BELIEFS AND EXPECTATIONS FROM PSYCHOTHERAPY AND ITS ASSOCIATION WITH PERSONALITY TRAITS, COPING STYLES AND PSYCHOLOGICAL FLEXIBILITY

THESIS

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DECLARATION

I hereby declare that the thesis titled "**Beliefs and Expectations from Psychotherapy and its association with Personality, Coping Styles and Psychological Flexibility**" embodies the original work carried out by the undersigned in Department of Psychiatry, All India Institute of Medical Sciences, Jodhpur.

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CERTIFICATE

This is to certify that the thesis titled "**Beliefs and Expectations from Psychotherapy and its association with Personality, Coping Styles and Psychological Flexibility**" is the bonafide work of Dr Harsh Khandelwal carried out under guidance and supervision, in the Department of Psychiatry, All India Institute of Medical Sciences, Jodhpur, Rajasthan.

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DEDICATED TO OUR PATIENTS WHO ARE OUR GREATEST TEACHERS

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SUMMARY

Background: Beliefs and Expectations in Psychotherapy is an essential factor that has significant implications for psychotherapeutic relationship and outcomes. Pre-treatment expectations and client improvement have been associated in numerous research. Studies have also identified a correlation between patients' optimistic outcome expectations from psychotherapy and improved therapeutic alliance, lower dropout rates, and maybe better clinical outcomes. These expectancies may change as a result of a number of variables. However, there is a paucity of evidence on these mediating elements that affect clients' perceptions and expectations about psychotherapy, either directly or indirectly. Sociodemographic characteristics, Personality Traits, Coping Styles and Psychological Flexibility are some of the factors that may alter the beliefs and expectations of clients in psychotherapy. Indian studies in this context are scarce, and understanding these correlates will help in appropriate patient selection for psychological interventions.

Aims: The aim of the study was to study the beliefs and expectations towards Psychotherapy as a treatment modality for the treatment of psychiatric disorders in patients attending psychiatry OPD and their association with Personality traits, Coping styles, and Psychological flexibility.

Methodology: Follow-up patients attending psychiatry OPD who met the selection criteria were explained the objective and methodology of the study, and written informed consent was taken. Socio-demographic data and clinical details were recorded, and open-ended questions were asked and audio recorded. The BEP (Beliefs in the efficacy of Psychotherapy) scale was used to measure the beliefs of the patients in psychotherapy, MPEQ (Milwaukee Psychotherapy Expectations Questionnaire) scale was used to measure the role and outcome expectations of the client in psychotherapy, the BFI-10 (Brief Factor Inventory-10) was used to assess the personality traits, Coping Behaviour Assessment Scale (Indian Adaptation) was used to assess the coping styles of the patients and AAQ-II (Acceptance and Action Questionnaire II) scale was used to assess the Psychological Inflexibility of the

respondents. WHO translation method was used to translate BEP, MPEQ, BFI-10, and AAQ-II scales into Hindi.

Results: A total of 304 patients participated in the study (Males (N)=150, Females (N) =154). The mean age of the study population was 31.30 ± 9.44. 29.9 % of the study population had no prior experience with psychotherapy. BEP scores correlated significantly positively with Extraversion (p=0.004), Agreeableness (p=0.001), problem-focused coping *(p=0.013),* Duration of illness (*p=0.022*), Duration of treatment (*p=0.008*), and the number of follow-ups. (*p<0.001*). There was a significant negative correlation between avoidant coping and BEP scores *(p<0.001).* MPEQ scores were positively correlated with Openness (*p=0.019*) and Agreeableness (*p<0.001*), problem-focused coping (*p=0.002*), Age (p=0.013), Duration of treatment (*p<0.001*) as well as Number of follow-ups (*p=0.005*). Role expectations were positively correlated with Openness (*p=0.007*), Agreeableness (*p=0.001*), as well as the duration of treatment (p<0.001) and the number of follow-ups (*p<0.001*). Outcome expectations, on the other hand, positively correlated with Extraversion (*p=0.022*), Agreeableness (*p<0.001*), and Age (*p<0.001*). Higher Beliefs were seen in the Urban Population (*p=0.003*), single (*p=0.003*), graduates and post-graduates (*p<0.001*), lower middle and lower socioeconomic categories (*p<0.001*), those who had prior experience with psychotherapy (p<0.001) administered by a psychologist (*p=0.001*) and those with a family history of psychiatric illness with exposure to psychotherapy (*p=0.007*). People exposed to unstructured interventions in the past (*p=0.028*) and those with a family history of psychiatric illness with exposure to therapy (*p=0.049*) had higher role expectations. People belonging to Joint families (*p=0.030*) & who had therapy experience administered by a psychologist (*p=0.032*) had higher outcome expectations. Those with a higher education status had a higher role (*p=0.001*) as well as outcome expectations (*p=0.007*). The maximum variance in the beliefs in the efficacy of psychotherapy was found to be because of avoidant coping ($SR^2 = 0.029$).

Conclusion: This study found that Beliefs in the efficacy of Psychotherapy were positively correlated with the personality traits of Extraversion and Agreeableness and Problem-focused Coping Styles and negatively with the Avoidant coping style. Expectations from Psychotherapy correlated positively with Openness and Agreeableness along with age, problem-focused coping, duration of treatment, and the

number of follow-ups. People with an urban background, higher education status, a lower or lower middle socioeconomic status, and those with prior experience with psychotherapy and a positive family history of psychiatric illness with exposure to a psychological intervention had higher expectations from psychotherapy. This clinic-demographic profile can be used for appropriate patient selection for psychological interventions in resource-limited clinical settings.

LIST OF ABBREVIATIONS

APA	American Psychiatric Association
WHO	World Health Organization
CBT	Cognitive Behavioural Therapy
BEP	Beliefs in the efficacy of Psychotherapy
MPEQ	Milwaukee Psychotherapy Expectations Questionnaire
BFI	Brief Factor Inventory
AAQ	Acceptance and Action Questionnaire
OPD	Out Patient Department
DOI	Duration of Illness
DOT	Duration of Treatment

INTRODUCTION

Psychotherapy or *therapy* has been practiced since ancient times as a healing method across the world. Earlier religious and cultural practices formed the majority part of psychotherapeutic practices, whether we consider the ancient Greek mythology or the Indian Bhagwat Gita. Though more didactic, these practices helped people not only to deal with day-to-day stress but also provided a pathway to self-awareness and change. Subsequently, psychotherapy schools have progressed from the Freudian psychoanalytical approach that dominated the first half of the 20th century to the widely practiced cognitive behavioural approach that has dominated psychotherapy in the last three decades. Humanism and existential psychotherapies are the new third-wave psychotherapies that have evolved in recent times. [1]

According to Wolberg (1967), '*psychotherapy is the treatment, by psychological means, of problems of an emotional nature in which a trained person deliberately establishes a professional relationship with the patient with the object of removing, modifying or retarding existing symptoms, of mediating disturbed patterns of behaviour and of promoting positive personality growth and development.'* [2]

Psychotherapy forms an integral part of the treatment of various psychiatric disorders along with the use of medications. It has been seen to be an effective treatment modality for treating a range of psychiatric disorders, from the neurotic spectrum to the psychotic spectrum disorders. Psychotherapeutic practices require in-depth training to employ a range of interventions available in the psychological toolbox. Although access to professional psychotherapy services in the country remains limited, the importance of its use in the psychiatric practice cannot be overlooked, and ways to utilize it need to be evaluated.

According to a resolution passed by the APA in 2012, evidence for the efficacy of psychotherapy can be found in thousands of studies and meta-analyses conducted over several decades. Psychotherapy as a treatment modality has been effective across clinical settings and diagnoses.[3]

Research has shown that while psychotherapy does modify a person's emotional and cognitive state, it also leads to neurobiological changes in the structure and function

of our brain. Some researchers even reported similar efficacy for psychotherapy as compared to pharmacotherapy in several studies as a treatment modality for the treatment of psychiatric disorders.[4]

In India, psychotherapy and counselling are largely synonymous in the psychiatric practice. A large patient load, complex socioeconomic and cultural milieu, and lack of trained professionals are only a few of the various challenges present in the practice of structured psychotherapy in the Indian psychiatric practice. [5]

According to Carson and Chowdhury (2000), counselling or therapy is generally an unfamiliar, misunderstood, or undervalued venture in India. They further explain that therapy or psychotherapy, in particular, are generally viewed negatively and are usually associated by Indians with the treatment of hospitalized mentally ill individuals.[6] With the increasing education rates, access to social media, and decreasing socioeconomic gaps, the relevance of mental health is increasing in the Indian population, and so is the utilization of mental health services. But treatment gaps exist, and the perception of seeking professional psychological help continues to be stigmatized.

Various factors can affect the process of formation of a psychotherapeutic relationship as well as the outcomes of the psychotherapy itself. These factors may be at the level of the client, such as the clinical diagnosis and severity, psychosocial milieu, client motivation and engagement in therapy, pre-treatment beliefs, myths and expectations towards the process and outcomes related to therapy, personality-related factors, transference issues, and so on. Similarly, therapist-related factors such as empathy, positive regard and affirmation, collecting client feedback and managing countertransference issues significantly affect the therapeutic relationship. These factors interact with each other and differentially affect each other's influence on the therapeutic relationship and have been the subjects of research for decades. Some factors, such as the client's resistance and stage of change, client preferences, socio-cultural and religious factors, coping styles, and their beliefs and expectations towards psychotherapy, are unique to each client. Quite often, psychotherapies are offered to patients based on their respective diagnoses without considering specific patient factors. Some psychotherapies are indeed better suited to certain specific disorders. However, matching psychotherapy to only a diagnosis is incomplete and not always

effective. The factors mentioned above should thus be considered whenever patients are selected for a particular psychotherapeutic intervention to make it more personalized and effective. [7]

Beliefs and Expectations in Psychotherapy

Until the 1960s, when clinical psychologists began researching the significance of client expectations in the field of psychotherapy, the effect of expectations was primarily a sociological construct. Schulte (2008) defined expectations as 'cognitions about a likely future event or state.'[8] Any given client may have varying expectations and preconceived assumptions or views about what they might experience during therapy and how much it can benefit their overall well-being even before they have come in contact with a therapist or a doctor. These beliefs and expectations might be modified in the context of various factors unique to each client, such as the type and duration of illness, severity of symptoms, the experience of the client-therapist therapeutic relationship, and the unique sociocultural settings of each client.

