the validity of the measurement instruments, exploratory and confirmatory factor analyses were used (Hancock & Mueller, 2010; Neuman, 2000; Tabachnick & Fidell, 2001). Cronbach's coefficient alpha estimated the reliability of scales by determining the internal consistency of the test or the average correlation of items in the test (Nunnally & Bernstein, 1994, p. 295).

The aim of Article 2 was to determine the nature of clients' expectations and satisfaction with psychological treatment in a South African setting. In order to reach these aims for the second article and due to the hierarchical nature of this data, where clients are regarded as replicates for the psychologist being evaluated, hierarchical linear models were used in the analysis of this data to adjust for the non independence of data (McCoach, 2006). Hierarchical linear models were also used to examine associations of biographical variables with the expectations and satisfaction with therapy. Cohen's *d* was used to determine the practical significance of differences between groups (Price & Oswald, 2006).

The aim of Article 3 was to determine the relationship between clients' psychological treatment expectations and their psychological treatment satisfaction. In order to reach this aim for the third article, PROC SURVEYREG in SAS (SAS Institute Inc., 2011) was used to determine correlations between different subscores, taking the hierarchical nature of the data into account. *R*-square, the proportion of variance explained by variables, was also incorporated and used to determine the practical significance of correlations (Ellis & Steyn, 2003).

1.10 Research Questions and Research Hypotheses

The research questions that needed to be answered in this study were:

- Are the measurement instruments, i.e. Milwaukee Psychotherapy Expectations Questionnaire (MPEQ, 2011) and The Satisfaction with Therapy and Therapist scale (STTS-R, 1999) valid and reliable in a South African context?
- What is the nature of clients' expectations of and satisfaction with psychological treatment in a South African setting?
- What is the relationship between clients' psychological treatment expectations and their psychological treatment satisfaction?

The following research hypotheses were formulated for this thesis:

- Concerning the first article, it was hypothesised that the Milwaukee Psychotherapy Expectations Questionnaire (2011) and The Satisfaction with Therapy and Therapist Scale (1999) will be proven valid and reliable as measurement instruments in the South African context.
- The next aim was descriptive and exploratory, and therefore no hypotheses were made.
- With regard to the last research aim, it is hypothesised that an inverted proportional relationship will be found between clients' treatment expectations and their satisfaction with psychological treatment.

1.11 Ethical Considerations

The Health Research Ethics Committee of the Faculty of Health Sciences (HREC), North-West University (Potchefstroom Campus) endorsed ethical approval for this study (NWU-00195-14-A1). This application follows a stringent protocol and covers all aspects of

ethical decision-making pertaining to research. The promotor also acted as a soundboard for ethical decision-making throughout the study.

The importance of the following ethical principles is acknowledged:

- **Professional competence**

The researcher is a practicing clinical psychologist, registered with the HPCSA for the past nine years. The researcher would like to apply the findings of this PhD study to facilitate the improvement of client satisfaction with psychological treatment in a South African context. With the purpose of ensuring that statistically correct and appropriate procedures were followed, statistical consultations were scheduled with a statistician, Dr. S. M. Ellis, who was also a co-supervisor and promoter to this study (S. M. Ellis, personal consultations, April 2016).

- **Scientific integrity**

The study followed a quantitative research design; the research methodology was directed by deductive measurement, analysis, and interpretation of stipulated hypotheses. Research questions further guided the investigation. The research is deductive and states a hypothesis; it involved the gathering, analysis, interpretation, and presentation of numerical data without exposing participants to preventable risks.

- **Relevance and value**

Advantages for the client include the expectation that participants will benefit from the experience through careful reflection on the question at hand. Furthermore, clients were enabled to give feedback about the therapy process and become more actively involved in their own health-care and personal growth.

The research also holds advantages for the community at large. Continued Professional Development (CPD) workshops or courses about quality assurance in psychotherapy will be hosted and added to the current ethical content of Continuing

Education Units (CEUs). This ethical content enhancement will prove indispensable to all South African psychologists regarding knowledge of client satisfaction and client expectations.

- **Respect for persons**

Participants could elect to withdraw from the study at any stage. The researcher informed participants about the research project, the reason for the study, and that the outcome would be utilised to improve the satisfaction of clients during psychotherapy. Participation in the study was voluntary. Participants had the option not to participate after they were thoroughly informed about the research. If they chose to participate, their participation could be stopped at any point, if they so wished.

- **Distributive justice and inclusion criteria**

Recruitment, selection, inclusion, and exclusion criteria were nondiscriminatory, unbiased, and based on sound scientific principles. Criteria for inclusion are based purely on the nature and aims of the study. Adult clients over the age of eighteen, whom have recently been in therapy and whom have terminated therapy, either voluntarily or as agreed upon by both the client and the therapist at the end of the therapy process, were invited to participate in this study. The participants had to be proficient in English due to the procedural use of this language in the applicable psychometric testing. Only clinical, educational, counselling, and industrial psychologists were approached to participate in the research. Research psychologists were thus excluded for the purposes of this study. The participating psychologists had to be registered with the HPCSA in either one of the before-mentioned registration categories and had to be qualified for more than three years. The only other exclusion was psychologists that were friends with the researcher or that the researcher worked with.

- **Informed consent**

Post-psychotherapy clients were obtained from thirteen psychologists of the private sector, practising in Gauteng and the North-West provinces. A directory listing all psychologists currently registered with the HPCSA was utilised to identify private practising psychologists in the relevant areas to request their participation in this study. The participating psychologists acted as gatekeepers by identifying potential research subjects and determining which clients may be approached. They were also in a position of responsibility to ensure the well-being and privacy of prospective study subjects, primarily protecting the interests of this group and providing the researcher with access to possible future participants. In keeping with autonomy interests, written informed consent was also obtained from the clients who elected to participate.

- **Privacy and confidentiality**

Questionnaires were completed anonymously using only a numerical system to ensure the privacy and anonymity of all the participants. Participants were required to sign informed consent forms for participating in this study, including for the research findings to be published anonymously or by using pseudonyms. The researcher e-mailed these consent forms to the participants. Once completed and signed the participant returned these via e-mail or self-addressed, stamped return envelopes. Participants were given the opportunity to verify all information before including it in the research findings. Steps were taken throughout the research process to maintain the anonymity of the participants and ensure the safety and confidentiality of the documentation. Upon completion of the study and publication of the thesis, all documents and confidential information are to be safely stored for a period of six years. Computer based data was protected with a password.

- **Risk of harm and likelihood of benefit**

The questionnaires that were used were merely attitudinal and satisfaction surveys and should therefore not have caused any discomfort to the participants. No personal problems were asked or addressed when completing these questionnaires and thus the emotional impact of attitudinal surveys was quite low. Advantages for the client included the expectation that participants will benefit from the experience through careful reflection on the question at hand. Furthermore, clients were enabled to give feedback about the therapy process and become more actively involved in their own health care.

- **Publication of results and feedback**

Participants were required to sign informed consent forms for participating in this study, including for the research findings to be published anonymously or by using pseudonyms. Reports were made on the results of the study and feedback to the participants. Feedback to the participants was given in the form of articles on the findings of the study. No specific feedback was given to any particular psychologist. This was done purposefully, so as not to be (perceived as) threatening to any psychologist or participant of the study.

1.12 Outline of the Study

Section A presents an overall introduction to client satisfaction with psychological treatment for the South African context.

In Section B the guidelines used by the author, as required by the *Journal of Psychology in Africa*, are outlined, followed by the author's article, *Psychometric Properties of Scales Measuring Client Expectations and Satisfaction with Psychological Treatment in a South African context* (Section B: Article 1). This is followed by the article, *The Nature of Clients' Expectations and Satisfaction with Psychological Treatment in a South African*

Context (Section B: Article 2). Section B concludes with Article 3, *The Relationship between Client Psychological Treatment Expectations and Satisfaction in South Africa*.

Section C is a critical reflection.

References

- Alrubaiee, L., & Alkaa'ida, F. (2011). The mediating effect of patient satisfaction in the patients' perceptions of healthcare quality: Patient trust relationship. *International Journal of Marketing Studies*, 3(1), 103–127.
<http://dx.doi.org/10.5539/ijms.v3n1p103>
- American College of Emergency Physicians. (2014). *Quality of care and the outcomes management movement*. Retrieved from <http://www.acep.org/clinical---Practice-Management/Quality-of-Care-and-the-Outcomes-Management-Movement/>
- American Psychological Association (APA). (2006). Presidential task force on evidence-based practice: Evidence-based practice in psychology. *American Psychologist*, 61, 271–285.
- Amyx, D., Mowen, J. C., & Hamm, R. (2000). Patient satisfaction: A matter of choice. *Journal of Services Marketing*, 14(7), 555–572.
- Anderson, T., Patterson, C. L., McClintock, A. S., & Song, X. (2013). Factorial and predictive validity of the expectations about counseling-brief (EAC-B) with clients seeking counseling. *Journal of Counseling Psychology*, 60, 496–507.
- Ankuta, G. Y., & Abeles, N. (1993). Client satisfaction, clinical significance, and meaningful change in psychotherapy. *Professional Psychology: Research and Practice*, 24, 70–74.
- APA Presidential Task Force on Evidence-Based Practice. (2006). Evidence-based practice in psychology. *American Psychologist*, 61(4), 271–285.
<http://dx.doi.org/10.1037/0003-066X.61.4.271>
- Ardito, R. B., & Rabellino, D. (2011). Therapeutic alliance and outcome of psychotherapy: Historical excursus, measurements, and prospects for research. *Frontiers in Psychology*, 2, 270. <http://dx.doi.org/10.3389/fpsyg.2011.00270>

- Association for Behavioral and Cognitive Therapies. (2003). Myths & facts about empirically supported treatments: Conceptions and misconceptions. *American Psychologist*, 61, 271–285. Retrieved from <http://www.abct.org/Professionals/?m=mPro&fa=MythsAbdFacts>
- Barr, D. A. (2004). Race/Ethnicity and Patient Satisfaction: Using the appropriate method to test for perceived differences in care. *Journal Of General Internal Medicine*, 19(9), 937–943.
- Barton, P. L. (2010). *Understanding the U.S. health services system* (4th ed.). Washington, DC: AUPHA Press.
- Beattie, P. F., Pinto, M. B., Nelson, M. K., & Nelson, R. (2002). Patient satisfaction with outpatient physical therapy: Instrument validation. *Physical Therapy*, 82, 557–65.
- Beitel, M., Hutz, A., Sheffield, K. M., Gunn, C., Cecero, J. J., & Barry, D. T. (2009). Do psychologically-minded clients expect more from counselling? *Psychology and Psychotherapy: Theory, Research and Practice*, 82, 369–383. <http://dx.doi.org/10.1348/147608309X436711>
- Berke, D. M., Rozell, C. A., Hogan, T. P., Norcross, J. A., & Karpiak, C. P. (2011). What clinical psychologists know about evidence-based practice: Familiarity with online resources and research methods. *Journal of Clinical Psychology*, 67, 329–339.
- Bitner, M., W. Faranda, A. Hubbert and V. Zeithaml (1997), "Customer Contribution and Roles in Service Delivery," *International Journal of Service Industry Management*, 8 (3), 193-205.
- Bjertnaes, O. A., Sjetne, I. S., & Iversen, H. H. (2011). Overall patient satisfaction with hospitals: Effects of patient-reported experiences and fulfilment of expectations. *BMJ Quality & Safety*, 21, 39–46. <http://dx.doi.org/10.1136/bmjqs-2011-000137>

- Bless, C., Higson-Smith, C., & Kagee, A. (2007). *Fundamentals of social research methods: An African perspective*. Cape Town: Juta & Company.
- Bleustein, C., Rothschild, D. B., Valen, A., Valaitis, E., Schweitzer, L., & Jones, R. (2014). Wait times, patient satisfaction scores, and the perception of care. *American Journal of Managed Care*, 20(5), 393–400.
- Boshoff, C., & Gary, B. (2004). The relationships between service quality, customer satisfaction and buying intentions in the private hospital industry. *African Journal of Business Management*, 35(4), 27–37.
- Bovbjerg, V. E., Trowbridge, E. R., Barber, M. D., Martirosian, T. E., Steers, W. D., & Hullfish, K. L. (2009). Patient-centered treatment goals for pelvic floor disorders: Association with quality-of-life and patient satisfaction. *American Journal of Obstetrics and Gynaecology*, 200(5), 568.e1–6.
<http://dx.doi.org/10.1016/j.ajog.2008.11.020>
- Bowling, A., Rowe, G., Lambert, N., Waddington, M., Mahtani, K. R., Kenten, C., ...Francis, S. A. (2012). The measurement of patients' expectations for health care: A review and psychometric testing of a measure of patients' expectations. *Health Technology Assessment*, 16(30), i–xii, 1–509. <http://dx.doi.org/10.3310/hta16300>
- Branson, L., Buxton, M., & Fryman, H. (2014). Patient satisfaction measures and their impact on patients' rating of a hospital. *International Journal of Management & Human Resources*, 2(1), 1–13.
- Brehm, J. W. (1966). *A theory of psychological reactance*. New York: Academic Press.
- British Association for Counselling and Psychotherapy. (2010). *Ethical framework for good practice in counselling & psychotherapy* [PDF file]. Retrieved from http://www.bacp.co.uk/admin/structure/files/pdf/566_ethical%20framework%20feb2010.pdf

- Brunero, S., Lamont, S., & Fairbrother, G. (2009). Using and understanding consumer satisfaction to effect an improvement in mental health service delivery. *Journal of Psychiatric and Mental Health Nursing, 16*, 272–278.
- Bruwer, B., Sorsdahl, K., Harrison, J., Stein, D. J., Williams D., & Seedat, S. (2011). Barriers to mental health care and predictors of treatment dropout in the South African stress and health study. *Psychiatric Services, 62*(7), 774–81.
<http://dx.doi.org/10.1176/appi.ps.62.7.774>
- Buyse, V., & Wesley, P. W. (2006). Evidence-based practice: How did it emerge and what does it really mean for the early childhood field? *Zero to Three, 27*(2), 50–55.
- Chao, R., Metcalfe, W. E., Lueck, W., & Petersen, S. (2004). *Exploring client satisfaction: From a holistic perspective* [PDF file]. Retrieved from
<https://www.counseling.org/resources/library/vistas/vistas05/Vistas05.art63.pdf>
- Chimbindi, N., Barnighausen, T., & Newell, M. L. (2014). Patient satisfaction with HIV and TB treatment in a public programme in rural KwaZulu-Natal: Evidence from patient-exit interviews. *BMC Health Services Research, 14*, 32.
<http://dx.doi.org/10.1186/1472-6963-14-32>
- Constantino, M., Glass, C. R., Arnkoff, D. B., Ametrano, R. M., & Smith, J. Z. (2011). Expectations. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Evidence-based responsiveness* (pp. 354–376). New York: Oxford University Press.
- Corsini, R. J. (2002). *The dictionary of psychology*. New York: Brunner-Routledge
- Craig, S. S., & Hennessy, J. J. (1989). Personality differences and expectations about counseling. *Journal of Counseling Psychology, 36*, 401–407.
- Cronkite, R., Moos, R., & Finney, J. (1983). *The context of adaptation: An integrative prospective on community and treatment environments*. New York: Wiley.

- Crowe, R., Gage, H., Hampson, S., Hart, J., Kimber, A., Storey, L., & Thomas, H. (2002). The measurement of satisfaction with healthcare: Implications for practice from a systematic review of the literature. *Health Technology Assessment*, 6(32), 1–244.
- Dagnan, D., Jahoda, A., & Kilbane, A. (2013). Preparing for therapy with people with intellectual disabilities. In J. L. Taylor, W. R. Lindsay, R. P. Hastings, & C. Hatton (Eds.), *Psychological therapies for adults with intellectual disabilities* (pp. 55–68). Oxford: Wiley Blackwell.
- Davis, D., & Hobbs, G. (1989). Measuring outpatient satisfaction with rehabilitation services. *Quality Review Bulletin*, 15(6), 192–197.
- Derksen, F., Bensing, J., & Largo-Janssen, A. (2013). Effectiveness of empathy in general practice: a systematic review. *British Journal of General Practice*, 63(606), 76–84. <http://dx.doi.org/10.3399/bjgp13X660814>
- Donabedian, A. (1980). *The definition of quality and approaches to its assessment*. Ann Arbor, MI: Health Administration Press.
- Donabedian, A. (1988). The quality of care: How can it be assessed? *Journal of the American Medical Association*, 260, 1743–1748.
- Doran, D., Pickard, J., Harris, J., Coyte, P. C., Macrae, A. R., Lashinger, H., ...Carrier, J. (2007). The relationship between characteristics of home care nursing service contracts under managed competition and continuity of care and client outcomes: Evidence from Ontario. *Healthcare Policy*, 2(4), 97–113.
- Duckro, P., George, C., & Beal, D. (1979). Effects of failure to meet client preference in a counseling interview. *Journal of Counseling Psychology*, 26(1), 9–14.
- Ellis, S. M., & Steyn, H. S. (2003). Practical significance (effect size) versus or in combination with statistical significance (p-values). *Management Dynamics*, 12(4), 51–53.

- Feenstra, J. D., & Horn, E. K. (2014). Therapeutic assessment promotes treatment readiness but does not affect symptom change in patients with personality disorders: Findings from a randomized clinical trial. *American Psychological Association, 14*, 1040–3590.
- Festinger, L. (1957). *A Theory of cognitive dissonance*. Stanford, CA: Stanford University Press.
- Fiske, S. T., & Taylor, S. E. (1991). *Social cognition* (2nd ed.). New York: McGraw-Hill.
- Fitzpatrick, R., & Hopkins, A. (1983). Problems in the conceptual framework of patient satisfaction research: An empirical exploration. *Sociology of Health and Illness, 5*(3), 297–311.
- Fox, J. G., & Storms, D. M. (1981). A different approach to sociodemographic predictors of satisfaction with health care [PDF file]. *Social Science and Medicine, 15*(A), 557–564. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/6976620>
- Frattali, C. M. (1991). *Measuring client satisfaction*. Retrieved from <http://www.asha.org/SLP/healthcare/Measuring-Client-Satisfaction/>
- Garety, P. A., Craig, T. K., Dunn, G., Fornells-Ambrojo, M., Colbert, S., Rahman, N., ...Power, P. (2006). Specialised care for early psychosis: symptoms, social functioning and patient satisfaction: randomised controlled trial. *British Journal of Psychiatry, 188*, 37–45.
- Garfield, S. L. (1994). Research on client variables in psychotherapy. In A. E. Bergin, & L. S. Garfield (Eds.), *Handbook of psychotherapy and behaviour change* (4th ed.) (pp. 190–228). New York: Wiley.
- Garzon, F. L., & Tilley, K. A. (2009). Do lay Christian counseling approaches Work? What we currently know. *Journal of Psychology and Christianity, 28*(2), 130–140. Retrieved from http://digitalcommons.liberty.edu/ccfs_fac_pubs/54

- Gigantesco, A., Picardi, A., Chiaia, E., Balbi, A., & Morosini, P. (2002). Patients' and relatives' satisfaction with psychiatric services in a large catchment area in Rome. *European Psychiatry, 17*(3), 139–47.
- Gill, L., & White, L. (2009). A critical review of patient satisfaction. *Leadership in Health Services, 22*(1), 8–19.
- Gladstein, G. A. (1969). Client expectations, counseling experience, and satisfaction. *Journal of Counseling Psychology, 16*, 476–481.
- Glass, C. R., Arnkoff, D. B., & Shapiro, S. J. (2001). Expectations and preferences. *Psychotherapy, 38*(4), 455–461. <http://dx.doi.org/10.1037/0033-3204.38.4.455>
- Goldfarb, D. E. (2002). College counseling centre clients' expectations about counseling: How they relate to depression, hopelessness, and actual-ideal self-discrepancies. *Journal of College Counseling, 5*, 142–152.
- Goncalves, H. M., & Sampaio, P. (2012). The customer satisfaction-customer loyalty relationship: Reassessing customer and relational characteristics moderating effects. *Management Decision, 50*(9), 1509–1526. <http://dx.doi.org/10.1108/00251741211266660>
- Grimmer, K., Sheppard, L., Pitt, M., Magarey, M., & Trott, P. (1999). Differences in stakeholder expectations in the outcome of physiotherapy management of acute low back pain. *International Journal for Quality in Health Care, 11*, 155–162.
- Habbal, Y. (2007). *Determining patient's satisfaction with medical care* [PDF file]. Retrieved from <http://www.ism.edu/docs/Youssef-Habbal-SAM07.pdf>
- Hancock, G. R., & Mueller, R. O. (2010). *The reviewer's guide to quantitative methods in social sciences*. New York: Routledge.

- Harmon, S. C., Lambert, M. J., Smart, D. M., Hawkins, E., Nielsen, S. L., Slade, K., & Lutz, W. (2007). Enhancing outcome for potential treatment failures: Therapist-client feedback and clinical support tools. *Psychotherapy Research, 17*, 379–392.
- Harper Petersen, M. B. (1989). Commentary: Using patient satisfaction data: An ongoing dialogue to solicit feedback. *Quality Review Bulletin, 15*, 168–171.
- Hasler, G., Moergeli, H., Bachmann, R., Lambrevia, E., Buddeberg, C., & Schnyder U. (2004). Patient satisfaction with outpatient psychiatric treatment: The role of diagnosis, pharmacotherapy, and perceived therapeutic change. *Canadian Journal of Psychiatry, 49*(5), 315–321.
- Hatamizadeh, N., Jafary, P., Vameghi, R., & Kazemnezhad, A. (2012). Factors affecting client satisfaction and dissatisfaction in out-patient rehabilitation centers in Kurdistan province in Iran. *Iranian Red Crescent Medical Journal, 2*(2), 119–120.
- Hawthorne, G. (2006). Review of patient satisfaction measures. *Australian Government Department of Health and Ageing, 17*(6), 465–472. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/24698296>
- Health Professions Council of South Africa (HPCSA). (2013). *Professional board for psychology, ethical code of professional conduct*. Retrieved from <http://www.hpcsa.co.ca/>
- Holcomb, W. R., Parker, J. C., Leong, G. B., Thiele, J., & Higdon, J. (1998). Customer satisfaction and self-reported treatment outcomes among psychiatric inpatients. *Psychiatric Services, 49*(7), 929–934.
- Holikatti, P. C., Kar, N., Mishra, A., Shukla, R., Swain, S. P., & Kar, S. (2012). A study on patient satisfaction with psychiatric services. *Indian Journal of Psychiatry, 45*(4), 327–332.

- Hsieh, M. O., & Kagle, J. D. (1991). Understanding patient satisfaction and dissatisfaction with health care. *Health & Social Work, 16*(4), 281–290.
- Hubbeling, D., & Bertram, R. (2014). Hope, happiness and home treatment: a study into patient satisfaction with being treated at home. *Psychiatric Bulletin, 38*(6), 265–9.
<http://dx.doi.org/10.1192/pb.bp.112.040188>
- Hudak, P. L., McKeever, P., & Wright, J. G. (2003). The metaphor of patients as customers: Implications for measuring satisfaction. *Journal of Clinical Epidemiology, 56*(2), 103–108.
- Hulka, B. S., Kupper, L. L., Daly, M. B., Cassel, J. C. & Schoen, F. (1975). Correlates of satisfaction and dissatisfaction with medical care: A community perspective. *Medical Care, 13*, 648–658.
- Hulka, B. S., Zynanski, S. J., Cassel, J. C., & Thompson, S. J. (1971). Satisfaction with medical care in a low income population. *Journal of Chronic Diseases, 24*, 661–973.
- Hush, J. M., Cameron, K., & Mackey, M. (2011). Patient satisfaction with musculoskeletal physical therapy care: A systematic review. *Physical Therapy, 91*(1), 25–36.
<http://dx.doi.org/10.2522/ptj.20100061>
- Jackson, J. L., Chamberlin, J., & Kroenke, K. (2001). Predictors of patient satisfaction. *Social Science Medicine, 52*(4), 609–620.
- Jahoda, A., Pert, C., Trower, P., Stenfert-Kroese, B., Burford, B., & Dagnan, D. (2007). Establishing the building blocks of cognitive behavioural therapy for people with mild learning disabilities: An exploration of key process issues (CZH/4/181). Chief Scientist's Office, The Scottish Government.
- Jimmieson, N. J. (1998). Linking client and employee perceptions. *Journal of Occupational and Organizational Psychology, 71*, 81–96.

- Jin, J., Sklar, G. E., Oh, V. M. S., & Li, S. C. (2008). Factors affecting therapeutic compliance: A review from the patient's perspective. *Therapeutic and Clinical Risk Management, 4*(1), 269–286.
- Kazdin, A. E. (1999). The meanings and measurement of clinical significance. *Journal of Consulting and Clinical Psychology, 67*, 332–339.
- Kelley, H. H. (1967). Attribution theory in social psychology. In D. Levine (Ed.), *Nebraska Symposium on Motivation (Volume 15)* (pp. 192–238). Lincoln, NE: University of Nebraska Press.
- Kerssens, J. J., Groenewegen, P. P., Sixma, H. J., Boerma, W. G. W., & van der Eijk, I. (2004). Comparison of patient evaluations of health care quality in relation to WHO measures of achievement in 12 European countries. *Bulletin of the World Health Organization, 82*, 106–114.
- Kessels, R. P. C. (2003). Patients' memory for medical information. *Journal of the Royal Society of Medicine, 96*(5): 219–222.
- Kim, S. S., Kaplowitz, S., & Johnston, M. V. (2004). The effects of physician empathy on patient satisfaction and compliance. *Evaluation and the Health Professions, 27*(3), 237–51.
- Kirsch, I. (1990). *Changing expectations: A key to effective psychotherapy*. Pacific Grove, CA: Brooks/Cole.
- Kishor, B. V., Pal, D. K., Lodha, R. S., & Vishal, B. (2011). Clients' satisfaction with anti-retroviral therapy services at Hamidia Hospital Bhopal. *National Journal of Community Medicine, 2*(3), 241.
- Korsch, B., Gozzi, E. K., & Francis, V. (1968). Gaps in doctor-patient communication: Doctor-patient interaction and patient satisfaction. *Pediatrics, 42*, 855–871.

- Kravitz, R. L. (2001). Measuring patients' expectations and requests. *Annals of Internal Medicine*, 134(9), (Part 2), 881–888.
- Kravitz, R. L. (1998). Patient satisfaction with health care: Critical outcome or trivial pursuit? *Journal of General Internal Medicine*, 13(4), 280–282.
<http://dx.doi.org/10.1046/j.1525-1497.1998.00084.x>
- Kurti, S. (2015). *Patient satisfaction evaluation: A theoretical framework*. Retrieved from http://www.academia.edu/4085766/Patient_Satisfaction_Evaluation_-_A_Theoretical_Framework
- Larsen, D. E., & Rootman, I. (1976). Physician role performance and patient satisfaction. *Social Science and Medicine*, 10(1), 29–32.
- Lateef, F. (2010). Patient expectations and the paradigm shift of care in emergency medicine. *Journal of Emergencies, Trauma, and Shock*, 4(2), 163–167.
- Lawrie, S., McIntosh, A., & Rao, S. (2000). *Critical appraisal for Psychiatry*. London: Churchill Livingstone.
- Leadership Magazine. (2013). *Private medical care*. Retrieved from <http://www.leadershiponline.co.za/>
- Lebow, J. (1982). Consumer satisfaction with mental health treatment. *Psychological Bulletin*, 91(2), 244–259.
- Lebow, J. L. (1983). Client satisfaction with mental health treatment. *Evaluation Review*, 7(6), 729–752.
- Levin, K. A. (2006). Study design III: Cross-sectional studies. *Evidence-Based Dentistry*, 7, 24–25. <http://dx.doi.org/10.1038/sj.ebd.6400375>
- Lilienfeld, S. O., Ritschel, L. A., Lynn, S. J., Cautin, R. L., & Latzman, R. D. (2014). Why ineffective psychotherapies appear to work: A taxonomy of causes of spurious

- therapeutic effectiveness. *Perspectives on Psychological Science*, 9(4), 355–387.
<http://dx.doi.org/10.1177/1745691614535216>
- Linder-Pelz, S. (1982). Towards a theory of patient satisfaction. *Social Science and Medicine*, 16, 577–582.
- Linn, L. S. (1975). Factors associated with patient evaluation of health care. *Health and Society*, Fall, 531–548.
- Linn, L. S., & Greenfield, S. (1982). Patients suffering and patient satisfaction among the chronically ill. *Medical Care*, 20, 425–431.
- Lund, C., Petersen, I., Kleintjes, S., & Bhana, A. (2012). Mental health services in South Africa: Taking stock. *African Journal of Psychiatry*, 15(6), 402–405.
- Mavrogiorgou, P., Siebers, F., Juckel, G., & Kienast, T. (2013). Patient satisfaction with specialized mental health service for obsessive-compulsive disorder. *Annals of General Psychiatry*, 12(1), 41. <http://dx.doi.org/10.1186/1744-859X-12-41>
- May, E. J. (2002). Patients with back pain value the process, as well as outcomes of care. *Australian Journal of Physiotherapy*, 48(1), 57.
- McCoach, D. B. (2006). Hierarchical linear modelling. In G. R. Hancock, & R. O. Mueller (Eds.), *The reviewer's guide to quantitative methods in the social sciences* (pp. 123–140). New York: Routledge.
- McEwen, A., & Harris, G. (2010). Communication: Fundamental skills. In A. McEwen, & S. Kraszewski (Eds.), *Communication skills for adult nurses* (pp. 1–22). Berkshire, UK: McGraw-Hill.
- McLeod, S. A. (2008). *Cognitive dissonance*. Retrieved from www.simplypsychology.org/cognitive-dissonance.html
- Meyer, O. L., & Zane, N. (2013). The influence of race and ethnicity in clients' experiences of mental health treatment. *Journal of Community Psychology*, 41(7), 884–901.

- Miller, D. T., & Turnbull, W. (1986). Expectancies and interpersonal processes. *Annual Review of Psychology*, 37, 233–256.
<http://dx.doi.org/10.1146/annurev.ps.37.020186.001313>
- Mitchell, A. M., Garand, L., Dean D., Panzak G., & Taylor, M. (2010). Suicide assessment in hospital emergency departments: Implications for patient satisfaction and compliance. *Topics in Emergency Medicine*, 27(4), 302–312.
- Mosadeghrad, A. M. (2012). A conceptual framework for quality of care. *Mater Sociomed*, 24(4), 251–261. <http://dx.doi.org/10.5455/msm.2012.24.251-261>
- Nabbuye-Sekandi, J., Makumbi, F. E., Kasangaki, A., Kizza, I. B., Tugumisirize, J., Nshimye, E., ...Peters, D. H. (2011). Patient satisfaction with services in outpatient clinics at Mulago hospital, Uganda. *International Journal of Quality in Health Care*, 23(5), 516–523. <http://dx.doi.org/10.1093/intqhc/mzr040>
- Naidu, A. (2009). Factors affecting patients satisfaction and healthcare quality. *International Journal of Healthcare Quality Assurance*, 22, 366–381.
- National Department of Health. (2013). *National Health Insurance*. Retrieved from <http://www.doh.gov.za/list.php?type=Natiopnal%20Health%20Insurance>
- National Health Insurance for South Africa. (2015). *Towards universal health coverage* (Version 40) [White paper]. Retrieved May 4, 2016, from Department: Health, Republic of South Africa: <http://www.health-e.org.za/wp-content/uploads/2015/12/National-Health-Insurance-for-South-Africa-White-Paper.pdf>
- Neuman, W. L. (2000). *Social research methods: Qualitative and quantitative approaches* (4th ed.). Boston, MA: Allyn & Bacon.

- Newsome, P. R. H., & Wright, G. H. (1999). Patient management: A review of patient satisfaction: 1. Concepts of satisfaction. *British Dental Journal*, *186*, 161–165.
<http://dx.doi.org/10.1038/sj.bdj.4800053>
- Noble, L. M., Douglas, B.C., & Newman, S. P. (2001). What do patients expect of psychiatric services? A systematic and critical review of empirical studies. *Social Science and Medicine*, *52*(7), 985–998.
- Nock, M. K., & Kazdin, A. E. (2001). Parent expectancies for child therapy: Assessment and relation to participation in treatment. *Journal of Child and Family Studies*, *10*, 155–180.
- Norberg, M. M., Wetterneck, C. T., Sass D. A., & Kanter, J. W. (2011). Development and psychometric evaluation of the Milwaukee psychotherapy expectations questionnaire. *Journal of Clinical Psychology*, *67*(6), 574–590.
- Noyes, R. W. (1974). Expectation fulfilment as a measure of patient satisfaction. *American Journal of Obstetrics and Gynecology*, *118*(6), 36.
- Nunnally, J. C., & Bernstein, I. H. (1994). *Psychometric theory* (3rd ed.). New York, NY: McGraw-Hill.
- O'Neill, C. (1994). Benchmarking client satisfaction with general practitioner services: results and lessons from a population based survey. Retrieved from
<http://www.priory.com/fam/bench.htm>
- Oei, T. P. S., & Green, A. L. (2008). The satisfaction with therapy and therapist scale – revised (STTS-R) for group psychotherapy: Psychometric properties and confirmatory factor analysis. *American Psychological Association*, *39*(4), 435–442.
- Oliver, R. L. (1981). Measurement and evaluation of satisfaction processes in retail settings. *Journal of Retailing*, *57*(3), 25–48.

- Palazzo, C., Jourdan, C., Descamps, S., Nizard, R., Hamadouche, M., Anract, P.,
...Poiraudau S. (2014). Determinants of satisfaction 1 year after total hip
arthroplasty: The role of expectations fulfilment. *BMC Musculoskeletal Disorders*,
15(53). <http://dx.doi.org/10.1186/1471-2474-15-53>
- Palmer, R. H., Donabedian, A., & Povar, G. J. (1991). *Striving for quality in health care: An inquiry into policy and practice*. Chicago, IL: Health Administration Press.
- Parasuraman, A., Zeithaml, V.A., & Berry, L.L. (1985). A conceptual model of service
quality and its implication. *Journal of Marketing*, 49, 41–50.
- Pascoe, G. C. (1983). Patient satisfaction in primary health care: a literature review and
analysis. *Evaluation and program planning*, 6(3–4), 185–210.
- Patrick, D. L., Scrivens, E., & Charlton, J. R. H. (1983). Disability and patient satisfaction
with medical care. *Medical Care*, 21, 1062–1075.
- Patterson, C. L., Anderson, T., & Wei, C. (2014). Clients' pretreatment role expectations,
the therapeutic alliance, and clinical outcomes in outpatient therapy. *Journal of
Clinical Psychology*, 70(7), 673–680.
- Pifer, T. B., Bragg-Gresham, J. L., Dykstra, D. M., Shapiro, J. R., Oppenheimer, C. C.,
Gaylin, D. S., ...Held, P. J. (2003). Quality of life and patient satisfaction: ESRD
managed care demonstration. *Health Care Finance Review*, 24(4), 45–58.
- Popovic, M., Milne, D., & Barrett, P. (2007). Assessing clients' satisfaction with
psychological services: Development of a multidimensional client satisfaction survey
questionnaire. *Counselling Psychology Review*, 22(2), 15–29.
- Prakash, B. (2010). Patient satisfaction. *Journal of Cutaneous and Aesthetic Surgery*, 3(3),
151–155. <http://dx.doi.org/10.4103/0974-2077.74491>
- Price, I. I., & Oswald, I. I. (2006). *Relationship strength*. Retrieved from
http://psych.csurfresno.edu/psy144/content/statistics/relationship_strength.html

- Reeder, L. G. (1972). The patient-client as consumer: Some observations on the changing professional-client relationship. *Journal of Health and Social Behavior*, 13(4), 406–412.
- Reschovsky, J. D., Hadley, J., & Landon, B. E. (2006). Compensation methods and physicians group structure on physicians perceived incentives to alter services to patients. *Health Services Research*, 41(4), (Part 1), 1200–1220.
- Richmond, J. S., Berlin, J. S., Fishkind, A. B., Holloman, G. H., Zeller, S. L., Wilson, M. P., ...Ng, A. T. (2012). Verbal de-escalation of the agitated patient: Consensus statement of the American Association for Emergency Psychiatry project BETA de-escalation workgroup. *Western Journal Emergency Medicine*, 13(1), 17–25.
<http://dx.doi.org/10.5811/westjem.2011.9.6864>
- Rivers, P. A., & Glover, S. H. (2008). Health care competition, strategic mission, and patient satisfaction: Research model and propositions. *Journal of Health Organization and Management*, 22(6), 627–641.
- Robinson, J. P., Shaver, P. R., & Wrightsman, L. S. (Eds.). (1991). *Measures of personality and social psychological attitudes: Measures of social psychological attitudes* (Vol. 1). New York: Academic Press.
- Roothman, B. (2009). *Burnout and work engagement among South African psychologists* (Unpublished doctoral dissertation). North-West University, Potchefstroom, South Africa.
- Ruane, I. (2010). Obstacles to the utilisation of psychological resources in a South African township community. *South African Journal of Psychology*, 40(2), 214–225.
- South African College of Applied Psychology (SACAP). (2016). *Mental health in South Africa: Whose problem is it?* Retrieved from

<http://www.sacap.edu.za/blog/counselling/mental-health-south-africa-whose-problem-counselling/>

- Sackett, D. L., Straus, S. E., Richardson, W. S., Rosenberg, W., & Haynes, R.B. (2000). *Evidence-based medicine: How to practice and teach EBM (Vol. 2)*. London: Churchill Livingstone.
- Saha, S., Beach, M. C., & Cooper, L. A. (2008). Patient centeredness, cultural competence and healthcare quality. *Journal of the National Medical Association, 100*(11), 1275–1285.
- Saint-Germain, M. A. (2001). *Cross-sectional design*. Retrieved from <http://www.csulb.edu/~msaintg/ppa696/696preex.htm#Cross-Sectional%20Design>.
- SAS Institute Inc. (2011). *Base SAS ® 9.3 Procedures Guide: Statistical Procedures*. Cary, NC: SAS Institute Inc.
- Seligman, M. F. (1995). The effectiveness of psychotherapy: The consumer reports study. *American Psychologist, 50*, 965–974.
- Sharf, J., & Primavera, L. (2010). Dropout and therapeutic alliance: A meta-analysis of adult individual psychotherapy. *American Psychological Association: Theory, Research, Practice and Training, 47*(4), 637–645.
- Slywotzky, A. (2015). *The patient-to-consumer healthcare revolution*. Retrieved from [http://www.brinknews.com/the-patient-to-consumer-health care-revolution/](http://www.brinknews.com/the-patient-to-consumer-health-care-revolution/)
- Soremekun, O. A., Takayesu, J. K., & Bohan, S. J. (2011). Framework for analyzing wait times and other factors that impact patient satisfaction in the emergency department. *Journal of Emergency Medicine, 41*(6), 686–92.
<http://dx.doi.org/10.1016/j.jemermed.2011.01.018>

- South African Depression and Anxiety Group. (2013). *Newsletters*. Retrieved from http://www.sadag.org/index.php?option=com_content&view=article&id=10&Itemid=113
- Spiegel, A. D., & Hyman. H. H. (1998). *Strategic health planning: Methods and techniques applied to marketing and management*. Norwood, NJ: Ablex Publishing Corporation.
- SPSS Inc. (2013). *IBM SPSS Statistics (Version 22)* [Computer software]. Retrieved from <http://www-01.ibm.com/software/analytics/spss/>
- Strasser, S., Aharony, L., & Greenberger, D. (1993). The patient satisfaction process: Moving toward a comprehensive model. *Medical Care Review*, 50(2), 219–248.
- Stratmann, W. C., Block, J. A., Brown, S. P., & Rozzi, M. V. (1975). A study of consumer attitudes about health care: The control, cost, and financing of health services. *Medical Care*, 13(8), 659–668.
- Suchman, E. A. (1964). Sociomedical variations among ethnic groups. *American Journal of Sociology*, 70, 319-331.
- Swift, J. K., & Callahan, J. L. (2009). The impact of client treatment preferences on outcome: A meta-analysis. *Journal of Clinical Psychology*, 65(4), 368–381. <http://dx.doi.org/10.1002/jclp.20553>
- Swift, J. K., & Derthick, A. O. (2013). Increasing hope by addressing clients' outcome expectations. *Psychotherapy*, 50(3), 284–287. <http://dx.doi.org/10.1037/a0031941>
- Tabachnick, B. G., & Fidell, L. S. (2001). *Using multivariate statistics* (4th ed.). Boston, MA: Allyn & Bacon.
- Teddle, C., & Tashakkori, A. (2009). *Foundations of mixed methods research*. Thousand Oaks, CA: Sage Publications.