Out of the various pre-treatment patient characteristics described above, beliefs and expectations from the process and outcomes of psychotherapy is the one that potentially contributes to a large number of dropouts and, at the same time, are also easily malleable factor.

These expectations include process and outcome expectations. Process expectations include expectations about what will happen during therapy, the techniques used, the topics and areas covered, and what the client's and therapist's roles will be during therapy. Outcome expectations include the expectations about the desired results from therapy for the patient.[9] The belief factor is the number of beliefs patients come up with in the efficacy of psychotherapy as an effective treatment strategy for the treatment of his/her illness. These expectations are the main determinant of client actions in counselling, such as their level of personal participation, their readiness to discuss sensitive topics, and even whether they stay in treatment long enough to feel better.

Multiple studies have found a relationship between pre-treatment expectancies and client improvement. Studies have also found that positive outcome expectancies from psychotherapy in patients were linked to a better therapeutic alliance, reduction of

dropouts, and potentially better clinical outcomes. There can be several factors that can modify these expectancies. However, there is a dearth of literature on such mediating factors that directly or indirectly affect the beliefs and expectations of the clients regarding psychotherapy.

Role of sociodemographic factors and clinical variables

Various socio-demographic and cultural factors unique to the patient may affect and modify the client's baseline beliefs and expectations.

Factors such as age, gender, and past experiences with psychotherapy also influence variations in the beliefs and expectations of psychotherapy. For example, being older and female predicts more positive outcome expectations.[10] These may be attributed to a general overarching theme of a better treatment-seeking attitudes in females as well as greater beliefs that in times of distress psychological interventions are required and may help.

Past experience shapes all kinds of human beliefs and expectations. Studies have found that positive past experiences indicate positive outcome expectations for psychotherapy [11] and art therapies [12]. Similarly, feedback regarding prior experiences, opinions, or attitudes from the media, friends, and family members also influences expectations in a significant manner [13].

Religious, socio-economic, and ethnic backgrounds also define people's world view in various ways. In a study by Belaire and Young (2002) highly religious Christians expected a non-Christian counsellor to engage in more religious activities during sessions than moderately devout Christians. Both moderate and conservative Christians expected a non-Christian counsellor to be accepting and tolerating of Christian ideas. [14] Similarly, Egistoddir and Gerstein (2000) found that Icelandic students had higher expectations about counsellor expertise than did Americans, and they also expected them to be more culturally competent. [15]

Clinically, several clinical variables may contribute to the beliefs and expectations a patient might have regarding the psychotherapeutic process or outcomes. For instance, a patient with a higher severity of illness or a longer duration of illness might expect

their treatment to last longer than someone with a milder degree or a shorter duration of distress.

For example, Constantino et al. (2014) investigated the correlation of participant characteristics with patient's treatment beliefs in psychotherapy in 65 adult outpatients. They found that patient's manic symptoms were associated with higher baseline expectations, whereas substance abuse symptoms and Axis II comorbidity were associated with lower baseline expectations. Patients' psychotic symptoms were positively correlated to post-Session one expectancies, and better global functioning was linked to greater post-Session one credibility beliefs. [16] Similarly, Vîslă et al. (2021) in their study found that higher depression levels at the beginning of psychotherapy were associated with worse outcome expectations. [17]

Beliefs & Expectations in Psychotherapy & Personality

The five-factor model of personality is a graded organization of personality traits in terms of five basic dimensions: Extraversion, Agreeableness, Conscientiousness, Neuroticism, and Openness to Experience. This model has been used for this study to assess personality traits in the patients and their association with beliefs and expectations regarding psychotherapy.[18]

As per personality theorists, the therapeutic relationship is just one of many characteristics of counselling related to the fundamental aspects of personality. Studies have found that patients tend to seek therapists of similar personalities as they tend to associate better with them. Patients with higher agreeableness and conscientiousness and lower neuroticism preferred a therapist who was warm and emotionally in control, whereas participants with lower agreeableness and conscientiousness and higher neuroticism preferred a therapist who was low on warmth and with emotion dysregulation. [19]

According to studies, people who are friendly, warm, cooperative, and trustworthy are more inclined to seek counselling from those who share their characteristics (i.e., facilitative conditions). Individuals who exhibit these characteristics, as well as those who are open-minded and responsible, expect to take an active position in the counselling process. Individuals who are more conventional, guarded, and reluctant, on the other hand, have higher expectations for a directing counsellor who will do the

majority of the talking and take responsibility for the psychotherapy's direction and success. In practice, therapists expect that ideal clients should be hardworking, amiable, conversational, open to investigating new concerns, and actively participate in the counselling process. [20]

The evaluation of the five factors can thus offer a thorough picture of the client's personality, including emotional, attitudinal, interpersonal, and motivational styles. This may help the therapist better understand the patient and come across as more empathic, promoting a better rapport between them.

Beliefs & Expectations in Psychotherapy & Coping styles

Coping style denotes '*an enduring personality trait that predisposes people to deal differentially with anticipated or experienced change. It is a characteristic way of behaving to reduce discomfort and to adapt to a changing environment that is outside of one's control*' [21]

The compensation and capitalization models are two opposing hypotheses concerning how patients' pre-treatment attitudes and subsequent therapeutic responses interact, according to Cronbach and Snow (1977). [22]

Because psychotherapeutic modalities such as CBT are intended to make up for patients' coping deficiencies by teaching them how to stop self-defeating attitudes and patterns of behaviour, the compensation model predicts that patients with weak coping skills before treatment will experience the greatest improvements after treatment. The capitalization model, however, predicts that because CBT builds on patients' strengths, those who had the best coping mechanisms prior to treatment will experience the greatest improvements.[22]

In times of stress, a person might use various kinds of coping strategies. They may avoid dealing with the stressor altogether by distracting themselves, denying the problem completely, or even taking support of substances. These constitute the avoidant coping styles.

On the other hand, Problem-focused coping strategies, as the name suggests, seek to modify or eliminate a stressor. Problem-focused coping occurs when the person

adapts a method to try to deal with the stressor directly. Planning, problem-solving, or removing the stressor entirely are all instances of problem-focused coping.

Emotion-focused coping is attempting to deal with one's emotional reaction to the stressor. Emotion-focused coping is utilized when you strive to diminish, eliminate, or merely endure your emotional response to a stressor. Examples include disengagement, expressing anger and dissatisfaction, seeking emotional support, or ruminating. [23]

There is a dearth of studies assessing the relationship between beliefs and expectations in psychotherapy and client coping styles so as to substantiate these assumptions. Nonetheless, active coping styles may, in general, reflect a better motivation to change, which might, in turn, lead to greater positive beliefs as well as positive process & outcome expectations from the psychotherapeutic process, which might further increase the client's engagement. Whether coping styles affect client beliefs and expectations remains an important research question.

Beliefs & Expectations in Psychotherapy & Psychological flexibility

Psychological flexibility is referred to as the "*ability to contact the present moment more fully as a conscious human being, and to change or persist in behaviour when doing so serves valued ends*" [24]

According to the psychological flexibility model, suffering occurs when a person's behavioural range is functionally limited and less sensitive to adjusting to the current situation to facilitate living in one of the available life-affirming directions. This is due to the dominance of cognition and a pattern of avoiding/escaping unwanted internal experiences (psychological inflexibility).[25]

On the other hand, it is hypothesised that emotional wellbeing is more likely to exist when an individual's behavioural repertoire is functionally large and flexible in the presence of challenging internal experiences, receptive to the limits of the present settings and guided by what individuals choose to be the most essential principles for their life. [26]

Greater psychological flexibility could also be an outcome of the therapy process itself as in humanistic therapies like Acceptance & Commitment therapy (ACT). [25]

More psychological flexibility will result in less resistance and greater motivation to go through the process of change, which may have a big impact on the therapy process itself as well.

The rationale behind the study

Beliefs and Expectations in Psychotherapy is a significant component that affects intake, retention, as well as outcomes following psychotherapy. Relevant sociodemographic characteristics, personality, coping strategies, and psychological flexibility are all aspects that can contribute considerably to a client's beliefs and expectations. Some of these factors are modifiable, and early interventions may significantly change their impact on the client's beliefs and expectations regarding psychotherapy and subsequent retention in therapy. These parameters may guide the selection of patients who may be well-suited for psychotherapeutic interventions and may yield better clinical outcomes in resource-limited countries such as India. Evidence from India on beliefs in the efficacy of psychotherapy, psychotherapy process and outcome expectations, and their correlates are currently scarce. Indian patients are typically anchored in their complicated socio-cultural backgrounds, and their psychological framework differs from that of the western population, where the majority of research has been undertaken in this area. In general, Indian patients seek therapy passively and regard their doctors as mentors, elevating them to pedestals, resulting in a more passive engagement in the therapeutic process. In contrast, the new urban, educated, and internet-savvy population appears to be a potentially unexplored study population with varied attitudes and notions regarding their psychological health. Clinical characteristics that are unique to the country's demographic and distinct clinical environments where psychotherapies are conducted contribute to the complexity of this study subject.

This study seeks to evaluate some of the aspects mentioned above in Indian clinical settings, which will help to enhance and personalise this evidence-based therapy modality by creating suitable clinical profiles that can be selected for appropriate psychological interventions. This exercise may potentially translate into better clinical outcomes for the patients.

REVIEW OF LITERATURE

The literature on the effects of expectancies in psychotherapy is a growing field in psychotherapy research. Although the work began a few decades ago, it is only in the recent years, that the understanding of the pre-treatment factors and its role in psychotherapy outcomes has vastly expanded.

The current literature review gives an overview of the progress made in this area and examines the relationship of beliefs and expectations from psychotherapy process and outcomes along with its association with personality, coping styles and the phenomenon of psychological flexibility. In some studies, beliefs and expectations has been assumed to be studied by proxy factors such as client engagement or professional help seeking attitudes. The role of the baseline sociodemographic factors and clinical profiles has also been explored to make the literature review comprehensive.