- Tempier, R., Pawliuk, N., Perreault, M., & Steiner, W. (2002). Satisfaction with clinical case management services of patients with long-term psychoses. *Community Mental Health J*, 38(1), 51–59. <http://dx.doi.org/10.1023/A:1013907914849>
- The Bill of Rights of the Constitution of the Republic of South Africa. (1996). *Government Gazette*. (No. 17678).
- The Rolling Stones. (1991). I can't get no satisfaction. On *Hot Rocks I* [CD]. London: Teal Trutone Music.
- The Society of Clinical Child and Adolescent Psychology (Division 53 of the APA). (2014). *Society of clinical child and adolescent psychology*. Retrieved from <https://www.apa.org/about/division/div53.aspx>
- Thompson, K. (2003). US Department of HHS, 2002, 2004, 2005: Stigma and public health policy for schizophrenia. *The Psychiatric Clinics of North America*, 26(1), 273–294.
- Tuli, F. (2010). The basis of distinction between qualitative and quantitative research in social science: Reflection on ontological, epistemological and methodological perspectives. *Ethiopian Journal of Education & Sciences*, 6(1), 97–108.
- Wadhwa, S. S. (2002). Customer satisfaction and health care delivery systems: Commentary with Australian bias. *E-Journal of Nuclear Medicine*, 1(1), 1539–4638. Retrieved from <http://ispub.com/IJNUC/1/1/8617>
- Walker, M. S., Ristvedt, S. L., & Haughey, B. H. (2003). Patient care in multidisciplinary cancer clinics: Does attention to psychosocial needs predict patient satisfaction? *Psycho-Oncology*, 12(3), 291–300.
- Ward, M. R., & Rosen, K. H. (2000). Clients' perceptions of the therapeutic process: A common factors approach (Academic thesis). Virginia Polytechnic Institute and State University, Blacksburg, Virginia.

- Ware, J. E., Davies-Avery, A., & Stewart, A. L. (1977). *The measurement and meaning of patient satisfaction: A review of the literature*. Santa Monica, CA: RAND Publication.
- Ware, J. E., Snyder, M. K., Wright, W. R., & Davies, A. R. (1983). Defining and measuring patient satisfaction with medical care. *Evaluation and Program Planning*, 6(3-4), 247-263.
- Weisman, E., & Koch, J. (1989). Progress notes: Special patient satisfaction issue. *Quality Review Bulletin*, 15(6), 166-167.
- White, J. (2008). Qualitative research and the politics of knowledge in an age of evidence: Developing a research-based practice of immanent critique. *Social Science and Medicine*, 67, 195-203.
- Williams, B., Coyle, J., & Healy, D. (1998). The meaning of patient satisfaction. *Social Science and Medicine*, 47, 1351-1359.
- Wissing, M. P., & Van Eeden, C. (2002). Empirical clarification of the nature of psychological well-being. *South African Journal of Psychology*, 32, 32-44.
- World Health Organization. (2001). *Mental health: World health ministers call for action* [PDF file]. Retrieved from http://www.who.int/mental_health/media/en/249.pdf
- World Health Organization. (2012). *Developing and evaluating communication strategies to support informed decisions and practice based on evidence*. Retrieved from <http://www.decide-collaboration.eu/world-health-organization>
- Zhiwei, Z., Gerstein, D. R., & Friedmann P. D. (2008). Patient satisfaction and sustained outcomes of drug abuse treatment. *Journal of Health Psychology*, 13(3):388-400. <http://dx.doi.org/10.1177/1359105307088142>

SECTION B: ARTICLE 1

**PSYCHOMETRIC PROPERTIES OF SCALES MEASURING CLIENT
EXPECTATIONS AND SATISFACTION WITH PSYCHOLOGICAL TREATMENT
IN A SOUTH AFRICAN CONTEXT**

To be submitted to the

Journal of Psychology in Africa

2.1 Guidelines for authors:

JOURNAL OF PSYCHOLOGY IN AFRICA

Instructions to authors

Editorial policy

Submission of a manuscript implies that the material has not previously been published, nor is it being considered for publication elsewhere. Submission of a manuscript will be taken to imply transfer of copyright of the material to the owners, Africa Scholarship Development Enterprise. Contributions are accepted on the understanding that the authors have the authority for publication. Material accepted for publication in this journal may not be reprinted or published without due copyright permissions. The Journal has a policy of anonymous peer review. Papers will be scrutinised and commented on by at least two independent expert referees or consulting editors as well as by an editor. The Editor reserves the right to revise the final draft of the manuscript to conform to editorial requirements.

Publishing ethics

By submitting to the *Journal of Psychology in Africa* for publication review, the author(s) agree to any originality checks during the peer review and production processes. A manuscript is accepted for publication review on the understanding that it contains nothing that is abusive, defamatory, fraudulent, illegal, libellous, or obscene. During manuscript submission, authors should declare any competing and/or relevant financial interest which might be potential sources of bias or constitute conflict of interest. The author who submits the manuscript accepts responsibility for notifying all co-authors and must provide contact information on the co-authors.

The Editor-in-Chief will collaborate with Taylor and Francis using the guidelines of the Committee on Publication Ethics [<http://publicationethics.org>] in cases of allegations of research errors; authorship complaints; multiple or concurrent (simultaneous) submission; plagiarism complaints; research results misappropriation; reviewer bias; and undisclosed conflicts of interest.

Manuscripts

Manuscripts should be written in English and conform to the publication guidelines of the latest edition of the American Psychological Association (APA) publication manual of instructions for authors.

Submission

Manuscripts should be prepared in MSWord, double spaced with wide margins and submitted via email to the Editor-in-Chief at elias.mpofu@sydney.edu.au. Before submitting a manuscript, authors should peruse and consult a recent issue of the *Journal of Psychology in Africa* for general layout and style.

Manuscript format

All pages must be numbered consecutively, including those containing the references, tables and figures. The typescript of a manuscript should be arranged as follows:

- Title: this should be brief, sufficiently informative for retrieval by automatic searching techniques and should contain important keywords (preferably <13).
- Author(s) and Address(es) of author(s): The corresponding author must be indicated. The author's respective addresses where the work was done must be indicated. An e-mail address, telephone number and fax number for the corresponding author must be provided.
- Abstract: Articles and abstracts must be in English. Submission of abstracts translated to French, Portuguese and/ or Spanish is encouraged. For data-based contributions, the abstract should be structured as follows: Objective – the primary purpose of the paper, Method – data source, participants, design, measures, data analysis, Results – key findings, implications, future directions and Conclusions – in relation to the research questions and theory development. For all other contributions (except editorials, book reviews, special announcements) the abstract must be a concise statement of the content of the paper. Abstracts must not exceed 150 words. The statement of the abstract should summarise the information presented in the paper but should not include references.
- Text: (1) Per APA guidelines, only one space should follow any punctuation; (2) Do not insert spaces at the beginning or end of paragraphs; (3) Do not use colour in text; and (4) Do not align references using spaces or tabs, use a hanging indent.
- Tables and figures: These should contain only information directly relevant to the content of the paper. Each table and figure must include a full, stand-alone caption, and each must be sequentially mentioned in the text. Collect tables and figures together at the end of the manuscript or supply as separate files. Indicate the correct placement in the text in this form <insert Table 1 here>.

Figures must conform to the journals style. Pay particular attention to line thickness, font and figure proportions, taking into account the journal's

printed page size – plan around one column (82 mm) or two column width (170 mm). For digital photographs or scanned images the resolution should be at least 300 dpi for colour or greyscale artwork and a minimum of 600 dpi for black line drawings. These files can be saved (in order of preference) in PSD, PDF or JPEG format. Graphs, charts or maps can be saved in AI, PDF or EPS format. MS Office files (Word, Powerpoint, Excel) are also acceptable but DO NOT EMBED Excel graphs or Powerpoint slides in a MS Word document.

Referencing

Referencing style should follow latest edition of the APA manual of instructions for authors.

• References in text: References in running text should be quoted as follows: (Louw & Mkize, 2012), or (Louw, 2011), or Louw (2000, 2004a, 2004b). All surnames should be cited the first time the reference occurs, e.g., Louw, Mkize, and Naidoo (2009) or (Louw, Mkize, & Naidoo, 2010). Subsequent citations should use et al., e.g. Louw et al. (2004) or (Louw et al., 2004). 'Unpublished observations' and 'personal communications' may be cited in the text, but not in the reference list. Manuscripts submitted but not yet published can be included as references followed by 'in press'.

• Reference list: Full references should be given at the end of the article in alphabetical order, using double spacing. References to journals should include the author's surnames and initials, the full title of the paper, the full name of the journal, the year of publication, the volume number, and inclusive page numbers. Titles of journals must not be abbreviated. References to books should include the authors' surnames and initials, the year of publication, full title of the book, the place of publication, and the publisher's name. References should be cited as per the examples below:

Reference samples

Journal article

Peltzer, K. (2001). Factors at follow-up associated with adherence with adherence with directly observed therapy (DOT) for tuberculosis patients in South Africa. *Journal of Psychology in Africa*, 11, 165–185.

Book

Gore, A. (2006). *An inconvenient truth: The planetary emergency of global warming and what we can do about it*. Emmaus, PA: Rodale.

Edited book

Galley, K. E. (Ed.). (2004). *Global climate change and wildlife in North America*. Bethesda, MD: Wildlife Society.

Chapter in a book

Cook, D. A., & Wiley, C. Y. (2000). Psychotherapy with members of the African American churches and spiritual traditions. In P. S. Richards & A. E. Bergin (Eds.), *Handbook of psychotherapy and religiosity diversity* (pp 369–396). Washington, DC: American Psychological Association.

Magazine article

Begley, S., & Murr, A. (2007, July 2). Which of these is not causing global warming? A. Sport utility vehicles; B. Rice fields; C. Increased solar output. *Newsweek*, 150 (2), 48–50.

Newspaper article (unsigned)

College officials agree to cut greenhouse gases. (2007, June 13). *Albany Times Union*, p. A4.

Newspaper article (signed)

Landler, M. (2007, June 2). Bush's Greenhouse Gas Plan Throws Europe Off Guard. *New York Times*, p. A7.

Unpublished thesis

Appoh, L. (1995). The effects of parental attitudes, beliefs and values on the nutritional status of their children in two communities in Ghana (Unpublished master's thesis). University of Trondheim, Norway.

Conference paper

Sternberg, R. J. (2001, June). Cultural approaches to intellectual and social competencies. Paper presented at the Annual Convention of the American Psychological Society, Toronto, Canada.

Lead authors will receive a complimentary issue of the journal issue in which their article appears. The Journal does not place restriction on manuscript length but attention is drawn to the fact that a levy is charged towards publication costs which is revised from time to time to match costs of manuscript development production. Instructions for remitting the publication levy are provided to lead or corresponding authors by the Editorial Assistant of the journal.

2.2 Manuscript: Psychometric properties of scales measuring client expectations and satisfaction with psychological treatment in a South African context

**Psychometric properties of scales measuring client expectations and satisfaction with
psychological treatment in a South African context**

E. J. van der Merwe, E. van Rensburg, S. M. Ellis

School of Psychosocial Behavioural Sciences, North-West University: Potchefstroom
Campus, Potchefstroom.

Correspondence to:

E. J. van der Merwe*

C/o Prof E. van Rensburg

School of Psychosocial Behavioural Sciences

North-West University: Potchefstroom Campus

Private Bag X6001,

Potchefstroom,

2520

South Africa

014 590 1757 or 083 978 3155

*All correspondence to: E-mail: ernst.vandermerwe@angloamerican.com

Abstract

The aim of this study was to do a first-phase screening of the psychometric properties of two scales measuring facets of client expectations and satisfaction with psychological treatment in a South African context. Both scales were developed in a Western context to measure aspects of outcome and process expectations, as well as to develop facets of satisfaction with therapy and satisfaction with the therapist, comprising satisfaction of clients with their psychological treatment. The present quantitative study included a convenience sample of 204 adult participants ($N = 204$) from different cultural contexts in the North-West and Gauteng provinces gathered from 13 independent practicing psychologists. The reliability and validity of the scales did not vary much from the internationally reported results and the scales were found acceptable for use in a South African context in this specific subgroup.

Key words: client, patient, expectations and satisfaction, measurement, scales, psychometric properties, reliability, validity, South African context

Psychometric properties of scales measuring client expectations and satisfaction with psychological treatment in a South African context

Introduction

The Constitution of South Africa considers healthcare a basic human right, requiring availability of high-quality health services to all in the country. This increase in physical services also expanded psychological services (National Health Insurance for South Africa, 2015). All over the world, but especially in South Africa, people are increasingly utilising psychological and mental health services (Lund, Petersen, Kleintjes, & Bhana, 2012). The cause of this amplified use may be linked to an increase in psychological ailments (South African Depression and Anxiety Group, 2013), the upsurge in the utilisation of said services by previously disadvantaged groups (World Health Organization, 2001), and a decrease in stigma (Bruwer et al., 2011; Ruane, 2010). With the increasing emphasis on clinical governance in healthcare provision, National Health Services in South Africa find themselves in a situation of having to justify their work using standardised outcome measures (National Department of Health, 2013).

The Health Professions Council of South Africa (HPCSA) and the American Psychological Association (APA) stipulate the emphasis on high-quality service. The tendency to validate economic and professional decision-making through focussing on empirical research has also been emphasised by numerous other professional organisations in recent years (Levant, 2005; the Association for Behavioral and Cognitive Therapies, 2013, and the Society of Clinical Child and Adolescent Psychology, 2014). Pressure has emanated from public and private health insurance by refusing coverage of practices lacking in systematic evidence of usefulness and thus embracing evidence-based practice (EBP). The high cost of psychological services also necessitates the service of psychologists to be of the

highest quality. A great need for a way to exclude quack practitioners or nonempirical-based treatments in order to protect the public became clear. Evidence-based treatment (EBT) as such a method aims to specify the manner in which professionals should make decisions by identifying specific evidence in place for a practice, and rating it according to plausible scientific soundness (Spring, 2007). Evidence-based practices thus require practitioners to consistently evaluate and utilise the best available research (Berke, Rozell, Hogan, Norcross, & Karpiak, 2011). The latest development in the field, stemming from the consumer revolution in healthcare, follows the formal introduction of EBP in psychology as of 1992 (Buysse & Wesley, 2006). One of the main reasons for successfully incorporating EBPs into treatment services is the enormous expanse of studies linking it to clients' improved health outcomes, and the general attitude that treatments should be based in scientific evidence (Sackett, Straus, Richardson, Rosenberg, & Haynes, 2000). EBP has largely superseded empirically validated treatments, and is much more clinician friendly as it considers the contextual realities of practice (Edwards, 2009).

The concept of EBP proclaims client satisfaction appropriate for practitioners to meet their clients' needs and expectations (Berke et al., 2011). Superordinate concepts have emerged from the development of principles of accountability for health professions around the concept of EBPs. This importance of evidence-based empirically validated practices in order to meet client satisfaction motivates attention to this particular study area even further.

The topic of client satisfaction with clinical services has gained rapid recognition in recent years as an outcome of quality of care (American College of Emergency Physicians, 2014). Donabedian (1988) stated, "It is futile to argue about the validity of patient satisfaction as a measure of quality ... information about patient satisfaction should be as indispensable to assessment of quality as to the design and management of health care systems" (p. 1746).

From a business and marketing perspective, client satisfaction takes on additional significance. As Wadhwa (2002) affirms, within a competitive marketplace a happy customer leads to an increased market share.

As far back as 1972 Reeder anticipated that the client-professional relationship will be transformed as the healthcare profession takes into account the clients' desires, expectations, grievances, and satisfactions. As such, the medical care and allied health fields have continued to evolve toward consumer representation (Kurti, 2015; Reeder, 1972; Wadhwa, 2002). These changes are evident in the increasing number of papers published that relate to client satisfaction within the healthcare field (Gill & White, 2009; Kravitz, 1998; Rivers & Glover, 2008). Kurti (2015) cited 3038 publications in PubMed, of which 85% have been published since 1993. These findings designate mounting interest in this category of research (Branson, Buxton & Fryman, 2014; Williams, Coyle, & Healy, 1998).

The field of client satisfaction, in relation to psychological treatment, focuses on multidimensional components that determine an individual's perception of the quality of healthcare delivered (Sitzia & Wood, 1997). From the client's perspective, satisfaction can be seen as an evaluation of the quality of care as a conclusion, and as an outcome variable in its own right (Donabedian, 1980), but also as an indicator of weaknesses in service (Frattali, 1991). Within this framework of patient-centred healthcare, client satisfaction emerged as an important indicator of the quality of client care (Hush, Cameron, & Mackey, 2011). The significance of this dominant paradigm is further emphasised by the evidence that satisfied clients are more likely to adhere to treatment, benefit from their healthcare, and enjoy a high quality of life (Walker, Ristvedt, & Haughey, 2003). By targeting the aspects of psychotherapeutic treatment that clients consider of utmost importance, clinicians may optimise client satisfaction and the quality of care, which in turn, is in keeping with quality assurance, accreditation, and ethical competency of the practitioner.

Oei and Green (2008), the developers of the Satisfaction with Therapy and Therapist Scale (STTS-R) that is included in this study as a measuring instrument, indicated in their definition of *Patient Satisfaction* that it constitutes two factors, namely *Satisfaction with Therapy*, and *Satisfaction with the Therapist*.

Researchers have found that satisfaction relates to the fulfilment of client expectations (Bjertnaes, Sjetne, & Iversen, 2011; Bowling et al., 2012; Duckro, Beal, & George, 1979; Gill & White, 2009; Palazzo et al., 2014; Swift & Callahan, 2009). Thus, client expectations play an important role in the process by which an outcome of care can be said to be satisfactory or unsatisfactory. Clients bring to any evaluation process a set of positive expectations following their beliefs about idyllic or anticipated situations of the care they will receive. When the experience fulfils these expectations, patients are likely to be satisfied; when the experience fails to meet with expectations, patients may be dissatisfied (Duckro et al., 1979; Kurti, 2015; Larsen & Rootman, 1976; Noble, Douglas, & Newman, 2001).

Client expectations with regard to psychological treatment thus refer to the anticipatory beliefs about what is to be encountered or experienced during a consultation or in a healthcare system (Lateef, 2010; Palmer, Donabedian, & Povar, 1991), and can be thought of as attitudes or the visualisation clients hold concerning the process of interaction with the treatment.

The developers of the Milwaukee Psychotherapy Expectations Questionnaire (MPEQ) that was also included as a measurement instrument in this study, defined patients' psychotherapeutic expectations in terms of two broad classes of expectations. These are expectations about the *Process* of therapy and expectations about the *Outcome* of therapy (Norberg, Wetterneck, Sass, & Kanter, 2011). *Process Expectations* refer to patients' beliefs about what will happen during therapy and includes the behaviours of the therapist and client, the procedures that will occur, and the length of treatment. Outcome expectations (or

prognostic expectations) refer to patients' expectations for improvement and the expected helpfulness of therapy or treatment success (Constantino, Glass, Arnkoff, Ametrano, & Smith, 2011).

Psychometric Assessment of the Satisfaction Construct

A thorough review of the literature on patient or client satisfaction measurement yielded many published articles (Kravitz, 1998; Kurti, 2015; Rivers & Glover, 2008). Client satisfaction seems to be an important variable that is increasingly being utilised in mental health service evaluations. This progressively popular appeal of client satisfaction measurement seems to be connected with its role in quality assurance, continuously improving quality systems; and providing useful information for the development and enhancement of clinical care (Sackett et al., 2000). Evaluating client satisfaction is thus important for all stakeholders since it has shown that low satisfaction can lead to poor compliance with treatment and consequently to nonoptimal health outcomes (Hasler et al., 2004). It is believed to be a multidimensional (Lebow, 1982) measure of consumer satisfaction that assesses the extent to which treatment gratifies the wants, wishes, and desires of clients for service. As such, it is measured over a wide range of facets, including availability, accessibility, and suitability of services, procedural competence of the providers, interpersonal skill, as well as the physical setting where services are delivered.

The most widely used methods for assessing and gathering data as it relates to satisfaction are surveys (Harmon et al., 2007). The advantages of using surveys are directness, clear purpose, forthright responses, and an undisputable connection to satisfaction (Lebow, 1982).

According to Feenstra and Horn (2014) the general field of psychological assessment lacks published empirical evidence regarding its clinical utility and a number of other studies

have openly criticised satisfaction studies for being insufficiently concerned with methodology (Gill & White, 2009; Hawthorne, 2006; Llife et al., 2006). The most significant methodological problems noted were reliability, validity, and utilitarian problems, and practical problems that challenge the usefulness of the gathered data (including issues such as primitive data analysis). Consequently, various measures pertaining to facets of client expectations and satisfaction have already been developed, but very few have been validated.

Even more uncommon are measures that have been cross-culturally validated for research and application in the South African context. Bedell, Van Eeden, and Van Staden (1999) indicated the importance of considering cultural context when assessing patient satisfaction, whereas Foxcroft and Roodt (2001) purports measures developed and standardised in one cultural context cannot be presumed equally valid in another.

It can thus be surmised that there exists a boundless need for more information, differentiation, and standardisation of the definitions and constructs. However, the greater need presents itself specifically concerning the applicability of the measurement of clients' expectations and satisfaction with psychological treatment being introduced in the South African context. Careful consideration regarding statistical characteristics and the factor structure of measures used to assess this construct with the intention of validating conclusions drawn in this field of research is essential.

The survey in the current study seeks to fulfil this need and address the lacuna apparent in current research by means of a first-phase screening validation of the psychometric properties of two scales that measure facets of client expectations and satisfaction with psychological treatment in a South African context. Hence, the motivation for including the Milwaukee Psychotherapy Expectations Questionnaire (MPEQ)—developed by Norberg et al. (2011)—as well as the Satisfaction with Therapy and Therapist Scale (STTS-R)—developed by Oei and

Shuttlewood (1999)—as measurement instruments for the purposes of the current study can be set out as follows:

- The instruments measure facets associated with models found in the literature pertaining to important components of clients' expectations and satisfaction as it relates to psychological treatment (Norberg et al., 2011; Oei & Green, 2008; Oei & Shuttlewood, 1999).
- Both instruments have been administered and psychometrically tested in a Western context and found to demonstrate sound psychometric properties, good internal consistency, test–retest reliability, along with support for convergent, discriminant, and predictive validity (Norberg et al., 2011; Oei & Green, 2008; Oei & Shuttlewood, 1999).
- The wording or phrasing of the item statements simplified comprehension and the brief nature of the revised questionnaire is less time-consuming for participants.
- The measures were designed to assess the patients' expectations and level of satisfaction with their therapeutic endeavour. The researcher used his clinical experience to concede that these statements reflected the needs, wants, expectations, and complaints that clients hold in practice.

Method

Aim and Research Design

The aim of the research was to determine whether the Milwaukee Psychotherapy Expectations Questionnaire (MPEQ) and the Satisfaction with Therapy and Therapist Scale (STTS-R) are valid and reliable measurement instruments in a South African context.

In this study, a quantitative research paradigm was applied—an organized method for combining deductive logic with precise empirical observations. The elected approach is thus

in line with evidence-based practices. A cross-sectional survey design was utilised (Levin, 2006; Shaughnessy & Zechmeister, 1994).

Participants completed their questionnaires in English via e-mail. Thirteen contributing psychologists acted as gatekeepers, identifying and determining possible clients to approach. Each participant completed a biographical questionnaire regarding their age, gender, therapy duration, occupation, socio-economic demographics, and source of referral; as well as the Milwaukee Psychotherapy Expectations Questionnaire and the Satisfaction with Therapy and Therapist Scale as requested from the researcher.

The Ethics committee of the North-West University gave their approval for this project (approval number: NWU-00195-14-A1).

Participants and Context

The study included a convenience sample of 204 post-psychotherapy clients (participants) from 13 contributing psychologists practising in the private sectors of Gauteng and the North-West provinces. Of the participants, 108 were White, 76 Black, nine Indian and nine Coloured (two participants did not indicate their ethnicity). Demographical particulars were as follows: Most of the participants (45.6%) were Afrikaans-speaking individuals from the Gauteng Province in South Africa, which is an urban area. The participants who indicated their preferred language as Setswana amounted to 55 individuals (27.5%) and 52 (25.5%) of the participants were English-speaking individuals. The sample included 77 males and 120 females. Typically, more females than males consult psychologists (Winerman, 2005). Ages ranged from 18 to 70+, with the majority being between 31 and 40 years of age (Table A). Most of the participants were self-referred (47.1%), held a high school level of education, and were from professional occupational levels. The majority (24.5%) attended between 5 and 8 therapy sessions. Data collection took place during the last three months of 2015.

< Insert Table A approximately here >

Data Collection

Measurement Instrument for Psychotherapeutic Expectations

Norberg et al. developed the Milwaukee Psychotherapy Expectations Questionnaire (MPEQ) during 2011. Studies have indicated that patients tend to improve more in programs when they have high expectations for independence and open sharing of personal problems in an involving and expressive environment (Cronkite, Moos, & Finney, 1983). It presented initial evidence in assessing both process and outcome expectations in therapy. The questionnaire also inherently measured clients' expectations about the components and effects of therapy. The instrument demonstrated good internal consistency and test–retest reliability along with support for convergent, discriminant, and predictive validity (Norberg et al., 2011). The MPEQ is the first psychometrically sound brief measure of both process and outcome of therapy. The MPEQ consists of a list of statements describing expectations about therapy that clients may have. The statements cover expectations regarding their own behaviour in therapy, their therapist, and the therapy setting. Participants scored each statement on a scale of 1 to 5, whereby a score of 1 would indicate that the participant did not hold this expectation at all and a score of 5 would indicate complete agreement with the stated expectation. Examples of statements include “I expect my therapist will provide support”; “My therapist will be sincere”; “I will be able to express my true thoughts and feelings”, and “After therapy I will be a much more optimistic person”.

Measurement Instruments for Client Satisfaction with Psychotherapy

Oei and Shuttlewood (1999) developed the Satisfaction with Therapy and Therapist Scale (STTS-R) for group psychotherapy designed to assess patients' level of satisfaction with their therapeutic endeavour. The STTS-R has sound psychometric properties and as such serves as

a useful instrument in assessing a patient's level of satisfaction with both group therapy and therapist in research as well as clinical settings. The STTS-R has a factor structure of a 13-item scale that is determined by way of principle components factor analysis. The statements are scored on a scale of 1 through 5 whereby 1 represents "strongly disagree" or not satisfied and a 5 "strongly agree" or completely satisfied. In addition, an outcome variable question determines the client's perception of the efficacy of the treatment. Statements include "The therapist listened to what I was trying to get across"; "I would recommend the program to a friend", and "I would return to the clinic if I needed help".

Data Analysis

Construct validity estimates the ability of an instrument to measure the underlying construct of interest (Strauss & Smith, 2009). Exploratory Factor Analysis (EFA) has traditionally been used to explore the possible underlying factor structure of a set of observed variables by grouping variables that are correlated (Child, 1990; Tabachnick & Fidell, 2007). It can be assumed that the underlying constructs of these measurement instruments are correlated so that an oblique rotation technique can be used to improve the interpretability of the extracted components. By performing a principal components factor analysis with Oblimin rotation on the data, the underlying factor structure as presented by the pattern matrix can be compared to the factor structure from literature (a priori model). EFA was also performed to look at the structure of the measured phenomena as dictated by the data, because underlying patterns in phenomena may differ in various cultural contexts.

Conversely, the technique of Confirmatory Factor Analysis (CFA) analyses priori measurement models in which both the number of factors and their correspondence with the indicators are explicitly specified (Kline, 2011). To test the fit of the data to the specified model there are several fit indices, and it is recommended that researchers use one from each

of three broad classes of fit indices. The chi-square test is an absolute fit index, but it is regarded as an overly strict indicator of model fit given its power to detect even trivial deviations from the proposed model (Hancock & Mueller, 2010). Therefore the chi-square test statistic divided by its degrees of freedom (CMIN/DF) is used where ratios as high as 3, 4 or even 5 can still be regarded as a good model fit (Mueller, 1996). The Comparative Fit Index (CFI) compares the fit of a null model with the fit of the researcher's model (Marsh, Balla, & McDonald, 1988). CFI is a relative fit index and values of above 0.9 (Mueller, 1996) are regarded indicative of a good overall fit. The Root Mean Square Error of Approximation (RMSEA) is a fit index based on the noncentral chi-square distribution reported with its confidence interval whereby values of less than .08 are regarded as a good fit (McCullem, Brown, & Sugarawa, 1996). The use of these fit indices is well supported by literature (Byrne, 2001; Hancock & Mueller, 2010; Mueller, 1996).

Reliability of the before-mentioned expectations and satisfaction scales was examined by calculating the internal consistency coefficient using Cronbach's coefficient alpha (Neuman, 2000; Nunnally, 1978; Tabachnick & Fidell, 2001). The standard of what level of reliability of instruments should be considered acceptable differs somewhat in various contexts. Anastasi and Urbina (1997) considered indices of .80 to .90 as desirable, whereas Nunnally (1978) recommended minimum standards of .80 and .90 for basic and applied research respectively. Huysamen (1996) suggested that reliability coefficients should be .85 or higher if measures were to be used to make decisions about individuals. Moreover, in the past, leading scholars have proposed that average inter-item correlation, a forthright test of internal consistency, should be used in conjunction with Cronbach's alpha (Clark & Watson, 1995). Recommendations are that the average inter-item correlation falls in the range of .15–.50. If broader, high-order constructs are measured a mean correlation as low as .15–.20 is desirable. However, by contrast, for a valid measure of a narrower construct for instance

“talkativeness” a much higher mean intercorrelation (perhaps in the .40–.50 range) is needed (Clark & Watson, 1995).

All data analyses were done using SPSS Version 23 (SPSS Inc., 2016). Confirmatory Factor Analysis (CFA) incorporated AMOS software Version 23 (Amos Development Company, 2016).

Results

Exploratory Factor Analysis (EFA)

A principal components analysis (PCA) was conducted on the 13 items of the MPEQ, as well as on the first 12 items of the STTS-R, to establish the structure of the measures. Item 13 of the STTS-R was not included in the analysis because it measures global satisfaction, thus it could be reasoned that it would contain elements of both constructs.

The Kaiser-Meyer-Olkin (KMO) analysis was carried out to examine the criteria of PCA for identifying the factor structure. The oblique rotation (Oblimin with Kaiser Normalisation) method was employed. The Kaiser-Meyer-Olkin (KMO) measure verified the sampling adequacy for the analysis. KMOs = .91 for the MPEQ, and .96 for the STTS-R was obtained—that, according to Hatcheson and Sofroniou (1999), can be seen as superb. Bartlett’s test of sphericity ($p < 0.000$) indicated that correlations between items were sufficiently large for factor analysis. The percentage variance explained by the extracted factors was 65% for the MPEQ and 76% for the STTS-R. Table 1 shows the factor loadings after the rotation based on correlations among the items of the MPEQ. The items that cluster on the same components suggest that Component 1 represents Expectations with Process and Component 2 Expectations with Outcome.

< Insert Table 1 approximately here >

Although Item 13 (“I expect that I will tell my therapist if I have any concerns about therapy”) had a higher loading on Component 2 (Outcome Expectations), it also had a significant loading on Component 1 (Process Expectations) as indicated in the literature. All items had loadings larger than 0.34 on their respective factors, indicating towards construct validity.

Table 2 shows the factor loadings after the rotation based on correlations among the items of the STTS-R. The item clusters of the components suggest that Component 1 represents Satisfaction with Therapy (ST) and Component 2 signifies Satisfaction with the Therapist (SWT), as indicated in the literature of the most recent development of the research by Oei and Green (2008). All items had loadings larger than 0.43 on their respective factors, indicating towards construct validity.

< Insert Table 2 approximately here >

Item 4 (“The therapist provided an adequate explanation regarding my therapy”) had a high loading on Component 1 (SWT), and this would suggest that it represents satisfaction with the therapist rather than satisfaction with therapy. The phrasing of the statement might be misleading as it contains the word *therapist*, even though it enquires about the satisfaction with therapy. All other items had loadings larger than 0.43 on their respective factors, indicating towards construct validity.

Construct validity was confirmed to a large degree by EFA. This was correspondingly tested by CFA.

Confirmatory Factor Analysis (CFA)

A Confirmatory Factor Analysis (CFA) as conducted with AMOS 23 software Version 23 (Amos Development Company, 2016), indicated the goodness of fit indices values obtained for the postulated model of this study’s structure, revealed satisfactory values for most of the estimated indices and are indicated in Table 3.

< Insert Table 3 approximately here >

CFAs are shown in Figure 1, 2, and 3 together with standardised regression weights. All expectation items had statistical significant standardised regression weights larger than 0.63 on their respective factors ($p < 0.001$). The correlation between Outcome and Process Expectations was 0.79, and this was statistically significant (Figure 1).

< Insert Figure 1 approximately here >

The MPEQ yielded a CMIN/DF value of 3.7, representing a good model fit (Mueller, 1996); a CFI of .900, also indicating of a good overall fit; and a RMSEA value of .115, indicative of an unacceptable fit (Table 3). Therefore 2 of the 3 fit measures indicate acceptable construct validity.

All satisfaction items had statistical significant standardised regression weights of above 0.75 on their respective factors ($p < 0.001$). The correlations between Satisfaction with Therapist (SWT) and Satisfaction with Therapy (ST) were 0.94; the correlations between Global Satisfaction and Satisfaction with Therapist were 0.84; and the correlation between Global Satisfaction and Satisfaction with Therapy was 0.80. All correlations were statistically significant (Figure 2).