Attitudes towards psychotherapy, Sociodemographic Factors & Clinical Factors

In a metanalysis by **Swift & Greenberg (2012)** in which a total of 83,834 adult clients from 669 studies were included, the dropout rate from therapy on an average was found to be 19.7 % with 1 in every 5 patients dropping out of therapy. Patients who were younger, who saw professionals in training, in university-based settings, who had a personality/eating disorder, and who got therapy that was not manualized or time-limited had greater dropout rates. Results for gender, marital status, and education levels were inconsistent.[27]

In a study done on 732 university students by **Cepeda & Short (1998)**, participants completed questionnaires about their perceived likelihood of seeking professional psychological help (The Intention of Seeking Counselling Inventory), attitudes toward psychotherapy (The Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPH)), fears of psychotherapy (Thoughts About Psychotherapy Survey), psychological distress (Texas Hopkins Symptom Checklist-21 (HSCL-21)), social support (The, Wilcox Social Support Network Survey), and self-concealment (Self Concealment Scale). According to the study, people who wanted to keep their personal information private were more inclined to avoid therapy than to actually go

to it. Although a greater perceived likelihood of seeking assistance was linked to a lack of social support, this effect was balanced by high levels of self-concealment. According to the situation for which help would have been sought, specific types of distress (seeking help for psychological and interpersonal concerns, R^2 =0.24, p=0.001; academic-related problems, R^2 =0.10, p=0.0001; and drug use concerns, R^2 =0.04, p=0.001) predicted the estimated possibility of seeking help. [28]

In a study by **Have et al. (2010)** the, data was collected from the European Study of Epidemiology of Mental Disorders (ESEMeD), a survey representative of the adult population of 6 countries: Belgium, France, Germany, Italy, the Netherlands and Spain (n = 8,796). World Mental Health Composite International Diagnostic Interview (CIDI version 3.0) was used to explore attitudes towards mental health help seeking and associated service use. The respondents' attitudes related to their opinions of the effectiveness of mental health care as well as their convictions that they would seek professional assistance if they were experiencing a significant emotional problem, would feel secure discussing personal problems with a specialist, and would not feel ashamed if friends found out they were receiving professional assistance. Nearly 33% of those surveyed said that having professional assistance for coping with significant emotional problems was worse than or on par with receiving no assistance. At least two of the four attitudes that were examined had to do with being a woman, being under 65, earning a lot of money, living in Spain or Italy, suffering from a mood disorder, or having previously sought help. Even after adjusting for prior service usage, all four attitudes were found to be significantly linked to the use of mental health services.[29]

Serafini et al. (2016) investigated the relationship between outcome expectations and associated treatment outcomes in motivational enhancement therapy delivered in English (N=461) and Spanish (n=405) as part of secondary analyses of two large multisite RCTs that compared the outcomes in the two groups using a single item about abstinence expectations prior to starting treatment. Even after controlling for the severity of drug use at baseline, the MET-S study found that outcome expectancies were strongly related to the majority of substance use outcomes (but not in the MET-E). Individuals in MET-S who stated that they were "unsure" they would achieve abstinence during treatment had a greater rate of drug-positive urine toxicological

tests than those who stated that they were "sure" they would achieve abstinence (F = 18.83, *p=0.001*). The study concluded that individual characteristics and cultural factors may play a role in the relationship between treatment outcomes and outcome expectations. [30]

Boge et al. (2021) used the Patient Satisfaction Questionnaire (PSQ), which is divided into four subscales to assess patient satisfaction with therapy, bias towards therapist, effects of therapy, and stigma, in Syrian refugees, internally displaced people, and KRI host community members regarding mental health care in the governorate of Duhok (n=101). The participants had received counselling or psychotherapy within the previous six months and had gone to more than four sessions prior to the assessment, regardless of whether they were taking medication. They discovered very high satisfaction rates with a moderate amount of bias. About 58.9% of respondents expressed concerns about their therapist's gender, religious affiliations, race, and country of origin. About 47.0% respondents rejected the self-stigmatizing items, while about 83.5% approved of the treatment's outcomes with therapy.[31]

In a study done by **Johnson (1998)** on 218 college students the Bem Sex Role Inventory and the Attitudes Toward Seeking Professional Psychological Help measures were completed by the respondents. It was found that women showed less stigma associated with seeking professional psychological help and were more willing to recognize a need for seeking help than men.[32]

Similarly, in a study done on 200 university students of Delhi by **Arshad et al. (2012)**, students responded to the Attitude Toward Seeking Professional Psychological Help Scale (ATSPPHS) questionnaire. The ATSPPHS consists of four subscales: Need (recognition of need), Stigma Tolerance (the degree of tolerance against stigma associated with help-seeking action), Openness (interpersonal openness), and Confidence (confidence in mental health professionals). Results showed that Indian University students have favourable attitudes toward seeking counselling help similar to participants in other studies and women fared better in their study as well.[33]

Allen et al. (2022) investigated expectations about seeking psychotherapy among Polynesian Americans (N=593). Participants completed the Attitudes Toward Seeking

Professional Psychological Help Scale (ATSPPH), Milwaukee Psychotherapy Expectations Questionnaire (MPEQ), Psychotherapy Expectancy Inventory-Revised (PEI-R), and Intentions to Seek Counselling Inventory (ISCI). A significantly higher proportion of either gender favoured the same gender therapist. There were no significant variations among Polynesian American ethnicities in attitudes toward seeking professional psychological help (ATSPPH; F=51.70, df=52), nor were there significant differences in intention to seek counselling for psychological and interpersonal difficulties (F=51.31, df=52). The intent of Polynesian American ethnicities to seek academic counselling differed significantly (F=53.10, df=52, p=0.01). Although there were no significant differences in advice seeking or audience seeking across the group, women scored higher than men on expectations about the psychotherapy process and outcomes. The intention to seek psychotherapy was positively connected with the expectation to take command during sessions and receive guidance from the therapist, which could be explained by Polynesians' cultural context of deferring to authority figures for counsel in times of distress. [34]

Expectations & Beliefs in Psychotherapy:

Bloch et al. (1976) examined the link between patients' expectations of therapeutic improvement and their actual outcomes following 8 and 12 months of group psychotherapy at Stanford University (n=59). They discovered a significantly favourable association between expectations and outcomes only when assessments came from patients, as opposed to those made by therapists or outside evaluators. The authors speculated that patients might enter therapy with certain expectations & continue to hold them throughout the therapy process and ultimately determine outcomes.[35]

Overall and Aronson (1963) examined the treatment expectations of patients from lower socioeconomic levels at the University of Maryland Medical School (N=40) who were about to have their first consultation by a questionnaire with 35 items about potential therapist behaviour in session. Following the session, they were asked three questions to determine whether their expectations had been satisfied. Their therapists were simultaneously asked to complete questionnaires prior to and after the initial interview in order to analyse their own behaviour as well as the fitness of each patient in therapy. Most of the pre-interview questions were answered in affirmative and

reflected the expectation that the therapist will be simultaneously active, passive, medical and psychiatric in his approach. The post interview results showed that the therapist was less medical and supportive than the patients anticipated. Higher rates of non-return for treatment were significantly correlated with discrepant expectation and perception of the interview. This discrepancy was a better predictor for non-return than discrepant patient perception and therapist reflections.[36]

Grencavage and Norcross (1990) in their review on the common factors literature identified positive expectations of the patients and optimism for improvement as an ideal common change factor. The authors examined through 50 studies to find similarities among putative therapeutic common factors in various psychotherapies. The number of factors proposed per publication ranged from 1 to 20, with a total of 89 distinct commonalities proposed. Analyses found that change processes accounted for 41% of proposed commonalities, while client attributes accounted for just 6% of articulated commonalities. The development of a therapeutic alliance (56% of all authors), the potential for catharsis (38%), the acquisition and practical application of new behaviours (32%), clients' positive expectancies (26%), favourable therapist characteristics (24%), and the provision of a rationale as a change process (24%) were the most consensual commonalities across all categories.[37]

Furthermore, in a review of psychotherapy outcome literature, **Norcross & Lambert (1992**) provided an estimate that at least 15% of the improvement in psychotherapy patients is attributable to the effect of expectancies.[38]

Arnkoff et al. (2001) in their review of 24 studies on the relationship of patient expectations of change and psychotherapy outcomes found significant association in 12 studies. 5 studies revealed mixed findings, while 7 studies showed no significant associations. Client expectations outperformed therapist factors, client adjustment, and symptoms in predicting the therapeutic alliance after the first session. The association of Role expectations and Role preferences with outcomes could not be established due to mixed findings in most studies.[39]

In a review by **Dew & Bickman (2005),** significant association was found in 10 out of 13 studies between pre-treatment outcome expectations and actual outcomes post therapy. The review also suggested a significant relationship between expectations

and therapeutic relationship. The review also discovered that numerous studies made use of measures of expectancies that evaluate various types of expectancies without independently analysing results for role and outcome expectancies [9]

In a study done on 185 British adults by **Furnham et al. (2009)**, a 4-part questionnaire that assessed patient reaction to psychotherapy, Attitudes to, and beliefs about psychotherapy, Mental illness and psychotherapy along with Personal details was used. The study found that participants were generally very positive about psychotherapy believing the process to be highly beneficial. They had a somewhat rudimentary but slightly realistic understanding of the nature and effectiveness of psychotherapy. The participants appeared to be fairly knowledgeable about the method, goal, and techniques used in psychotherapy. They rejected outdated clichés, such as the idea that clients of psychotherapy sit on a couch, because they were aware that medications are rarely administered. The majority, for instance, continued to assume that patients are asked about their dreams, which is incorrect.[40]

In an extensive meta-analysis of publications published through 2009 by **Constantino et al. (2011)** involving 8,016 patients from 46 distinct clinical samples, the relationship between post-treatment symptomatology and patients' self-reported result expectancies (measured at baseline or Session 1) was studied. A modest, but significant positive impact (d = 0.24) suggested that greater posttreatment symptom reduction was associated with higher expectations of the efficacy of a treatment. This association was unaffected by the study design (comparative trial, open trial, or naturalistic), the diagnosis (mood, anxiety, substance use, or other), the treatment orientation (cognitive-behavioural or other), the type of therapy (individual, group, or other), the publication date, or any other factor.[41]