< Insert Figure 2 approximately here >

The STTS-R (3-factor) yielded a CMIN/DF value of 2.794 that represents a good model fit; a CFI of .954 that is indicative of a good overall fit (Mueller, 1996); and a RMSEA value of .094 indicating a mediocre fit with a confidence interval of .078 to .111 (Table 3). From the goodness-of-fit indices, it seems apparent that the 3-factor model provides a good fit to the observed data. However, the large correlations between these factors might indicate towards a 1-factor model measuring overall satisfaction.

Although all items had statistical significant standardised regression weights of above 0.73 on the one-factor model, the fit indices were slightly better for the 3-factor model.

< Insert Figure 3 approximately here >

The STTS-R (1-factor) yielded a CMIN/DF value of 3.4, which represents a good model fit; a CFI of .937 that is indicative of a good overall fit (Mueller, 1996); and a RMSEA value of .108 indicating an unacceptable fit with a confidence interval of .092 to .124 (Table 3).

Reliability

Reliability (internal consistency) of the MPEQ and STTS-R showed a very good internal consistency, with alpha values above 0.90 (Nunnally, 1978). In respect of expectations on the MPEQ, $\alpha = .90$ for Process Expectations; $\alpha = .91$ for Outcome Expectations; and $\alpha = .81$ for the Expectation Total. The current study's coefficient alpha for Process Expectations was higher than that reported for Western populations (Oei & Green, 2008; Oei & Shuttlewood, 1999). The mean inter-item correlation for Process Expectations was 0.52 while for Outcome Expectations it was 0.73. The mean inter-item correlation higher than 0.55 might indicate high similarity between these items (Table 4).

The two factors on the STTS-R also had good internal consistency with alpha values above 0.85 (Kline, 2011). Alpha values of .91 and .87 were found for the Satisfaction with Therapy (ST) and Satisfaction with Therapist (SWT) constructs respectively, while the mean inter-item correlations were 0.64 and 0.53 respectively (Table 4). The high mean inter-item correlation for satisfaction with therapy might likewise indicate high similarity between these items.

< Insert Table 4 approximately here >

Furthermore, descriptive statistics for both scales are indicated (Table 4). The scales showed good item-total correlations that ranged between .31–.77. Means were high (4.01 and 4.37 for the MPEQ; 23.57 and 24.88 for the STTS-R's respective subscales). Reliability,

internal consistency, construct validity, and criterion-related validity of the scales were found to be good. This renders the scales preliminary reliable for further exploration in a South African context.

Discussion

Given the worldwide emphasis on quality, the importance placed on EBP, and the topic of client satisfaction, it was considered important to validate these scales for use in South Africa. The aim of this research was to establish whether the two measuring instruments used were valid and reliable for application in the South African context. The importance of scientific evaluation of client satisfaction and client expectations in the paradigm of evidence-based practice is increasingly emphasised, therefore necessitating the requisite for valid instruments.

Previous research studies have examined the factor structure of the MPEQ and the STTS-R (Norberg et al., 2011; Oei & Green, 2008; Oei & Shuttlewood, 1999), but to our knowledge, this is the first study assessing its use in a South African population. To determine the psychometric properties of the MPEQ and the STTS-R, an assessment of fit between the model and the observed variables were presented by means of the CFA approach.

Concerning client satisfaction, validity was evaluated with the aid of testing exploratory principal components factor analyses and confirmatory factor analyses. CFA is a preferred method in scale development when there is an existing established theoretical background of scale development (Noar, 2013). The PCA measure verified the sampling adequacy for the analysis, with superb KMOs. The scales manifested a similar underlying factor pattern and explained variance with exploratory and confirmatory factor analyses. All the satisfaction items had statistical significant regression weights on their respective factors

($p < .001$), and all correlations between the subscales or constructs were statistically significant.

The literature indicates that Oei and Green (2008), by using a larger sample of patients, point out two conceptually coherent factors that accounted for 66.9% of the variance; and CFA revealed a 2-factor solution to be the best-fitting model.

The goodness-of-fit indices values obtained for the postulated model of this study's structure, shown in Table 3, revealed satisfactory values for most of the estimated indices. As also indicated in Table 3, a subscale of STTS-R had a mediocre fit as reflected in RMSEA indices with the upper point of the 90% confidence interval above .10. The factor pattern is in line with that hypothesised by the developers, and it can thus be concluded that the scale has construct validity in a South African context despite the fact that its model fit determined by RMSEA index was unsatisfactory (the small number of participants could have played a role in the latter finding).

Pertaining to the reliability of the satisfaction scale considered in this study it is clear that reliability was high and the internal consistency of the questionnaire extremely desirable. An excellent reliability index for the satisfaction scale was obtained, with all alpha coefficients larger than 0.85 for the current study. The reliability indices obtained in the study are a good indication of the reliability estimate of the satisfaction scale used. This finding indicates that items are a good sample of the intended construct and that it does not draw on bordering constructs (Clark & Watson, 1995; Steiner, 2003).

During the development of the Satisfaction with Therapy and Therapist Scale, Oei and Shuttlewood (1999) found the following results in an Australian population: Two factors accounted for 64.7% of the total variance and the alpha Cronbach for the two factors were 0.91 and 0.80, with the scale alpha at 0.90. Furthermore, the scale also possessed good concurrent and discriminant validity. The results from the current study thus compare

favourably, and are in line with high internal consistency estimates reported for the findings from the test's developers. The Cronbach alpha coefficient used to provide an indication of the STTS-R's internal consistency during the 2008 study, reported coefficients that ranged between .89 and .93 that also reflects good internal consistency.

With reference to client expectations, validity was correspondingly assessed by testing exploratory principal component factor analyses and confirmatory factor analyses. CFAs were also preferred because there is an existing established theoretical background for the development of the MPEQ. The PCA measure verified the sampling adequacy for the analysis, quoting superb KMOs. The scale manifested a similar underlying factor pattern and explained variance with exploratory and confirmatory factor analyses. All the expectation items had statistical significant regression weights on their respective factors ($p < .001$), and all correlations between the subscales or constructs were statistically significant.

The goodness-of-fit-indices values obtained for the postulated model of the structure of this study (Table 3), revealed satisfactory values for most of the estimated indices. As also indicated in Table 3, the MPEQ scale had a mediocre fit; reflected in RMSEA indices with the upper point of the 90% confidence interval above .10. However, the factor pattern is in line with the factor hypothesised by the developers, and it can thus be concluded that the scale has construct validity in a South African context despite the fact that its model fit determined by RMSEA index was unsatisfactory. The small number of participants could also have played a role in this latter finding.

Norberg et al. revealed a 2-factor solution for the MPEQ during 2011. This was supported by EFA and CFA in three additional samples in the Midwest United States.

Pertaining to reliability of the expectations scale deliberated in this study, reliability was very high and the internal consistency of the questionnaire extremely desirable. An excellent reliability index was obtained for the MPEQ in the current study, with all alpha coefficients

larger than 0.85. The reliability indices obtained in the study are a good indication of the reliability estimate of the scale. This finding indicates that items are a good sample of the intended construct and that it does not draw on bordering constructs (Clark & Watson, 1995; Steiner, 2003).

Norberg et al. (2011) also reported high internal consistency estimates for the MPEQ, with alpha coefficients always larger than 0.85. The results of Cronbach alpha indices represents the inter-relatedness of the items (Steiner, 2003), and gave an indication of a reliable measure of the MPEQ in a South African sample.

Generally the reliability indices for the scales evaluated in the current study was in line with that reported in Western groups (Norberg et al., 2011; Oei & Green, 2008; Oei & Shuttlewood, 1999). As was indicated in Table 4, the scales scrutinised in this study showed satisfactory item-total and/or average inter-item correlations within the suggested range. The internal consistency or homogeneity of the scales was thus supported. The coefficients are high and it can thus be accepted that the MPEQ and STTS-R will provide reliable measures of the South African group's expectations and satisfaction with psychological treatment. Furthermore, the exploratory factor analysis gave a satisfactory fit, thus we can expect that in a South African context the measuring instruments have sufficient validity. Consequently, in a South African context construct validity and reliability of the measurement instruments have been proven.

The researchers concluded that the STTS-R and the MPEQ have satisfactory psychometric properties for use in a South African context. These scales introduce an instrument whereby general client satisfaction and expectations with psychological treatment can thus be operationalised to measure clients' expectations and satisfaction with psychological treatment in South Africa. The results from such assessments can be used to modify educational programmes and CPD content, aimed at enhancing satisfaction with

therapy. It can be concluded that the most promising satisfaction scale for use in the South African context is the 3-factor model of the STTS-R. The entirety of the sample is representative of clients from diverse multicultural and social backgrounds. The findings of this study encourage psychological education researchers to consider these scales for client expectation and satisfaction enhancement among graduate psychological education and CPD programmes.

Limitations and Recommendations

Limitations of the current study are acknowledged. Because a cross-sectional survey design was employed in this study, a test–retest method remains a consideration for future. Data from a greater number of psychologists will be useful and it remains a consideration for future reliability. It is furthermore recommended that future studies also include samples from other regional areas and consider accounting for personal characteristics of the participants. Distinguishing categories relating to information on cut-off scores and different levels of expectations and satisfaction functioning would prove to be useful. The current study did not include indices of personality functioning or psychopathology (APA, 1994), therefore it is recommended that they be included in future research.

Conclusion

The current study reported on the validation of the MPEQ and STTS-R for application in the South African context. It therefore contributes measures of client’s expectations, and satisfaction with their psychological treatment for exploration in the South African context. The development of the above-mentioned scales includes a theoretical and empirical research background (Norberg et al., 2011; Oei & Green, 2008; Oei & Shuttlewood, 1999); and the scales demonstrated favourable psychometric properties in the current study. The results also

support the usefulness of the MPEQ and STTS-R as brief, reliable, and valid measures for both client expectations and of client satisfaction when measuring clients' psychological treatment in South Africa. The recommendation is to include clients' expectations of, and satisfaction with psychological treatment into training and psychological curricula with the purpose of improving the level of satisfaction experienced by clients. These scales introduce an instrument whereby general client satisfaction and expectations with psychological treatment can thus be operationalised and measured.

EBP in psychology involves “the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences” (APA, 2006, p. 5). As such, the data from the present study confirms the observations made by many clinicians in Africa that evidence-based treatment models developed in the Western world require little adaptation for use in other cultural contexts, provided that clinicians show responsiveness to client context which is, as discussed above, a feature of all appropriate psychotherapy.

Acknowledgements

The researchers gratefully acknowledge contributors' data collection inputs.

References

- American College of Emergency Physicians. (2014). *Quality of care and the outcomes management movement*. Retrieved from <http://www.acep.org/clinical---Practice-Management/Quality-of-Care-and-the-Outcomes-Management-Movement/>
- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: American Psychiatric Association.
- Amos Development Company. (2016). *Amos 23.0.0 (Build 817)* [Computer software]. Retrieved from <http://amosdevelopment.com>
- Anastasi, A., & Urbina, S. (1997). *Psychological testing* (7th ed.). Upper Saddle River, NJ: Prentice Hall.
- APA Presidential Task Force on Evidence-Based Practice. (2006). Evidence-based practice in psychology. *American Psychologist, 61*(4), 271–285. <http://dx.doi.org/10.1037/0003-066X.61.4.271>
- Association for Behavioral and Cognitive Therapies. (2013). Myths & facts about empirically supported treatments: Conceptions and misconceptions. *American Psychologist, 61*, 271–285. Retrieved from <http://www.abct.org/Professionals/?m=mPro&fa=MythsAbdFacts>
- Bedell, B., Van Eeden, R., & Van Staden, F. (1999). Culture as moderator variable in psychological test performance: Issues and trends in South Africa. *Journal of Industrial Psychology, 25*(3), 1–7.
- Berke, D. M., Rozell, C. A., Hogan, T. P., Norcross, J. A., & Karpiak, C. P. (2011). What clinical psychologists know about evidence-based practice: Familiarity with online resources and research methods. *Journal of Clinical Psychology, 67*, 329–339.

- Bjertnaes, O. A., Sjetne, I. S., & Iversen, H. H. (2011). Overall patient satisfaction with hospitals: Effects of patient-reported experiences and fulfilment of expectations. *BMJ Quality & Safety*, *21*, 39–46. <http://dx.doi.org/10.1136/bmjqs-2011-000137>
- Bowling, A., Rowe, G., Lambert, N., Waddington, M., Mahtani, K. R., Kenten, C., ...Francis, S. A. (2012). The measurement of patients' expectations for health care: A review and psychometric testing of a measure of patients' expectations. *Health Technology Assessment*, *16*(30), i–xii, 1–509. <http://dx.doi.org/10.3310/hta16300>
- Branson, L., Buxton, M., & Fryman, H. (2014). Patient satisfaction measures and their impact on patients' rating of a hospital. *International Journal of Management & Human Resources*, *2*(1), 1–13.
- Bruwer, B., Sorsdahl, K., Harrison, J., Stein, D. J., Williams, D., & Seedat, S. (2011). Barriers to mental health care and predictors of treatment dropout in the South African stress and health study. *Psychiatric Services*, *62*(7), 774–81. <http://dx.doi.org/10.1176/appi.ps.62.7.774>
- Buysse, V., & Wesley, P. W. (2006). Evidence-based practice: How did it emerge and what does it really mean for the early childhood field? *Zero to Three*, *27*(2), 50–55.
- Byrne, B. M. (2001). *Structural equation modeling with AMOS: Basic concepts, applications, and programming*. Mahwah, NJ: Lawrence Erlbaum Associates.
- Child, D. (1990). *The essentials of factor analysis* (2nd ed.). London: Cassel Educational Limited.
- Clark, L. A., & Watson, D. (1995). Constructing validity: Basic issues in objective scale development. *Psychological Assessment*, *7*(3), 309–319.
- Constantino, M., Glass, C. R., Arnkoff, D. B., Ametrano, R. M., & Smith, J. Z. (2011). Expectations. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Evidence-based responsiveness* (pp. 354–376). New York: Oxford University Press.

- Cronkite, R., Moos, R., & Finney, J. (1983). *The context of adaptation: An integrative prospective on community and treatment environments*. New York: Wiley.
- Crowe, R., Gage, H., Hampson, S., Hart, J., Kimber, A., Storey, L., & Thomas, H. (2002). The measurement of satisfaction with healthcare: Implications for practice from a systematic review of the literature. *Health Technology Assessment*, 6(32), 1–244.
- Donabedian, A. (1980). *The definition of quality and approaches to its assessment*. Ann Arbor, MI: Health Administration Press.
- Donabedian, A. (1988). The quality of care: How can it be assessed? *Journal of the American Medical Association*, 260, 1743–1748.
- Duckro, P., George C., & Beal, D. (1979). Effects of failure to meet client preference in a counseling interview. *Journal of Counseling Psychology*, 26(1), 9–14.
- Edwards, J. A. (2009). Treating posttraumatic stress disorder in South Africa: An integrative model grounded in case-bases research. *Journal of Psychology in Africa*, 12(2), 189–198.
- Ellis, S. M., & Steyn, H. S. (2003). Practical significance (effect size) versus or in combination with statistical significance (p-values). *Management Dynamics*, 12(4), 51–53.
- Feenstra, J. D., & Horn, E. K. (2014). Therapeutic assessment promotes treatment readiness but does not affect symptom change in patients with personality disorders: Findings from a randomized clinical trial. *American Psychological Association*, 14, 1040–3590.
- Field, A. (2005). *Discovering statistics using SPSS*. London: Sage.
- Foxcroft, C., & Roodt, G. (2001). *An introduction to psychological assessment in the South African context*. Oxford: Oxford University Press.

- Frattali, C. M. (1991). *Measuring client satisfaction*. Retrieved from <http://www.asha.org/SLP/healthcare/Measuring-Client-Satisfaction/>
- Gilbert, G. R., & Veloutsou, C. (2006). A cross-industry comparison of customer satisfaction. *Journal of Services Marketing*, 20(5), 298–307.
- Gill, L., & White, L. (2009). A critical review of patient satisfaction. *Leadership in Health Services*, 22(1), 8–19.
- Hancock, G. R., & Mueller, R. O. (2010). *The reviewer's guide to quantitative methods in social sciences*. New York: Routledge.
- Harmon, S. C., Lambert, M. J., Smart, D. M., Hawkins, E., Nielsen, S. L., Slade, K., & Lutz, W. (2007). Enhancing outcome for potential treatment failures: Therapist-client feedback and clinical support tools. *Psychotherapy Research*, 17, 379–392.
- Hasler, G., Moergeli, H., Bachmann, R., Lambreva, E., Buddeberg, C., & Schnyder, U. (2004). Patient satisfaction with outpatient psychiatric treatment: The role of diagnosis, pharmacotherapy, and perceived therapeutic change. *Canadian Journal of Psychiatry*, 49(5), 315–321.
- Hatcheson, G., & Sofroniou, N. (1999). *The multivariate social scientist*. London: Sage.
- Hawthorne, G. (2006). Review of patient satisfaction measures. *Australian Government Department of Health and Ageing*, 17(6), 465–472. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/24698296>
- Hill, R. (2003). *Satisfaction*. Milton Keynes: Wiley & Sons.
- Hush, J. M., Cameron, K., & Mackey, M. (2011). Patient satisfaction with musculoskeletal physical therapy care: A systematic review. *Physical Therapy*, 91(1), 25–36. <http://dx.doi.org/10.2522/ptj.20100061>
- Huysamen, G. K. (1996). *Psychological measurement: An introduction with South African examples*. Pretoria: J. L. van Schaik.

- Jimmieson, N. J. (1998). Linking client and employee perceptions. *Journal of Occupational and Organizational Psychology*, 71, 81–96.
- Kaiser, H. F., & Rice, J. (1974). “Little Jiffy, Mark IV”. *Educational and Psychological Measurement*, 34, 111–117.
- Kane, R. L., Maciejewski, M., & Finch, M. (1997). The relationship of patient satisfaction with care and clinical outcomes. *Medical Care*, 35(7), 714–730.
- Kishor, B. V., Pal, D. K., Lodha, R. S., & Vishal, B. (2011). Clients’ satisfaction with anti-retroviral therapy services at Hamidia Hospital Bhopal. *National Journal of Community Medicine*, 2(3), 241.
- Kline, R. B. (2011). *Principles and practice of structural equation modeling*. New York: Guilford Press.
- Kravitz, R. L. (1998). Patient satisfaction with health care: Critical outcome or trivial pursuit? *J Gen Intern Med*, 13(4), 280–282. <http://dx.doi.org/10.1046/j.1525-1497.1998.00084.x>
- Kurti, S. (2015). *Patient satisfaction evaluation: A theoretical framework*. Retrieved from http://www.academia.edu/4085766/Patient_Satisfaction_Evaluation_-_A_Theoretical_Framework
- Larsen, D. E., & Rootman, I. (1976). Physician role performance and patient satisfaction. *Social Science and Medicine*, 10(1), 29–32.
- Lateef, F. (2010). Patient expectations and the paradigm shift of care in emergency medicine. *Journal of Emergencies, Trauma, and Shock*, 4(2), 163–167.
- Lebow, J. (1982). Consumer satisfaction with mental health treatment. *Psychological Bulletin*, 91(2), 244–259.
- Lebow, J. L. (1983). Client satisfaction with mental health treatment. *Evaluation Review*, 7, 729–752.

- Levant, R. F. (2005). *Report on the 2005 presidential task force on evidence based practice*. Retrieved from <http://www.apa.org/practice/ebpreport.pdf>
- Levin, K. A. (2006). Study design III: Cross-sectional studies. *Evidence-Based Dentistry*, 7, 24–25. <http://dx.doi.org/10.1038/sj.ebd.6400375>
- Lliffe, S., Wilcock, J., Manthorpe, J., Moriarty, J., Cornes, M., Clough, R., & Bright, L. (2008). Can clinicians benefit from patient satisfaction surveys? Evaluating the NSF for older people, 2005–2006. *Journal of Royal Society of Medicine*, 101(12), 598–604.
- Lund, C., Petersen, I., Kleintjes, S., & Bhana, A. (2012). Mental health services in South Africa: Taking stock. *African Journal of Psychiatry*, 15(6), 402–405.
- Marsh, H. W., Balla, J. R., & McDonald, R. P. (1988). Goodness of fit indexes in confirmatory factor analysis: The effect of sample size. *Psychological Bulletin*, 103, 391–410.
- McCullem, R. C., Brown, M. W., & Sugarawa, H. M. (1996). Power analysis and determination of sample size for covariance structure modeling. *Psychological Methods*, 1(2), 130–149.
- Mueller, R. O. (1996). *Basic principles of structural equation modeling: An introduction to LISREL and EQS*. New York: Springer.
- National Department of Health. (2013). *National Health Insurance*. Retrieved from <http://www.doh.gov.za/list.php?type=Natiopnal%20Health%20Insurance>
- National Health Insurance for South Africa. (2015). *Towards universal health coverage* (Version 40) [White paper]. Retrieved May 4, 2016, from Department: Health, Republic of South Africa: <http://www.health-e.org.za/wp-content/uploads/2015/12/National-Health-Insurance-for-South-Africa-White-Paper.pdf>

- Neuman, W. L. (2000). *Social research methods: Qualitative and quantitative approaches*. Boston, MA: Allyn & Bacon.
- Noar, S. M. (2013). The role of structural equation modeling in scale development. *Structural Equation Modeling A Multidisciplinary Journal*, 10(4), 622–647.
http://dx.doi.org/10.1207/S15328007SEM1004_8
- Noble, L. M., Douglas, B. C., & Newman, S. P. (2001). What do patients expect of psychiatric services? A systematic and critical review of empirical studies. *Social Science and Medicine*, 52(7), 985–98.
- Norberg, M. M., Wetterneck, C. T., Sass, D. A., & Kanter, J. W. (2011). Development and psychometric evaluation of the Milwaukee psychotherapy expectations questionnaire. *Journal of Clinical Psychology*, 67(6), 574–590.
- Nunnally, J. (1978). *Psychometric theory*. New York: McGraw-Hill.
- Nunnally, J. C., & Bernstein, I. H. (1994). *Psychometric theory* (3rd ed.). New York: McGraw-Hill.
- O'Connor, S. J., & Shewchuk, R. (2003). Commentary – patient satisfaction: What is the point? *Healthcare Management Review*, 28(1), 21–24.
- Oei, T. P. S., & Green, A. L. (2008). The satisfaction with therapy and therapist scale – revised (STTS-R) for group psychotherapy: Psychometric properties and confirmatory factor analysis. *American Psychological Association*, 39(4), 435–442.
- Oei, T. P. S., & Shuttlewood, G. J. (1999). Development of a satisfaction with therapy and therapist scale. *Australian and New Zealand Journal of Psychiatry*, 33, 748–753.
- Oliver, R. L. (1981). Measurement and evaluation of satisfaction processes in retail settings. *Journal of Retailing*, 57(3), 25–48.
- Palazzo, C., Jourdan, C., Descamps, S., Nizard, R., Hamadouche, M., Anract, P., ...Poiraudau S. (2014). Determinants of satisfaction 1 year after total hip

- arthroplasty: The role of expectations fulfilment. *BMC Musculoskeletal Disorders*, 15(53). <http://dx.doi.org/10.1186/1471-2474-15-53>
- Palmer, R. H., Donabedian, A., & Povar, G. J. (1991). *Striving for quality in health care: An inquiry into policy and practice*. Chicago, IL: Health Administration Press.
- Reeder, L. G. (1972). The patient-client as consumer: Some observations on the changing professional-client relationship. *Journal of Health and Social Behavior*, 13(4), 406–412.
- Rivers, P. A., & Glover, S. H. (2008). Health care competition, strategic mission, and patient satisfaction: Research model and propositions. *Journal of Health Organization and Management*, 22(6), 627–641.
- Ruane, I. (2010). Obstacles to the utilisation of psychological resources in a South African township community. *South African Journal of Psychology*, 40(2), 214–225.
- Sackett, D. L., Straus, S. E., Richardson, W. S., Rosenberg, W., & Haynes, R. B. (2000). *Evidence-based medicine: How to practice and teach EBM* (Vol. 2). London: Churchill Livingstone.
- Shaughnessy, J., & Zechmeister, E. (1994). *A practical introduction to research methods in psychology* (2nd ed.). New York: McGraw-Hill.
- Sitzia, J., & Wood, N. (1997). Patient satisfaction: A review of issues and concepts. *Social Science & Medicine*, 45(12), 1829–1843.
- South African Depression and Anxiety Group. (2013). *Newsletters*. Retrieved from http://www.sadag.org/index.php?option=com_content&view=article&id=10&Itemid=113
- Spring, B. (2007). Evidence-based practice in clinical psychology: What it is, why it matters; what you need to know. *Journal of Clinical Psychology*, 63(7), 611–631.

- SPSS Inc. (2016). *IBM SPSS Statistics (Version 23) [Computer software]*. Retrieved from <http://www-01.ibm.com/software/analytics/spss/>
- Steiner, D. L. (2003). Starting at the beginning: An introduction to coefficient alpha and internal consistency. *Journal of Personality Assessment*, *80*, 99–103.
http://dx.doi.org/10.1207/S15327752JPA8001_18
- Strauss, M. E., & Smith, G. T. (2009). Construct validity: Advances in theory and methodology. *Annual Review Clinical Psychology*, *27*(5), 1–25.
<http://dx.doi.org/10.1146/annurev.clinpsy.032408.153639>
- Swift, J. K., & Callahan, J. L. (2009). The impact of client treatment preferences on outcome: A meta-analysis. *Journal of Clinical Psychology*, *65*(4), 368–381.
<http://dx.doi.org/10.1002/jclp.20553>
- Tabachnick, B. G., & Fidell, L. S. (2001). *Using multivariate statistics* (4th ed.). Boston, MA: Allyn & Bacon.
- Tabachnick, B. G., & Fidell, L. S. (2007). *Using multivariate statistics* (5th ed.). Boston, MA: Allyn & Bacon.
- The Society of Clinical Child and Adolescent Psychology (Division 53 of the APA). (2014). *Society of clinical child and adolescent psychology*. Retrieved from <https://www.apa.org/about/division/div53.aspx>
- Urden, K. D. (2002). Patient satisfaction measurement: Current issues and implications. *Outcomes Management*, *6*(6), 125–131.
- Wadhwa, S. S. (2002). Customer satisfaction and health care delivery systems: Commentary with Australian bias. *E-Journal of Nuclear Medicine*, *1*(1), 1539–4638. Retrieved from <http://ispub.com/IJNUC/1/1/8617>

- Walker, M. S., Ristvedt, S. L., & Haughey, B. H. (2003). Patient care in multidisciplinary cancer clinics: Does attention to psychosocial needs predict patient satisfaction? *Psycho-Oncology*, *12*(3), 291–300.
- Williams, B. (1994). Patient satisfaction: A valid concept? *Social Science and Medicine*, *38*(4), 509–516.
- Williams, B., Coyle, J., & Healy, D. (1998). The meaning of patient satisfaction. *Social Science and Medicine*, *47*, 1351–1359.
- Winerman, L. (2005). Helping men to help themselves: Research aims to understand why men are less likely than women to seek mental health help, and what psychologists can do to change that. *American Psychological Association*, *36*(6), 57.
- World Health Organization. (2001). *Mental health: World health ministers call for action* [PDF file]. Retrieved from http://www.who.int/mental_health/media/en/249.pdf
- Yi, Y. (1990). *A critical review of customer satisfaction*. Chicago, IL: American Marketing Association.

Table A: Biographical particulars frequency distributions (N = 204)

	Description	Frequency	Percentages
Gender	Male	77	37,7%
	Female	120	58,8%
Age	18 - 20	19	9,3%
	21 - 30	36	17,6%
	31 - 40	46	22,5%
	41 - 50	44	21,6%
	51 - 60	34	16,7%
	61 - 70	19	9,3%
	70+	6	2,9%
Race	White	108	52,9%
	Black	76	37,3%
	Indian	9	4,4%
	Coloured	9	4,4%
Sessions Attended	1	28	13,7%
	2 - 3	33	16,2%
	3 - 5	49	24,0%
	5 - 8	50	24,5%
	8+	35	17,2%
Occupation	Management	14	6,9%
	Professional	60	29,4%
	Administrative	35	17,2%
	Tradesperson	29	14,2%
	Customer Service	9	4,4%
	Operators	4	2,0%
	Unskilled	10	4,9%
	Student	29	14,2%
	Unemployed	11	5,4%
Education	Primary School	13	6,4%
	High School	104	51,0%
	University	55	27,0%
	Post-graduate	29	14,2%
Language	Afrikaans	93	45,6%
	English	52	25,5%
	Setswana	55	27,0%
Referral Source	Self-referred	96	47,1%
	GP	86	42,2%
	Other	21	10,3%

Table 1: Factor loadings after Oblimin rotation: Correlations among items of the MPEQ

Item No.	Statement	Component	
		Process Expectations (1)	Outcome Expectations (2)
6	I Expect that my therapist will be interested in what I have to say	.815	
8	I Expect that I will attend every appointment	.801	
1	I Expect that my therapist will provide support	.796	
4	I Expect that I will feel comfortable with my therapist	.768	
7	I Expect that my therapist will be sympathetic	.761	
5	I Expect that my therapist will be sincere	.759	
3	I Expect that I will be able to express my exact thoughts and feelings	.672	
2	I Expect that my therapist will provide me with feedback	.613	
12	After therapy, I will be a much more optimistic person		1.004
11	I anticipate being a better person as a result of therapy		.835
10	After therapy, I will have the strength(s) needed to avoid future feelings of distress		.812
9	Therapy will provide me with an increased level of self-respect		.805
13	I expect that I will tell my therapist if I have any concerns about therapy	.340	.424

Factor loadings smaller than 0.3 were suppressed to improve interpretability of the factor structure

Table 2: Factor loadings after Oblimin rotation: Correlations among items of the STTS-R

Item No.	Statement	Component	
		Sat. with Therapist (SWT)	Sat. with Therapy (ST)
5	I would recommend the program to a friend	.952	
9	I am now able to deal more effectively with my problems	.952	
3	My needs were met by the program	.947	
7	I would return to the clinic if I needed help	.801	
4	The therapist provided an adequate explanation regarding my therapy	.709	
1	I am satisfied with the quality of therapy I received	.697	
8	The therapist was friendly and warm towards me		.984
6	The therapist was not negative or critical towards me		.826
12	The therapist seemed to understand what I was thinking and feeling		.671
2	The therapist listened to what I was trying to get across		.639
10	I felt free to express myself	.407	.467
11	I was able to focus on what was of actual concern to me	.437	.466

Factor loadings smaller than 0.3 were suppressed to improve interpretability of the factor structure

Table 3: Goodness of fit indices values for the postulated model structure: MPEQ and STTS-R (Construct Validity)

Scale	Validity: EFA			Validity: CFA				
	Exploratory Factor Analyses (EFA)			Confirmatory Factor Analyses (CFA)				
	KMO	% Variance Explained	P	CMIN/DF	CFI	RMSEA	LO 90 (CI)	HI 90 (CI)
MPEQ:	0.911	64.645	<.001	3.695	0.900	0.115	0.100	0.131
STTS-R: 3-factor model	0.954	76.021	<.001	2.794	0.954	0.094	0.078	0.111
STTS-R: 1-factor model	0.959	69.815	<.001	3.352	0.937	0.108	0.092	0.124

LO 90 and HI 90 indicate the lower and higher 90% confidence limits of the RMSEA

Figure 1: Results of CFA measurement model for MPEQ with standardised regression weights and correlation

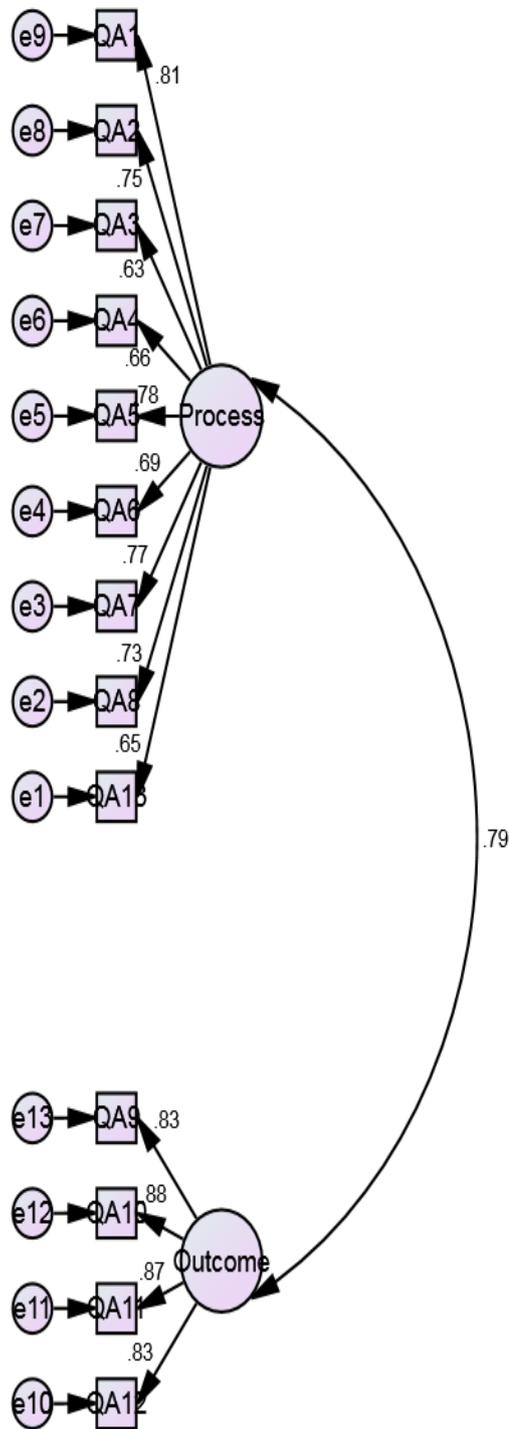


Figure 2: Results of CFA measurement model for STTS-R (3-factor model) with standardised regression weights and correlations

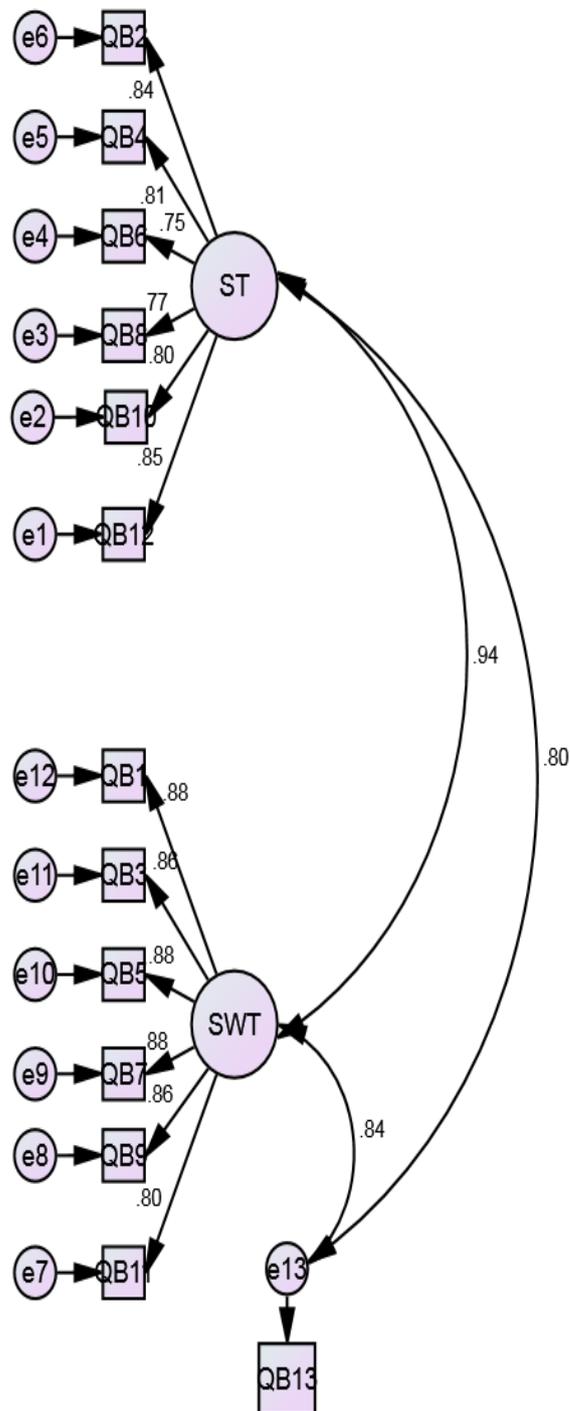


Figure 3: Results of CFA measurement model for STTS-R (1-factor model) with standardised regression weights and correlations

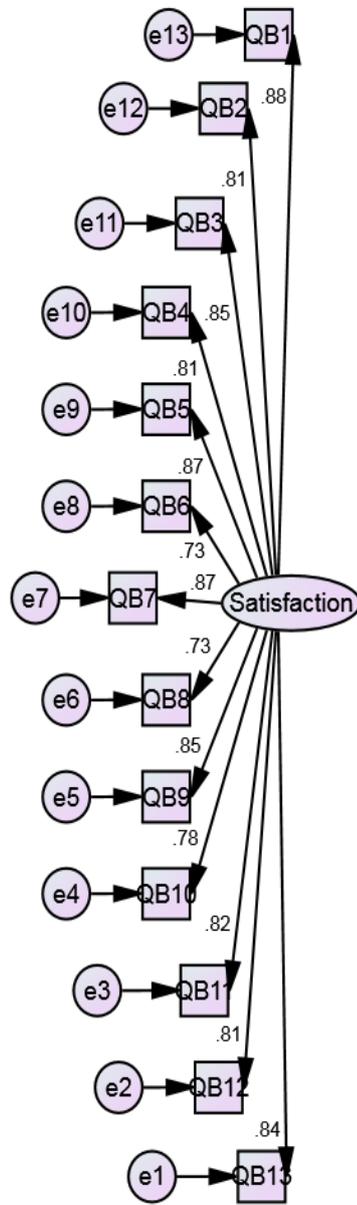


Table 4: Descriptive statistics, mean inter-item correlation and reliability indices for the MPEQ and STTS-R scales (n = 204)

Scale	M	SD	Range Min-max	Range of item-total correlations	Mean inter-item correlations	Cronbach Alpha (α)
MPEQ:						
Process Expectations	4.37	0.66	1.89 - 5.00	.31 - .77	0.520	0.90
Outcome Expectations	4.01	0.96	1.00 - 5.00	.69 - .76	0.727	0.91
Expectation Total	8.39	1.50	3.64 - 10.00	.73 - .73	0.725	0.81
STTS-R:						
Satisfact. with Therapy (ST)	24.88	4.73	8.00 - 30.00	.53 - .72	0.644	0.91
Satisfact. With Therapist (SWT)	23.57	5.90	6.00 - 30.00	.44 - .69	0.530	0.87
Satisfact. Global	4.08	0.99	1.00 - 5.00	-	-	(Item 13)

SECTION B: ARTICLE 2

**THE NATURE OF CLIENTS' EXPECTATIONS AND SATISFACTION WITH
PSYCHOLOGICAL TREATMENT IN A SOUTH AFRICAN CONTEXT**

To be submitted to the
South African Journal of Psychology

3.1 Guidelines for authors:

South African Journal of Psychology Information for Contributors

Submission of a manuscript

SAJP is a peer-reviewed journal publishing empirical, theoretical, and review articles on all aspects of psychology. Articles may focus on South African, African, or international issues. Manuscripts to be considered for publication should be e-mailed to sajp@up.ac.za. A covering letter with postal address, e-mail address, and telephone number should be included. The covering letter should indicate that the manuscript has not been published elsewhere and is not under consideration for publication in another journal. An acknowledgement of receipt will be e-mailed to the author (within seven days, if possible) and the manuscript will be sent for review by three independent reviewers. The manuscript number must always be quoted in ALL correspondence to the editor. Only one article per author will be published per calendar year. Exceptions to this rule will be at the sole discretion of the editor (with the associate editors) in the case of an exceptional article that needs to be published, a special issue where the specific article will make a significant contribution, or a written response to a *riposte*, etc.