Tambling (2012) examined the effects of pretherapy expectations in couple therapy patients in his literature review. It was concluded that studies clearly proved that pre therapy interpersonal expectations significantly influenced cognitions, behaviours, and interpersonal process outcomes. Expectations were found to be clearly related to therapy initiation, therapy continuation, alliance building, and treatment outcomes in a number of ways, according to the existing research. There is evidence that suggests expectations for couple therapy shift over time, but little is known about how this

occurs or how these expectations for couple therapy may be related to processes and outcomes in couple therapy, thus additional research is necessary. [42]

Swift et al. (2012) recruited adult clients (n =57) from two psychology department training clinics to complete measures of outcome expectations (TDCRP Patient Attitudes and Expectations Questionnaire), generalised hope (State Hope Scale), and suffering (Outcome Questionnaire 45.2) (After the initial phone conversation). These factors, along with previous therapy experience and the length of time between appointments, correctly predicted appointment status for 88.7% of the sample. Attendance was greater when the wait time was shorter (OR =1.58, p=0.01) and for people who had previously received therapy (OR=9.89, p =0.05). Initial outcome expectations were significantly associated with overall levels of hope (r=0.59, p=0.01) and inversely related with severity of distress (r=0.59, p=0.01) (r=0.48, p=0.01). [43]

In a study by **Frankl et al. (2014)**, 159 patients with substance use disorders filled out the PEX-S (Psychotherapy Expectation Questionnaire-short form) during the therapy evaluation. A subsample of these patients (n = 41; 24 in individual therapy and 17 in group therapy) provided details regarding their therapy, including their psychotherapy experiences (also measured with the PEX-S) and therapeutic alliance (measured with the Working Alliance Questionnaire-short version). The study found that the strength of the therapeutic alliance increased with the degree of agreement between patients' expectations and what they experience in group therapy. No meaningful association was seen in individual psychotherapy. Defensiveness was inversely connected with retention in therapy. The results demonstrated that substance use disorder patients who think they will gain by repressing painful memories, emotions, and thoughts will discontinue visiting for appointments. Both the PEX-S Internal Orientation and External Orientation subscales obtained high average scores, indicating that patients wish to be able to reflect on their internal processes and do concrete work on changes in daily life. The findings highlight the fact that SUD patients anticipate therapy to be specific and grounded in their difficulties.[44]

Constantino et al. (2017) investigated the relationship between individual characteristics and general treatment outcome expectation in 178 socially anxious people. General outcome expectations (Credibility/Expectation Questionnaire (CEQ)), general distress (Brief Symptom Inventory), social anxiety severity (Social

Interactions Anxiety Scale (SAIS)), general state hope (State Hope Scale (SHS)), and psychological mindedness (Psychological Mindedness Scale (PMS)) were all assessed. To assess the intent to seek therapy, participants were asked two study-specific questions: (1) "Are you actively contemplating psychotherapy for any psychological difficulties?" and (2) "Are you actively considering psychotherapy for social anxiety concerns?" Prior therapy experience and satisfaction, as well as patient demographics, were taken into account. It was found that positive opinions about therapy and intent to seek therapy were substantially associated with participants' general outcome expectation. Multivariate regression models revealed a positive relationship between psychological mindedness and outcome expectations (B =0.59, p=0.001). Subgroup analyses revealed that greater satisfaction with the treatment (B = 5.26, p=0.001) was associated with higher outcome expectations in individuals who had previously received therapy. [11]

Szymańska et al. (2017) through a survey of former patients of the Academic Center for Psychotherapy (AOP) (n=276), investigated the relationship between "patient's characteristics" before psychotherapy, including "expectations of the therapy," "experience in the therapy," including the "psychotherapeutic relationship," and "assessment of the direct effectiveness of the psychotherapy." Using the structural equation model (SEM), the study discovered a high positive association between "the direct effectiveness of the psychotherapy" and the concept of "a good relationship with the psychotherapist." "The expectation of support" was a key mediating element between the other patient characteristics and the expected effectiveness of the psychotherapy. Patients viewed their relationship with the psychotherapist as positive when they found the therapist to be “activating the patient”; “interpreting and informing the patient”; & “focusing on the transference relationship” & vice versa. [45]

Bitan and Abayed (2020) used the Expectations of the active processes in psychotherapy scale (EAPPS) to examine process expectations in therapy in therapists (n = 107), patients (n = 97), and lay individuals with no prior experience in psychotherapy (n = 160). Seven mechanisms of change were also ranked by the respondents in terms of perceived relevance. The study found that whereas patients and laypeople valued cognitive and emotional reconstruction more than therapists, therapists valued emotional processing and interaction between patients and

themselves. Additionally, whereas patients and laypeople considered cognitive control as the most significant process of change, therapists saw the study of unconscious contents as the most significant mechanism of change. [46]

In a study by **Vislă et al. (2021)**, outcome expectations were evaluated at the pre-treatment, Session 5, Session 10, and posttreatment points in patients with generalised anxiety disorder (N = 80) who were receiving different forms of cognitive-behavioral therapy. Results showed that patients' expectation of their treatment's success had significantly increased linearly with progress in therapy. They discovered that lower pre-treatment outcome expectations were linked to greater educational status. which was in contrast to another study's findings (Vislă et al., 2019), which found no relationship between patient educational status and their initial treatment outcome expectation. High baseline depression was linked to a lower anticipation for a favourable treatment outcome. Early changes in patients' overall self-efficacy were predictive of changes in treatment outcome expectations.[47]

Personality and Psychotherapeutic Expectations and/or outcomes:

Conte et al. (1991) conducted a study in which 90 psychiatric outpatients completed self-report measures of four ego functions (Judgment, Synthetic-Integrative Functioning, Mastery-Competence, and Ego Strength) as well as an eight-trait personality test (Acceptance, Submission, Passivity, Depression, Rejection, Aggression, Assertion, and Sociability). Clinicians compared their outcomes at the start and completion of therapy using a 21-item scale (Psychiatric Outpatient rating scale). Mastery-Competence had a significant correlation with both the discharge (r=-0.35) and change measures (r=-.36). Ego Strength and discharge (r=0-.36) and change (r=-0.28) ratings had a strong relationship. These results corroborated the generally held belief that, regardless of presenting issues, individuals who have the greatest capacity for managing their environment and interpersonal issues are likely to gain the most from psychotherapy. While Depression, Rejection, and Conflict were linked to negative results (r's =0.34, 0.33, and 0.28, respectively, p=0.05), Sociability was positively correlated with positive outcomes (r = -0.33, p=0.05). [48]

Over a two-year period, **Miller (1991)** documented his experience using the five-factor model of personality, as operationalized by the NEO Personality Inventory

(NEO-PI), to facilitate psychotherapy treatment with 101 private-practice, outpatient, psychotherapy patients. The outcome was divided into five categories: extremely good (21 cases), good (27 cases), fair (16 cases), mixed (11 cases), and poor (4 cases). Neuroticism (N) influenced the patient's level and duration of discomfort, Extraversion (E) affected the patient's enthusiasm for therapy, and Openness (0) influenced the patient's reactions to the therapist's interventions. The patient's attitude toward the therapist's personality was impacted by agreeableness (A), whereas the patient's motivation to engage in the psychotherapy work was influenced by conscientiousness (C).[49]

Hatchett and Han (2006) conducted a study in an undergraduate student population of two universities to establish a relationship between expectations from therapy and the Five Factor Model (FFM) of personality in a nonclinical population. The Expectations About Counselling Inventory (EAC-B) responses from the students (n=460) were scored, and the results indicated three factors: supportive environments, counsellor expertise, and client involvement. They discovered that extraversion, agreeableness, and conscientiousness were all positively correlated with expectations that psychotherapy would take place in a supportive environment. The therapist's competence expectations were negatively correlated with agreeableness and openness. Expectations of client participation in treatment sessions were positively correlated with extraversion, openness, agreeableness, and conscientiousness.[20]

Anestis et al. (2020) studied the congruence of client personality and therapist preference with 454 undergraduate students and 227 community members. The Interpersonal adjective scales - Big Five (IASR-B5), a 124-item self-report questionnaire was used to assess participant personality. To assess client preferences for therapist qualities, a modified IASR-B5 was employed. Each personality factor was associated with a preference for therapists who had similar features; participant neuroticism was the least associated with preferred therapist neuroticism. Participant conscientiousness (undergraduates only) and agreeableness (both groups) were also adversely correlated with therapist neuroticism. People with higher levels of agreeableness and conscientiousness and lower levels of neuroticism preferred a therapist who was warm and emotionally in control, whereas people with lower levels

of agreeableness and conscientiousness and higher levels of neuroticism preferred a therapist who was lesser in warmth and affectively dysregulated.[19]

Coping and expectations and beliefs in psychotherapy:

In their trial, **Simons et al (1985)** recruited 35 moderately depressive outpatients who were randomly randomised to either cognitive therapy or antidepressant medication therapy for 12 weeks. Although improvement did not differ by treatment type, initial scores on Rosenbaum's Self-Control Schedule (SCS), which evaluated learnt resourcefulness, were found to be differentially correlated with outcome in the two groups. Patients with high SCS ratings did better with cognitive treatment, while those with low SCS levels did better with medication. This showed that individuals who have active coping abilities may recover faster with CBT than those who do not.[50]

On the other hand, **Burns & Nolen-Hoeksema (1991)** conducted a study done in 307 patients of mood disorders by using the Self-Help Inventory which assesses the various coping methods patient used to cope with their low mood. Despite the fact that active coping techniques were significantly associated with a reduction in the severity of depression, the study indicated that neither those who actively deal nor those who do not are more likely to benefit from CBT. Pretherapy patient expectations regarding the usefulness of coping skills were not associated with baseline or future depression, assignment completion, or therapeutic response.[51]

In a study by **Baldwin (1974)** based on the results of Byrnes' Repression-Sensitization Scale, two groups of 49 university students were identified as repressors and sensitizers. In order to research the effects of defensive orientation on expectations for a therapeutic relationship, students completed the Jourard Self-Disclosure Questionnaire and a Likert-type scale assessing psychotherapy dimensions. The study found that repressors are far less likely than sensitizers to seek out psychotherapy in the future, and anticipate more planned rather than unplanned activities from the therapist, and to be much more open about their own issues during sessions.[52]

A Meta- analysis of 18 studies by **Beutler & Moos (2018)** demonstrated a strong correlation between coping mechanisms and psychotherapy outcomes and suggested that patients who are externalizers benefit more from symptom-focused

psychotherapy, whilst internalizers typically benefit more from insight-focused psychotherapy. The number of studies were small, most of them used indirect measures for assessing the coping styles and had limited generalizability due to being centred mostly in north America. [53]

Psychological Flexibility and Expectations and Beliefs in Psychotherapy:

Direct correlation between psychological flexibility and psychotherapeutic expectations has not been studied. However, the correlation s between psychological flexibility and psycho-therapeutic emotional work as well as outcomes particularly from a humanistic standpoint has been studied.

Brandon et al. (2021) investigated the extent to which clients' psychological flexibility, specifically acceptance-and-mindfulness and commitment (Cognitive and Affective Mindfulness Scale Revised (CAMS-R)) and behavioural activation (Valuing Questionnaire—Progress Subscale (VQ)), changed following episodes of routine psychotherapy of diverse treatment orientations and were predictors of outcome changes (CCAPS-34, Distress Index Subscale& Flourish). Acceptance-and-mindfulness and commitment-and-behavioral activation scores increased statistically significantly from baseline to post therapy. Moreover, changes in psychological flexibility were significant predictors of changes in both thriving and distress, explaining 42% and 23% of those respective therapy outcomes. The authors suggested that although combining therapeutic approaches may improve psychological flexibility slightly, greater specific focus to increasing it may assist the work of different psychotherapists due to its potential significance in reaching common therapy objectives.[54]

Marshall and Brockmann (2016) explored the links between psychological flexibility, self-compassion, and emotional well-being in 144 university psychology students. Students completed measures of psychological flexibility (The Acceptance and Action Questionnaire-II), defusion (Drexel Defusion Scale), mindfulness (Philadelphia Mindfulness Scale), self-compassion (The Self-Compassion Scale-Short Form), valued living (The Valuing Questionnaire (VQ)), and meaning (The Meaning in Life Questionnaire (MLQ)). Outcome measures of emotional distress (the Depression Anxiety Stress Scales-21), emotional well-being (Satisfaction with Life

Scale (SWLS) and the Rosenberg Self-Esteem Scale (RSES)). The study showed that Self-compassion was significantly related to psychological flexibility and its individual processes, such as non-judgmental acceptance, defusion, and valued living. It was also shown that there was a substantial favourable association between self-compassion and emotional well-being. In contrast, there was a significant negative association between self-compassion and emotional distress indices such as sadness, anxiety, and stress.[55]

Silberstein et al. (2012) investigated the relationship between Mindfulness (Mindful Attention and Awareness Scale (MAAS)), Psychological Flexibility (Acceptance and Action Questionnaire II (AAQ-II)), and fourteen aspects of Emotional Schemas (Leahy Emotional Schema Scale) and fourteen aspects of Emotional Schemas (Leahy Emotional Schema Scale) (LESS). 107 adult cognitive-behavioural outpatient study participants completed these self-report questionnaires. The study found that individuals with higher levels of dispositional mindfulness demonstrated more psychological flexibility and were more likely to endorse more adaptive components of emotional schemas. Individuals who seemed to be less psychologically flexible or to have lower levels of dispositional mindfulness were more likely to have less adaptive and rigid responses to emotional experience. [56]

Yasinski et al. (2020) investigated the process of change in cognitive behavioural therapy for treatment resistant depression and its association with psychological flexibility, rumination, avoidance, and emotional processing in a subsample of depressed adult patients (n = 49) who had not fully responded to antidepressant medication and were randomised to receive cognitive-behavioral therapy (CBT). The Beck Depression Inventory was developed to determine the severity of depression. The Change and Growth Experiences Scale (CHANGE) was used to analyse the mechanisms facilitating change after therapy, which included characteristics such as avoidance, ruminative processing, and emotional processing, as well as a multi-modal measure of psychological flexibility. Three sessions were coded for each of the 49 participants: baseline (session 2), pre-sudden gain (or control), and post-depression spike (or control). Each time, each participant's session was classified individually. According to the results, psychological flexibility before a sudden gain was associated with less depression at the 12-month follow-up. Interaction analyses showed that

avoidance and rumination predicted higher depressive symptoms at the 12-month follow-up when flexibility was low during the post-spike period, whereas emotional processing predicted lower symptoms. None of these traits were related to results when flexibility was high. These results highlighted the significance of psychological flexibility as a therapeutic goal in CBT for depression that is resistant to therapy. [57]

In a study by **Masuda et al. (2011)**, two cross-sectional studies sought to determine if psychological flexibility modulates the relationships between self-concealment and negative psychological outcomes in 591 university students of Georgia. The first study looked at whether psychological flexibility (measured by AAQ-16) can buffer the relationship between self-concealment (measured by Self Concealment Scale (SCS)) and emotional suffering in difficult interpersonal contexts (measured by The Interpersonal Reactivity Index – Personal Distress Scale (IRI-PD)). Study 2 evaluated whether psychological flexibility mediates the association between self-concealment and overall psychological ill-health (measured by The General Health Questionnaire-12 (GHQ-12) scale) in addition to duplicating the findings of Study 1. Psychological flexibility was discovered to partially regulate the association between self-concealment and emotional suffering in stressful interpersonal circumstances, as well as the relationship between self-concealment and general psychological ill-health.[58]

Gulati and Saha (2018) used the Acceptance and Action Questionnaire-2 and Myers Briggs Preference Questionnaire to examine the association between psychological flexibility and personality in 60 Indian adults (30 men and 30 females). The results discovered a significant (r=-0.09) association between the two variables. The correlation for males was found to be negative (r=-0.374), but the correlation for females was found to be positive (r=0.06). [59]

Indian Literature:

Literature from India is sparse as the practice of a structured psychotherapy itself is missing from a greater part of the practice of mental health practitioners in the country.

Neki (1973) suggested the concept of Guru–chela(teacher–disciple) relationship as a more culturally appropriate model for psychotherapeutic relationship in the Indian scenario.[60]

According to **Agarwal (1989)**, an important reason for not practising psychotherapy in India is enormous workload on psychiatrists and inability of Indian masses to understand and appreciate psychotherapeutic help on account of low level of education. [61]

There are certain aspects of the Indian society that brings unique challenges that merit careful consideration and evaluation when we talk about establishing a psychotherapeutic relationship.

Hoch (1990) opined on the difficulties encountered in psychotherapy work in India based on her 32 years of experience. She stated that the challenges faced were a result of the profound impacts of tradition and culture. Discouragement of egoistic and individualistic strivings, complex family structures, and the view of the doctor-patient relationship as an instructional passive interaction are all elements that directly impede the use of western psychiatric approaches in Indian practice.[62]

According to **Surya and Jayaram (1996)**, an Indian patient as compared to patients in the west prefers dependency patterns in a psychotherapeutic alliance; is more ready to accept obvious circumstantial support in the form of therapy, less ready to seek psychological explanations of his inner self; more demanding with respect to individual requirements and time; more flexible with respect to ego-boundaries and involves the therapist in a more direct role; and his ideal support figure is the joint family elder.[63]

According to **Chadda and Deb (2013)**, the inflexible hierarchical composition of families in India often poses a problem for open communication of thoughts and feelings. Socio-economic status, educational level and family structure are some of the factors that should be taken into account by the therapist. They further explain that in a collectivistic society like India, the self is defined and perceived through the communal identity with family identity forming a significant component of the self-identity which further hamper treatment seeking too.[64]

Bhargava et al. (2016) suggested that previous researchers argued that the Indian society with its religious and sociocultural factors represents a distinct milieu when it comes to the practice of psychotherapy but with globalization, increasing literacy levels, higher awareness on human rights and the widespread use of internet even

among the rural population, whether these observations stand today is an important question.[65]

Lodha and De Sousa (2018) explored the limitations of office-based psychotherapy in India in their review. They explained that when it comes to patient related factors, most patients who seek psychiatric treatment want their doctor to give them drugs and advice, but they rarely want to come in and talk about their problems in order to explore the various aspects of their issues or discover a root cause. Patients lack faith in psychotherapy as a treatment because of time constraints, financial constraints, a lack of readiness to speak or discuss, a reluctance to open up in front of a therapist, and ingrained beliefs that only talking and counselling cannot help.[66]

The lack of original studies in Indian settings highlights the need to explore this area of research.

AIMS AND OBJECTIVES

Aim: To study the beliefs and expectations towards Psychotherapy as a treatment modality for the treatment of psychiatric disorders in patients attending psychiatry OPD and their association with Personality traits, Coping styles and Psychological flexibility.

Objectives:

Primary: To assess the association of Personality traits, Coping styles and Psychological flexibility with beliefs in the efficacy of Psychotherapy in the patients attending the Psychiatry OPD.

Secondary:

- To assess expectations from Psychotherapy process and outcomes and its correlation with Personality traits, Coping styles and Psychological flexibility.
- To determine association of sociodemographic and clinical variables with patient's beliefs and expectations from psychotherapy.

MATERIALS AND METHODS

Study setting: Out-patient department of Psychiatry at All India Institute of Medical Sciences, Jodhpur, Rajasthan

Study design: A Cross sectional study design

Study Participants: Follow-up patients attending OPD in Department of Psychiatry

Selection criteria

Inclusion criteria: -

1. Adult follow-up patients aged 18-60 years of age.
2. Patients with a diagnosis of neurotic and mood disorders including but not limited to major depressive disorder, generalized anxiety disorder and panic disorder, phobias, social anxiety disorder, dissociative and conversion disorders, and substance use disorder.