Where authors are invited to revise their manuscripts for re-submission, the editor must be notified (by e-mail) of the author's intention to resubmit and the revised manuscript re-submitted within six weeks. After a longer period, it will be treated as a completely new submission.

Manuscript structure

Manuscripts (including references and tables) should be no longer than 20 pages (5 000 words), and must include the full title of the manuscript, the name(s) of the author(s) and their affiliations, and the name, postal address, and e-mail address of the corresponding author.

An abstract, no longer than 300 words, and an alphabetical list of at least six keywords should be provided. The introduction to the article does not require a heading. Tables and figures, with suitable headings/captions and numbered consecutively, should follow the reference list, with their approximate positions in the text indicated.

The manuscript should be an MS Word document in 12-point Times Roman font with 1.5 line spacing. The American Psychological Association (APA, ver. 5) style guidelines and referencing format should be adhered to.

Short submissions

SAJP invites short reports on any aspect of theory and practice in psychology. We encourage manuscripts which either showcase preliminary findings of research in progress or focus on larger studies. Reports (of no more than 2 500 words) should be presented in a manner that will make the research accessible to our readership.

Language

Manuscripts should be written in English. It is compulsory that manuscripts be accompanied by a declaration that the language has been properly edited, together with the name and address of the person who undertook the language editing.

Ethics

Authors should take great care to spell out the steps taken to facilitate ethical clearance, i.e. how they went about complying with all the ethical issues alluded to in their study, either directly or indirectly, including informed consent and permission to report the findings. If, for example, permission was not obtained from all respondents or participants, the authors should carefully explain why this was not done.

3.2 Manuscript: The nature of clients' expectations and satisfaction with psychological treatment in a South African context

The Nature of Clients' Expectations and Satisfaction with Psychological Treatment in a
South African Context

Ernst J. van der Merwe, Esmé van Rensburg, Suria M. Ellis

School of Psychosocial Behavioural Sciences, North-West University: Potchefstroom
Campus, Potchefstroom

Correspondence to:

E. J. van der Merwe*

C/o Prof E. van Rensburg,

School of Psychosocial Behavioural Sciences,

North-West University: Potchefstroom Campus,

Private Bag X6001,

Potchefstroom, 2520, South Africa

Tel +27 14 590 1757 or +27 83 978 3155

Fax +2786 760 3231

*All correspondence to: E-mail:

ernst.vandermerwe@angloamerican.com

Abstract

This study explored the nature of clients' expectations and satisfaction with their psychological treatment in a South African context. A quantitative cross-sectional study was conducted, comprising a convenience sample of 204 post-psychotherapy participants from 13 contributing psychologists, practising in the private sectors of Gauteng and the North-West provinces of South Africa. The study incorporated the Milwaukee Psychotherapy Expectations Questionnaire (MPEQ), and the Satisfaction with Therapy and Therapist Scale (STTS-R), together with a biographical questionnaire to gather data about the treatment expectations and satisfaction of clients. The results advocated accountability for all health professionals in meeting the needs and satisfaction of their clients by incorporating objective measures into the determination of client satisfaction and expectations. Results furthermore hold implications for the science of psychology from an evidence-based framework, for medical aids and medical insurance, and for training and student education. An important implication is that therapists will have to start looking at evaluating themselves in terms of effectiveness as reflected in good business practices.

Keywords

Client expectations, client satisfaction, psychological treatment, South Africa

The dawning of the twenty-first century as the information age has equipped clients as users of healthcare services with knowledge, and has positioned them to better evaluate and understand previously inconceivable material (Slywotzky, 2015). Clients are now better informed than ever and are correspondingly asked on a routine basis to evaluate the quality of services they receive.

The development of consumerism in the health field, as well as transforming client-professional relationships steered the health-care professional to take into account the clients' desires, satisfaction, and dissatisfaction. The increasing number of published papers relating to client satisfaction within the healthcare field further underpins the importance thereof and designates a growing interest in this category of research (Branson, Buxton, & Fryman, 2014; Gill & White, 2009; Junewicz & Youngner, 2015; Kravitz, 1998; Rivers & Glover, 2008; Williams, Coyle, & Healy, 1998). Consumer satisfaction surveys are now a standard part of practice in many mental health facilities (Brown, Ford, Deighton, & Wolpert, 2014; Harmon et al., 2007; Lebow, 1982) and the significance thereof lies not only in the data presented, but also in the far more important concept of quality health services and the client partaking in their own healthcare.

This uprising in the evaluation of health service quality and accompanying increased scholarly interest follows the introduction of evidence-based practices (EBP) in psychology (Buysse & Wesley, 2006). EBP involves "the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (American Psychological Association, 2006, p. 5). Principles of accountability for the health professions have subsequently emerged around the concept of EBP (Edwards, 2009); advocating conscientious use of current, best evidence in making decisions about the care of individual clients. Evidence-based empirically validated treatment requires practitioners to consistently evaluate and utilise the best available research in order to meet the needs and satisfaction of their clients (Berke, Rozell, Hogan, Norcross & Karpiak, 2011; Lilienfeld, Ritschel, Lynn, Cautin, & Latzman, 2014).

Healthcare providers and researchers alike have interminably believed that clients would be satisfied with good services and dissatisfied with poor services (Amyx, Mowen, & Hamm, 2000). However, research findings indicate that the actual experience is only one of several factors that determine whether a client is satisfied or dissatisfied with their healthcare (Asadi-Lari, Tamburini, & Gray, 2004; Jimmieson, 1998). A client's expectations, prospects, personal characteristics, health status, and physician choice (subject to managed care health insurance plans) also constitute client satisfaction and play a vital role in clients' appraisal of

their satisfaction with healthcare (Amyx et al., 2000). Moreover, certain aspects of a client's experience with healthcare appear to be more influential than that of others (Frattali, 1991). Accordingly, in several studies researchers have found that satisfaction relates to the fulfilment of clients' expectations (Bjertnaes, Sjetne, & Iversen, 2011; Bleich, Ozaltin, & Murray, 2009; Bowling et al., 2012; Duckro, Beal, & George, 1979). Client expectations play an important role in the process by which an outcome of care can be said to be satisfactory or unsatisfactory, as clients bring to any evaluation process a set of expectations that result from their beliefs about idyllic prospects or anticipated situations (Miller & Turnbull, 1996). When an experience fulfils certain positive expectations that clients hold about the care they will receive, patients are likely to be satisfied, and when experience fails to meet expectations, patients may be dissatisfied (Bleich et al., 2009; Kurti, 2015; Noble, Douglas, & Newman, 2001).

It makes sense then that the consumer's view as an assessor of treatment has merit and remains indispensable to assessment of quality in healthcare. Comparatively, psychological treatment must be judged by whether clients obtained what they sought and were satisfied with their experience, just as evaluation of other health services are determined by such considerations.

Within this framework of patient-centred healthcare, client satisfaction emerged as an important indicator of quality client care. The significance of the client satisfaction paradigm is further emphasised by evidence that satisfied clients are more likely to adhere to treatment; obtain better clinical outcomes (Sandoval, Levington, Blackstein-Hirsch, & Brown, 2005); benefit from their healthcare; and have a higher quality of life (Walker, Ristvedt, & Haughey, 2003). By targeting these aspects of psychotherapeutic treatment that clients consider of utmost importance, clinicians may optimise client satisfaction and the quality of care, which in turn, is in keeping with quality assurance, accreditation, and ethical competency of the practitioner. Satisfying clients in a competitive marketplace consequently benefits clinicians, healthcare facilities, shareholders, and clients similarly (Newsome & Wright, 1999).

Despite the widespread use of consumer evaluation in mental health settings, coherent literature has yet to develop (Junewicz & Youngner, 2015; Kurti, 2015; Lebow, 1982). Research into patient satisfaction with and expectations of healthcare provision, as well as with health services in general is limited in South Africa (Govender, McIntyre, Grimwood, & Maartens, 2000; Wouters, Heunis, van Rensburg, & Meulemans, 2008). Moreover, the literature on patient satisfaction, specifically with psychological treatment or psychotherapy

services within a South African context appears to be even more deficient (Govender et al., 2000; Myburgh, Solanki, Smith, & Lalloo, 2005).

Limitations to satisfaction research in South Africa include poorly designed studies (i.e. small sample size), a lack of sophisticated statistical analysis (i.e. confirmatory factor-analytical analysis by means of structural equation modelling) and poorly controlled studies (Brown et al., 2014; Gill & White, 2009; Hawthorne, 2006). Although many studies were conducted on clients' expectations of and satisfaction with psychological treatment in the United States and Europe, a lack of research in this field within a South African setting (Westaway, Rheeder, van Zyl, & Seager, 2002) necessitates the current research even further.

Consequently, the aim of this research was to determine and explore the nature of clients' expectations and satisfaction with psychological treatment in a South African context. The nature therefore implies how it manifests in different biographical variables, for example, any patterns in gender, occupation, and source of referral. Specific reference was given to the hierarchical nature of the data and associations with biographical variables in order to conclude whether any such associations existed between biographical variables, and expectations, and the satisfaction of clients.

This research will subsequently add to the understanding of, and extend the current available literature on patient satisfaction with psychotherapy in South Africa.

Method

Research Design

This study followed a quantitative research paradigm, an organized method for combining deductive logic with precise empirical observations (Levin, 2006). This approach is thus further in line with EBP. A cross-sectional survey design was used, which is appropriate where groups of subjects at various stages of development are studied simultaneously and whereby the survey technique of data collection gathers information from the target population by means of questionnaires (Burns & Grove, 1993; Shaughnessy & Zechmeister, 1994).

Participants

The study included a convenience sample of 204 post-psychotherapy clients (participants) from 13 contributing psychologists, practising in the private sectors of Gauteng and the North-West provinces of South Africa. Of the participants, 108 were white, 76 black, nine Indian, and nine coloured (two did not indicate their race). Most of the participants were

Afrikaans-speaking (45.6%) individuals from the Gauteng province in South Africa, which is an urban area. 55 participants (or 27.5%) indicated that their preferred language was Setswana, and 52 (25.5%) of the participants were English-speaking individuals. The sample included 77 males and 120 females – typically, more females than males consult psychologists (Winerman, 2016). Ages ranged from 18 to 70+, with the majority between 31 and 40 years of age (Table 1). Most of the participants were self-referred (47.1%), held a high school level of education, and were from professional occupational levels. The majority (24.5%) attended between five to eight therapy sessions. The data was collected during the last three months of 2015.

Measurement Instruments

Measurement Instrument for Psychotherapeutic Expectations. The Milwaukee Psychotherapy Expectations Questionnaire (MPEQ) was utilised to gather data about the treatment expectations of clients. Norberg, Wetterneck, Sass and Kanter developed the MPEQ during 2011, and it presented initial evidence in assessing both process and outcome expectations in therapy. The questionnaire was also established to measure clients' expectations about the components and effects of therapy. The instrument demonstrated good internal consistency and test–retest reliability, along with support for convergent, discriminant, and predictive validity (Norberg et. al, 2011). The MPEQ is the first psychometrically sound brief measure of both process and outcome expectations of therapy. The questionnaire consists of a list of 13 statements describing expectations about therapy that clients may have. The statements cover expectations regarding their own behaviour in therapy, their therapist, and the therapy setting. Each statement was scored by the participants on a scale of one to five, where a score of one would indicate that the participant did not foster this expectation or did not agree with this statement at all. A score of five would indicate that the participant did foster this expectation and is in complete agreement with the statement. Examples of statements include, “I expect my therapist will provide support”; “My therapist will be sincere”; “I will be able to express my true thoughts and feelings”, and “After therapy I will be a much more optimistic person”. The questionnaire is sub-divided into nine statements comprising the *Process Expectations* subscale, and four statements that cover the *Outcome Expectations* subscale. Subscale scores are calculated by summing the items included on a factor and then dividing by the number of items included. The *Total* score is the sum of both subscale scores (Norberg et. al, 2011). Process and Outcome

expectations will therefore be interpreted in terms of the average means that were processed to a score of one to five, while the Expectations Total was processed to a score out of 10.

Measurement Instrument for Client Satisfaction with Psychotherapy. The Satisfaction with Therapy and Therapist Scale (STTS-R) was used to gather data about the treatment satisfaction of clients. The STTS-R was developed by Oei and Shuttlewood during 1999 and designed to assess patients' level of satisfaction with their therapeutic endeavour. The STTS-R has sound psychometric properties and as such serves as a useful instrument in assessing a patient's level of satisfaction with both therapy and therapist, in research as well as clinical settings. The STTS-R has a factor structure of a 13-item scale that is determined by way of principle components factor analysis. The statements are scored on a scale of one to five where one represents "strongly disagree" and five "strongly agree". Statements include, "The therapist listened to what I was trying to get across"; "I would recommend the program to a friend", and "I would return to the clinic if I needed help". Six statements comprise the *Satisfaction with Therapy (ST)* subscale, and six involve the level of *Satisfaction with the Therapist (SWT)*. The sum of the scores of the respective items represents the subscale score. In addition there is a client-rated measure of *Global* improvement (item 13), an outcome variable that determines the client's perception of the efficacy of the treatment. Therefore, Satisfaction with Therapy (ST), and Satisfaction with Therapist (SWT) will be interpreted in terms of a score out of 30, whilst the Global Satisfaction will therefore be interpreted in terms of the average means that were processed to a score of one to five.

Reliability and Validity

The reliability and validity of the STTS-R and MPEQ for the current population were determined in a previous article (Van der Merwe, Van Rensburg, & Ellis, 2016). Excellent reliability indices were obtained for both the MPEQ and the STTS-R in this study, with all alpha coefficients larger than 0.85. These findings indicated good reliability estimates of the scales and that these items were a good sample of the intended construct (Clark & Watson, 1995; Steiner, 2003). The measurement model was also previously discussed and verified in an earlier article by the same authors, and it indicated that all items had satisfactory construct validity as it relates to Outcome and Process Expectations, as well as to Satisfaction with Therapy and With the Therapist (Van der Merwe, Van Rensburg, & Ellis, 2016).

Procedure

Thirteen contributing psychologists acted as gatekeepers, identifying and determining which possible clients could be approached. The gatekeepers also obtained written informed consent from each participant before providing the researcher with their e-mail addresses, and anonymity was guaranteed. Participants were subsequently contacted via the provided e-mail addresses to explain the aim of the research and to request their participation. This was achieved by assuring clients of the anonymity of their results and emphasising that their psychologist will in no way be involved with or shown their individual responses. Furthermore, this also ensured objectivity of the participant. Participants were then given the opportunity to ask the researcher any questions that they might have had. Once the participant had agreed to participate and consented in writing, the researcher distributed the relevant questionnaires. The participants were required to complete a biographical questionnaire regarding their age, gender, therapy duration, occupation, socio-economic demographics, and source of referral; the Milwaukee Psycho-therapy Expectations Questionnaire, as well as the Satisfaction with Therapy and Therapist Scale. Questionnaires were completed in English via e-mail.

Ethical Considerations

Approval was obtained from the Ethics committee of the North-West University for this project (approval number: NWU-00195-14-A1).

Data Analysis

The statistical analysis was done with the SPSS version 23 program (SPSS Inc., 2016) and SAS (SAS Institute Inc., 2016) programmes. In these analyses, the dependence of clients from the same psychologist in terms of satisfaction and expectation had to be taken into account. In this regard, McCoach (2006) states that “hierarchical linear modelling allows” us “to adjust for and model this non-independence”, and “explains both the between-cluster and within-cluster variability of an outcome variable of interest” (p. 123).

Hierarchical Linear Modelling (HLM) was used to examine the effect of categorical biographical variables, for example gender, occupation, and source of referral, on expectations and satisfaction scores. In these models, the psychologist was considered as primary unit of measurement whilst the covariance matrix was assumed unstructured. The average expectations and satisfaction scores for different biographical groups, mean square error (MSE), variance due to the psychologist, *p*-values and effect sizes were determined to examine this effect. This type of analysis would customarily be done by means of *t* tests and

ANOVAs, but because the clients are not independent but bound to the psychologist, we employed a Hierarchical Linear Model.

Statistical significance (p -value < 0.05) is not relevant in this context, given the fact that this was a convenience sample. However, p -values will be reported for completeness, but more emphasis will be given to the interpretation of effect sizes. The effect size is independent of sample size and is a measure of practical significance that can be understood as a large enough effect to be important in practice (Ellis & Steyn, 2003). Cohen (1988) gives the following guidelines for the interpretation of effect sizes for the difference in means: small effect: $d = 0.2$; medium effect: $d = 0.5$; and large effect: $d = 0.8$. These are only guidelines and should not be applied too rigidly. Furthermore, when dealing with people one can usually expect a medium effect size.

PROC SURVEYREG in SAS was used to determine correlations between ordered biographical variables with the different scores of expectations and satisfaction, taking the hierarchical nature of the data into account. R-square, the proportion of variance explained by variables, was used to determine the practical significance of correlations (Ellis & Steyn, 2003). The guidelines suggest a small effect when R-square is approximately 0.01; 0.1 is taken as a medium effect, and 0.25 as a large effect.

Results

The data obtained in this study comprised 204 post-psychotherapy participants from 13 contributing psychologists, practising in the private sectors of Gauteng and the North-West provinces of South Africa. The participants were diverse in their backgrounds and encompassed relatively different cultural contexts.

< Insert Table 1 approximately here >

The nature of a group of clients' expectations and satisfaction with psychological treatment in a South African context is indicated in Table 2. Concerning the expectations of this group, it seems as if the clients held very high expectations in general. Process Expectations averaged 4.38 out of 5, and the Outcome Expectations were high at 4.02 out of a maximum of 5, indicating that clients' expectations for the process were even higher than those for the outcome. The Expectation Total was also high with an average score of 8.39 out of 10.

With reference to satisfaction, it appears that in general satisfaction of the clients was very high. Satisfaction with Therapy averaged 24.88 out of 30, and Satisfaction with the

Therapist was high at 23.57 out of a maximum of 30. The Global Satisfaction was also high with an average score of 4.08 out of 5.

< Insert Table 2 approximately here >

The results of the HLM for gender are indicated in Table 3. The p -value of 0.005 indicated a statistically significant difference between the two genders regarding Process Expectations. The residual MSE was .404 and the variance of the psychologist was 0.037; indicating that, in this case, the error regarding psychologist was small in relation to the MSE, meaning that the psychologist did not have a large influence. Females on average had higher Expectations for the Process when compared to males (males = 4.16 and females = 4.42). The effect size (Cohen's d) was 0.40 (medium) indicating a practically significant, higher expectation for females in term of Process Expectations, when compared to those of the males.

Although statistical significant differences (p -value = 0.03) in Outcome Expectations were indicated it was not practically significant with the Cohen's $d = 0.29$, indicating a small effect size for females also having higher Outcome Expectations. The MSE was .749 and the variance of the psychologist was 0.256; meaning that the error regarding psychologist was larger than for Process.

The difference in Expectation Total was also statistically significant (p -value = 0.01), but only a small effect size for females having higher Total Expectations. The residual MSE was 1.976 and the variance of the psychologist was 0.377; indicating that the error regarding psychologist was small in relation to MSE.

The results of the difference in gender for satisfaction indicated that Satisfaction with Therapy, the Therapist, and the Global Satisfaction Total was not found to be statistically significant and therefore indicated insignificant effect sizes (Cohen's d -values ranged between 0.07 and 0.17).

< Insert Table 3 approximately here >

Other variables such as occupation and referral source were also explored. The results of the HLM for occupation are indicated in Table 4. No statistical significant differences were indicated, but with regard to the management or professional and administrative occupations, both these groups obtained high average scores on all the subscales pertaining to Expectations and Satisfaction. In contrast, the tradesperson and unskilled or unemployed occupational groups' average scores on all the Expectations and Satisfaction subscales tended to be lower when compared to management or professional and administrative occupations.

Although not statistically significant, management or professional occupations on average had higher Expectations for the Process when compared to tradesperson and unskilled or unemployed occupational groups. The effect sizes (Cohen's d) were 0.49 and 0.41 respectively (medium), indicating practically significant, higher expectations for management or professional occupations in terms of Process Expectations.

Although not statistically significant, administrative occupations on average also had higher Expectations for the Process when compared to tradesperson and unskilled or unemployed groups. The effect sizes (Cohen's d) were 0.50 and 0.42 respectively (medium), indicating practically significant, higher expectations for administrative occupations in terms of Process Expectations.

< Insert Table 4 approximately here >

The results of the HLM for source of referral are indicated in Table 5. No statistically significant differences were found for Expectations and Satisfaction concerning the source of referral. However, medium effect sizes of .51 and .45 were found for Outcome Expectations, indicating that clients who made the appointment themselves, or those that were referred by their General Practitioner, held on average practically significant, higher expectations than others regarding the Outcomes of their therapy. Their Satisfaction also tended to be higher. The residual MSE was .741 and the variance of the psychologist was 0.225, meaning that the error regarding psychologist was smaller in relation to MSE.

< Insert Table 5 approximately here >

Table 6 indicates the correlations between ordered biographical variables with expectations and satisfaction scores taking into account the hierarchical nature of the data.

Education showed a small (R-square = 0.018) negative relationship ($p = .060$), with Expectations of the Outcome ($r = -.136$). This indicates that highly educated clients would tend to expect less from the outcomes of therapy than uneducated clients did.

Satisfaction with the Therapist and Satisfaction with Therapy correlated positively ($p = .055$ and $.077$ respectively) with the number of sessions, indicating that the more sessions clients had with a psychologist, the more satisfied they were with both the therapist and with therapy. However, it is of small importance in practice (R-square = 0.018 and 0.015 respectively).

The variable age correlated significantly negative ($p=.045$) with Global Satisfaction, with a correlation coefficient of $-.153$. This indicated that older clients tend to be globally less satisfied and accordingly rate their satisfaction lower. However, it is of small importance in practice (R-square = 0.023).

< Insert Table 6 approximately here >

Discussion

In this article clients' expectations and satisfaction with psychological treatment in a group of South Africans was explored and evaluated to determine the nature of clients' expectations and satisfaction with their psychological treatment. This was done in order to conclude whether patterns existed and what, if any, the nature thereof was within said context. Specific reference was given to correlations between biographical variables and the expectation and satisfaction of clients by taking into account the hierarchical nature of the data.

Concerning the Expectations, it was found that clients held very high Expectations in general. Furthermore, findings indicate that Expectations for the Process that refer to expectations assessing aspects of the therapist, client, therapeutic relationship, and the change process (Norberg et al., 2011) were higher than those for the Outcome that in turn relate to expectations of how the client may change as a result of therapy (Norberg et al., 2011). The before-mentioned finding indicates that clients' Expectations about the therapist, the therapeutic relationship, and the change process were high, and that participants expect a great deal from the therapy process. In addition, these findings concur with the findings of Bleich et al. (2009).

The Expectation Total, i.e. the sum of both Process and Outcome Expectations (Norberg et al., 2011), was also high. This denotes that the South African population of the current study held high expectations for their psychotherapeutic endeavours, as it relates to Expectations about client change, as well as the course of, and relationships in therapy, and includes both the roles of the therapist and client. This result corresponds with the 2005 findings of Dew and Bickman.

With reference to Satisfaction, the satisfaction of clients was also generally very high. Findings indicated that Satisfaction with Therapy referring in a general to the acceptance of therapy as a valid endeavour, and its likelihood to produce benefit in the client's life (Oei & Shuttlewood, 1999), were slightly higher than the Satisfaction with the Therapist, referring to clients' evaluation of the therapist (Oei & Shuttlewood, 1999). The Global Satisfaction, a client-rated measure of global improvement or "outcome" assessment (Oei & Green, 2008), was also high. These findings are in line with most literature, which indicates high ratings on satisfaction studies (Angantyr, Rimner, Nordén, & Norlander, 2015; Gill & White, 2009; Hall & Dornan, 1990; Hansson, 1989; Marepula, 2012; Tsisis, Tsoukas, & Deutsch, 2000;

Williams & Calnan, 1991). The findings of the current study therefore suggest that South Africans too reported high levels of satisfaction with their psychological treatment.

The results of the HLM for gender indicated that females had higher Expectations for the Process of therapy, as it refers to clients' beliefs about what will happen during therapy. It also includes the behaviours or roles of the therapist and the client, the procedures that will occur, and the length of treatment, compared to those of the male participants. In practice, females expected more from the psychological process than males, and these include beliefs, roles, procedures, and length of therapy. Wilhelm et al. (2005) found that in particular, young female patients typically expected to receive strategies to enhance coping, and tended to receive more psycho-education and recommendations for support, correlating with the results of this study.

Nguyen Thi, Briancon, Empereur, and Guillemin (2002) found that men tended to give higher satisfaction ratings than women on four dimensions of satisfaction and that women tended to complain more often than men do. The researchers explained that these findings might indicate that women expect more than men do, or that women have different experiences than men. This finding might be further explained by the higher Expectations as it relates to Process, and thus corresponds to the findings of the present study. Females are generally greater consumers of services and a comprehensive survey by the Boston Consulting Group in 2008, found that health care was a source of frustration for women who reported dissatisfaction with their General Practitioners and specialists (Silverstein & Sayre, 2009). In addition, typically more females than males consult psychologists (Winerman, 2016). In contrast to the above, a 2015 study by Angantyr et al. found no gender differences regarding treatment results or satisfaction with the treatment, and women reported slightly higher overall satisfaction in the 2014 study of Robillos, Lale, Wooldridge, Heller, and Sarkin.

HLM of source of referral indicated that Outcome Expectations – items related to how the client may change because of therapy – were higher for clients who made the appointment themselves and for those that were referred by their General Practitioner than for others. This indicates that being referred by a medical professional for treatment, as well as the client's own motivation for seeking the help themselves, raised expectations regarding the outcomes of therapy for clients. Clients enter into therapy for many diverse reasons by the use of a number of routes, and have varying prior experiences; consequently their expectations can differ enormously (Ward, Linville, & Rosen, 2008). Being referred by a professional for therapy may thus be more credible and convincing for clients, resulting in

raising or promoting the expectations of clients for change because of therapy (Moore, Tambling, & Anderson, 2013).

In all cases, the variance of the psychologist in relation to residual MSE was found to be small; indicating that the effect of the psychologist in this South African study was small. This is a rather pronounced finding, indicating that the psychologist did not have a large effect on the clients' Expectations of and Satisfaction with Therapy. Moreover, it would appear that the Expectations of all participants were met and that the psychologists were thus able to meet the expectations of the clients adequately and satisfied their treatment needs.

Lastly, the correlations between the hierarchical nature of the data and the ordered biographical variables indicated that highly educated clients would tend to expect less from the Outcomes of Therapy. These are sometimes referred to as *Prognostic Expectations* (Norberg et al., 2011), and denote clients' expectancy for improvement and the anticipated helpfulness of therapy. The 2014 study of Mooney, Gibbons, Gallop, Mack, and Crits-Christoph, which examined the relation between credibility ratings and a variety of patient factors, found that education, in addition to expectations, may influence clients' perceptions of the credibility of a treatment rationale. Clients may view the therapist as the *expert* and consequently expect improvements. This finding might also be explained in terms of the fact that educated clients tend to be more critical and perhaps better informed. Correspondingly, Bruwer et al. (2011) found that low mental health literacy and stigma led to perceptions that treatment is ineffective and may even decrease the perceived need for treatment. The latter finding motivates the result found in this study, because better-educated clients are better informed and less prone to stigma or misinformation. These well-educated clients may also be more realistic in terms of their Expectations because of their educated nature. Educated clients may very well also realise that the science of psychology and the psychologist has limitations and that the process of change involves a conscious and consistent effort from individuals themselves.

Findings indicated that the more sessions a client had with a psychologist the more satisfied they were with both the Therapist and with Therapy. A study in 2000 by Draper, Jennings, Baron, Erdur, and Shankar also found a positive relationship between the outcome of therapy and the number of sessions the clients attended, with most improvement recorded at session six and ten. This is a logical and self-explanatory finding, because unsatisfied clients would most probably not return for subsequent sessions, and those that do return tend to be more satisfied (Topham & Wampler, 2008; Holcomb et al., 1998).

The finding in the current study indicated that older clients tended to be globally less satisfied and accordingly rate their Global Satisfaction lower. In previous studies researchers found that age, in addition to expectations, may influence clients' perceptions of the credibility of a treatment rationale (Mooney et al., 2014), and as such this finding conforms to the literature on this fact. In contrast to this finding, research conclusions in some literature indicate that older clients may very well be more satisfied in general (Rosenheck, Wilson, & Meterko, 1997). Older clients experience several psycho-educational challenges that might decrease their ability and capacity for change (Von Humboldt & Leal, 2015). Furthermore, taking into account that physical health was not incorporated in the study, this finding might be further explained by the physical health of older clients who were likely to be poorer and frailer. It would appear that the physical health of older clients tends to influence satisfaction negatively in general. As such, Strine, Chapman, Balluz, Moriarty, & Mokdad (2008) revealed that chronic patients tend to express less satisfaction with their treatment. Older clients also hold more experience with healthcare visits in general, which may further influence their rating of global satisfaction. However, Tucker and Adams (2001) found that unclear and contradictory relationships do exist between satisfaction and age. However, the current research indicated that older clients were less satisfied with the efficacy and Global improvement of their treatment.

Conclusion

The contribution of this research cannot be underestimated. Firstly, the results obtained from this study conform to the ideologies of evidence-based practices in psychology that involves the best available research integrated with clinical expertise in the context of patient characteristics, culture and preference (APA, 2006, p. 5), advocating accountability for all health professionals in meeting the needs and satisfaction of their clients. The only way of ensuring that the needs of our clients are fulfilled is to integrate objective measurement as a necessary part of the determination of client satisfaction and expectations. Determining the needs, satisfaction, and expectations of clients furthermore holds implications for the science of psychology and thus points to psychotherapy providing evidence of being a science.

Secondly, from an evidence-based framework therapists will also have to evaluate clients' satisfaction. Client satisfaction has implications for medical aids and medical

insurance that are increasingly demanding evidence-based practice confirmation from psychologists, which includes evaluation.

Thirdly, client satisfaction holds implications for training. Not only will students have to be better educated regarding taking into account client populations and their specific needs, but also regarding the necessity of evaluating clients' expectations and satisfaction.

An important implication is that therapists will have to start looking at evaluating themselves in terms of effectiveness. Evaluation of client expectation and satisfaction reflects good business practice – psychologists can no longer just assume that what they are doing is effective.

References

- Allik, J., & McCrae, R. R. (2004). Towards geography of personality traits: Patterns of profiles across 36 cultures. *Journal of Cross-Cultural Psychology, 35*(1), 13–28. <http://dx.doi.org/10.1177/0022022103260382>
- Amyx, D., Mowen, J. C., & Hamm, R. (2000). Patient satisfaction: A matter of choice. *Journal of Services Marketing, 14*(7), 555–572. <http://dx.doi.org/10.1108/08876040010352727>
- Angantyr, K., Rimner, A., Nordén, T., & Norlander, T. (2015). Primary care behavioral health model: Perspectives of outcome, client satisfaction, and gender. *Social Behavior and Personality: An International Journal, 43*(2), 287–302. Retrieved from <https://www.sbp-journal.com/index.php/sbp/article/view/4323>
- APA Presidential Task Force on Evidence-Based Practice. (2006). Evidence-based practice in psychology. *American Psychologist, 61*(4), 271–285. <http://dx.doi.org/10.1037/0003-066X.61.4.271>
- Asadi-Lari, M., Tamburini, M., & Gray, D. (2004). Patients' needs, satisfaction, and health related quality of life: Towards a comprehensive model. *Health and Quality Life Outcomes, 2*(32), 1-15. <http://dx.doi.org/10.1186/1477-7525-2-32>
- Berke, D. M., Rozell, C. A., Hogan, T. P., Norcross, J. A., & Karpiak, C. P. (2011). What clinical psychologists know about evidence-based practice: Familiarity with online resources and research methods. *Journal of Clinical Psychology, 67*, 329–339.
- Bjertnaes, O. A., Sjetne, I. S., & Iversen, H. H. (2011). Overall patient satisfaction with hospitals: Effects of patient-reported experiences and fulfilment of expectations. *BMJ Quality & Safety, 21*, 39–46. <http://dx.doi.org/10.1136/bmjqs-2011-000137>
- Bleich, S. N., Ozaltin, E., & Murray, C. K. (2009). How does satisfaction with the health-care system relate to patient experience? *Bulletin of the World Health Organization, 87*(4), 271–278. <http://dx.doi.org/10.1590/S0042-96862009000400012>
- Bowling, A., Rowe, G., Lambert, N., Waddington, M., Mahtani, K. R., Kenten, C., ...Francis, S. A. (2012). The measurement of patients' expectations for health care: A review and psychometric testing of a measure of patients' expectations. *Health Technology Assessment, 16*(30), i–xii, 1–509. <http://dx.doi.org/10.3310/hta16300>
- Branson, L., Buxton, M., & Fryman, H. (2014). Patient satisfaction measures and their impact on patients' rating of a hospital. *International Journal of Management & Human Resources, 2*(1), 1–13.