Exclusion criteria: -

1. Patients with a Psychotic illness
2. Patients with Acute Disturbance (unable to participate in study due to severe distress)
3. Patients with cognitive disorders, intellectual disability, organic brain syndromes, epilepsy, head injury
4. Patients who are unable to read Hindi or English

Sampling Method: Purposive sampling

Sample size

Volpe found a positive correlation of 0.16 between the BEP scale and the Extraversion component of the five-factor model of personality, using this for sample size calculation, a sample size of 304 patients at level of significance (alpha value) of 0.05 and 80% statistical power (beta value of 0.20) was calculated.

The standard normal deviate for $\alpha = Z_\alpha = 1.9600$

The standard normal deviate for $\beta = Z_\beta = 0.8416$

$C = 0.5 * \ln[(1+r)/(1-r)] = 0.1614$

Total sample size = $N = [(Z_\alpha+Z_\beta)/C]^2 + 3 = 304$

Study duration

After approval by the Ethics committee, data was collected between 1st January 2021 till 30th June 2022 at Department of Psychiatry, All India Institute of Medical Sciences, Jodhpur, Rajasthan

OPERATIONAL DEFINITION OF PSYCHOTHERAPY

For this study, psychotherapy was considered as "any form of psychological intervention that helps a patient change his behaviour or help overcome specific psychological problems and issues in a desired way"

For the purpose of this study, the past history of psychological intervention was divided into the following categories:

I. **Structured Psychotherapy**: These include people who are being administered a well-defined structured psychotherapy that is usually governed by a personalized model for the patient and the number of sessions and the duration of each such session is pre-defined.

II. **Unstructured Interventions:**

   a. **Scheduled Counselling**: These include patients who receive supportive counselling about specific issues they are facing either at pre-scheduled routine follow ups by the treating doctor or at a pre-scheduled appointment by a clinical psychologist. These sessions are not governed by a specific model and do not have specific number or duration of sessions.

   b. **Behavioural intervention including lifestyle interventions**: These may include advice about modification of specific behaviour patterns or lifestyle choices of patients that affect the prognosis of their respective diseases. For e.g., Dietary and physical activity advice, relaxation exercise, Coping skills training, Assertiveness training, Goal setting and various other eclectic methods of counselling.

   c. **Psychoeducation and Pharmacological treatment:** These include education about the patient's illness in a comprehensive manner with regards to diagnosis, symptoms, treatment options, prognosis, signs of relapse and relapse prevention strategies along with information on prescribed medications and their side effects.

Data collection tools:

1. **Clinical case sheet:**

   The clinical case sheet contained sociodemographic data (name, age, sex, marital status, residence, family structure, religion, education level, occupation and occupational status, socioeconomic status, family history of psychiatric illness), clinical variables (diagnosis, duration of illness, duration of treatment and no of follow ups, past experience with psychotherapy/counselling).

   In the clinical data sheet, the following open-ended questions were asked to the participants:

   a. What do you think should be discussed during counselling/psychotherapy? (Like family issues, personal issues, some confidential information)
   b. Which do you prefer medicine only/ talk therapy or counselling/ both for the treatment of your illness? Why?
   c. What should be your role in counselling / psychotherapy?
   d. How can a doctor help you in counselling? What are your expectations from the doctor?
   e. How was your past experience with therapy?

      The question answer session was audio-recorded after taking written consent from the participants and was analysed later for drawing inferences.

2. **Beliefs in the Efficacy of Psychotherapy scale** [67](Erin Volpe, 2014)**:**

   The BEP scale includes 13 items that measures the belief system of a person regarding efficacy of psychotherapy. It was designed specifically to focus on the outcome expectations of a client for psychotherapy. BEP scale measures the general cultural belief system and their beliefs about psychotherapy and therapists specifically, rather than other forms of mental health services. Items are scored on a 5-point Likert scale (1=strongly disagree, 2=disagree, 3=neutral/don't know, 4=agree, 5=strongly agree). For this study, Cronbach's Alpha was 0.78, suggesting good internal consistency. Possible range of responses ranged from 13 (minimum possible score) to 65 (maximum possible score). More the score, more is the belief in the efficacy of psychotherapy. Permission has been taken from the author to use and translate this tool.

3. **Milwaukee Psychotherapy Expectations Questionnaire** [68](Melissa Norberg, 2011)**:**

   The MPEQ measures the expectations regarding the process and outcomes of psychotherapy in a patient and includes 13 items divided into two factors i.e., Process (9 items) i.e., the expectations a client may have regarding the process of Psychotherapy and Outcome (4 items) i.e., the expectations a client may have regarding the desired outcomes from psychotherapy. Both factors have shown high internal consistency ($\alpha > .85$). For this study the Cronbach's alpha was 0.92. Item responses are recorded on a Likert scale of 0 to 10, ranging from "not at all", "somewhat" and "very much so". Subscale scores are calculated by summing the items included on a factor. The total score is the sum of both subscale scores. Permission has been taken from the author to use and translate this tool.

4. **Brief Personality Factor Inventory -10** [69](Richard Carciofo, 2007)**:**

   This is a 10-item scale that assesses the personality dimensions of the participant based on the Big Five Factor Model of Personality. Each item scores from 1-5 and total score ranges from 10-50. Final score is obtained by adding all 10 items. Every item has 1-5 Likert scoring ((1 –Strongly Disagree, 2-Disagree, 3-Neutral, 4-Agree,5-Strongly Agree) For item 1,7,3,4,5 Reversed scoring was done prior to computation. The Domains covered include Extraversion, Agreeableness, Conscientiousness, Neuroticism & Openness to Experience. It is an open access tool.

5. **Acceptance and Action Questionnaire-II** [70](Bond et al., 2011)**:**

   This is a 7-item scale that measures the psychological inflexibility of the participant. Each item has score from 1-7 and total score ranges from 7 –49. Final score is obtained by adding 7 items. Each item has 1-7 Likert scoring ranging from 1 never true to 7 always true (Domain: Acceptance, Psychological Flexibility, Experiential Avoidance) More the score more is the psychological inflexibility of the participant. Cronbach's alpha is 0.92 for this scale. It is an open access data tool.

6. **Coping Behaviour Assessment Scale (Indian Adaptation)** [71](Gaukaran Janghel, 2017)**:**

   This scale is a 28 item self-report questionnaire is designed to measure various coping styles used by the respondent to cope with a stressful life event. It is rated by a two-point Likert scale. Response category is "YES" and "NO", for 'YES' response score '2' and for 'NO' response scores '1' is assigned.

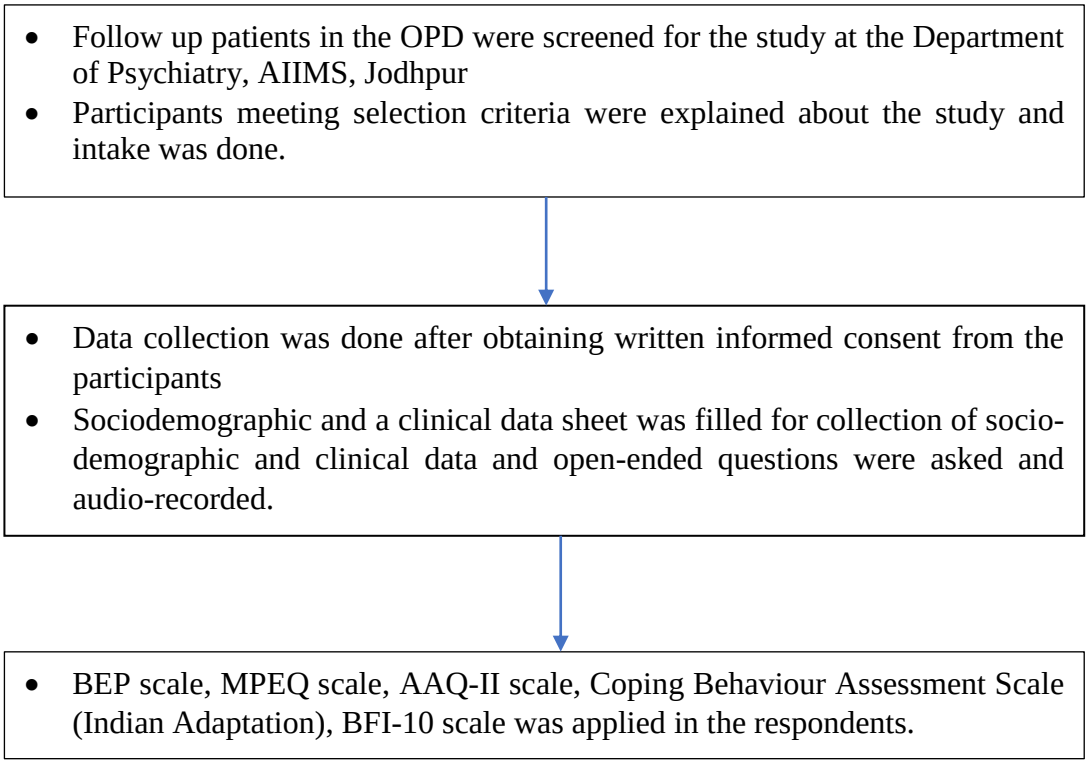
   14 dimensions are covered by this scale. These are self-distraction, active coping, denial, substance use, use of emotional support, use of instrumental support, behavioural disengagement, venting, positive reframing, planning, humour, acceptance, religion and self-blame. Every dimension has two items. Three subscales have been validated for this instrument divided into Avoidant Coping (Self Distraction, Substance Use, Denial, Behavioural Disengagement), Problem Focused Coping (Active Coping, Use of Informational Support, Positive Reframing, Planning) and Emotion Focused Coping (Emotional Support, Venting, Humour, Acceptance, Self-blame, Religion). It is an open access tool.

The WHO translation method cross-language equivalence procedure was followed to adapt the Hindi-version of the BEP, MPEQ, BFI-10 and AAQ-II scales. The tools were translated in Hindi, reviewed by an expert panel following which a refined version was back translated into English by an independent health professional not verse with the questionnaire.