- Brown, A., Ford, T., Deighton, J., & Wolpert, M. (2014). Satisfaction in child and adolescent mental health services: Translating users' feedback into measurement. *Adm Policy Mental Health*, 4(4), 434–446. <http://dx.doi.org/10.1007/s10488-012-0433-9>
- Bruwer, B., Sorsdahl, K., Harrison, J., Stein, D. J., Williams, D., & Seedat, S. (2011). Barriers to mental health care and predictors of treatment dropout in the South African stress and health study. *Psychiatric Services*, 62(7), 774–781. <http://dx.doi.org/10.1176/appi.ps.62.7.774>
- Burns, N., & Grove, S. K. (1993). *The practice of nursing research: Conduct, critique and utilization* (2nd ed.). Philadelphia: W. B. Saunders.
- Buyse, V., & Wesley, P. W. (2006). Evidence-based practice: How did it emerge and what does it really mean for the early childhood field? *Zero to Three*, 27(2), 50–55.
- Clark, L. A., & Watson, D. (1995). Construct validity: Basic issues in objective scale development. *Psychological Assessment*, 7, 309–319.
- Cohen, J. (1988). *Statistical power analysis for behavioural sciences* (2nd ed.). Hillsdale, NJ: Erlbaum.
- Constantine, M. G., & Sue, D. W. (2006). Factors contributing to optimal human functioning in people of colour in the United States. *The counselling Psychologist*, 34(2), 228–244.
- Dew, S. E., & Bickman, L. (2005). Client expectancies about therapy. *Mental Health Services Research*, 7, 21–33. <http://dx.doi.org/10.1007/s11020-005-1963-5>
- Diener, E., & Suh, E. M. (2000). Measuring subjective well-being to compare the quality of life of cultures. In E. Diener, & E. M. Suh (Eds.), *Culture and subjective well-being* (pp. 185–218). Cambridge, MA: MIT Press.
- Direko, L. P. (2002). *The Afrocentric world as compared to the Eurocentric worldview: Implications for Psychotherapy*. Unpublished manuscript, School of Psychosocial Behavioural Sciences, North-West University (Potchefstroom Campus), Potchefstroom.
- Draper, M. R., Jennings, J., Baron, A., Erdur, O., & Shankar, L. (2000). Dose-effect relationship in brief therapy based on a nationwide college counseling center sample. *The Research Consortium of Counseling & Psychological Services*, 1.
- Duckro, P., George, C., & Beal, D. (1979). Effects of failure to meet client preference in a counseling interview analogue. *Journal of Counseling Psychology*, 26(1), 9–14.

Retrieved from

<https://www.google.co.za/#q=Duckro%2C+Beal%2C+%26+George%2C+1979>

- Edwards, D. J. A. (2009). Treating posttraumatic stress disorder in South Africa: An integrative model grounded in case-based research. *Journal of Psychology in Africa, 19*(2), 189–198.
- Ellis, S. M., & Steyn, H. S. (2003). Practical significance (effect sizes) versus or in combination with statistical significance (p-values). *Management Dynamics, 12*(4), 51–53.
- Frattali, C. M. (1991). *Measuring client satisfaction*. Retrieved from <http://www.asha.org/SLP/healthcare/Measuring-Client-Satisfaction/>
- Gill, L., & White, L. (2009). A critical review of patient satisfaction. *Leadership in Health Services, 22*(1), 8–19. <http://dx.doi.org/10.1108/17511870910927994>
- Govender, V., McIntyre, D., Grimwood, A., & Maartens, G. (2000). *The cost and perceived quality of care for people with HIV/AIDS in the Western Cape Province in South Africa*. Bethesda, MD: Abt Associates Inc. Retrieved from <http://www.phrplus.org/Pubs/sar14.pdf>
- Hall, J. A., & Dornan, M. C. (1990). Patient sociodemographic characteristics as predictors of satisfaction with medical care: A meta-analysis. *Social Science and Medicine, 30*(7): 811–818. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/2138357>
- Hansson, L. (1989). The quality of outpatient psychiatric care: A survey of patient satisfaction in a sectorised care organisation. *Scandinavian Journal of Caring Sciences, 3*, 71–82. <http://dx.doi.org/10.1111/j.1471-6712.1989.tb00375.x>
- Harmon, S. C., Lambert, M. J., Smart, D. M., Hawkins, E., Nielsen, S. L., Slade, K., & Lutz, W. (2007). Enhancing outcome for potential treatment failures: Therapist-client feedback and clinical support tools. *Psychotherapy Research, 17*, 379–392.
- Hawthorne, G. (2006). *Review of patient satisfaction measures*. Canberra: Australian Government Department of Health and Ageing.
- Holcomb, W. R., Parker, J. C., Leong, G. B., Thiele, J., & Higdon, J. (1998). Customer satisfaction and self-reported treatment outcomes among psychiatric inpatients. *Psychiatric Services, 49*(7), 929–934.
- Jimmieson, N. J. (1998). Linking client and employee perceptions. *Journal of Occupational and Organizational Psychology, 71*, 81–96.

- Junewicz, A., & Youngner, S. J. (2015). Patient-satisfaction surveys on a scale of 0 to 10: Improving health care, or leading it astray? *Hastings Center Report*, 45(3), 43–51. <http://dx.doi.org/10.1002/hast.453>
- Kravitz, R. L. (1998). Patient satisfaction with health care: Critical outcome or trivial pursuit? *J Gen Intern Med*, 13(4), 280–282. <http://dx.doi.org/10.1046/j.1525-1497.1998.00084.x>
- Kurti, S. (2015). *Patient satisfaction evaluation: A theoretical framework*. Retrieved from http://www.academia.edu/4085766/Patient_Satisfaction_Evaluation_-_A_Theoretical_Framework
- Lebow, J. (1982). Consumer satisfaction with mental health treatment. *Psychological Bulletin*, 91(2), 244–259.
- Lehman, A. F., & Zastowny, T. R. (1983). Patient satisfaction with mental health services: A meta-analysis to establish norms. *Evaluation and Program Planning*, 6(3-4), 265–274.
- Levin, K. A. (2006). Study design III: Cross-sectional studies. *Evidence-Based Dentistry*, 7, 24–25. <http://dx.doi.org/10.1038/sj.ebd.6400375>
- Lilienfeld, S. O., Ritschel, L. A., Lynn, S. J., Cautin, R. L., & Latzman, R. D. (2014). Why ineffective psychotherapies appear to work: A taxonomy of causes of spurious therapeutic effectiveness. *Perspectives on Psychological Science*, 9(4), 355–387. <http://dx.doi.org/10.1177/1745691614535216>
- Marepula, L. O. (2012). *Patient satisfaction with the care provided in a psychiatric hospital in Cape Town*. Retrieved from http://etd.uwc.ac.za/xmlui/bitstream/handle/11394/4500/Marepula_MCUR_2012.pdf?sequence=1
- McCoach, D. B. (2006). Hierarchical linear modelling. In G. R. Hancock, & R. O. Mueller (Eds.), *The reviewer's guide to quantitative methods in the social sciences* (pp. 123–140). New York: Routledge.
- McCulloch, C. E. (2005). Repeated measures ANOVA, R.I.P? *Chance*, 18(3), 29–33.
- Miller D. T, & Turnbull, W. (1986). Expectancies and interpersonal processes. *Annual Review of Psychology*, 37, 233–256.
- Mooney, T. K., Gibbons, M. B., Gallop, R., Mack, R. A., & Crits-Christoph, P. (2014). Psychotherapy credibility ratings: Patient predictors of credibility and the relation of credibility to therapy outcome. *Psychotherapy Research*, 24(5), 565–577. <http://dx.doi.org/10.1080/10503307.2013.847988>

- Moore, L. E., Tambling, R. B., & Anderson, S. R. (2013). The intersection of therapy constructs: The relationship between motivation to change, distress, referral source, and pressure to attend. *The American Journal of Family Therapy, 41*(3), 245–258.
- Myburgh, N. G., Solanki, G. C., Smith M. J., & Lalloo, R. (2005). Patient satisfaction with health care providers in South Africa: The influences of race and socioeconomic status. *International Journal of Quality Health Care, 17*(6), 473–477.
- Newsome, P. R. H., & Wright, G. H. (1999). Patient management: A review of patient satisfaction: 1. Concepts of satisfaction. *British Dental Journal, 186*, 161–165.
- Nguyen Thi, P. L., Briancon, S., Empeur, F., & Guillemin, F. (2002). Factors determining inpatient satisfaction with care. *Social Science and Medicine, 54*(4), 493–504.
Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/11848270>
- Noble, L. M., Douglas, B.C., & Newman, S. P. (2001). What do patients expect of psychiatric services? A systematic and critical review of empirical studies. *Social Science and Medicine, 52*(7), 985–998.
- Norberg, M. M., Wetterneck, C. T., Sass D. A., & Kanter, J. W. (2011). Development and psychometric evaluation of the Milwaukee psychotherapy expectations questionnaire. *Journal of Clinical Psychology, 67*(6), 574–590.
- Oei, T. P. S., & Green, A. L. (2008). The satisfaction with therapy and therapist scale – revised (STTS-R) for group psychotherapy: Psychometric properties and confirmatory factor analysis. *American Psychological Association, 39*(4), 435–442.
- Oei, T. P. S., & Shuttlewood, G. J. (1999). Development of a satisfaction with therapy and therapist scale. *Australian and New Zealand Journal of Psychiatry, 33*, 748–753.
- Rivers, P. A., & Glover, S. H. (2008). Health care competition, strategic mission, and patient satisfaction: Research model and propositions. *Journal of Health Organisation and Management, 22*(6), 627–641.
- Robillos, E., Lale, R., Wooldridge, J., Heller, R., & Sarkin, A. (2014). Gender and the relative importance of mental health satisfaction domains. *Evaluation and Program Planning, 43*, 9–15. <http://dx.doi.org/10.1016/j.evalprogplan.2013.10.003>
- Rosenheck, R., Wilson, N. J., & Meterko, M. (1997). Influence of patient and hospital factors on consumer satisfaction with inpatient mental health treatment. *Psychiatric Services, 48*, 1553–1561. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/9406263>

- Rosenthal, R., Rosnow, R. L., & Rubin, D. B. (2000). *Contrasts and effect sizes in behavioural research: A correlational approach*. Cambridge: Cambridge University Press.
- Sandoval, G. A., Levington, C., Blackstein-Hirsch, P., & Brown, A. D. (2005). Selecting predictors of cancer patients' overall perceptions of the quality of care received. *Annals of Oncology*, *17*(1), 151–156.
- SAS Institute Inc. (2016). *The SAS System for Windows: Release 9.4 TS Level 1M3*. Cary, NC: SAS Institute Inc.
- Shaughnessy, J., & Zechmeister, E. (1994). *A practical introduction to research methods in psychology* (2nd ed.). New York: McGraw-Hill.
- Silverstein, M. J., & Sayre, K. (2009). The Female Economy. *Harvard Business Review*. Retrieved from <http://sites.asiasociety.org/womenleaders/wp-content/uploads/2010/05/Harvard-article-female-economy.pdf>
- Slywotzky, A. (2015). *The patient-to-consumer healthcare revolution*. Retrieved from <http://www.brinknews.com/the-patient-to-consumer-healthcare-revolution/>
- SPSS Inc. (2016). *IBM SPSS Statistics (Version 23)* [Computer software]. Retrieved from <http://www-01.ibm.com/software/analytics/spss/>
- Steiner D. L. (2003). Starting at the beginning: An introduction to coefficient alpha and internal consistency. *Journal of Personality Assessment*, *80*, 99–103.
- Strine, T. W., Chapman, D. P., Balluz, L. S., Moriarty, D. G., & Mokdad, A. H. (2008). The associations between life satisfaction and health-related quality of life, chronic illness, and health behaviors among U.S. community-dwelling adults. *Journal of Community Health*, *33*(1), 40–50.
- Topham, G. L., & Wampler, K. S. (2008). Predicting dropout in a filial therapy program for parents and young children. *American Journal of Family Therapy*, *36*(1), 60–78.
- Tsasis, P., Tsoukas, C., & Deutsch, G. (2000). Evaluation of patient satisfaction in a specialized HIV/AIDS care unit of a major hospital. *AIDS Patient Care*, *14*(7), 347–349.
- Tucker, J. III, & Adams, S. R. (2001). Incorporating patients' assessments of satisfaction and quality: An integrative model of patients' evaluations of their care. *Managing Service Quality*, *11*(4), 272–286.
- Van der Merwe, E. J., Van Rensburg, E., & Ellis, S. (2016). Psychometric properties of scales measuring client expectations and satisfaction with psychological treatment in a South African context. [Manuscript in preparation].

- Von Humboldt, S., & Leal, I. (2015). Disclosing the challenges of older clients in person-centered therapy: The client's perspective. *Person-Centered and Experiential Psychotherapies*, 13(3). Retrieved from <http://www.tandfonline.com/doi/full/10.1080/14779757.2015.1058290>
- Walker, M. S., Ristvedt, S. L., & Haughey, B. H. (2003). Patient care in multidisciplinary cancer clinics: Does attention to psychosocial needs predict patient satisfaction? *Psycho-Oncology*, 12(3), 291–300.
- Ward, M. R., Linville, D. C., & Rosen, K. H. (2008). Clients' perceptions of the therapeutic process: A common factors approach. *Journal of Couple & Relationship Therapy*, 6(3), 25–43. http://dx.doi.org/10.1300/J398v06n03_02
- Westaway, M. S., Rheeder, P., Van Zyl, D. G., & Seager, J. R. (2002). Development of a 25-item patient satisfaction scale for black South African diabetic outpatients. *Pubmed*, 25(3), 68–75.
- Wilhelm, K., Wedgwood, L., Malhi, G., Mitchell, P., Austin, M. P., Kotze, B., ...Parker, G. (2005). Great expectations: factors influencing patient expectations and doctors recommendations at a Mood Disorder Unit. *Journal of Affective Disorders*, 88(2), 187–192.
- Williams, B., Coyle, J., & Healy, D. (1998). The meaning of patient satisfaction. *Social Science and Medicine*, 47, 1351–1359.
- Williams, S., & Calnan, M. (1991). Convergence and divergence: Assessing criteria of consumer satisfaction across general practice, dental and hospital settings. *Social Science and Medicine*, 33(6), 707–716.
- Winerman, L. (2016). Helping men to help themselves. *American Psychological Association*, 36, 57.
- Wouters, E., Heunis, C., van Rensburg, D., & Meulemans, H. (2008). Patient satisfaction with antiretroviral services at primary health-care facilities in the Free State, South Africa: A two-year study using four waves of cross-sectional data. *BMC Health Services Research*, 8, 210. <http://dx.doi.org/10.1186/1472-6963-8-210> Abstract retrieved June 7, 1999, from IDEAL database: <http://www.europe.idealibrary.com>

Table 1: Biographical particulars frequency distributions (N = 204)

Variable	Description	Frequency	Percentages
Gender	Male	77	37.7%
	Female	120	58.8%
Age	18-20	19	9.3%
	21-30	36	17.6%
	31-40	46	22.5%
	41-50	44	21.6%
	51-60	34	16.7%
	61-70	19	9.3%
	70+	6	2.9%
Race	White	108	52.9%
	Black	76	37.3%
	Indian	9	4.4%
	Coloured	9	4.4%
Sessions attended	1	28	13.7%
	2-3	33	16.2%
	3-5	49	24.0%
	5-8	50	24.5%
	8+	35	17.2%
Occupation	Management	14	6.9%
	Professional	60	29.4%
	Administrative	35	17.2%
	Tradesperson	29	14.2%
	Customer service	9	4.4%
	Operators	4	2.0%
	Unskilled	10	4.9%
	Student	29	14.2%
	Unemployed	11	5.4%
Education	Primary school	13	6.4%
	High school	104	51.0%
	University	55	27.0%
	Post-graduate	29	14.2%
Language	Afrikaans	93	45.6%
	English	52	25.5%
	Setswana	55	27.0%
Referral source	Self-referred	96	47.1%
	GP	86	42.2%
	Other	21	10.3%

Table 2: Descriptive variables and reliability on the nature of expectations and satisfaction

Variable	Mean	Standard Deviation	Cronbach Alpha (α)
Process Expectations	4.38	0.66	0.90
Outcome Expectations	4.02	0.96	0.91
Expectation Total	8.39	1.51	0.81
Satisfaction with Therapy (ST)	24.88	4.73	0.91
Satisfaction With Therapist (SWT)	23.57	5.91	0.87
Satisfaction Global	4.08	0.99	(Item 13)

Table 3: Results of HLM concerning differences in expectations and satisfaction with regard to gender.

Variable	Means		Residual Estimates	Variance	<i>p</i> -value	Effect size
	Male	Female	MSE	Psychologist		Cohen's <i>d</i>
Process Expectations	4.16	4.42	0.404	0.037	0.005	0.40
Outcome Expectations	3.65	3.94	0.749	0.256	0.030	0.29
Expectations Total	7.82	8.37	1.976	0.377	0.010	0.36
Satisfaction with Therapy	23.50	24.33	19.201	3.520	0.21	0.17
Satisfaction with Therapist	21.72	22.63	29.602	6.265	0.27	0.15
Global Satisfaction	3.98	3.90	0.832	0.256	0.58	0.07

Table 4: Results of HLM concerning differences in expectations and satisfaction with regard to occupation

Mean Scores obtained on:	Management / Professional	Administrative	Tradesperson	Unskilled / Unemployed	Student	MSE	Variance Psychologist	p-value
Expectation Process	4.432	4.439	4.108	4.162	4.251	0.405	0.032	0.071
Expectation Outcome	3.856	4.051	3.654	3.835	3.627	0.751	0.228	0.291
Expectation Total	8.294	8.513	7.780	8.022	7.881	1.997	0.323	0.179
Satisfaction Therapy	24.133	24.851	22.695	24.024	23.791	18.268	3.949	0.336
Satisfaction Therapist	22.715	23.520	20.975	21.665	21.444	28.287	7.341	0.273
Satisfaction Global	4.017	3.902	3.740	3.892	3.942	0.818	0.233	0.731

Table 5: Results of HLM concerning differences in expectation and satisfaction with regard to referral source

	Means			MSE	Variance	<i>p</i> -value
	Self	GP	Other		Psychologist	
Process Expectations	4.354	4.301	4.332	0.419	0.232	0.861
Outcome Expectations	3.906	3.854	3.410	0.741	0.225	0.076
Expectation Total	8.269	8.172	7.735	2.008	0.305	0.325
Satisfaction with Therapy	24.643	23.267	24.487	18.446	3.298	0.101
Satisfaction with Therapist	22.818	22.093	21.222	28.894	5.887	0.420
Global Satisfaction	4.000	3.861	3.952	0.814	0.247	0.612

Table 6: Correlations calculated with HLM between biographical variables

Variables		Age	Education	Number of therapy sessions
Process Expectations	Correlation Coefficient	-0.005	-0.027	0.077
	Sig. (2-tailed)	0.945	0.712	0.268
	N	204	201	195
Outcome Expectations	Correlation Coefficient	-0.026	-0.136	0.044
	Sig. (2-tailed)	0.740	<u>0.060</u>	0.509
	N	201	201	195
Expectation Total	Correlation Coefficient	-0.015	-0.075	0.062
	Sig. (2-tailed)	0.854	0.296	0.370
	N	204	201	195
Satisfaction Therapy	Correlation Coefficient	-0.114	-0.058	0.134
	Sig. (2-tailed)	0.160	0.410	<u>0.055</u>
	N	204	201	195
Satisfaction Therapist	Correlation Coefficient	-0.074	-0.075	0.123
	Sig. (2-tailed)	0.331	0.327	<u>0.077</u>
	N	204	201	195
Satisfaction Global	Correlation Coefficient	-0.153	-0.082	0.080
	Sig. (2-tailed)	<u>0.045</u>	0.278	0.251
	N	197	194	188

*. Correlation is significant at the 0.05 level (2-tailed).
Correlations effect size: 0.1 small; 0.3 medium; 0.5 large

SECTION B: ARTICLE 3

**THE RELATIONSHIP BETWEEN CLIENT PSYCHOLOGICAL TREATMENT
EXPECTATIONS AND SATISFACTION IN SOUTH AFRICA**

To be submitted to

Professional Psychology: Research and Practice

4.1 Guidelines for authors:

Professional Psychology: Research and Practice

Instructions for Authors

Submission

Manuscripts should be submitted electronically through the *Manuscript Submission Portal*.

General correspondence may be directed to Sharon Ramos, the journal's Manuscript Coordinator.

For potential use by the editorial office and later by the production office, the corresponding author should supply: Email address, Mailing address, Phone number, Fax number, and Affiliation

For all other authors, please supply names, email addresses, and affiliations.

Submit manuscripts in either Microsoft Word (.doc) or Rich Text Format (.rtf) and keep a copy of the manuscript to guard against loss.

Manuscript Length and Style

Full-length manuscripts should not exceed 25 pages total (including cover page, abstract, text, references, tables, and figures), with margins of at least 1 inch on all sides and a standard font (for example, Times New Roman) of 12 points (no smaller). The entire paper (text, references, tables, etc.) must be double spaced.

For general guidelines to style, authors should study articles previously published in the journal.

They should note that the readership of Professional Psychology: Research and Practice consists of psychologists from a broad range of subspecialties engaged mainly in practice, and some in training careers.

The introduction of the manuscript should be written to anchor the topic in the experiential world of these readers. The final section should be an implications and applications section, which provides concrete and usable information that can be used in everyday clinical practice or in training programs. View additional writing guidelines.

Masked Review Policy

Professional Psychology: Research and Practice uses a masked reviewing system.

In order to permit anonymous review, all authors' names, affiliations, and contact information should be removed from the manuscript itself and included instead in the submittal letter. Every effort should be made by the authors to see that the manuscript itself contains no clues to their identities.

Please ensure that the final version for production includes a byline and full author note for typesetting.

Manuscript Preparation

Prepare manuscripts according to the Publication Manual of the American Psychological Association (6th edition). Manuscripts may be copyedited for bias-free language (see Chapter 3 of the Publication Manual).

Review APA's Checklist for Manuscript Submission before submitting your article.

Double-space all copy. Other formatting instructions, as well as instructions on preparing tables, figures, references, metrics, and abstracts, appear in the Manual. Additional guidance on APA Style is available on the APA Style website.

Tables

Use Word's Insert Table function when you create tables. Using spaces or tabs in your table will create problems when the table is typeset and may result in errors.

Abstract and Keywords

All manuscripts must include an abstract containing a maximum of 250 words typed on a separate page. After the abstract, please supply up to five keywords or brief phrases.

References

List references in alphabetical order. Each listed reference should be cited in text, and each text citation should be listed in the References section.

Examples of basic reference formats:

- Journal Article:

Hughes, G., Desantis, A., & Waszak, F. (2013). Mechanisms of intentional binding and sensory attenuation: The role of temporal prediction, temporal control, identity prediction, and motor prediction. *Psychological Bulletin*, 139, 133–151. <http://dx.doi.org/10.1037/a0028566>

- Authored Book:

Rogers, T. T., & McClelland, J. L. (2004). *Semantic cognition: A parallel distributed processing approach*. Cambridge, MA: MIT Press.

- Chapter in an Edited Book:

Gill, M. J., & Sypher, B. D. (2009). Workplace incivility and organizational trust. In P. Lutgen-Sandvik & B. D. Sypher (Eds.), *Destructive organizational communication: Processes, consequences, and constructive ways of organizing* (pp. 53–73). New York, NY: Taylor & Francis.

Figures

Graphics files are welcome if supplied as Tiff or EPS files. Multipanel figures (that is, figures with parts labeled a, b, c, d, etc.) should be assembled into one file.

The minimum line weight for line art is 0.5 point for optimal printing.

For more information about acceptable resolutions, fonts, sizing, and other figure issues, please see the general guidelines.

When possible, please place symbol legends below the figure instead of to the side.

APA offers authors the option to publish their figures online in color without the costs associated with print publication of color figures.

The same caption will appear on both the online (color) and print (black and white) versions. To ensure that the figure can be understood in both formats, authors should add alternative wording (for example, "the red (dark gray) bars represent") as needed.

Ethical Principles

It is a violation of APA Ethical Principles to publish "as original data, data that have been previously published" (Standard 8.13).

In addition, APA Ethical Principles specify that "after research results are published, psychologists do not withhold the data on which their conclusions are based from other competent professionals who seek to verify the substantive claims through reanalysis and who intend to use such data only for that purpose, provided that the confidentiality of the participants can be protected and unless legal rights concerning proprietary data preclude their release" (Standard 8.14).

APA expects authors to adhere to these standards. Specifically, APA expects authors to have their data available throughout the editorial review process and for at least 5 years after the date of publication.

Authors are required to state in writing that they have complied with APA ethical standards in the treatment of their sample, human or animal, or to describe the details of treatment.

- *Download Certification of Compliance with APA Ethical Principles Form* (PDF, 26KB)

The APA Ethics Office provides the full Ethical Principles of Psychologists and Code of Conduct electronically on its website in HTML, PDF, and Word format. You may also request a copy by emailing or calling the APA Ethics Office (202-336-5930). You may also read "Ethical Principles," December 1992, *American Psychologist*, Vol. 47, pp. 1597–1611.

4.2 Manuscript: The Relationship between Client Psychological Treatment Expectations and Satisfaction in South Africa

The Relationship between Client Psychological Treatment Expectations and Satisfaction in South Africa

Ernst J. van der Merwe, Esmé van Rensburg, Suria M. Ellis

School of Psychosocial Behavioural Sciences, North-West University: Potchefstroom
Campus, Potchefstroom.

Correspondence to:

E. J. van der Merwe*

C/o Prof E. van Rensburg

School of Psychosocial Behavioural Sciences

North-West University: Potchefstroom Campus

Private Bag X6001

Potchefstroom

2520

South Africa

*All correspondence to: E-mail: ernst.vandermerwe@angloamerican.com

Abstract

The aim of this study was to determine the relationship between clients' psychological treatment expectations and their psychological treatment satisfaction within a South African context. The data included a convenience sample of two hundred and four adult participants ($N = 204$) from different cultural contexts in the North West and Gauteng provinces of South Africa and was gathered from thirteen independent practicing psychologists. Two scales, both of which were developed in a Western context, were employed to measure facets of psychological treatment expectations, as well as aspects relating to clients' satisfaction with psychological treatment. Satisfaction measurement comprised outcome and process factors of clients with their psychological treatment. Structural equation modeling (SEM) was incorporated to determine the relationship between expectations and satisfaction. A significant relationship was found to exist between clients' treatment expectations and their satisfaction with psychological treatment in the said context.

Keywords: Client, patient, expectations, satisfaction, relationship, South Africa

The Relationship between Client Psychological Treatment Expectations and Satisfaction in South Africa

Client satisfaction as a research domain in health care has since the inaugural quality assurance work of Donabedian during the 1980s (Gill & White, 2009) increased in momentum. Client satisfaction can be seen as part of the quality outcomes movement focussing on performance improvement and outcome measurement (Marjoua & Bozic, 2012). This innovative research area in psychology focusses on the client, and the enhancement of their health-care experiences is strongly linked to their expectations and the positive realisation thereof (Wolf, Niederhauser, Marshburn, & LaVela, 2014). In the not so recent past, the health-care provider was commonly seen as the expert and the clients, unable to comprehend the vast magnitude of the professional knowledge of the health-care provider, had to resign themselves to the clinician's judgement of what was appropriate or best for them. The consumer revolution in health care has had numerous favourable outcomes and patients are now more actively involved than ever in the decision-making process, selecting health-care plans, service providers and participating directly in judgements about their treatment (Targett, 2011). The latest development in the field, stemming from the consumer revolution in health care, follows the formal introduction of Evidence-based practice (EBP) in psychology as of 1992 (Buysse & Wesley, 2006). The emergence of the twenty-first century as the information era has also furnished clients with awareness and has positioned them to better evaluate and comprehend previously unimaginable material (Slywotzky, 2015). Clients are now well versed and correspondingly asked on a routine basis to evaluate the quality of services they receive. These changes are evident in the increasing number of papers published within the health-care field that relate to client satisfaction (Gill & White, 2009; Kravitz, 1998; Kurti, 2015; Rivers & Glover, 2008). This increase denotes an increasing scholarly interest in the research category of health-care quality, and especially

client satisfaction and client expectations (Branson, Buxton & Fryman, 2014; Vukmir, 2006; Williams, Coyle, & Healy, 1998; Wolf et al., 2014).

The topic of client satisfaction with clinical treatment has thus in recent years gained rapid recognition as an outcome of quality care (American College of Emergency Physicians, 2014). The precursor of the study of quality in health care, Avedis Donabedian (1980), further distinguished patient satisfaction as an indispensable measure of quality in the design and management of health-care systems. Business and industry trends centre on empirical research to validate economic and business decision-making. From a commercial and marketing outlook, client satisfaction acquires additional significance as within a competitive marketplace a happy customer leads to an increased market share (Frattali, 1991). This propensity for authenticating financial and professional direction by concentrating on empirical research has already been emphasised by numerous professional organisations (American Psychological Association, 2006; The Association of Behavioral and Cognitive Therapies, 2013, and The Society of Clinical Child and Adolescent Psychology, 2014). The American Psychological Association (APA, 2006) therefore strongly recommends that their members conduct investigations to provide evidence supporting or rejecting the use of specific interventions.

On international level, pressure has also emanated from the public and private health insurance, by refusing coverage of practices lacking in systematic evidence of practicality and thus embracing EBP (Sanders, 2010). The high cost of professional services, and therefore of psychologists' therapeutics necessitate psychological services to be of the highest quality. A pronounced need for a way to exclude quack practitioners or nonempirical-based treatments in order to protect the public became clear (Edwards, 2009). Evidence-based treatment (EBT), as such a method, aims to specify the way in which professionals should make decisions by identifying specific evidence in place for a practise, and rating it according

to plausible scientific soundness (Spring, 2007). Evidence-based practices thus require practitioners to consistently evaluate and utilise the best available research (Berke, Rozell, Hogan, Norcross, & Karpiak, 2011). One of the main reasons for successfully incorporating EBPs into treatment services is the enormous expanse of studies linking it to clients' improved health outcomes and the general attitude that treatments should be based on scientific evidence (Sackett, Straus, Richardson, Rosenberg, & Haynes, 2000). EBP has largely superseded empirically validated treatments and are much more clinician-friendly as it allows for the contextual realities of practice (Edwards, 2009).

The concept of EBP proclaims client satisfaction appropriate for practitioners to meet their clients' needs and expectations (Berke et al., 2011). Superordinate concepts have emerged from the development of principles of accountability for health professions around the concept of EBPs (Edwards, 2009). This importance of evidence-based empirically validated practices in order to meet client satisfaction, motivates this particular study area even more.

From the client's perspective, satisfaction can be seen as an evaluation of the quality of care as a conclusion, as well as an outcome variable in its own right; and furthermore as an indicator of weaknesses in service (Wicks & Roethlein, 2009). Within this framework of patient-centred health care, client satisfaction has emerged as an important indicator of the quality of client care. This dominant paradigm's significance is further emphasised by the evidence that satisfied clients are more likely to adhere to treatment, benefit from their health care (Sandoval, Levington, Blackstein-Hirsch, & Brown, 2005), and have a higher quality of life (Akter, D'Ambra, Ray & Hani, 2013; Walker, Ristvedt, & Haughey, 2003). By targeting the aspects of psychotherapeutic treatment that clients consider of utmost importance, clinicians may optimise client satisfaction and the quality of care, which in turn, is in keeping with quality assurance, accreditation, and ethical competency of the practitioner (Edwards,

2009). Satisfying clients in a competitive marketplace therefore benefits health-care facilities, clinicians, and clients alike.

Clients' expectations play an important role in the process by which an outcome of care can be said to be satisfactory or unsatisfactory, and in several studies, researchers have found satisfaction to be related to the fulfilment of client expectations (Bjertnaes, Sjetne, & Iversen, 2012; Bleich, Ozaltin, & Murray, 2009; Bowling et al., 2012; Duckro, Beal, & George, 1979). Furthermore, the research in health care and mental health care, as well as the literature of the service marketing industry (Gill & White, 2009) indicates that satisfaction is influenced by expectations (Bleich et al., 2009; Palazzo et al., 2014). Clients bring to any evaluation process a set of expectations that result from their beliefs about idyllic or anticipated situations (Miller & Turnbull, 1986). Clients have predetermined positive expectations of the care that they will receive during a health-care encounter, and when the experience lives up to these expectations (Ekberg, Barnes, Kessler, Malpass, & Shaw, 2016), clients are likely to be satisfied. When experience fails to meet expectations, clients may very well be dissatisfied (Bleich et al., 2009; Kurti, 2015; Noble, Douglas, & Newman, 2001).

Palmer et al. (1991) defines "patient satisfaction" as a judgement made by a recipient of care as to whether their expectations for care have been met or not. Consistent with this, client expectations with regard to psychological treatment refer to the anticipatory beliefs about what is to be encountered or experienced during a consultation or within a health-care system (Vukmir, 2006). It can be considered as attitudes or the visualisation that the clients hold concerning the process of interaction with the treatment (Heidegger, Saal, & Nuebling, 2006). Perceived occurrences and authentic interactions during, or because of therapy, produce anticipated care-related evaluations.

Nock and Kazdin (2001) alluded to another important aspect when they defined expectations for psychotherapy as "clients' beliefs about the contributions of both the

therapist and client in therapy” (p. 156). Psychotherapy expectations also include outcome and treatment expectations (Constantino, Glass, Arnkoff, Ametrano, & Smith, 2011). Outcome expectations concern the likelihood of treatment success, while treatment expectations relate to the role or process of the therapeutic work.

The purpose of research exploring client satisfaction is to understand and enhance progressive aspects of psychological treatment. The contribution of client satisfaction research is consequently discernible on the following levels:

Firstly, it plays an important part in contributing to current knowledge on clients’ expectations of, and satisfaction with psychological services in general and more specifically the South African context. This vital new information will contribute to the expansion of the existing knowledge of psychology as a subject, considering that relevant data regarding psychological services not previously researched in South Africa will be presented.

Secondly, increased knowledge on the expectations and experiences of clients regarding psychological treatment, and the satisfaction thereof promotes high-quality psychological services since psychologists will have an additional enhanced and discriminating understanding of appropriate factors and components contributing to client satisfaction with treatment. In addition to, and perhaps even more important, factors that do not contribute favourably to client satisfaction can be identified.

Thirdly, the knowledge gained will result in assisting psychologists and especially newly qualified, inexperienced psychologists in avoiding pitfalls concerning treatment. Therefore, the aim of the research was to determine and explore the relationship between clients’ psychological treatment expectations, and their satisfaction with psychological treatment in South Africa.

Method

Design

This study followed a quantitative research paradigm as an organized method for combining deductive logic with precise empirical observations. This approach is thus in line with evidence-based practices where the use of strong statistical evidence is preferable (APA, 2006). A cross-sectional survey design was utilised as these type of designs are deemed appropriate where groups of subjects at various stages of development are studied simultaneously (Levin, 2006), and the survey technique of data collection gathered information from the target population by means of questionnaires (Burns & Grove, 1993; Räsänen, 2006; Shaughnessy & Zechmeister, 1994).

Participants

The study included a convenience sample of 204 post-psychotherapy clients from thirteen contributing psychologists, practising in the private sectors of Gauteng and the North-West provinces. Of the participants, 108 were white, 76 black, nine Indian, and nine coloured (two did not indicate their race). Most of the participants (93) were Afrikaans-speaking (45.6%) individuals from the Gauteng province in South Africa, which is an urban area. The participants that indicated that their preferred language was Setswana amounted to 55 individuals or 27.5%; 52 (25.5%) of the participants were English-speaking individuals (four participants did not indicate their language preference). Because the questionnaires were administered in English, the participants had to be fluent in English, even though they were not English mother-tongue speakers. The sample included 77 males and 120 females – typically, more females than males do consult psychologists (Winerman, 2016). Ages ranged from 18 to 70+, with the majority being between 31 and 40 years of age (Table 1). Most of the participants were self-referred (47.1%), held a high-school level of education, and were

from professional occupations. The majority (24.5%) attended between five to eight therapy sessions. Data was collected during the last three months of 2015.

Procedure

Thirteen psychologists contributed to the data, acting as gatekeepers discussing with potential clients the probability of participating in the research study. The gatekeepers obtained written informed consent from each participant before providing the researchers with the client's e-mail addresses. Anonymity was guaranteed. Participants were subsequently contacted via the provided e-mail address to explain the research opportunity in detail to participants, and to request their participation. This was purposely done to avoid affecting the past therapeutic role of the treating psychologists. The purpose hereof was achieved by assuring clients of the anonymity of their results and emphasising that their former therapist will in no way be involved with or never be shown their individual responses. Furthermore, this procedure also ensured that the treating psychologist remained unaware of the answers provided by the clients and safeguarded objectivity on the part of the researchers, participants and the practicing psychologists. Participants were then given the opportunity to question the researchers on matters of concern regarding the questionnaire or the research. Once the participant had agreed to participate and consented in writing to all the related processes, the researchers distributed the relevant questionnaires. The participants were required to complete a biographical questionnaire regarding their age, gender, therapy duration, occupation, socio-economic demographics, and source of referral; as well as the Milwaukee Psychotherapy Expectations Questionnaire, and the Satisfaction with Therapy and Therapist Scale. Questionnaires were completed in English via e-mail and the data was collected during the last three months of 2015.

Measures

Measurement instrument for psychotherapeutic expectations. The Milwaukee Psychotherapy Expectations Questionnaire (MPEQ) was utilised to gather data about the treatment expectations of clients. Norberg, Wetterneck, Sass, and Kanter developed the MPEQ during 2011, and it presented initial evidence in assessing both Process and Outcome Expectations in therapy. The questionnaire was also established to measure clients' expectations about the components and effects of therapy. The instrument demonstrated good internal consistency and test–retest reliability, along with support for convergent, discriminant, and predictive validity (Norberg et. al, 2011). The MPEQ is the first psychometrically sound brief measure of both Process and Outcome Expectations of therapy. The questionnaire consists of a list of 13 statements describing expectations about therapy that clients may have. The statements cover expectations regarding their own behaviour in therapy, their therapist, and the therapy setting. Each statement was rated by the participants on a scale of 1 to 5, where a score of 1 would indicate that the participant did not foster this expectation or did not agree with this statement at all. A score of 5 would indicate that the participant did foster this expectation and is in complete agreement with the statement. Examples of statements include, “I expect my therapist will provide support”; “My therapist will be sincere”; “I will be able to express my true thoughts and feelings” and “After therapy I will be a much more optimistic person”. The MPEQ is sub-divided into nine statements comprising the Process Expectations subscale, and four statements encompassing the Outcome Expectations subscale. Subscale scores are calculated by summing the items included on a factor and then dividing by the number of items included. The total score is the sum of both subscale scores (Norberg et. al, 2011).

Measurement instrument for client satisfaction with psychotherapy. The Satisfaction with Therapy and Therapist Scale (STTS-R) was used to gather data about the

treatment satisfaction of clients. The STTS-R was developed by Oei and Shuttlewood during 1999 and designed to assess patients' level of satisfaction with their therapeutic endeavour. The STTS-R has sound psychometric properties and as such serves as a useful instrument in assessing a patient's level of satisfaction with both therapy and the therapist, in research as well as clinical settings. The STTS-R has a factor structure of a 13-item scale that is determined by way of principle components factor analysis. The statements are rated on a scale of 1 to 5 where 1 represents "strongly disagree" and 5 "strongly agree". Statements include, "The therapist listened to what I was trying to get across"; "I would recommend the program to a friend" and "I would return to the clinic if I needed help". Six statements comprise the Satisfaction with Therapy subscale, and six implicate the level of Satisfaction with the Therapist. The sum of the scores of the respective items represents the subscale score. In addition there is a client-rated measure of global improvement (item 13), an outcome variable that determines the client's perception of the efficacy of the treatment.

Reliability and validity. The reliability of the MPEQ and STTS-R were determined in previous research by the current authors by means of Cronbach's alpha coefficients as well as exploratory and confirmatory factor analysis (Van der Merwe, Van Rensburg, & Ellis, 2016). Excellent reliability indices were obtained for both the MPEQ and the STTS-R in the mentioned study. All alpha coefficients were larger than 0.85 (Van der Merwe et al., 2016), and the internal consistency of the questionnaire was exceptionally desirable, indicating good reliability, and that items were a good sample of the intended construct and not drawing on bordering constructs (Clark & Watson, 1995; Steiner, 2003).

Ethical aspects

Approval for this project was obtained from the Ethics Committee of the North-West University (approval number: NWU-00195-14-A1). Written informed consent was obtained

from each participant after a methodical briefing, emphasising the reassurance of anonymity regarding research findings publication. Confidentiality was protected through assigning participant numbers to each participating participant and psychologist, and anonymity yet again guaranteed.

Data analysis

The statistical analysis was carried out with the IBM SPSS program version 23 (SPSS Inc., 2016), and SEM using IBM SPSS AMOS 23 was incorporated to determine the relationship between clients' expectations of psychotherapy and their satisfaction with psychotherapy.

As already indicated the measurement model was verified and indicated satisfactory construct validity (Van der Merwe et al., 2016). Thus, the structural part of the model currently becomes important and forms the focus of this research article. The structure of the relationships among clients' expectations and satisfaction were determined through SEM. The CMIN/DF (chi-square statistic divided by its degrees of freedom), Root mean square error approximation (RMSEA), Comparative fit index (CFI), and Akaike information criterion (AIC) were used as measures of the complete, conservative and augmenting classes of fit indices (Hooper, Coughlan, & Mullen, 2008; McQuitty & Wolf, 2013). Conversely, it has become good practice to account for multiple fit indices, typically from three broad classes (Hancock & Mueller, 2010). Clarification of the CMIN/DF value hinges greatly on the investigator, but in practice interpretation ratios as high as 3, 4 or even 5 may still signify a good model fit (Mueller, 1996). Mueller (1996) described values of above 0.9 as indicative of a good overall fit for CFI. Blunch (2008) stated that models with RMSEA values of 0.10 and larger should not be accepted.

Results

The study comprised 204 post-psychotherapy participants from 13 contributing psychologists, practising in the private sectors of Gauteng and the North-West provinces of South Africa. The participants varied in their backgrounds and consisted of relatively different cultural contexts.

< Insert Table 1 approximately here >

The relationship between clients' psychological treatment expectations and their satisfaction with psychological treatment within a South African context is indicated in Table 2. All correlations were found to be statistically significant ($p < 0.001$) and were of medium (.3) to large (.5) effect (Cohen, 1988; Steyn, 2002). These results show that there are medium to large relationships between clients' expectations and their satisfaction with psychological treatment in the South African context. These relationships were likewise all positive, that is, that if a client holds low expectations their satisfaction will also be low, and if expectations were high satisfaction afterwards would tend to be high.

The results of the SEM model (Figure 1) indicated that satisfaction could be predicted from expectations (Table 2). The before-mentioned findings are in keeping with the literature suggesting expectations are an important component of clinical outcomes and client satisfaction (Bialosky, Bishop, & Cleland, 2010; Fuertes, Anand, Haggerty, Kestenbaum, & Rosenblum, 2015). Expectations of the process and expectations of the outcome have a high correlation of 0.79 between them, which has an influence on their relationships with satisfaction. Although the correlation of these two expectation factors with satisfaction is statistically significant (Table 2), only expectations of the outcome have a statistically significant unique contribution as indicated by the structural part of the SEM (Figure 1).

< Insert Table 2 approximately here >

< Insert Figure 1 approximately here >

Squared Multiple Correlation (Table 3) indicates what percentage of the satisfaction's variance is explained by the expectations of the outcome. Twenty seven percent of the variance of satisfaction is explained by expectations. A variance of 1% is considered small, 10% is reflected as a medium variance, and 25% is interpreted as a large variance. This means that the variance of satisfaction, as explained by outcome expectations, was found to be important in practice.

Expectations of the process does not have a statistically significant unique contribution on satisfaction ($\beta = .106$ and $p = .141$) respective of the model. The structural part of the model will explain and form the focus of this article that now takes on additional significance (Table 3).

The Squared Multiple Correlation of the three components of satisfaction were found to be .812 for Satisfaction with Therapy, .945 for Satisfaction with the Therapist, and .712 for Global Satisfaction, indicating that Satisfaction with Therapy, and Satisfaction with the Therapist had a larger contribution to Satisfaction than Global Satisfaction.

< Insert Table 3 approximately here >

Because of the high correlation between the subscales of satisfaction ($r = 0.80, 0.84$ and 0.94), it was decided to group together all items of satisfaction into one satisfaction construct (Figure 2). Although a more acceptable RMSEA value was found for this model, the AIC of the three-factor model was lower for the three-factor model, indicating a better fit (Burnham & Anderson, 2002). The measures of fit are indicated in Table 4.

The Model fit summary yielded a CMIN/DF ratio value of 3.066 and 2.526 for the different structural models respectively. This ratio represents a good model fit (Mueller, 1996). The CFI value was .910 and .896, which is acceptable as Mueller (1996) described values of above 0.9 as indicative of a good overall fit for a comparative fit index. The RMSEA value was unsatisfactory at .101 (Table 4), as Blunch (2008) stated that models with

RMSEA values of 0.10 and larger should not be accepted. The smaller the AIC, the better the model fit (Burnham & Anderson, 2002; Tabachnick & Fidell, 2001).

The relationships (correlations) between the different components of the satisfaction construct motivated that all 13 items be grouped together (as stated previously), and resulted in an acceptable RMSEA index of .087, with the limits of the 90% confidence interval between .079 and .094 (Table 4).

< Insert Table 4 approximately here >

The structural equation model of Figure 1 indicates the standardised regression coefficients and correlations with *p*-values (Figure 1). Process and outcome expectations showed a significant correlation with satisfaction as relating to therapy and therapist satisfaction.

The model as depicted in Figure 2 indicates one Satisfaction construct. Furthermore, it shows that client expectations correlate statistically significant with their satisfaction of psychological treatment in South Africa, and that compelling positive relationships exist between the constructs. The unique contribution that emanates from expectations of the outcome is also indicated.

< Insert Figure 2 approximately here >

The implication of these results will be indicated in the discussion.

Discussion

In the study under review, the relationship between clients' expectations and their satisfaction with psychological treatment in South Africa was explored. All correlations between the before-mentioned constructs were statistically significant, and indicated medium to large relationships between clients' expectations and their satisfaction with psychological treatment. These observed correlations are in line with the 1997-literature review of Sitzia

and Wood, who concluded that expectations are critical, and form the basis for the subjective assessment or the rating of satisfaction (Sitzia & Wood, 1997). The findings furthermore confirm the theories of patient satisfaction that emphasise the role of treatment expectations (Constantino et al., 2011; De Siqueira, Dos Santos, Dos Santos, & Marchini, 2012; Holcomb, Parker, Leong, Thiele, & Higdon, 1998). The relationships found in the current study were all positive, signifying that if a client has low expectations their satisfaction will also be low, and if expectations were high, satisfaction would also be high. The latter finding is not congruent with the results of Sitzia and Woods' (1997) literature review, which suggested that clients with lower expectations tended to be more satisfied. However, Sitzia and Wood did indicate in their literature review that there are also differing expectations for different aspects of care (Sitzia & Wood, 1997), which can feasibly explain the positive relationships found in the current study. The all-inclusive results in this South African sample of the current study indicate that there exists a strong relationship between clients' expectation and their satisfaction with psychological treatment.

The results of this research are noteworthy, because there are concerns about South African psychologists' awareness of client satisfaction and of client expectations. Although the findings are in line with other research in this area, the implications thereof are remarkable in lieu of the fact that the results indicate that we as psychologists should change our view concerning clients' expectations of therapy, as well as reassess our measures of successful therapy.

A large variance of 27% of the satisfaction construct was explained by outcome expectations. A unique contribution thus stems from outcome expectations, when the simultaneous relationship between process and outcome expectations with satisfaction is considered. Thus, when process expectations are present, outcome expectations have the larger or unique contribution. In practice this means that if a client has positive outcome

expectations, that is, expectations concerning how the client might change as a result of therapy (Norberg et al., 2011), the client will probably also have greater satisfaction. This finding is an important conclusion therapists ought to consider at the onset of therapy. Fostering and formulating positive and realistic expectations for the outcome of the therapeutic process will have an effect on the client's satisfaction. This finding corresponds with the conclusion of the 2016-study of Ekberg et al. who found that clients engage more readily when provided with an explanation that manages their expectations at the outset of therapy (Ekberg et al., 2016). Expectation of the process will more likely influence satisfaction when outcome is not present or rated less important by a client, for example, clients looking for self-enrichment without a specific resolve (Norberg et al., 2011). Expectations regarding outcomes furthermore have an influence on the client's resolve, because if a client holds the expectation that he or she will improve at the end of the therapeutic endeavour, they are more likely to improve and consequently their satisfaction will be higher (Garland, Haine, & Lewczyk Boxmeyer, 2007). If a client does not expect to improve by the end of therapy, their determination and satisfaction will be lower.

An improved understanding and management of patients' expectations can furthermore enhance patient satisfaction, which in turn refers to the fulfilment of a desire or need of the client. Personality types and other factors may also have a role to play here because this is not a causal relationship, and these factors were not measured or accounted for in this study. One can furthermore argue that if a client does not have good outcome expectations, that client will probably be unwilling to enter into, and engage effectively with therapy. The 2009-study by Aubuchon-Endsley and Callahan found client expectations to be strong predictors of dropout rates, accounting for 11% to 14% of the variance in premature termination (Aubuchon-Endsley, & Callahan, 2009). This result is consistent with literature on client "dropout" studies, which likewise found a moderately strong relationship between

psychotherapy dropout and therapeutic alliance, thus indicating that clients with weaker therapeutic alliances were more likely to drop out of therapy (Sharf & Primavera, 2010). Psychologists are thus also ethically obliged to keep record of their own dropout rates and attempt to link these with client expectation and satisfaction.

The correlations of the satisfaction components were found to be high, indicating high correlations between process and outcome expectations with the satisfaction construct. Consequently, these were grouped together into one satisfaction construct, resulting in a better model fit (Hox & Bechger, 1998) as reflected in the RMSEA indices with 90% confidence interval. Regardless of the factor model used, outcome expectations had a unique contribution to satisfaction.

Conclusion

Worldwide the importance of patient satisfaction is recognised as an imperative strategic asset for quality improvement (Kurti, 2015; Reichheld, 2003). Individual clinicians, medical groups, hospitals, and health plans have vested interests to be engrossed in patient satisfaction. Those organisations and providers who recognise this will ultimately develop and maintain a better competitive advantage, and will acquire the benefits associated with a satisfied community of health-care consumers (Wadhwa, 2002 as quoted by Kurti, 2015). In today's highly competitive health-care market, satisfaction serves not only as a gauge for quality and improvement, but also serves to entice patients and insurers (Rivers & Glover, 2008). Client satisfaction furthermore conforms to the ideologies of evidence-based practices in psychology, in that it encompasses the best available research, integrated with clinical expertise in the context of patient characteristics, culture and preference (APA, 2006, p. 5), thus advocating accountability for all health professionals in meeting the needs and satisfaction of their clients.

The evaluation of client satisfaction is internationally recognised as a facet of evidence-based practice. A great need exists for an increased awareness of evidence-based practices among South African psychologists. This cognisance requires a responsiveness to include the evaluation of client satisfaction in our practices, should we want to conduct ourselves internationally within the EBP framework.

It was surmised that client satisfaction, or dissatisfaction, is a complex phenomenon and is linked to patients' expectations and personal traits. Patient satisfaction is by nature multidimensional and satisfaction with one facet of care may not necessarily carry over to another. The study confirms that a clear relationship exists between client's Expectations of and Satisfaction with psychological treatment in South Africa, thus emphasising the importance of understanding this relationship beforehand, and clarifying this with a client even before the onset of therapy.

Numerous factors influence the process and outcome expectations of psychotherapy. The client's outcome expectations have been shown to predict their satisfaction with therapy accurately. Thus, it would seem that if one is able to increase or enhance these expectations of the outcome, satisfaction will also be higher and this is the ultimate goal of therapy. This intensification can and should be incorporated into the therapy process at the onset of therapy, even before addressing the presenting problem of the client. One has to bear in mind that this is not a causal relationship, but a once-off recording, and besides outcome expectations other factors may play a part in satisfaction. As such, process expectations has been shown as an important contributing part in satisfaction with therapy.

Within South Africa, there exists a pronounced void in psychologists understanding of evidence-based practice, and consequently also in the determining of client satisfaction. This is something that will increasingly be required by health care, but gaps exist in the knowledge, and training of psychologists in this EBP concept as a whole.

It is suggested that a follow-up study or future research explore these factors more fully. However, a possible relationship between higher outcome expectations and higher satisfaction amongst the South African study is apparent. During 2014, the researchers Patterson, Anderson, and Wei concluded that clients entering in outpatient therapy with strong expectations about the therapist's expertise facilitated positive clinical outcomes. However, these effects were not brought about by the therapeutic alliance; unlike they hypothesised, and left unanswered questions as to how expectations influenced outcomes. The researchers' conclusions in the present study are in agreement with these findings, but suggest that client expectations regarding the outcome of the therapy process, provide the *unique* contribution by influencing satisfaction.

The results also support the usefulness of the MPEQ and STTS-R as brief reliable measures for assessing clients' psychological treatment expectations and satisfaction in South Africa. Increased knowledge on client's expectations regarding psychological treatment and their satisfaction, endorses high-quality psychological services throughout South Africa.

References

- Akter, S., D'Ambra, J., Ray, P., & Hani, U. (2013). Modelling the impact of health service quality on satisfaction, continuance and quality of life. *Behaviour & Information Technology, 32*, 1225–1241.
- American College of Emergency Physicians. (2014). *Quality of care and the outcomes management movement*. Retrieved from <http://www.acep.org/clinical---Practice-Management/Quality-of-Care-and-the-Outcomes-Management-Movement/>
- American Psychological Association (APA). (2006). Presidential task force on evidence-based practice: Evidence-based practice in psychology. *American Psychologist, 61*, 271–285.
- Association for Behavioral and Cognitive Therapies. (2003). Myths & facts about empirically supported treatments: Conceptions and misconceptions. *American Psychologist, 61*, 271–285. Retrieved from <http://www.abct.org/Professionals/?m=mPro&fa=MythsAbdFacts>
- Aubuchon-Endsley, N. L., & Callahan, J. L. (2009). The hour of departure: predicting attrition in the training clinic from role expectancies. *Training and Education in Professional Psychology, 3*(2), 120e126. <http://dx.doi.org/10.1037/a0014455>.
- Berke, D. M., Rozell, C. A., Hogan, T. P., Norcross, J. A., & Karpiak, C. P. (2011). What clinical psychologists know about evidence-based practice: Familiarity with online resources and research methods. *Journal of Clinical Psychology, 67*, 329–339.
- Bialosky, J. E., Bishop, M. D., & Cleland, J. A. (2010). Individual expectation: An overlooked, but pertinent, factor in the treatment of individuals experiencing musculoskeletal pain. *Physical Therapy, 90*(9), 1345–1355.

- Bjertnaes, O. A., Sjetne, I. S., & Iversen, H. H. (2011). Overall patient satisfaction with hospitals: Effects of patient-reported experiences and fulfilment of expectations. *BMJ Quality & Safety*, *21*, 39–46. <http://dx.doi.org/10.1136/bmjqs-2011-000137>
- Bleich, S. N., Ozaltin, E., & Murray, C. K. (2009). How does satisfaction with the health-care system relate to patient experience? *Bulletin of the World Health Organization*, *87*(4), 271–278. <http://dx.doi.org/10.1590/S0042-96862009000400012>
- Blunch, N. J. (2008). *Introduction to structural equation modelling using SPSS and AMOS*. London: Sage.
- Bowling, A., Rowe, G., Lambert, N., Waddington, M., Mahtani, K. R., Kenten, C., ...Francis, S. A. (2012). The measurement of patients' expectations for health care: A review and psychometric testing of a measure of patients' expectations. *Health Technology Assessment*, *16*(30), i–xii, 1–509. <http://dx.doi.org/10.3310/hta16300>
- Branson, L., Buxton, M., & Fryman, H. (2014). Patient satisfaction measures and their impact on patients' rating of a hospital. *International Journal of Management & Human Resources*, *2*(1), 1–13.
- Burnham, K. P., & Anderson, D. R. (2002). *Model selection and multimodel inference: A practical information-theoretic approach* (2nd ed.). New York: Springer-Verlag.
- Burns, N., & Grove, S. K. (1993). *The practice of nursing research: Conduct, critique and utilization*, (2nd ed.). Philadelphia: W. B. Saunders.
- Buyse, V., & Wesley, P. W. (2006). Evidence-based practice: How did it emerge and what does it really mean for the early childhood field? *Zero to Three*, *27*(2), 50–55.
- Clark, L. A., & Watson, D. (1995). Constructing validity: Basic issues in objective scale development. *Psychological Assessment*, *7*(3), 309–319.
- Cohen, J. (1988). *Statistical power analysis for behavioural sciences* (2nd ed.). Hillsdale, NJ: Erlbaum.

- Constantino, M., Glass, C. R., Arnkoff, D. B., Ametrano, R. M., & Smith, J. Z. (2011). Expectations. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Evidence-based responsiveness* (pp. 354–376). New York: Oxford University Press.
- De Siqueira, G. P., Dos Santos, M. B., Dos Santos, J. F., & Marchini, L. (2013). Patients' expectation and satisfaction with removable dental prosthesis therapy and correlation with patients' evaluation of the dentists. *Acta Odontol Scand*, *71*(1), 210–214.
- Donabedian, A. (1980). *The definition of quality and approaches to its assessment (Vol 1): Explorations in quality assessment and monitoring*. Ann Arbor, MI: Health Administration Press.
- Duckro, P., George, C., & Beal, D. (1979). Effects of failure to meet client preference in a counseling interview. *Journal of Counseling Psychology*, *26*(1), 9–14.
- Edwards, J. A. (2009). Treating posttraumatic stress disorder in South Africa: An integrative model grounded in case-based research. *Journal of Psychology in Africa*, *12*(2), 189–198.
- Ekberg, S., Barnes, R. K., Kessler, D. S., Malpass, A., & Shaw, A. R. (2016). Managing clients' expectations at the outset of online cognitive behavioural therapy (cbt) for depression. *Health Expectations*, *19*(3), 557–569.
- Frattali, C. M. (1991). *Measuring client satisfaction*. Retrieved from <http://www.asha.org/SLP/healthcare/Measuring-Client-Satisfaction/>
- Fuertes, J. N., Anand, P., Haggerty, G., Kestenbaum, M., & Rosenblum, G. C. (2015). The physician-patient working alliance and patient psychological attachment, adherence, outcome expectations, and satisfaction in a sample of rheumatology patients. *Behavioral Medicine* *3*, *41*(2), 60–8.
<http://www.tandfonline.com/doi/abs/10.1080/08964289.2013.875>

- Garland, A. F., Haine-Schlagel, R. A., & Lewczyk Boxmeyer, C. (2007). Determinates of youth and parent satisfaction in usual care psychotherapy. *Evaluation and Program Planning*, 30(1), 45–54. <http://dx.doi.org/10.1016/j.evalprogplan.2006.10.003>
- Gill, L., & White, L. (2009). A critical review of patient satisfaction. *Leadership in Health Services*, 22(1), 8–19.
- Hancock, G. R., & Mueller, R. O. (2010). *The reviewer's guide to quantitative methods in social sciences*. New York: Routledge.
- Heidegger, T., Saal, D., & Nuebling, M. (2006). Patient satisfaction with anaesthesia care: What is patient satisfaction, how should it be measured, and what is the evidence for assuring high patient satisfaction? *Best Practice and Research Clinical Anaesthesiology*, 20(2), 331–346.
- Holcomb, W. R., Parker, J. C., Leong, G. B., Thiele, J., & Higdon, J. (1998). Customer satisfaction and self-reported treatment outcomes among psychiatric inpatients. *Psychiatric Services*, 49(7), 929–934.
- Hooper, D., Coughlan, J., & Mullen, M. R. (2008). Structural equation modelling: Guidelines for determining model fit. *The Electronic Journal of Business Research Methods*, 6(1), 53–60.
- Hox, J. J., & Bechger, T. M. (1998). An introduction to structural equation modeling. *Family Science Review*, 11, 354–373.
- Kravitz, R. L. (1998). Patient satisfaction with health care: Critical outcome or trivial pursuit? *J Gen Intern Med*, 13(4), 280–282. <http://dx.doi.org/10.1046/j.1525-1497.1998.00084.x>
- Kurti, S. (2015). *Patient satisfaction evaluation: A theoretical framework*. Retrieved from http://www.academia.edu/4085766/Patient_Satisfaction_Evaluation_-_A_Theoretical_Framework

- Levin, K. A. (2006). Study design III: Cross-sectional studies. *Evidence-Based Dentistry*, 7, 24–25. <http://dx.doi.org/10.1038/sj.ebd.6400375>
- Marjoua, Y., & Bozic, K. J. (2012). Brief history of quality movement in US healthcare. *Current Reviews in Musculoskeletal Medicine*, 5(4), 265–273. <http://dx.doi.org/10.1007/s12178-012-9137-8>
- McQuitty, S., & Wolf, M. (2013). Structural Equation Modeling: A practical introduction. *Journal of African Business*, 14(1), 58–69. <http://dx.doi.org/10.1080/15228916.2013.765325>
- Miller, D. T., & Turnbull, W. (1986). Expectancies and interpersonal processes. *Annual Review of Psychology*, 37, 233–256. <http://dx.doi.org/10.1146/annurev.ps.37.020186.001313>
- Mueller, R. O. (1996). *Basic principles of structural equation modeling: An introduction to LISREL and EQS*. New York: Springer.
- Noble, L. M., Douglas, B.C., & Newman, S. P. (2001). What do patients expect of psychiatric services? A systematic and critical review of empirical studies. *Social Science and Medicine*, 52(7), 985–998.
- Nock, M. K., & Kazdin, A. E. (2001). Parent expectancies for child therapy: Assessment and relation to participation in treatment. *Journal of Child and Family Studies*, 10, 155–180.
- Norberg, M. M., Wetterneck, C. T., Sass D. A., & Kanter, J. W. (2011). Development and psychometric evaluation of the Milwaukee psychotherapy expectations questionnaire. *Journal of Clinical Psychology*, 67(6), 574–590.
- Oei, T. P. S., & Green, A. L. (2008). The satisfaction with therapy and therapist scale – revised (STTS-R) for group psychotherapy: Psychometric properties and confirmatory factor analysis. *American Psychological Association*, 39(4), 435–442.

- Oei, T. P. S., & Shuttlewood, G. J. (1999). Development of a satisfaction with therapy and therapist scale. *Australian and New Zealand Journal of Psychiatry*, 33, 748–753.
- Palazzo, C., Jourdan, C., Descamps, S., Nizard, R., Hamadouche, M., Anract, P., ...Poiraudau S. (2014). Determinants of satisfaction 1 year after total hip arthroplasty: The role of expectations fulfilment. *BMC Musculoskeletal Disorders*, 15(53). <http://dx.doi.org/10.1186/1471-2474-15-53>
- Palmer, R. H., Donabedian, A., & Povar, G. J. (1991). *Striving for quality in health care: An inquiry into policy and practice*. Chicago, IL: Health Administration Press.
- Patterson, C. L., Anderson, T., & Wei, C. (2014). Clients' pretreatment role expectations, the therapeutic alliance, and clinical outcomes in outpatient therapy. *Journal of Clinical Psychology*, 70(7), 673–680.
- Räsänen, P. (2006). *Routine measurement of health-related quality of life in assessing cost-effectiveness in secondary healthcare* (Academic dissertation). University of Helsinki and Hospital District of Helsinki and Uusimaa, Finland. Retrieved from <https://helda.helsinki.fi/bitstream/handle/10138/20314/routinem.pdf?...1>
- Reichheld, F. F. (2003). The one number you need to grow. *Harvard Business Review*, 81, 46–54. <https://hbr.org/2013/12/the-one-number-you-need-to-grow>
- Rivers, P. A., & Glover, S. H. (2008). Health care competition, strategic mission, and patient satisfaction: Research model and propositions. *Journal of Health Organization and Management*, 22(6), 627–641.
- Sackett, D. L., Straus, S. E., Richardson, W. S., Rosenberg, W., & Haynes, R.B. (2000). *Evidence-based medicine: How to practice and teach EBM (Vol. 2)*. London: Churchill Livingstone.

- Sanders, M. R. (2010). Adopting a public health approach to the delivery of evidence-based parenting interventions. *Canadian Psychology, 51*, 17–30.
<http://dx.doi.org/10.1037/a0018295>
- Sandoval, G. A., Levington, C., Blackstein-Hirsch, P., & Brown, A. D. (2005). Selecting predictors of cancer patients' overall perceptions of the quality of care received. *Annals of Oncology, 17*(1), 151–156.
- SAS Institute Inc. (2011). *SAS OnlineDoc® 9.3*. Cary, NC: SAS Institute Inc. Retrieved from
<https://www.google.co.za/#q=SAS+Institute+Inc.+2011.+SAS+OnlineDoc%C2%AE+9.3.+Cary%2C+NC:+SAS+Institute+Inc.>
- Sharf, J., & Primavera, L. (2010). Dropout and therapeutic alliance: A meta-analysis of adult individual psychotherapy. *American Psychological Association: Theory, Research, Practice and Training, 47*(4), 637–645.
- Shaughnessy, J., & Zechmeister, E. (1994). *A practical introduction to research methods in psychology* (2nd ed.). New York: McGraw-Hill.
- Sitzia, J., & Wood, N. (1997). Patient satisfaction: A review of issues and concepts. *Social Science Medicine, 45*(12), 1829–1843.
- Slywotzky, A. (2015). *The patient-to-consumer healthcare revolution*. Retrieved from
[http://www.brinknews.com/the-patient-to-consumer-health care-revolution/](http://www.brinknews.com/the-patient-to-consumer-health-care-revolution/)
- Spring, B. (2007). Evidence-based practice in clinical psychology: What it is, why it matters; what you need to know. *Journal of Clinical Psychology, 63*(7), 611–631.
- SPSS Inc. (2016). *IBM SPSS Statistics (Version 23)* [Computer software]. Retrieved from
<http://www-01.ibm.com/software/analytics/spss/>

- Steiner, D. L. (2003). Starting at the beginning: An introduction to coefficient alpha and internal consistency. *Journal of Personality Assessment*, *80*, 99–103.
http://dx.doi.org/10.1207/S15327752JPA8001_18
- Steyn, H. S. (2002). Practically significant relationships between two variables. *SA Journal of Industrial Psychology*, *28*(3), 10–15.
- Tabachnick, B. G., & Fidell, L. S. (2007). *Using multivariate statistics* (5th ed.). Boston, MA: Allyn & Bacon.
- Targett, K. (2011). An introduction to clinical governance and patient safety. *Occupational Medicine*, *61*(4), 283. <http://dx.doi.org/10.1093/occmed/kqr013>
- The Society of Clinical Child and Adolescent Psychology (Division 53 of the APA). (2014). *Society of clinical child and adolescent psychology*. Retrieved from <https://www.apa.org/about/division/div53.aspx>
- Van der Merwe, E. J., Van Rensburg, E., & Ellis, S. (2016). Psychometric properties of scales measuring client expectations and satisfaction with psychological treatment in a South African context. [Manuscript in preparation].
- Vukmir, R. B. (2006). Customer satisfaction. *International Journal of Health Care Quality Assurance*, *19*(1), 8–31.
- Walker, M. S., Ristvedt, S. L., & Haughey, B. H. (2003). Patient care in multidisciplinary cancer clinics: Does attention to psychosocial needs predict patient satisfaction? *Psycho-Oncology*, *12*(3), 291–300.
- Wicks, A. M., & Roethlein, C. J. (2009). A satisfaction-based definition of quality. *Journal of Business & Economic Studies*, *15*(1), 82.
- Williams, B., Coyle, J., & Healy, D. (1998). The meaning of patient satisfaction. *Social Science Medicine*, *47*, 1351–1359.

Winerman, L. (2016). Helping men to help themselves. *American Psychological Association, 36*, 57.

Wolf, J. A., Niederhauser, V., Marshburn, D., & LaVela, S. L. (2014). Defining patient experience. *Patient Experience Journal, 1*(1) 7–19. Retrieved from <http://pxjournal.org/journal/vol1/iss1/3>

Table 1: Biographical characteristics of clients and frequency distributions (N = 204)

Variable	Description	Frequency	Percentages
Gender	Male	77	37.7%
	Female	120	58.8%
Age	18 - 20	19	9.3%
	21 - 30	36	17.6%
	31 - 40	46	22.5%
	41 - 50	44	21.6%
	51 - 60	34	16.7%
	61 - 70	19	9.3%
	70+	6	2.9%
Race	White	108	52.9%
	Black	76	37.3%
	Indian	9	4.4%
	Coloured	9	4.4%
Sessions attended	1	28	13.7%
	2 - 3	33	16.2%
	3 - 5	49	24.0%
	5 - 8	50	24.5%
	8+	35	17.2%
Occupation	Management	14	6.9%
	Professional	60	29.4%
	Administrative	35	17.2%
	Tradesperson	29	14.2%
	Customer Service	9	4.4%
	Operators	4	2.0%
	Unskilled	10	4.9%
	Student	29	14.2%
	Unemployed	11	5.4%
Education	Primary School	13	6.4%
	High School	104	51.0%
	University	55	27.0%
	Post-graduate	29	14.2%
Language	Afrikaans	93	45.6%
	English	52	25.5%
	Setswana	55	27.0%
Referral Source	Self-referred	96	47.1%
	GP	86	42.2%
	Other	21	10.3%

Table 1 continued

Descriptive statistics, mean and Standard Deviations for the MPEQ and STTS-R scales (N = 204)

Scale	M	SD
MPEQ:		
Process Expectations	4.37	0.66
Outcome Expectations	4.01	0.96
Expectation Total	8.39	1.5
STTS-R:		
Satisfaction with Therapy	24.88	4.73
Satisfaction With Therapist	23.57	5.9
Satisfact. Global	4.08	0.99

Table 2: Correlations between expectation and satisfaction of clients (SAS PROC SURVEYREG)

Variables		Satisfaction with Therapy	Satisfaction with Therapist	Satisfaction Global
Process	<i>r</i>	0.43	0.42	0.3
Expectations	<i>p-value</i>	<0.001	<0.001	<0.001
	<i>N</i>	191	191	191
Outcome	<i>r</i>	0.45	0.49	0.34
Expectations	<i>p-value</i>	<0.001	<0.001	<0.001
	<i>N</i>	191	191	191
Expectation	<i>r</i>	0.47	0.49	0.35
Total	<i>p-value</i>	<0.001	<0.001	<0.001
	<i>N</i>	191	191	191

Figure 1: Structural equation modelling - Satisfaction with Therapist, Therapy & Global Satisfaction. Model 1 with standardised regression coefficients and correlations with *p*-values

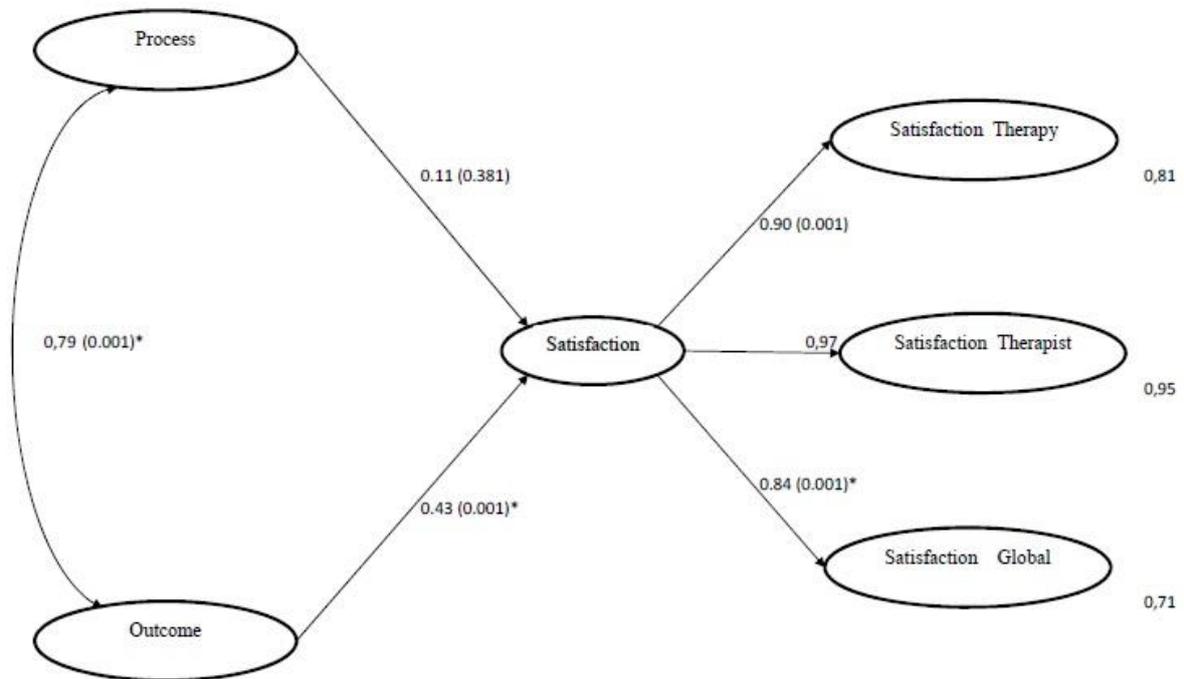


Table 3: Results of Structural Equation Modelling (SEM) and Squared Multiple Correlations: Expectation and Satisfaction of clients

			Model 1 (3-factor)		Model 2 (1-factor)	
			Estimate	p-value	Estimate	p-value
Satisfaction	<---	Process	0.106	0.381	0.141	0.244
Satisfaction	<---	Outcome	0.432	***	0.399	***

*** < 0.001

Squared Multiple Correlations

	Estimate
Satisfaction (Model 1)	0.270
Satisfaction (Model 2)	0.268

.01 = small

.1 = medium

.25 = large

Squared Multiple Correlations: Satisfaction components Model 1

	Estimate
Satisfaction Therapy	0.812
Satisfaction Therapist	0.945
Satisfaction Global	0.712

Correlations

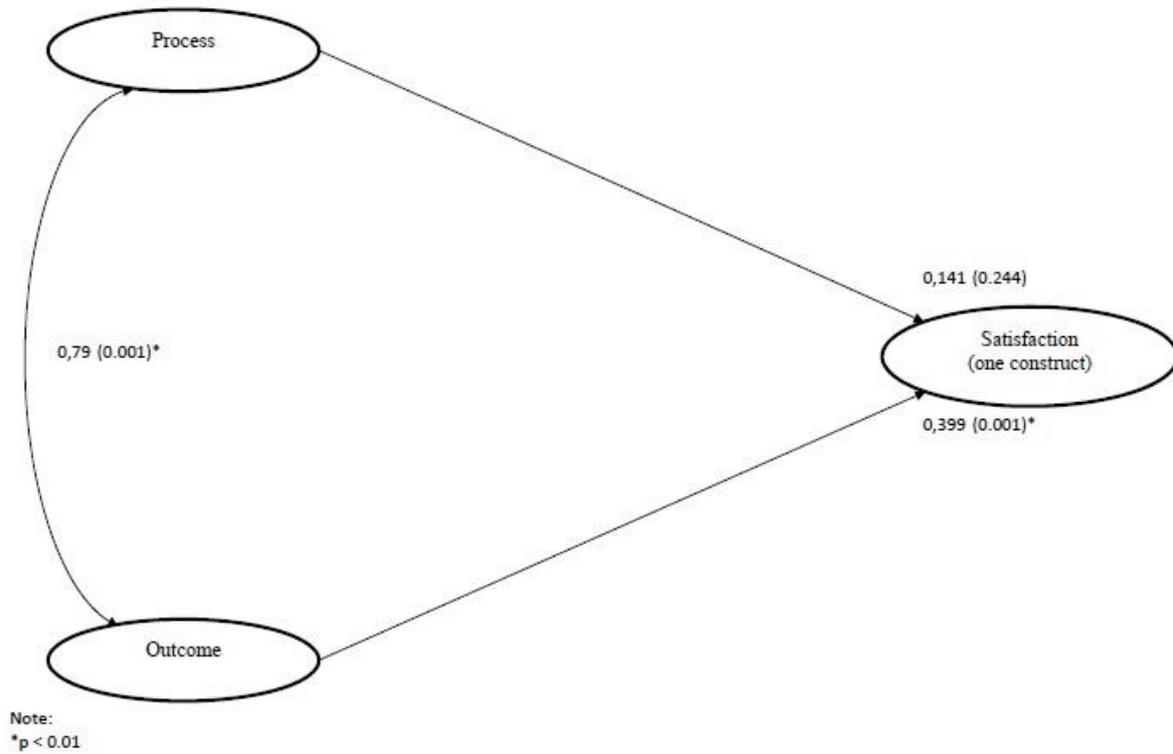
			Estimate	p-value
Outcome	<-->	Process	0.79	<0.001

Table 4: Summary of goodness of fit measures for SEM Model 1 and 2.