Data Collection

Participants meeting selection criteria were explained about the study. Data collection was done after obtaining written informed consent from the proposed study participants. Sociodemographic and a clinical data sheet was filled for collection of sociodemographic and clinical data and open-ended questions were asked to the participants to assess their beliefs and expectations from psychotherapy as a treatment modality and audio recorded. BEP scale, MPEQ scale, BFI-10 scale, Coping Behaviour Assessment Scale (Indian Adaptation) and AAQ-II scale was applied in the respondents.

FLOWCHART OF THE STUDY



Ethical Considerations:

- Ethical Approval was granted from the institutional ethics committee
- Informed written consent was obtained from the study participants
- For the use of various scales and questionnaires and to translate the same in Hindi language, permission was sought from their respective authors
- Relevant clinical information revealed during the process of this study was communicated to the treating team of the patient
- There were no potential risks for the patients participating in the study

Data Analysis

The statistical package for social sciences (SPSS version 21, Chicago, US) was used to analyse the data. Demographic data, clinical variables, scores in the mentioned scales, Mean and standard deviation was calculated for the continuous variables and frequency and percentages was calculated for the ordinal or nominal variables. Shapiro Wilk Test was used to test for normality of the data and *p value* was found to be less than 0.05 suggestive of deviation from normal distribution. Since the data was not normal in distribution, non-parametric tests were used for analysis. Comparison of variables based on ordinal or categorical data was done by Mann U Whitney and Kruskal Wallis test accordingly. Spearman's correlation (*rho*) was used to assess correlation. After checking for the essential assumptions, Simple and Multiple Linear Regression was applied to check for the strength of association between the continuous variables with significant correlation with the primary outcome variable. The *p value* less than 0.05 was deemed significant.

RESULTS

A total of 304 patients participated in the study. Sociodemographic and clinical details were recorded and scores on Belief in the Efficacy of Psychotherapy Scale (BEP), Milwaukee Psychotherapy Expectations Questionnaire (MPEQ), Brief Factor Inventory (BFI-10), Coping Behaviour Assessment Scale and Acceptance and Action Questionnaire (AAQ-II) were obtained.

Descriptive Statistics

Sociodemographic Variables

The study population consisted of 150 males & 154 females. The majority (69.7%) of the respondents belonged to the urban background, were married (61.7 %), Hindus (98.7%) and belonged to nuclear families (79.9%), had studied up to graduation (38.8%) or high school (34.5%), were employed (41.1 %) and belonged to Lower Middle (58.2%) socioeconomic strata as per Modified Kuppuswamy Scale (Table 1A).

Table 1A: Descriptive Statistics of Socio-Demographic Variables

Variable		Frequency	Percentage
Sex			
	Male	150	49.3
	Female	154	59.7
Residence			
	Urban	212	69.7
	Rural	92	30.3
Education			
	Primary School	12	3.9
	High School	105	34.5
	Graduate	118	38.8
	Postgraduate & above	69	22.7
Marital Status			
	Married	186	61.2
	Single	118	38.8
Family Type			
	Nuclear	243	79.9
	Joint	61	20.1
Employment			
	Employed	125	41.1
	Household	95	31.3
	Unemployed	84	27.6
Socioeconomic Status			
	Upper	13	4.3
	Upper-Middle	96	31.6
	Lower-Middle	177	58.2
	Upper Lower	8	2.6
	Lower	10	3.3

The majority of the respondents had a diagnosis of a depressive disorder (48.4%) which included Major Depressive Disorder, Dysthymia as well as Bipolar Depression. A significant (41.4 %) had a diagnosis belonging to the neurotic, stress-related, or somatoform diagnostic category. The rest of the respondents belonged to substance use disorders (5.9%), Personality Disorders (3.3%), and Sexual Disorders (1 %) categories (Table 1B).

Table 1B: Descriptive Statistics of Clinical Variables

Variable	Frequency	Percentage
Diagnosis		
Substance Use Disorders	18	5.9
Depressive Disorders	147	48.4
Neurotic, Stress Related & Somatoform Disorders	126	41.4
Sexual Disorders	3	1.0
Personality Disorders	10	3.3
Prior Experience with Psychotherapy		
Structured	72	23.7
Unstructured	141	46.4
No Prior Experience	91	29.9
Therapy Administered By		
Psychiatrist	194	63.8
Psychologist	19	6.3
Family History		
Yes, With Therapy Experience	13	4.3
Yes, Without Therapy Experience	43	14.1
None	248	81.6

The mean age of the study population was 31.3 ± 9.4 years with a maximum age of 58 years and a minimum age of 18 years. The mean duration of illness was 52.84 ± 57.48 months with a maximum duration of 300 months and a minimum of 0.75 months. The mean duration of treatment was 11.92 ± 21.63 months, with a maximum of 144 months and a minimum of 0.23 months. The mean number of follow-ups at the study facility was 5.32 ± 5.03 (Table 1C)

Table 1C: Descriptive Statistics of Continuous Variables

Variable	Mean± SD	Median	Range (max-min)
Age	31.30 ± 9.44	29.00	40 (18-58)
Duration of Illness	52.84 ± 57.48	36.00	299.25 (0.75-300)
Duration Of Treatment	11.92 ± 21.63	3.00	143.77 (144-0.23)
No of Follow ups at The Facility	5.32 ± 5.03	4.00	39 (40-1)

Summary of Measures for Psychological Assessment

Table 2 summarises the mean BEP scale scores reflecting the study population's belief in the efficacy of psychotherapy. The mean BEP score was 49.73 ±7.63. The scale has a maximum score of 65.

The Mean MPEQ score was 107.00 ± 16.90. The mean score on the Role Subscale was 65.04 ± 10.80 and the Outcome subscale was 41.95 ± 7.40. The maximum possible score on the MPEQ is 130 divided into Role (80) and Outcome (50) expectations.

The mean scores on the Brief Factor Inventory-10 (BFI-10) are summarized in the table 2. The mean scores on all 5 dimensions of the five-factor model of personality were Openness (6.25 ± 1.35), Conscientiousness (6.28 ± 1.77), Extraversion (5.97 ± 2.11), Agreeableness (6.83 ± 1.85) and Neuroticism (6.70 ± 2.07).

The respondents reported "YES" or "NO" responses on the Coping Behaviour Assessment Scale-Indian Adaptation that were coded as "2" or "1" respectively for computing scores. The mean scores for the study population for Avoidant coping was 1.46 ± 0.21, Emotion Focused coping score was 1.52 ± 0.15 and Problem Focused coping had a score of 1.61 ± 0.21. This reflects that the overall the study population has been using Problem Focused and Emotion Focused Coping Styles more than Avoidant Coping.

The mean score for AAQ-II scale was 32.65± 9.95.

Table 2: Mean Scores of Psychological Measures

Scale	Mean ± SD	Median	IQR
BEP	49.73 ± 7.63	50	10
MPEQ Total	107.00 ± 16.90	108	28
MPEQ Role	65.04 ± 10.80	66	18
MPEQ Outcomes	41.95 ± 7.40	44	13
Brief Factor Inventory -10			
Openness	6.25 ± 1.35	6	1
Conscientiousness	6.28 ± 1.77	6	2
Extraversion	5.97 ± 2.11	6	3
Agreeableness	6.83 ± 1.85	7	2
Neuroticism	6.70 ± 2.07	7	2
Coping Scale Behaviour Scale – Indian Adaptation			
Avoidant Coping	1.46 ± 0.21	1.50	0.37
Problem Focused Coping	1.61 ± 0.21	1.62	0.25
Emotion Focused Coping	1.52 ± 0.15	1.50	0.25
AAQ-II	32.65± 9.95	34	14

Association of Variables with Sociodemographic Factors

The variables of the study were compared according to the various sociodemographic factors in the study.

As shown in Table 3A, there was no significant difference amongst the variables across either of the sexes except for coping. Males seemed to be significantly using more avoidant coping methods as compared to Women (*p<0.001)*

Table 3A: Comparison of Variables according to Sex (Mann Whitney U test)

	Mean rank		**Test statistic**	***p* value**
	Female (N=154)	**Male (N=150)**		
BEP	147.61	157.27	12,824	0.338
MPEQ	151.06	153.90	11,766	0.778
MPEQ-Role	149.84	155.09	11,949	0.602
MPEQ-Outcomes	156.79	148.32	10.907	0.399
Brief factor inventory -10				
Openness	153.92	151.11	11,336	0.771
Conscientiousness	154.61	150.45	11,234	0.675
Extraversion	144.54	160.25	12,743	0.115
Agreeableness	153.54	151.49	11,394	0.836
Neuroticism	155.94	148.97	12,079	0.485
Coping Behaviour Assessment Scale				
Avoidant Coping	134.46	171.02	8,771	**<0.001**
Problem Focused coping	149.53	155.55	11,092	0.545
Emotion Focused Coping	146.19	158.98	10,578	0.199
AAQ-II	160.68	144.10	12810	0.100

When compared between urban and rural groups, the people residing in urban setups seemed to have significantly higher scores on the BEP scale (*p=0.003*) when compared to people from rural backgrounds. A significantly higher AAQ-II scores were also seen in the urban population as compared to the rural population (*p=0.04*) suggesting a higher psychological inflexibility in the urban population. (Table 3B)

Table 3B: Comparison of Variables according to Residence

(Mann Whitney U test)

	Mean Rank		**Test Statistic**	***p* value**
	Urban (N=212)	**Rural (N=92)**		
BEP	162.46	129.55	7,641	**0.003**
MPEQ	156.57	143.13	8890	0.221
MPEQ-Role	158.98	137.57	8,378	0.051
MPEQ-Outcomes	152.79	151.83	9,690	0.930
Brief Factor Inventory-10				
Openness	148.92	160.76	10,511	0.259
Conscientiousness	149.49	159.43	10,390	0.356
Extraversion	153.32	150.61	9,578	0.802
Agreeableness	154.00	149.04	9,433	0.645
Neuroticism	157.04	142.03	8,789	0.167
Coping Behaviour Assessment Scale				
Avoidant Coping	149.68	159	10,350	0.388
Problem Focused coping	148.45	161.83	10,610	0.216
Emotion Focused Coping	150.17	157.86	10,245	0.478
AAQ-II	162.13	130.31	7,710	**0.04**