Model Fit Summary

Model	CMIN/DF	CFI	RMSEA	LO 90	HI 90	AIC
Model 1	3.066	0.910	0.101	0.088	0.114	411.7
Model 2	2.526	0.896	0.087	0.079	0.094	909.8

Figure 2: SEM (One Satisfaction Construct) Model 2 with standardised regression coefficients and correlations with p -values



SECTION C: CRITICAL REFLECTION

CONCLUSIONS, IMPLICATIONS, AND RECOMMENDATIONS

5.1 Introduction

In this the final segment (Section C) a critical reflection of the main findings is summarised, implications indicated, and some recommendations are made for future research with specific attention to the construct of “Patient Experience”.

5.2 Conclusions from Literature

The literature suggests that patient satisfaction is by nature multidimensional and that patterns do exist. Consequently it was surmised that client satisfaction, or dissatisfaction, is a complex phenomenon and is linked to patients’ expectations and personal traits. The studies likewise indicate that regardless of the field in which it is considered, the concept of satisfaction is complex (Gill & White, 2009), multifaceted, not yet strongly defined, and holds no agreed- upon definition (Hawthorne, 2006; Heidegger, Saal, & Neubling, 2006). There does however seem to be an agreement as far as that the perfect conception of satisfaction with health care has still not been attained, and that comprehending the process by which a client derives to be satisfied or dissatisfied continues to elude us (Crowe et al., 2002).

The analysis stemming from the literature compels the current author to come to the conceptualisation of the following definition of client satisfaction:

***Patient/Client Satisfaction** is a multi-dimensional construct, dynamic, continually altering, and an iterative process of cognitive, affective, and conative perception formation. It is an attitudinal response enhanced by individual differences that culminates in positive evaluations, ameliorated by prior expectations of distinct dimensions of health care where quality – expressed as satisfaction or dissatisfaction – could pertain to settings and amenities of care, to aspects of technical management, to features of interpersonal care, and to the physiological, physical, psychological or social consequences of care.*

A composite definition of expectations was also arrived at:

Client Expectations are judgements and beliefs about experiences during psychological treatment. It encompasses attitudes and conceptions about the process of collaboration between client and therapist, and the culmination of said process.

Client satisfaction with regard to psychological treatment is an innovative research area in psychology that focusses on the client and the enhancement of their health-care experiences. It is strongly linked to patients' expectations and whether these were positively realised (Wolf, Niederhauser, Marshburn, & LaVela, 2014). Scientific progress has progressed to the extent that interventions at individual, public policy, and organisational levels can be made. Applications are found in evaluation (assessment) and interventions in various life contexts (such as therapy, health promotion, and occupational engagement), as well as in organisational development. Client satisfaction is seen as part of the quality-outcomes movement focussing on performance improvement and outcome measurement (Marjoua & Bozic, 2012). From this review, it is clear that applications for client satisfaction have been found in many real-life contexts in which it can contribute to an improvement for all people.

An advantage of client satisfaction is that it has the ability to bring about/cause benefit for many people on the entire mental-health continuum – given that its theory, research evidence, needs, and techniques are further developed. Client satisfaction will furthermore benefit the minority who are at risk of being overlooked; will accentuate the need for culture-sensitive intervention programmes, and as such should be evaluated for applicability in the African or South African contexts. Constantine and Sue (2006) also propose that Western notions of optimal functioning or quality of life may not be applicable to people of colour in the USA. Their research indicated that the role of culture values, beliefs, and adaptive practices in relation to optimal functioning that ascertain a higher quality of life should be

explored for people of colour. This conviction aids recognition of the way in which they succeeded in dealing with adverse circumstances of their past. The findings of this thesis are thus similarly in line with the recommendations of Constantine and Sue (2006).

5.3 Conclusions from the Current Study

Article 1

The aim of this study was to establish whether the two measuring instruments used were valid and reliable for application in the South African context. The first article reported that the STTS-R and the MPEQ have satisfactory psychometric properties for use in a South African context, and that the most promising model for use in the South African context is the three-factor model of the STTS-R. A cross-sectional survey design was employed; thus, a test-retest method remains a consideration for future studies in this regard.

Article 2

To determine the nature of client's expectations and satisfaction with their psychological treatment, exploration in the second manuscript centred on expectation and satisfaction of these aims in a South African context. It was found that South African clients hold very high expectations in general. Expectations for the Process were also found to be higher than the expectations for Outcome. The results concluded that the specific reference that was given to correlations between ordered biographical variables and the expectations of clients, by taking into account the hierarchical nature of the data, was a valid research endeavour, and revealed many underlying patterns in the data.

Article 3

In the third article, the researchers aimed to determine whether correlations between clients' expectations and their satisfaction were significant. In this article, the researchers found that the correlations of the satisfaction components were high, indicating high

correlation between Process and Outcome expectations with the Satisfaction construct. It was surmised that client satisfaction or dissatisfaction is a complex phenomenon and is linked to patients' expectations and personal traits. Patient or client satisfaction is by nature multidimensional and the study confirms that a relationship exists between clients' expectations and satisfaction with psychological treatment in South Africa.

5.4 Implications for psychologists in South Africa

5.4.1 Current results embedded in "Patient Experience"

The current results are entrenched in the Patient Experience movement. Recently, awareness of performance and quality of health-care organisations has started to move beyond investigating the delivery of exceptional clinical care. Instead, considering and welcoming the patient experience as a vital quality gauge is relevant (The Beryl Institute, 2015). From the report on the State of Patient Experience (Wolf, 2013), it is clear that patient experience is growing sturdier, with community support flourishing. The past years have seen a move in the general perspective in health care from traditional models to a client or consumer view. It has been a time of global change surrounding priorities for health-care systems and policy, which holds great repercussions for experience performance (The Beryl Institute, 2015).

In a recently-published report on their benchmarking study concerning the state of patient experience (The Beryl Institute, 2015) researchers concluded that the patient-experience movement has blossomed and "moved from the fringes to the heart of healthcare" (Wolf, 2015, p. 23). The Beryl Institute is a global community of practice, devoted to enhancing patient experience (The Beryl Institute, 2015). Its commitment is to take note of how individuals and organisations are engaging in and addressing patient experience in their institutes. These include the organisations in which they work, as well as those organisations

where they engage as patients, consultants or community members (Wolf, 2015). The insinuation here is that all of us play a role in patient experience, balancing both an individual and a collective responsibility aimed at ensuring the best in experience for all involved with health care.

The Beryl Institute defines patient experience as “the sum of all interactions, shaped by an organisation’s culture, that influence patient perceptions across the continuum of care” (Wolf et al., 2014, p. 5). With regard to the definition of patient experience, the findings of their narrative synthesis of existing literature identified several concepts and recommendations to consider.

“First, the patient experience reflects occurrences and events that happen independently and collectively across the continuum of care. Also, it is important to move beyond results from surveys, for example those that specifically capture concepts such as ‘patient satisfaction’, because patient experience is more than satisfaction alone. Embedded within patient experience is a focus on individualised care and tailoring of services to meet patient needs and engage them as partners in their care. Next, the patient experience is strongly tied to patients’ expectations and if they were positively realised (beyond clinical outcomes or health status). Finally, the patient experience is integrally tied to the principles and practice of patient- and family-centred care” (Wolf et al., 2014, p. 5).

A necessary change has commenced in health care departing from a clinician-centred or even patient-centred approach, to one where the experience of clients involved is the ultimate degree of success, and one in which patient’ experiences do matter. This is a “noble cause, recognising the fundamental truth that we are human beings caring for human beings,

we can come to no other conclusion that we are all the patient experience” (The Beryl Institute, 2015, p. 23).

The Beryl Institute has a concise stand on the guiding principles for organisations to enrich the patient experience movement. These eight essential actions are as follows:

1. Identify and support accountable leadership with committed time and focused intent to shape and guide experience strategy.
2. Establish and reinforce a strong, vibrant, and positive organisational culture and all it comprises.
3. Develop a formal definition for what experience is to their organisation.
4. Implement a defined process for continuous patient and family input and engagement.
5. Engage all voices in driving comprehensive, systematic, and lasting solutions.
6. Look beyond clinical experience of care to all interactions and touch points.
7. Focus on alignment across all segments of the continuum and the spaces in between.
8. Encompass both a focus on healing and a commitment to well-being (The Beryl Institute, 2015, p. 22).

The Institute offers these as aspirational “wills” and not “shoulds”, and believes experience is a continuous effort, for the journey never truly ends (The Beryl Institute, 2015, p. 22). The nett results of the above studies indicate that the topics of client satisfaction and client expectations are about much more than the clients’ mere perception of care. As Jason A. Wolf, president of the *Patient Experience Journal* (2016), so astutely summarised, “The idea of experience reflects the biggest opportunity in health care, where experience encompasses quality, safety and service moments, is impacted by cost and the implications of accessibility and affordability” (Wolf, 2016, p. 1).

Positive experiences of clients create positive encounters, enduring recollections, and expanded obligations (Wolf, 2016). Clients as healthcare consumers choose to utilise services where they are treated well, with dignity, respect, and receive the maximum quality experience (Wolf, 2016). Clients' expectations, and in particular their experience "on the playing field of healthcare" (Wolf, 2016, p. 1), is no longer an abstract concept.

The current study can thus be seen as part of the "Patient Experience" movement, and aims to align itself with the vision of "Patient Experience" by acknowledging that is an imperative part of healthcare. The relevance of this thesis proposes support for these endeavours, and advances healthcare collectively.

5.4.2 Challenges for Psychologists

The results of this thesis are remarkable, but there exists concerns about South African psychologists' awareness of client satisfaction and of client expectations. Although the findings are in line with other research in this area, the implications thereof are striking. These results indicate that we as psychologists will have to change our perceptions concerning our clients, and reassess our measures of success in therapy, as well as fine-tune our definition of successful therapy.

Literature on client expectation in health care continues to increase and expand (Kravitz, 1996). The augmented requirements and expectations of clients are also more evident in twenty-first century practice, owing to images that are more accurate, and precise information being freely available. Amplified expectations need to be managed adequately by practitioners in order to improve outcomes and decrease liability. Furthermore, clients who enter into psychological treatment usually experience high levels of anxiety and stress. Managing the expectations of clients and their families now becomes even more challenging. We have to remind ourselves that our clients very often enter into therapy so emotionally

burdened and laden, that clients can almost not conceptualise or logically phrase the presenting problem. Thus, it is imperative that the psychologist assists clients to describe their difficulties in operational, workable language.

Quality in health care generally has two dimensions: the objective or technical part, as well as the subjective or qualitative dimension. Similarly, EBP specifies that measurement be performed in operational terms (Drisko, 2014), and an evaluation should comprise whether the outcome was achieved (did the problem change?), as well as whether the needs were met (i.e., was the client satisfied?). What clients think of their experience with the clinician and the health care system is similarly of importance to health-care planners, managers and policy makers because, this experience, expectations as much as the technical quality of care, will determine how clients use and benefit from the system.

EBP also stipulates that there should be a match between the knowledge of the therapist in terms of certain therapeutic styles and the needs and expectations of the client. Client preference must match with the four components of Evidence-Based Practice, i.e., “evidence-based practice is the integration of the best available research with clinical expertise in the context of patient characteristics, culture and preferences” (APA Presidential Task Force on Evidence-Based Practice, 2006), but determining client satisfaction actually becomes an ethical obligation of the psychologists to monitor themselves. In the same way as CPD was introduced by the HPCSA to keep practitioners abreast of current research, it is the ethical responsibility of each psychologist to conduct themselves in accordance with Evidence-Based Practices.

Clients enter into consultation with expectations of which they may or may not be explicitly aware. These expectations may be openly presented or the clinician may have to attempt to elicit them. Reactions to unmet expectations may range from disappointment to anger. Current information published by the HPCSA on issues of litigation (2011), shows that

about 70% of claims relate to poor communication from the professional. Situations in which the client feels real or perceived problems involving clinician communications manifest and exert an influence on a client's expectations. Thus, knowing and meeting the expectations of our clients can enhance their experience, help avoid negative reactions, result in better or optimal compliance, reduce exposure to liabilities, and even enrich a clinician's reputation within a community. An improved understanding and management of patients' expectations can furthermore enhance patient satisfaction, which in turn refers to the fulfilment of a desire or need of the client.

Correspondingly, clients may sometimes have unrealistic expectations. Integral to quality care and among the risk prevention efforts under our control is appropriate client education. Proper client education ensures that clients have realistic expectations about the risks, rehabilitation, and outcome of a psychological treatment or procedure. Examples of unrealistic client expectations include:

- Wanting to discuss several major problems, all in one standard consultation;
- The right to call the clinician twenty-four-hours a day for any personal problems;
- Thinking that the clinician will immediately know the exact diagnosis at first consultation and start treatment immediately;
- They will receive a specific treatment because they ask for it;
- The clinician will divulge confidential details about other family members, and
- That the clinician will provide a treatment without seeing them.

The astute clinician should know that to make meaningful progress, whilst enhancing client care, endorsing safety, promoting satisfaction, and improving quality, they are obligated to listen and respond to clients and customers. International research proved that the most effective way for the practitioners to mitigate these risks are to communicate well and try to develop a trusting relationship. As clinicians, we should be honoured that our clients

entrust us with their mental health and at all times strive to ensure our clients' understanding of the treatment rationale and their expectations thereof. Ample room must be left for questions and concerns not addressed. Explanations are necessary, for example, for why a certain treatment, further tests, or consultations are needed, and avoid using technical jargon. Communication needs to be clear, instant, and simple. Clinicians' decision-making can be complex and the logic may not be obvious to clients. Objectively stepping back, assessing, and exploring why certain requests are put forth can further enhance communication skills. Treating clients as individuals, managing their emotional pain, and providing adequate information on treatment are all equally as important as client safety elements.

Lastly, in order to manage unrealistic expectations and unreasonable requests from clients, each discerning clinician should also know not to allow clients to manipulate them with unreasonable or ludicrous demands. Their request for a second opinion is acceptable, as is the referral of a client to another clinician, if both parties cannot come to an agreement.

5.4.3 Methods of improving Client Satisfaction

- Over the past decade, research has emerged in the health-care field to demonstrate that patient satisfaction is an important indicator, and strategic asset for quality improvement (Reichheld, 2003).
- All across the world, today's health-care sector exemplifies quality in respect of patient satisfaction (Kurti, 2015).
- Individual clinicians, medical groups, hospitals and health plans all thus have vested interests to be engrossed in patient satisfaction. Organisations and providers who recognise this will ultimately develop and maintain a better competitive advantage, and will acquire the benefits associated with a satisfied community of health-care consumers (Wadhwa, 2002 as quoted by Kurti, 2015). In today's highly

competitive health-care market, satisfaction serves not only as a gauge for quality and improvement, but also serves to entice patients and insurers (Rivers & Glover, 2008).

- Dellande, Gilly and Graham (2004) found that clients tend to act in accordance with instructions from service providers who are regarded as experts in their field.
- Therefore, organisations should converse with clients about the expertise of their service providers. Including staff credentials in their brochures and publishing patient satisfaction surveys might also motivate other care providers towards improvement (Baker, 1998).
- An improved health-care market requires exemplification of quality in respect of patient satisfaction. To be competitive in this already competitive market, patient satisfaction should no longer be considered simply as a gauge for improvement of quality, but a paradigm shift should be acquired to have it serve to entice patients.
- In order to accomplish the suggested paradigm shift, organisations need to include staff credentials in their brochures and publish patient satisfaction surveys regularly. Teaching benefits of certain programs to clients might furthermore involve clients in their accountability and goal achievement.
- In order for an organisation to retain clients, their services should be of the highest quality. To insure this extraordinary quality, a continuous assessment of the clients' satisfaction should be maintained. The use of qualitative and quantitative survey methods have been suggested by Lamb (2004), as these valuations include clients in the health-care facilities' decision-making process.
- Psychologists are also obliged to, and should start keeping record of their own dropout rates and attempt to link these with client satisfaction. Before and perhaps

instead of blaming or labelling the client as not being ready for change, we need to take a long, hard look at our own service.

- As psychologists, we should surely also look at whether we offered what the client required. Similar to the HPCSA's regulations on CPD, measures also need to be implemented to ensure that a psychologists' work conforms to evidence-based practices, as well as compelling clinicians to provide proof of the client satisfaction measures and measurements they employ, thus establishing client satisfaction as an ethical obligation to all South African psychologists.
- Continued Professional Development (CPD) workshops and course material for training in psychotherapy should focus on increasing awareness of the client satisfaction and expectations constructs in psychology. Enhancing the current ethical content by means of guidelines on improving client satisfaction and client expectations in practice ought to prove obligatory to all South African psychologists.

5.5 Conclusion

As we continue to embrace our future, the band of care for clients will continue to evolve and a paradigm shift becomes inevitable with the aim of creating a more meaningful, impactful and efficient client care.

As we plan to meet and satisfy these increasing expectations, it becomes inevitable that elements of patient safety will have to be considered as well. When addressing satisfaction issues, matters related to errors in communication, safety (self-injury and suicide), outcome expectations, and therapeutic verification are indeed relevant.

The researchers were greatly satisfied with the results – and dare we say – proud. It was an enriching and enlightening experience for the researcher, who gained tremendous

knowledge that proved invaluable for his practice. The guidance and input from the study leader proved to be invaluable and meritorious.

References

- APA Presidential Task Force on Evidence-Based Practice. (2006). Evidence-based practice in psychology. *American Psychologist*, *61*(4), 271–285.
<http://dx.doi.org/10.1037/0003-066X.61.4.271>
- Baker, S. K. (1998). *Improving service and increasing patient satisfaction*. Retrieved from <http://www.aafp.org/fpm/980700fm/keane.html>
- Constantine, M. G., & Sue, D. W. (2006). Factors contributing to optimal human functioning in people of colour in the United States. *The counselling Psychologist*, *34*(2), 228–244.
- Crowe, R., Gage, H., Hampson, S., Hart, J., Kimber, A., Storey, L., & Thomas, H. (2002). The measurement of satisfaction with healthcare: Implications for practice from a systematic review of the literature. *Health Technology Assessment*, *6*(32), 1–244.
- Dellande, S., Gilly, M. C., & Graham, J. L. (2004). Gaining compliance and losing weight: The role of the service provider in health care services. *Journal of Marketing*, *68*(July), 78–91.
- Drisko, J. (2014). Research evidence and social work practice: The place of evidence-based practice. *Clinical Social Work Journal*, *42*, 123–133.
- Gill, L., & White, L. (2009). A critical review of patient satisfaction. *Leadership in Health Services*, *22*(1), 8–19.
- Hawthorne, G. (2006). Review of patient satisfaction measures. *Australian Government Department of Health and Ageing*, *17*(6), 465–472. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/24698296>
- Health Professions Council of South Africa (HPCSA). (2011). Conduct unbecoming [PDF file]. *The HPCSA Bulletin*, *2011*, 41–43. Retrieved from

http://www.hpcsa.co.za/Uploads/editor/UserFiles/downloads/publications/bulletin/Bulletin_2011.pdf

- Heidegger, T., Saal, D., & Nuebling, M. (2006). Patient satisfaction with anaesthesia care: What is patient satisfaction, how should it be measured, and what is the evidence for assuring high patient satisfaction? *Best Practice and Research Clinical Anaesthesiology*, 20(2), 331–346.
- Kravitz, R. L. (1996). Measuring patients' expectations and requests. *Annals of Internal Medicine*, 134(9), (Part 2), 881–888.
- Kurti, S. (2015). *Patient satisfaction evaluation: A theoretical framework*. Retrieved from http://www.academia.edu/4085766/Patient_Satisfaction_Evaluation_-_A_Theoretical_Framework
- Lamb, J. (2004). Technical help for researchers from ESRC and ONS. *Labour Market Bulletin*, 18.
- Marjoua, Y., & Bozic, K. J. (2012). Brief history of quality movement in US healthcare. *Current Reviews in Musculoskeletal Medicine*, 5(4), 265–273.
<http://dx.doi.org/10.1007/s12178-012-9137-8>
- Reichheld, F. F. (2003). The one number you need to grow. *Harvard Business Review*, 81, 46–54. <https://hbr.org/2013/12/the-one-number-you-need-to-grow>
- Rivers, P, A., & Glover, S. H. (2008). Health care competition, strategic mission, and patient satisfaction: Research model and propositions. *Journal of Health Organisation and Management*, 22(6), 627–641.
- The Beryl Institute. (2015). *State of patient experience 2015: A global perspective on the patient experience movement*. Retrieved from The Beryl Institute website:
<http://www.theberylinstitute.org/?page=PXBENCHMARKING>

- Wadhwa, S. S. (2002). Customer satisfaction and health care delivery systems: Commentary with Australian bias. *E-Journal of Nuclear Medicine*, 1(1), 1539–4638. Retrieved from <http://ispub.com/IJNUC/1/1/8617>
- Wolf, J. A. (2013). *A report on the Beryl Institute Benchmarking Study: The state of patient experience in American hospitals 2013: Positive trends and opportunities for the future* [PDF file]. Retrieved from <http://www.theberylinstitute.org/?page=PXBenchmarking2013>
- Wolf, J. A. (2015). The state of patient experience. *Patient Experience Journal*, 2(2). Retrieved from <http://www.theberylinstitute.org/?page=PXBENCHMARKING>
- Wolf, J. A. (2016). Patient experience: Driving outcomes at the heart of healthcare. *Patient Experience Journal*, 3(1), 1–4. Retrieved from <http://pxjournal.org/journal/vol3/iss1/1>
- Wolf, J. A., Niederhauser, V., Marshburn, D., & LaVela, S. L. (2014). Defining patient experience. *Patient Experience Journal*, 1(1), 7–19. Retrieved from <http://pxjournal.org/journal/vol1/iss1/3>

COMPLETE REFERENCE LIST

- Akter, S., D'Ambra, J., Ray, P., & Hani, U. (2013). Modelling the impact of health service quality on satisfaction, continuance and quality of life. *Behaviour & Information Technology, 32*, 1225–1241.
- Alrubaiee, L., & Alkaa'ida, F. (2011). The mediating effect of patient satisfaction in the patients' perceptions of healthcare quality: Patient trust relationship. *International Journal of Marketing Studies, 3*(1), 103–127.
<http://dx.doi.org/10.5539/ijms.v3n1p103>
- American College of Emergency Physicians. (2014). *Quality of care and the outcomes management movement*. Retrieved from <http://www.acep.org/clinical---Practice-Management/Quality-of-Care-and-the-Outcomes-Management-Movement/>
- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: American Psychiatric Association.
- American Psychological Association (APA). (2006). Presidential task force on evidence-based practice: Evidence-based practice in psychology. *American Psychologist, 61*, 271–285.
- Amos Development Company. (2016). *Amos 23.0.0 (Build 817)* [Computer software]. Retrieved from <http://amosdevelopment.com>
- Amyx, D., Mowen, J. C., & Hamm, R. (2000). Patient satisfaction: A matter of choice. *Journal of Services Marketing, 14*(7), 555–572.
- Anastasi, A., & Urbina, S. (1997). *Psychological testing* (7th ed.). Upper Saddle River, NJ: Prentice Hall.

- Anderson, T., Patterson, C. L., McClintock, A. S., & Song, X. (2013). Factorial and predictive validity of the expectations about counseling-brief (EAC-B) with clients seeking counseling. *Journal of Counseling Psychology, 60*, 496–507.
- Ankuta, G. Y., & Abeles, N. (1993). Client satisfaction, clinical significance, and meaningful change in psychotherapy. *Professional Psychology: Research and Practice, 24*, 70–74.
- APA Presidential Task Force on Evidence-Based Practice. (2006). Evidence-based practice in psychology. *American Psychologist, 61*(4), 271–285.
<http://dx.doi.org/10.1037/0003-066X.61.4.271>
- Ardito, R. B., & Rabellino, D. (2011). Therapeutic alliance and outcome of psychotherapy: Historical excursus, measurements, and prospects for research. *Frontiers in Psychology, 2*, 270. <http://dx.doi.org/10.3389/fpsyg.2011.00270>
- Association for Behavioral and Cognitive Therapies. (2003). Myths & facts about empirically supported treatments: Conceptions and misconceptions. *American Psychologist, 61*, 271–285. Retrieved from
<http://www.abct.org/Professionals/?m=mPro&fa=MythsAbdFacts>
- Aubuchon-Endsley, N. L., & Callahan, J. L. (2009). The hour of departure: predicting attrition in the training clinic from role expectancies. *Training and Education in Professional Psychology, 3*(2), 120e126. <http://dx.doi.org/10.1037/a0014455>.
- Baker, S. K. (1998). *Improving service and increasing patient satisfaction*. Retrieved from
<http://www.aafp.org/fpm/980700fm/keane.html>
- Barr, D. A. (2004). Race/Ethnicity and Patient Satisfaction: Using the appropriate method to test for perceived differences in care. *Journal Of General Internal Medicine, 19*(9), 937–943.

- Barton, P. L. (2010). *Understanding the U.S. health services system* (4th ed.). Washington, DC: AUPHA Press.
- Beattie, P. F., Pinto, M. B., Nelson, M. K., & Nelson, R. (2002). Patient satisfaction with outpatient physical therapy: Instrument validation. *Physical Therapy, 82*, 557–65.
- Bedell, B., Van Eeden, R., & Van Staden, F. (1999). Culture as moderator variable in psychological test performance: Issues and trends in South Africa. *Journal of Industrial Psychology, 25*(3), 1–7.
- Beitel, M., Hutz, A., Sheffield, K. M., Gunn, C., Cecero, J. J., & Barry, D. T. (2009). Do psychologically-minded clients expect more from counselling? *Psychology and Psychotherapy: Theory, Research and Practice, 82*, 369–383.
<http://dx.doi.org/10.1348/147608309X436711>
- Berke, D. M., Rozell, C. A., Hogan, T. P., Norcross, J. A., & Karpiak, C. P. (2011). What clinical psychologists know about evidence-based practice: Familiarity with online resources and research methods. *Journal of Clinical Psychology, 67*, 329–339.
- Bialosky, J. E., Bishop, M. D., & Cleland, J. A. (2010). Individual expectation: An overlooked, but pertinent, factor in the treatment of individuals experiencing musculoskeletal pain. *Physical Therapy, 90*(9), 1345–1355.
- Bitner, M., W. Faranda, A. Hubbert and V. Zeithaml (1997), "Customer Contribution and Roles in Service Delivery," *International Journal of Service Industry Management, 8* (3), 193-205.
- Bjertnaes, O. A., Sjetne, I. S., & Iversen, H. H. (2011). Overall patient satisfaction with hospitals: Effects of patient-reported experiences and fulfilment of expectations. *BMJ Quality & Safety, 21*, 39–46. <http://dx.doi.org/10.1136/bmjqs-2011-000137>

- Bleich, S. N., Ozaltin, E., & Murray, C. K. (2009). How does satisfaction with the health-care system relate to patient experience? *Bulletin of the World Health Organization*, 87(4), 271–278. <http://dx.doi.org/10.1590/S0042-96862009000400012>
- Bless, C., Higson-Smith, C., & Kagee, A. (2007). *Fundamentals of social research methods: An African perspective*. Cape Town: Juta & Company.
- Bleustein, C., Rothschild, D. B., Valen, A., Valaitis, E., Schweitzer, L., & Jones, R. (2014). Wait times, patient satisfaction scores, and the perception of care. *American Journal of Managed Care*, 20(5), 393–400.
- Blunch, N. J. (2008). *Introduction to structural equation modelling using SPSS and AMOS*. London: Sage.
- Boshoff, C., & Gary, B. (2004). The relationships between service quality, customer satisfaction and buying intentions in the private hospital industry. *South African Journal of Business Management*, 35(4), 27–37.
- Bovbjerg, V. E., Trowbridge, E. R., Barber, M. D., Martirosian, T. E., Steers, W. D., & Hullfish, K. L. (2009). Patient-centered treatment goals for pelvic floor disorders: Association with quality-of-life and patient satisfaction. *American Journal of Obstetrics and Gynaecology*, 200(5), 568.e1–6.
<http://dx.doi.org/10.1016/j.ajog.2008.11.020>
- Bowling, A., Rowe, G., Lambert, N., Waddington, M., Mahtani, K. R., Kenten, C., ...Francis, S. A. (2012). The measurement of patients' expectations for health care: A review and psychometric testing of a measure of patients' expectations. *Health Technology Assessment*, 16(30), i–xii, 1–509. <http://dx.doi.org/10.3310/hta16300>
- Branson, L., Buxton, M., & Fryman, H. (2014). Patient satisfaction measures and their impact on patients' rating of a hospital. *International Journal of Management & Human Resources*, 2(1), 1–13.

- Brehm, J. W. (1966). *A theory of psychological reactance*. New York: Academic Press.
- British Association for Counselling and Psychotherapy. (2010). *Ethical framework for good practice in counselling & psychotherapy* [PDF file]. Retrieved from http://www.bacp.co.uk/admin/structure/files/pdf/566_ethical%20framework%20feb2010.pdf
- Brunero, S., Lamont, S., & Fairbrother, G. (2009). Using and understanding consumer satisfaction to effect an improvement in mental health service delivery. *Journal of Psychiatric and Mental Health Nursing*, 16, 272–278.
- Bruwer, B., Sorsdahl, K., Harrison, J., Stein, D. J., Williams D., & Seedat, S. (2011). Barriers to mental health care and predictors of treatment dropout in the South African stress and health study. *Psychiatric Services*, 62(7), 774–81. <http://dx.doi.org/10.1176/appi.ps.62.7.774>
- Burnham, K. P., & Anderson, D. R. (2002). *Model selection and multimodel inference: A practical information-theoretic approach* (2nd ed.). New York: Springer-Verlag.
- Burns, N., & Grove, S. K. (1993). *The practice of nursing research: Conduct, critique and utilization*, (2nd ed.). Philadelphia: W. B. Saunders.
- Buyse, V., & Wesley, P. W. (2006). Evidence-based practice: How did it emerge and what does it really mean for the early childhood field? *Zero to Three*, 27(2), 50–55.
- Byrne, B. M. (2001). *Structural equation modeling with AMOS: Basic concepts, applications, and programming*. Mahwah, NJ: Lawrence Erlbaum Associates.
- Chao, R., Metcalfe, W. E., Lueck, W., & Petersen, S. (2004). *Exploring client satisfaction: From a holistic perspective* [PDF file]. Retrieved from <https://www.counseling.org/resources/library/vistas/vistas05/Vistas05.art63.pdf>
- Child, D. (1990). *The essentials of factor analysis* (2nd ed.). London: Cassel Educational Limited.

- Chimbindi, N., Barnighausen, T., & Newell, M. L. (2014). Patient satisfaction with HIV and TB treatment in a public programme in rural KwaZulu-Natal: Evidence from patient-exit interviews. *BMC Health Services Research*, *14*, 32.
<http://dx.doi.org/10.1186/1472-6963-14-32>
- Clark, L. A., & Watson, D. (1995). Constructing validity: Basic issues in objective scale development. *Psychological Assessment*, *7*(3), 309–319.
- Cohen, J. (1988). *Statistical power analysis for behavioural sciences* (2nd ed.). Hillsdale, NJ: Erlbaum.
- Constantine, M. G., & Sue, D. W. (2006). Factors contributing to optimal human functioning in people of colour in the United States. *The counselling Psychologist*, *34*(2), 228–244.
- Constantino, M., Glass, C. R., Arnkoff, D. B., Ametrano, R. M., & Smith, J. Z. (2011). Expectations. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Evidence-based responsiveness* (pp. 354–376). New York: Oxford University Press.
- Corsini, R. J. (2002). *The dictionary of psychology*. New York: Brunner-Routledge
- Craig, S. S., & Hennessy, J. J. (1989). Personality differences and expectations about counseling. *Journal of Counseling Psychology*, *36*, 401–407.
- Cronkite, R., Moos, R., & Finney, J. (1983). *The context of adaptation: An integrative prospective on community and treatment environments*. New York: Wiley.
- Crowe, R., Gage, H., Hampson, S., Hart, J., Kimber, A., Storey, L., & Thomas, H. (2002). The measurement of satisfaction with healthcare: Implications for practice from a systematic review of the literature. *Health Technology Assessment*, *6*(32), 1–244.
- Dagnan, D., Jahoda, A., & Kilbane, A. (2013). Preparing for therapy with people with intellectual disabilities. In J. L. Taylor, W. R. Lindsay, R. P. Hastings, & C. Hatton

- (Eds.), *Psychological therapies for adults with intellectual disabilities* (pp. 55–68).
Oxford: Wiley Blackwell.
- Davis, D., & Hobbs, G. (1989). Measuring outpatient satisfaction with rehabilitation services. *Quality Review Bulletin*, 15(6), 192–197.
- De Siqueira, G. P., Dos Santos, M. B., Dos Santos, J. F., & Marchini, L. (2013) Patients' expectation and satisfaction with removable dental prosthesis therapy and correlation with patients' evaluation of the dentists. *Acta Odontologica Scandinavica*, 71(1), 210–214.
- Dellande, S., Gilly, M. C., & Graham, J. L. (2004). Gaining compliance and losing weight: The role of the service provider in health care services. *Journal of Marketing*, 68(July), 78–91.
- Derksen, F., Bensing, J., & Largo-Janssen, A. (2013). Effectiveness of empathy in general practice: a systematic review. *British Journal of General Practice*, 63(606), 76–84.
<http://dx.doi.org/10.3399/bjgp13X660814>
- Donabedian, A. (1980). *The definition of quality and approaches to its assessment (Vol 1): Explorations in quality assessment and monitoring*. Ann Arbor, MI: Health Administration Press.
- Donabedian, A. (1988). The quality of care: How can it be assessed? *Journal of the American Medical Association*, 260, 1743–1748.
- Doran, D., Pickard, J., Harris, J., Coyte, P. C., Macrae, A. R., Lashinger, H., ...Carryer, J. (2007). The relationship between characteristics of home care nursing service contracts under managed competition and continuity of care and client outcomes: Evidence from Ontario. *Health Policy*, 2(4), 97–113.
- Drisko, J. (2014). Research evidence and social work practice: The place of evidence-based practice. *Clinical Social Work Journal*, 42, 123–133.

- Duckro, P., George C., & Beal, D. (1979). Effects of failure to meet client preference in a counseling interview. *Journal of Counseling Psychology, 26*(1), 9–14.
- Edwards, J. A. (2009). Treating posttraumatic stress disorder in South Africa: An integrative model grounded in case-based research. *Journal of Psychology in Africa, 12*(2), 189–198.
- Ekberg, S., Barnes, R. K., Kessler, D. S., Malpass, A., & Shaw, A. R. (2016). Managing clients' expectations at the outset of online cognitive behavioural therapy (cbt) for depression. *Health Expectations, 19*(3), 557–569.
- Ellis, S. M., & Steyn, H. S. (2003). Practical significance (effect size) versus or in combination with statistical significance (p-values). *Management Dynamics, 12*(4), 51–53.
- Feenstra, J. D., & Horn, E. K. (2014). Therapeutic assessment promotes treatment readiness but does not affect symptom change in patients with personality disorders: Findings from a randomized clinical trial. *American Psychological Association, 14*, 1040–3590.
- Festinger, L. (1957). *A Theory of cognitive dissonance*. Stanford, CA: Stanford University Press.
- Field, A. (2005). *Discovering statistics using SPSS*. London: Sage.
- Fiske, S. T., & Taylor, S. E. (1991). *Social cognition* (2nd ed.). New York: McGraw-Hill.
- Fitzpatrick, R., & Hopkins, A. (1983). Problems in the conceptual framework of patient satisfaction research: An empirical exploration. *Sociology of Health and Illness, 5*(3), 297–311.
- Fox, J. G., & Storms, D. M. (1981). A different approach to sociodemographic predictors of satisfaction with health care [PDF file]. *Social Science and Medicine, 15*(A), 557–564. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/6976620>

- Foxcroft, C., & Roodt, G. (2001). *An introduction to psychological assessment in the South African context*. Oxford: Oxford University Press.
- Frattali, C. M. (1991). *Measuring client satisfaction*. Retrieved from <http://www.asha.org/SLP/healthcare/Measuring-Client-Satisfaction/>
- Fuertes, J. N., Anand, P., Haggerty, G., Kestenbaum, M., & Rosenblum, G. C. (2015). The physician-patient working alliance and patient psychological attachment, adherence, outcome expectations, and satisfaction in a sample of rheumatology patients. *Behavioral Medicine* 3, 41(2), 60–8. <http://www.tandfonline.com/doi/abs/10.1080/08964289.2013.875>
- Garety, P. A., Craig, T. K., Dunn, G., Fornells-Ambrojo, M., Colbert, S., Rahman, N., ...Power, P. (2006). Specialised care for early psychosis: symptoms, social functioning and patient satisfaction: randomised controlled trial. *British Journal of Psychiatry*, 188, 37–45.
- Garfield, S. L. (1994). Research on client variables in psychotherapy. In A. E. Bergin, & L. S. Garfield (Eds.), *Handbook of psychotherapy and behaviour change* (4th ed.) (pp. 190–228). New York: Wiley.
- Garland, A. F., Haine-Schlagel, R. A., & Lewczyk Boxmeyer, C. (2007). Determinates of youth and parent satisfaction in usual care psychotherapy. *Evaluation and Program Planning*, 30(1), 45–54. <http://dx.doi.org/10.1016/j.evalprogplan.2006.10.003>
- Garzon, F. L., & Tilley, K. A. (2009). Do lay Christian counseling approaches Work? What we currently know. *Journal of Psychology and Christianity*, 28(2), 130–140. Retrieved from http://digitalcommons.liberty.edu/ccfs_fac_pubs/54
- Gigantesco, A., Picardi, A., Chiaia, E., Balbi, A., & Morosini, P. (2002). Patients' and relatives' satisfaction with psychiatric services in a large catchment area in Rome. *European Psychiatry*, 17(3), 139–47.

- Gilbert, G. R., & Veloutsou, C. (2006). A cross-industry comparison of customer satisfaction. *Journal of Services Marketing, 20*(5), 298–307.
- Gill, L., & White, L. (2009). A critical review of patient satisfaction. *Leadership in Health Services, 22*(1), 8–19.
- Gladstein, G. A. (1969). Client expectations, counseling experience, and satisfaction. *Journal of Counseling Psychology, 16*, 476–481.
- Glass, C. R., Arnkoff, D. B., & Shapiro, S. J. (2001). Expectations and preferences. *Psychotherapy, 38*(4), 455–461. <http://dx.doi.org/10.1037/0033-3204.38.4.455>
- Goldfarb, D. E. (2002). College counseling centre clients' expectations about counseling: How they relate to depression, hopelessness, and actual-ideal self-discrepancies. *Journal of College Counseling, 5*, 142–152.
- Goncalves, H. M., & Sampaio, P. (2012). The customer satisfaction-customer loyalty relationship: Reassessing customer and relational characteristics moderating effects. *Management Decision, 50*(9), 1509–1526. <http://dx.doi.org/10.1108/00251741211266660>
- Grimmer, K., Sheppard, L., Pitt, M., Magarey, M., & Trott, P. (1999). Differences in stakeholder expectations in the outcome of physiotherapy management of acute low back pain. *International Journal for Quality in Health Care, 11*, 155–162.
- Habbal, Y. (2007). *Determining patient's satisfaction with medical care* [PDF file]. Retrieved from <http://www.ism.edu/docs/Youssef-Habbal-SAM07.pdf>
- Hancock, G. R., & Mueller, R. O. (2010). *The reviewer's guide to quantitative methods in social sciences*. New York: Routledge.
- Harmon, S. C., Lambert, M. J., Smart, D. M., Hawkins, E., Nielsen, S. L., Slade, K., & Lutz, W. (2007). Enhancing outcome for potential treatment failures: Therapist-client feedback and clinical support tools. *Psychotherapy Research, 17*, 379–392.

- Harper Petersen, M. B. (1989). Commentary: Using patient satisfaction data: An ongoing dialogue to solicit feedback. *Quality Review Bulletin*, 15, 168–171.
- Hasler, G., Moergeli, H., Bachmann, R., Lambreva, E., Buddeberg, C., & Schnyder U. (2004). Patient satisfaction with outpatient psychiatric treatment: The role of diagnosis, pharmacotherapy, and perceived therapeutic change. *Canadian Journal of Psychiatry*, 49(5), 315–321.
- Hatamizadeh, N., Jafary, P., Vameghi, R., & Kazemnezhad, A. (2012). Factors affecting client satisfaction and dissatisfaction in out-patient rehabilitation centers in Kurdistan province in Iran. *Iranian Red Crescent Medical Journal*, 2(2), 119–120.
- Hatcheson, G., & Sofroniou, N. (1999). *The multivariate social scientist*. London: Sage.
- Hawthorne, G. (2006). Review of patient satisfaction measures. *Australian Government Department of Health and Ageing*, 17(6), 465–472. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/24698296>
- Health Professions Council of South Africa (HPCSA). (2011). Conduct unbecoming [PDF file]. *The HPCSA Bulletin*, 2011, 41–43. Retrieved from http://www.hpcsa.co.za/Uploads/editor/UserFiles/downloads/publications/bulletin/Bulletin_2011.pdf
- Health Professions Council of South Africa (HPCSA). (2013). *Professional board for psychology, ethical code of professional conduct*. Retrieved from <http://www.hpcsa.co.ca/>
- Heidegger, T., Saal, D., & Nuebling, M. (2006). Patient satisfaction with anaesthesia care: What is patient satisfaction, how should it be measured, and what is the evidence for assuring high patient satisfaction? *Best Practice and Research Clinical Anaesthesiology*, 20(2), 331–346.
- Hill, R. (2003). *Satisfaction*. Milton Keynes: Wiley & Sons.

- Holcomb, W. R., Parker, J. C., Leong, G. B., Thiele, J., & Higdon, J. (1998). Customer satisfaction and self-reported treatment outcomes among psychiatric inpatients. *Psychiatric Services, 49*(7), 929–934.
- Holikatti, P. C., Kar, N., Mishra, A., Shukla, R., Swain, S. P., & Kar, S. (2012). A study on patient satisfaction with psychiatric services. *Indian Journal of Psychiatry, 45*(4), 327–332.
- Hooper, D., Coughlan, J., & Mullen, M. R. (2008). Structural equation modelling: Guidelines for determining model fit. *The Electronic Journal of Business Research Methods, 6*(1), 53–60.
- Hox, J. J., & Bechger, T. M. (1998). An introduction to structural equation modeling. *Family Science Review, 11*, 354–373.
- Hsieh, M. O., & Kagle, J. D. (1991). Understanding patient satisfaction and dissatisfaction with health care. *Health & Social Work, 16*(4), 281–290.
- Hubbeling, D., & Bertram, R. (2014). Hope, happiness and home treatment: a study into patient satisfaction with being treated at home. *Psychiatric Bulletin, 38*(6), 265–9. <http://dx.doi.org/10.1192/pb.bp.112.040188>
- Hudak, P. L., McKeever, P., & Wright, J. G. (2003). The metaphor of patients as customers: Implications for measuring satisfaction. *Journal of Clinical Epidemiology, 56*(2), 103–108.
- Hulka, B. S., Kupper, L. L., Daly, M. B., Cassel, J. C. & Schoen, F. (1975). Correlates of satisfaction and dissatisfaction with medical care: A community perspective. *Medical Care, 13*, 648–658.
- Hulka, B. S., Zynanski, S. J., Cassel, J. C., & Thompson, S. J. (1971). Satisfaction with medical care in a low income population. *Journal of Chronic Diseases, 24*, 661–973.

- Hush, J. M., Cameron, K., & Mackey, M. (2011). Patient satisfaction with musculoskeletal physical therapy care: A systematic review. *Physical Therapy, 91*(1), 25–36.
<http://dx.doi.org/10.2522/ptj.20100061>
- Huysamen, G. K. (1996). *Psychological measurement: An introduction with South African examples*. Pretoria: J. L. van Schaik.
- Jackson, J. L., Chamberlin, J., & Kroenke, K. (2001). Predictors of patient satisfaction. *Social Science and Medicine, 52*(4), 609–620.
- Jahoda, A., Pert, C., Trower, P., Stenfert-Kroese, B., Burford, B., & Dagnan, D. (2007). Establishing the building blocks of cognitive behavioural therapy for people with mild learning disabilities: An exploration of key process issues (CZH/4/181). Chief Scientist's Office, The Scottish Government.
- Jimmieson, N. J. (1998). Linking client and employee perceptions. *Journal of Occupational and Organizational Psychology, 71*, 81–96.
- Jin, J., Sklar, G. E., Oh, V. M. S., & Li, S. C. (2008). Factors affecting therapeutic compliance: A review from the patient's perspective. *Therapeutics and Clinical Risk Management, 4*(1), 269–286.
- Kaiser, H. F., & Rice, J. (1974). "Little Jiffy, Mark IV". *Educational and Psychological Measurement, 34*, 111–117.
- Kane, R. L., Maciejewski, M., & Finch, M. (1997). The relationship of patient satisfaction with care and clinical outcomes. *Medical Care, 35*(7), 714–730.
- Kazdin, A. E. (1999). The meanings and measurement of clinical significance. *Journal of Consulting and Clinical Psychology, 67*, 332–339.
- Kelley, H. H. (1967). Attribution theory in social psychology. In D. Levine (Ed.), *Nebraska Symposium on Motivation (Volume 15)* (pp. 192–238). Lincoln, NE: University of Nebraska Press.

- Kerssens, J. J., Groenewegen, P. P., Sixma, H. J., Boerma, W. G. W., & van der Eijk, I. (2004). Comparison of patient evaluations of health care quality in relation to WHO measures of achievement in 12 European countries. *Bulletin of the World Health Organization*, 82, 106–114.
- Kessels, R. P. C. (2003). Patients' memory for medical information. *Journal of the Royal Society of Medicine*, 96(5): 219–222.
- Kim, S. S., Kaplowitz, S., & Johnston, M. V. (2004). The effects of physician empathy on patient satisfaction and compliance. *Evaluation and the Health Professions*, 27(3), 237–51.
- Kirsch, I. (1990). *Changing expectations: A key to effective psychotherapy*. Pacific Grove, CA: Brooks/Cole.
- Kishor, B. V., Pal, D. K., Lodha, R. S., & Vishal, B. (2011). Clients' satisfaction with anti-retroviral therapy services at Hamidia Hospital Bhopal. *National Journal of Community Medicine*, 2(3), 241.
- Kline, R. B. (2011). *Principles and practice of structural equation modeling*. New York: Guilford Press.
- Korsch, B., Gozzi, E. K., & Francis, V. (1968). Gaps in doctor-patient communication: Doctor-patient interaction and patient satisfaction. *Pediatrics*, 42, 855–871.
- Kravitz, R. L. (1996). Measuring patients' expectations and requests. *Annals of Internal Medicine*, 134(9), (Part 2), 881–888.
- Kravitz, R. L. (1998). Patient satisfaction with health care: Critical outcome or trivial pursuit? *Journal of General Internal Medicine*, 13(4), 280–282.
<http://dx.doi.org/10.1046/j.1525-1497.1998.00084.x>
- Kravitz, R. L. (2001). Measuring patients' expectations and requests. *Annals of Internal Medicine*, 134(9), (Part 2), 881–888.

- Kurti, S. (2015). *Patient satisfaction evaluation: A theoretical framework*. Retrieved from http://www.academia.edu/4085766/Patient_Satisfaction_Evaluation_-_A_Theoretical_Framework
- Lamb, J. (2004). Technical help for researchers from ESRC and ONS. *Labour Market Bulletin*, 18.
- Larsen, D. E., & Rootman, I. (1976). Physician role performance and patient satisfaction. *Social Science and Medicine*, 10(1), 29–32.
- Lateef, F. (2010). Patient expectations and the paradigm shift of care in emergency medicine. *Journal of Emergencies, Trauma, and Shock*, 4(2), 163–167.
- Lawrie, S., McIntosh, A., & Rao, S. (2000). *Critical appraisal for Psychiatry*. London: Churchill Livingstone.
- Leadership Magazine. (2013). *Private medical care*. Retrieved from <http://www.leadershiponline.co.za/>
- Lebow, J. (1982). Consumer satisfaction with mental health treatment. *Psychological Bulletin*, 91(2), 244–259.
- Lebow, J. L. (1983). Client satisfaction with mental health treatment. *Evaluation Review*, 7(6), 729–752.
- Levant, R. F. (2005). *Report on the 2005 presidential task force on evidence based practice*. Retrieved from <http://www.apa.org/practice/ebpreport.pdf>
- Levin, K. A. (2006). Study design III: Cross-sectional studies. *Evidence-based dentistry*, 7, 24–25. <http://dx.doi.org/10.1038/sj.ebd.6400375>
- Lilienfeld, S. O., Ritschel, L. A., Lynn, S. J., Cautin, R. L., & Latzman, R. D. (2014). Why ineffective psychotherapies appear to work: A taxonomy of causes of spurious therapeutic effectiveness. *Perspectives on Psychological Science*, 9(4), 355–387. <http://dx.doi.org/10.1177/1745691614535216>

- Linder-Pelz, S. (1982). Towards a theory of patient satisfaction. *Social Science and Medicine*, 16, 577–582.
- Linn, L. S. (1975). Factors associated with patient evaluation of health care. *Health and Society, Fall*, 531–548.
- Linn, L. S., & Greenfield, S. (1982). Patients suffering and patient satisfaction among the chronically ill. *Medical Care*, 20, 425–431.
- Lliffe, S., Wilcock, J., Manthorpe, J., Moriarty, J., Cornes, M., Clough, R., & Bright, L. (2008). Can clinicians benefit from patient satisfaction surveys? Evaluating the NSF for older people, 2005–2006. *Journal of Royal Society of Medicine*, 101(12), 598–604.
- Lund, C., Petersen, I., Kleintjes, S., & Bhana, A. (2012). Mental health services in South Africa: Taking stock. *African Journal of Psychiatry*, 15(6), 402–405.
- Marjoua, Y., & Bozic, K. J. (2012). Brief history of quality movement in US healthcare. *Current Reviews in Musculoskeletal Medicine*, 5(4), 265–273.
<http://dx.doi.org/10.1007/s12178-012-9137-8>
- Marsh, H. W., Balla, J. R., & McDonald, R. P. (1988). Goodness of fit indexes in confirmatory factor analysis: The effect of sample size. *Psychological Bulletin*, 103, 391–410.
- Mavrogiorgou, P., Siebers, F., Juckel, G., & Kienast, T. (2013). Patient satisfaction with specialized mental health service for obsessive-compulsive disorder. *Annals of General Psychiatry*, 12(1), 41. <http://dx.doi.org/10.1186/1744-859X-12-41>
- May, E. J. (2002). Patients with back pain value the process, as well as outcomes of care. *Australian Journal of Physiotherapy*, 48(1), 57.

- McCoach, D. B. (2006). Hierarchical linear modelling. In G. R. Hancock, & R. O. Mueller (Eds.), *The reviewer's guide to quantitative methods in the social sciences* (pp. 123–140). New York: Routledge.
- McCullem, R. C., Brown, M. W., & Sugarawa, H. M. (1996). Power analysis and determination of sample size for covariance structure modeling. *Psychological Methods, 1*(2), 130–149.
- McEwen, A., & Harris, G. (2010). Communication: Fundamental skills. In A. McEwen, & S. Kraszewski (Eds.), *Communication skills for adult nurses* (pp. 1–22). Berkshire, UK: McGraw-Hill.
- McLeod, S. A. (2008). *Cognitive dissonance*. Retrieved from www.simplypsychology.org/cognitive-dissonance.html
- McQuitty, S., & Wolf, M. (2013). Structural Equation Modeling: A practical introduction. *Journal of African Business, 14*(1), 58–69. <http://dx.doi.org/10.1080/15228916.2013.765325>
- Meyer, O. L., & Zane, N. (2013). The influence of race and ethnicity in clients' experiences of mental health treatment. *Journal of Community Psychology, 41*(7), 884–901.
- Miller, D. T., & Turnbull, W. (1986). Expectancies and interpersonal processes. *Annual Review of Psychology, 37*, 233–256. <http://dx.doi.org/10.1146/annurev.ps.37.020186.001313>
- Mitchell, A. M., Garand, L., Dean D., Panzak G., & Taylor, M. (2010). Suicide assessment in hospital emergency departments: Implications for patient satisfaction and compliance. *Topics in Emergency Medicine, 27*(4), 302–312.
- Mosadeghrad, A. M. (2012). A conceptual framework for quality of care. *Materia Socio Medica, 24*(4), 251–261. <http://dx.doi.org/10.5455/msm.2012.24.251-261>

- Mueller, R. O. (1996). *Basic principles of structural equation modeling: An introduction to LISREL and EQS*. New York: Springer.
- Nabbuye-Sekandi, J., Makumbi, F. E., Kasangaki, A., Kizza, I. B., Tugumisirize, J., Nshimye, E., ...Peters, D. H. (2011). Patient satisfaction with services in outpatient clinics at Mulago hospital, Uganda. *International Journal of Quality in Health Care*, 23(5), 516–523. <http://dx.doi.org/10.1093/intqhc/mzr040>
- Naidu, A. (2009). Factors affecting patients satisfaction and healthcare quality. *International Journal of Healthcare Quality Assurance*, 22, 366–381.
- National Department of Health. (2013). *National Health Insurance*. Retrieved from <http://www.doh.gov.za/list.php?type=Natiopnal%20Health%20Insurance>
- National Health Insurance for South Africa. (2015). *Towards universal health coverage* (Version 40) [White paper]. Retrieved May 4, 2016, from Department: Health, Republic of South Africa: <http://www.health-e.org.za/wp-content/uploads/2015/12/National-Health-Insurance-for-South-Africa-White-Paper.pdf>
- Neuman, W. L. (2000). *Social research methods: Qualitative and quantitative approaches* (4th ed.). Boston, MA: Allyn & Bacon.
- Newsome, P. R. H., & Wright, G. H. (1999). Patient management: A review of patient satisfaction: 1. Concepts of satisfaction. *British Dental Journal*, 186, 161–165. <http://dx.doi.org/10.1038/sj.bdj.4800053>
- Noar, S. M. (2013). The role of structural equation modeling in scale development. *Structural Equation Modeling A Multidisciplinary Journal*, 10(4), 622–647. http://dx.doi.org/10.1207/S15328007SEM1004_8

- Noble, L. M., Douglas, B. C., & Newman, S. P. (2001). What do patients expect of psychiatric services? A systematic and critical review of empirical studies. *Social Science and Medicine*, 52(7), 985–98.
- Nock, M. K., & Kazdin, A. E. (2001). Parent expectancies for child therapy: Assessment and relation to participation in treatment. *Journal of Child and Family Studies*, 10, 155–180.
- Norberg, M. M., Wetterneck, C. T., Sass D. A., & Kanter, J. W. (2011). Development and psychometric evaluation of the Milwaukee psychotherapy expectations questionnaire. *Journal of Clinical Psychology*, 67(6), 574–590.
- Noyes, R. W. (1974). Expectation fulfilment as a measure of patient satisfaction. *American Journal of Obstetrics and Gynecology*, 118(6), 36.
- Nunnally, J. (1978). *Psychometric theory*. New York: McGraw-Hill.
- Nunnally, J. C., & Bernstein, I. H. (1994). *Psychometric theory* (3rd ed.). New York, NY: McGraw-Hill.
- O'Connor, S. J., & Shewchuk, R. (2003). Commentary – patient satisfaction: What is the point? *Healthcare Management Review*, 28(1), 21–24.
- O'Neill, C. (1994). Benchmarking client satisfaction with general practitioner services: results and lessons from a population based survey. Retrieved from <http://www.priory.com/fam/bench.htm>
- Oei, T. P. S., & Green, A. L. (2008). The satisfaction with therapy and therapist scale – revised (STTS-R) for group psychotherapy: Psychometric properties and confirmatory factor analysis. *American Psychological Association*, 39(4), 435–442.
- Oei, T. P. S., & Shuttlewood, G. J. (1999). Development of a satisfaction with therapy and therapist scale. *Australian and New Zealand Journal of Psychiatry*, 33, 748–753.

- Oliver, R. L. (1981). Measurement and evaluation of satisfaction processes in retail settings. *Journal of Retailing*, 57(3), 25–48.
- Palazzo, C., Jourdan, C., Descamps, S., Nizard, R., Hamadouche, M., Anract, P., ...Poiraudau S. (2014). Determinants of satisfaction 1 year after total hip arthroplasty: The role of expectations fulfilment. *BMC Musculoskeletal Disorders*, 15(53). <http://dx.doi.org/10.1186/1471-2474-15-53>
- Palmer, R. H., Donabedian, A., & Povar, G. J. (1991). *Striving for quality in health care: An inquiry into policy and practice*. Chicago, IL: Health Administration Press.
- Parasuraman, A., Zeithaml, V.A., & Berry, L.L. (1985). A conceptual model of service quality and its implication. *Journal of Marketing*, 49, 41–50.
- Pascoe, G. C. (1983). Patient satisfaction in primary health care: a literature review and analysis. *Evaluation and program planning*, 6(3–4), 185–210.
- Patrick, D. L., Scrivens, E., & Charlton, J. R. H. (1983). Disability and patient satisfaction with medical care. *Medical Care*, 21, 1062–1075.
- Patterson, C. L., Anderson, T., & Wei, C. (2014). Clients' pretreatment role expectations, the therapeutic alliance, and clinical outcomes in outpatient therapy. *Journal of Clinical Psychology*, 70(7), 673–680.
- Pifer, T. B., Bragg-Gresham, J. L., Dykstra, D. M., Shapiro, J. R., Oppenheimer, C. C., Gaylin, D. S., ...Held, P. J. (2003). Quality of life and patient satisfaction: ESRD managed care demonstration. *Health Care Financial Review*, 24(4), 45–58.
- Popovic, M., Milne, D., & Barrett, P. (2007). Assessing clients' satisfaction with psychological services: Development of a multidimensional client satisfaction survey questionnaire. *Counselling Psychology Review*, 22(2), 15–29.
- Prakash, B. (2010). Patient satisfaction. *Journal of Cutaneous and Aesthetic Surgery*, 3(3), 151–155. <http://dx.doi.org/10.4103/0974-2077.74491>

- Price, I. I., & Oswald, I. I. (2006). *Relationship strength*. Retrieved from http://psych.csurfresno.edu/psy144/content/statistics/relationship_strength.html
- Räsänen, P. (2006). *Routine measurement of health-related quality of life in assessing cost-effectiveness in secondary healthcare* (Academic dissertation). University of Helsinki and Hospital District of Helsinki and Uusimaa, Finland. Retrieved from <https://helda.helsinki.fi/bitstream/handle/10138/20314/routinem.pdf?...1>
- Reeder, L. G. (1972). The patient-client as consumer: Some observations on the changing professional-client relationship. *Journal of Health and Social Behavior*, 13(4), 406–412.
- Reichheld, F. F. (2003). The one number you need to grow. *Harvard Business Review*, 81, 46–54. <https://hbr.org/2013/12/the-one-number-you-need-to-grow>
- Reschovsky, J. D., Hadley, J., & Landon, B. E. (2006). Compensation methods and physicians group structure on physicians perceived incentives to alter services to patients. *Health Services Research*, 41(4), (Part 1), 1200–1220.
- Richmond, J. S., Berlin, J. S., Fishkind, A. B., Holloman, G. H., Zeller, S. L., Wilson, M. P., ...Ng, A. T. (2012). Verbal de-escalation of the agitated patient: Consensus statement of the American Association for Emergency Psychiatry project BETA de-escalation workgroup. *Western Journal Emergency Medicine*, 13(1), 17–25. <http://dx.doi.org/10.5811/westjem.2011.9.6864>
- Rivers, P. A., & Glover, S. H. (2008). Health care competition, strategic mission, and patient satisfaction: Research model and propositions. *Journal of Health Organization and Management*, 22(6), 627–641.
- Robinson, J. P., Shaver, P. R., & Wrightsman, L. S. (Eds.). (1991). *Measures of personality and social psychological attitudes: Measures of social psychological attitudes* (Vol. 1). New York: Academic Press.

- Roothman, B. (2009). *Burnout and work engagement among South African psychologists* (Unpublished doctoral dissertation). North-West University, Potchefstroom, South Africa.
- Ruane, I. (2010). Obstacles to the utilisation of psychological resources in a South African township community. *South African Journal of Psychology, 40*(2), 214–225.
- Sackett, D. L., Straus, S. E., Richardson, W. S., Rosenberg, W., & Haynes, R.B. (2000). *Evidence-based medicine: How to practice and teach EBM (Vol. 2)*. London: Churchill Livingstone.
- Saha, S., Beach, M. C., & Cooper, L. A. (2008). Patient centeredness, cultural competence and healthcare quality. *Journal of the National Medical Association, 100*(11), 1275–1285.
- Saint-Germain, M. A. (2001). *Cross-sectional design*. Retrieved from <http://www.csulb.edu/~msaintg/ppa696/696preex.htm#Cross-Sectional%20Design>.
- Sanders, M. R. (2010). Adopting a public health approach to the delivery of evidence-based parenting interventions. *Canadian Psychology, 51*, 17–30.
<http://dx.doi.org/10.1037/a0018295>
- Sandoval, G. A., Levington, C., Blackstein-Hirsch, P., & Brown, A. D. (2005). Selecting predictors of cancer patients' overall perceptions of the quality of care received. *Annals of Oncology, 17*(1), 151–156.
- SAS Institute Inc. (2011). *Base SAS ® 9.3 Procedures Guide: Statistical Procedures*. Cary, NC: SAS Institute Inc.
- SAS Institute Inc. (2011). SAS OnlineDoc® 9.3. Cary, NC: SAS Institute Inc. Retrieved from <https://www.google.co.za/#q=SAS+Institute+Inc.+2011.+SAS+OnlineDoc%C2%AE+9.3.+Cary%2C+NC:+SAS+Institute+Inc.>

- Seligman, M. F. (1995). The effectiveness of psychotherapy: The consumer reports study. *American Psychologist, 50*, 965–974.
- Sharf, J., & Primavera, L. (2010). Dropout and therapeutic alliance: A meta-analysis of adult individual psychotherapy. *American Psychological Association: Theory, Research, Practice and Training, 47*(4), 637–645.
- Shaughnessy, J., & Zechmeister, E. (1994). *A practical introduction to research methods in psychology* (2nd ed.). New York: McGraw-Hill.
- Sitzia, J., & Wood, N. (1997). Patient satisfaction: A review of issues and concepts. *Social Science & Medicine, 45*(12), 1829–1843.
- Slywotzky, A. (2015). *The patient-to-consumer healthcare revolution*. Retrieved from [http://www.brinknews.com/the-patient-to-consumer-health care-revolution/](http://www.brinknews.com/the-patient-to-consumer-health-care-revolution/)
- Soremekun, O. A., Takayesu, J. K., & Bohan, S. J. (2011). Framework for analyzing wait times and other factors that impact patient satisfaction in the emergency department. *Journal of Emergency Medicine, 41*(6), 686–92.
<http://dx.doi.org/10.1016/j.jemermed.2011.01.018>
- South African College of Applied Psychology (SACAP). (2016). *Mental health in South Africa: Whose problem is it?* Retrieved from <http://www.sacap.edu.za/blog/counselling/mental-health-south-africa-whose-problem-counselling/>
- South African Depression and Anxiety Group. (2013). *Newsletters*. Retrieved from http://www.sadag.org/index.php?option=com_content&view=article&id=10&Itemid=113
- Spiegel, A. D., & Hyman, H. H. (1998). *Strategic health planning: Methods and techniques applied to marketing and management*. Norwood, NJ: Ablex Publishing Corporation.

- Spring, B. (2007). Evidence-based practice in clinical psychology: What it is, why it matters; what you need to know. *Journal of Clinical Psychology, 63*(7), 611–631.
- SPSS Inc. (2013). *IBM SPSS Statistics (Version 22)* [Computer software]. Retrieved from <http://www-01.ibm.com/software/analytics/spss/>
- SPSS Inc. (2016). *IBM SPSS Statistics (Version 23)* [Computer software]. Retrieved from <http://www-01.ibm.com/software/analytics/spss/>
- Steiner, D. L. (2003). Starting at the beginning: An introduction to coefficient alpha and internal consistency. *Journal of Personality Assessment, 80*, 99–103.
http://dx.doi.org/10.1207/S15327752JPA8001_18
- Steyn, H. S. (2002). Practically significant relationships between two variables. *South African Journal of Industrial Psychology, 28*(3), 10–15.
- Strasser, S., Aharony, L., & Greenberger, D. (1993). The patient satisfaction process: Moving toward a comprehensive model. *Medical Care Review, 50*(2), 219–248.
- Stratmann, W. C., Block, J. A., Brown, S. P., & Rozzi, M. V. (1975). A study of consumer attitudes about health care: The control, cost, and financing of health services. *Medical Care, 13*(8), 659–668.
- Strauss, M. E., & Smith, G. T. (2009). Construct validity: Advances in theory and methodology. *Annual Review Clinical Psychology, 27*(5), 1–25.
<http://dx.doi.org/10.1146/annurev.clinpsy.032408.153639>
- Suchman, E. A. (1964). Sociomedical variations among ethnic groups. *American Journal of Sociology, 70*, 319–331.
- Swift, J. K., & Callahan, J. L. (2009). The impact of client treatment preferences on outcome: A meta-analysis. *Journal of Clinical Psychology, 65*(4), 368–381.
<http://dx.doi.org/10.1002/jclp.20553>

- Swift, J. K., & Derthick, A. O. (2013). Increasing hope by addressing clients' outcome expectations. *Psychotherapy, 50*(3), 284–287. <http://dx.doi.org/10.1037/a0031941>
- Tabachnick, B. G., & Fidell, L. S. (2001). *Using multivariate statistics* (4th ed.). Boston, MA: Allyn & Bacon.
- Tabachnick, B. G., & Fidell, L. S. (2007). *Using multivariate statistics* (5th ed.). Boston, MA: Allyn & Bacon.
- Targett, K. (2011). An introduction to clinical governance and patient safety. *Occupational Medicine, 61*(4), 283. <http://dx.doi.org/10.1093/occmed/kqr013>
- Teddlie, C., & Tashakkori, A. (2009). *Foundations of mixed methods research*. Thousand Oaks, CA: Sage Publications.
- Tempier, R., Pawliuk, N., Perreault, M., & Steiner, W. (2002). Satisfaction with clinical case management services of patients with long-term psychoses. *Community Mental Health Journal, 38*(1), 51–59. <http://dx.doi.org/10.1023/A:1013907914849>
- The Beryl Institute. (2015). *State of patient experience 2015: A global perspective on the patient experience movement*. Retrieved from The Beryl Institute website: <http://www.theberylinstitute.org/?page=PXBENCHMARKING>
- The Bill of Rights of the Constitution of the Republic of South Africa. (1996). *Government Gazette*. (No. 17678).
- The Rolling Stones. (1991). I can't get no satisfaction. On *Hot Rocks I* [CD]. London: Teal Trutone Music.
- The Society of Clinical Child and Adolescent Psychology (Division 53 of the APA). (2014). *Society of clinical child and adolescent psychology*. Retrieved from <https://www.apa.org/about/division/div53.aspx>
- Thompson, K. (2003). US Department of HHS, 2002, 2004, 2005: Stigma and public health policy for schizophrenia. *The Psychiatric Clinics of North America, 26*(1), 273–294.

- Tuli, F. (2010). The basis of distinction between qualitative and quantitative research in social science: Reflection on ontological, epistemological and methodological perspectives. *Ethiopian Journal of Education & Sciences*, 6(1), 97–108.
- Urden, K. D. (2002). Patient satisfaction measurement: Current issues and implications. *Outcomes Management*, 6(6), 125–131.
- Van der Merwe, E. J., Van Rensburg, E., & Ellis, S. (2016). Psychometric properties of scales measuring client expectations and satisfaction with psychological treatment in a South African context. [Manuscript in preparation].
- Vukmir, R. B. (2006). Customer satisfaction. *International Journal of Health Care Quality Assurance*, 19(1), 8–31.
- Wadhwa, S. S. (2002). Customer satisfaction and health care delivery systems: Commentary with Australian bias. *E-Journal of Nuclear Medicine*, 1(1), 1539–4638. Retrieved from <http://ispub.com/IJNUC/1/1/8617>
- Walker, M. S., Ristvedt, S. L., & Haughey, B. H. (2003). Patient care in multidisciplinary cancer clinics: Does attention to psychosocial needs predict patient satisfaction? *Psycho-Oncology*, 12(3), 291–300.
- Ward, M. R., & Rosen, K. H. (2000). Clients' perceptions of the therapeutic process: A common factors approach (Academic thesis). Virginia Polytechnic Institute and State University, Blacksburg, Virginia.
- Ware, J. E., Davies-Avery, A., & Stewart, A. L. (1977). *The measurement and meaning of patient satisfaction: A review of the literature*. Santa Monica, CA: RAND Publication.
- Ware, J. E., Snyder, M. K., Wright, W. R., & Davies, A. R. (1983). Defining and measuring patient satisfaction with medical care. *Evaluation and Program Planning*, 6(3–4), 247–263.

- Weisman, E., & Koch, J. (1989). Progress notes: Special patient satisfaction issue. *Quality Review Bulletin*, 15(6), 166–167.
- White, J. (2008). Qualitative research and the politics of knowledge in an age of evidence: Developing a research-based practice of immanent critique. *Social Science and Medicine*, 67, 195–203.
- Wicks, A. M., & Roethlein, C. J. (2009). A satisfaction-based definition of quality. *Journal of Business & Economic Studies*, 15(1), 82.
- Williams, B. (1994). Patient satisfaction: A valid concept? *Social Science and Medicine*, 38(4), 509–516.
- Williams, B., Coyle, J., & Healy, D. (1998). The meaning of patient satisfaction. *Social Science and Medicine*, 47, 1351–1359.
- Winerman, L. (2005). Helping men to help themselves: Research aims to understand why men are less likely than women to seek mental health help, and what psychologists can do to change that. *American Psychological Association*, 36(6), 57.
- Winerman, L. (2016). Helping men to help themselves. *American Psychological Association*, 36, 57.
- Wissing, M. P., & Van Eeden, C. (2002). Empirical clarification of the nature of psychological well-being. *South African Journal of Psychology*, 32, 32–44.
- Wolf, J. A. (2013). *A report on the Beryl Institute Benchmarking Study: The state of patient experience in American hospitals 2013: Positive trends and opportunities for the future* [PDF file]. Retrieved from <http://www.theberylinstitute.org/?page=PXBenchmarking2013>
- Wolf, J. A. (2015). The state of patient experience. *Patient Experience Journal*, 2(2). Retrieved from <http://www.theberylinstitute.org/?page=PXBENCHMARKING>

- Wolf, J. A. (2016). Patient experience: Driving outcomes at the heart of healthcare. *Patient Experience Journal*, 3(1), 1–4. Retrieved from <http://pxjournal.org/journal/vol3/iss1/1>
- Wolf, J. A., Niederhauser, V., Marshburn, D., & LaVela, S. L. (2014). Defining patient experience. *Patient Experience Journal*, 1(1), 7–19. Retrieved from <http://pxjournal.org/journal/vol1/iss1/3>
- World Health Organization. (2001). *Mental health: World health ministers call for action* [PDF file]. Retrieved from http://www.who.int/mental_health/media/en/249.pdf
- World Health Organization. (2012). *Developing and evaluating communication strategies to support informed decisions and practice based on evidence*. Retrieved from <http://www.decide-collaboration.eu/world-health-organization>
- Yi, Y. (1990). *A critical review of customer satisfaction*. Chicago, IL: American Marketing Association.
- Zhiwei, Z., Gerstein, D. R., & Friedmann P. D. (2008). Patient satisfaction and sustained outcomes of drug abuse treatment. *Journal of Health Psychology*, 13(3):388–400. <http://dx.doi.org/10.1177/1359105307088142>