The population was also compared for differences as per the marital status. As shown in table 3C, single people were found to have significantly higher BEP scores (*p=0.003*) showing a higher belief in the efficacy of psychotherapy as compared to married population. However, no significant difference was found in the MPEQ scores. When personality dimensions were compared, Open-ness was found to be higher in married people (*p=0.048*) and neuroticism was found to be higher in single population. *(p<0.001).* It was also seen that married people significantly used more avoidant coping styles (*p=0.008*) while single people used more problem focused coping methods *(p<0.001).*

Table 3C: Comparison of Variables according to Marital Status

(Mann Whitney U test)

	Mean rank		**Test statistic**	***p* value**
	Single (N=118)	**Married (N=186)**		
BEP	171.39	140.51	8,744	**0.003**
MPEQ	159.16	148.28	10,188	0.293
MPEQ-Role	164.47	144.91	9,562	0.058
MPEQ-Outcomes	149.18	154.61	11,366	0.597
Brief Factor Inventory-10				
Openness	140.56	160.08	12,383	**0.048**
Conscientiousness	147.14	155.90	11,606	0.389
Extraversion	149.16	154.62	11,368	0.593
Agreeableness	154.87	148.77	11,414	0.600
Neuroticism	175.25	138.06	8,289	**<0.001**
Coping Behaviour Assessment Scale				
Avoidant Coping	136.05	162.94	12,915	**0.008**
Problem Focused coping	175.28	138.05	8,285	**<0.001**
Emotion Focused Coping	160.89	147.17	9,983	0.179
AAQ-II	154.86	151.00	10,695	0.709

When compared across different categories of education level (Table 3D), Kruskal Wallis test revealed that BEP scores were significantly different across the categories ($p<0.001$) with post-hoc analysis revealing significantly higher scores in higher education levels with the difference being significant between primary school and post-graduate (adjusted $p=0.012$), high school and graduate (adjusted $p=0.012$) and high school and post-graduate (adjusted $p<0.001$) pair of categories. Higher MPEQ scores were found in higher education levels ($p=0.001$) with the difference being significant in high school and post graduate pairs (adjusted $p=0.001$). Higher Role ($p=0.001$) as well as Outcome ($p=0.007$) expectations were seen in higher education levels. Both Role (adjusted $p= 0.002$) as well as Outcome (adjusted $p=0.007$) expectations were found to be significantly different between high school and post graduate levels. Extraversion was found to be significantly higher in higher education categories ($p=0.003$). Avoidant coping was found to differ significantly across the categories ($p=0.005$) with post hoc analyses revealing significant difference between high school and post graduate (adjusted $p=0.028$) and graduate and post graduate (adjusted $p=0.03$) categories. This suggests that avoidant coping was used in higher proportions in people studied up to graduate and high school as compared to post graduates.

Table 3D: Comparison of Variables according to Education

(Kruskal Wallis Test)

		Mean Ranks (df=3)				
	$\chi 2$	**Primary School (N=12)**	**High School (N=105)**	**Graduate (N=118)**	**Post Graduate & Above (N=69)**	***p value***
BEP	30.50	1	2	3	4	**<0.001**
MPEQ	17.27	1	2	3	4	**0.001**
MPEQ-Role	15.63	1	2	3	4	**0.001**
MPEQ-Outcomes	12.04	1	2	3	4	**0.007**
Brief Factor Inventory -10						
Openness	2.09	3	2	4	1	0.553
Conscientiousness	4.66	3	2	1	4	0.198
Extraversion	14.26	1	2	3	4	**0.003**
Agreeableness	7.15	1	2	3	4	0.067
Neuroticism	7.67	4	1	3	2	0.053
Coping Behaviour Assessment Scale						
Avoidant Coping	12.70	2	4	3	1	**0.005**
Problem Focused coping	2.49	1	3	2	4	0.476
Emotion Focused Coping	5.36	1	4	3	2	0.147
AAQ-II	1.09	4	1	2	3	0.778

Since the number of participants belonging to other religions were limited (n=4), the analysis was not performed for the group.

When compared as per family type, there was no significant difference in the BEP scores. However, people belonging to joint families were found to have a higher outcome expectation (*p=0.030*). Higher extraversion was seen in people from nuclear families (*p=0.042*). People from joint families were found to be significantly using more avoidant coping styles (*p=0.07*) (Table 3E)

Table 3E: Comparison of Variables according to Family Type

(Mann Whitney U test)

	Mean Rank		**Test Statistic**	***p* value**
	Nuclear (N=243)	**Joint (N=61)**		
BEP	154.91	142.90	6,826	0.340
MPEQ	148.58	168.11	8,364	0.121
MPEQ-role	149.83	163.14	8060.5	0.290
MPEQ-outcomes	147.04	174.25	8738	**0.030**
Brief Factor Inventory-10				
Openness	152.13	153.96	7500	0.879
Conscientiousness	151.30	157.29	7703.5	0.628
Extraversion	157.57	132.30	6,179	**0.042**
Agreeableness	146.14	177.84	8,957	0.10
Neuroticism	152.10	154.08	7,508	0.874
Coping Behaviour Assessment Scale				
Avoidant Coping	145.81	179.15	9,073	**0.007**
Problem Focused coping	150.78	159.36	7,830	0.489
Emotion Focused Coping	148.76	170.17	8,489	0.075
AAQ-II	153.40	148.93	7,193.5	0.722

Across different categories of employment, no significant difference was seen in BEP scores or MPEQ scores across the three subgroups. Significant difference was seen in the Extraversion (*p=0.009*) and Neuroticism (*p=0.008*) dimensions of personality. Significant difference was also seen for Problem Focused Coping (*p=0.004*). Post Hoc Analysis revealed higher Extraversion in the employed group (adjusted *p=0.007*) as compared to the unemployed group. A higher neuroticism was found in the unemployed group (adjusted *p=0.008*) as compared to the employed group. Problem focused coping was seen more in unemployed group as compared to household group (*adjusted p=0.003*) (Table 3F).

Table 3F: Comparison of Variables according to Employment

(Kruskal Wallis Test)

	$\chi 2$	**Mean Rank (df=2)**			***p* value**
		Employed (N=125)	**Unemployed (N=85)**	**Household (N=94)**	
BEP	1.642	2	3	1	0.440
MPEQ	5.633	1	2	3	0.060
MPEQ-role	4.789	1	2	3	0.091
MPEQ-outcomes	4.342	1	2	3	0.114
Brief Factor Inventory-10					
Openness	4.008	2	1	3	0.135
Conscientiousness	0.147	2	1	3	0.929
Extraversion	9.449	3	1	2	**0.009**
Agreeableness	0.446	2	1	3	0.800
Neuroticism	9.546	1	3	2	**0.008**
Coping Behaviour Assessment Scale					
Avoidant Coping	3.250	3	1	2	0.197
Problem Focused coping	11.191	2	3	1	**0.004**
Emotion Focused Coping	0.948	2	3	1	0.622
AAQ-II	2.735	1	3	2	0.255

Significant difference was found in BEP scores (*p<0.001*), Openness (*p=0.003*), Extraversion (*p<0.001*), Agreeableness (*p=0.001*) and Problem Focused Coping (*p=0.029*) when compared across different categories of socioeconomic strata. Post Hoc Analyses revealed that BEP scores were higher in lower (*adjusted p=0.009*), lower middle (*adjusted p<0.001*) and upper middle (*adjusted p = 0.006*) categories as compared to the upper socio-economic strata. Higher openness was found in Lower middle as compared to Upper middle population (*adjusted p=0.005*), Higher Extraversion was seen in Lower (*adjusted p<0.001*), Upper Lower (*adjusted p=0.032*), Upper Middle (*adjusted p<0.001*) and Lower Middle (*adjusted p=0.002*) categories as compared to Upper socioeconomic strata. Agreeableness was higher in Lower socioeconomic category as compared to Upper middle (*adjusted p=0.025*), Lower Middle (*adjusted p=0.003*) as well as Upper (*adjusted p=0.024*) Socioeconomic strata. Higher Problem focused coping was found in Upper category as compared to upper lower category (*adjusted p=0.021).* This is suggestive of a higher belief in the efficacy of psychotherapy in the lower or middle socioeconomic categories as compared to the upper socioeconomic categories along with a higher degree of openness, extraversion as well as agreeableness. (Table 3G)

Table 3G: Comparison of Variables according to Socioeconomic Status

(Kruskal Wallis test)

		Mean Ranks (df=4)					
	$\chi 2$	**Lower (N=10)**	**Upper - Lower (N=8)**	**Lower Middle (N=177)**	**Upper Middle (N=96)**	**Upper (N=13)**	***p value***
BEP	26.87	5	3	2	4	1	**<0.001**
MPEQ	1.05	2	4	3	5	1	0.901
MPEQ-role	2.15	2	5	4	3	1	0.707
MPEQ-outcomes	2.71	4	2	3	5	1	0.606
Brief Factor Inventory-10							
Openness	16.33	4	2	5	1	3	**0.003**
Conscientiousness	7.24	1	2	3	5	4	0.124
Extraversion	22.37	5	4	3	2	1	**<0.001**
Agreeableness	17.60	5	4	3	2	1	**0.001**
Neuroticism	4.52	1	4	3	5	2	0.339
Coping Behaviour Assessment Scale							
Avoidant Coping	6.76	2	4	5	3	1	0.149
Problem Focused coping	10.79	1	3	2	5	4	**0.029**
Emotion Focused Coping	2.73	2	3	4	5	1	0.603
AAQ-II	5.92	3	4	2	5	1	0.205

When compared across different diagnostic categories, distribution of neuroticism was significantly different across the categories (*p=0.001*) with higher neuroticism seen in neurotic, stress related and somatoform disorder category as compared to substance use disorders (*adjusted p=0.032*) as well as depressive disorder category (*adjusted p=0.018*). (Table 3H)

Table 3H: Comparison of Variables according to Diagnostic Categories

(Kruskal Wallis Test)

		Mean Ranks (df=4)					
	χ^2	**Substance Use Disorders (N=18)**	**Depressive Disorders (N=147)**	**Neurotic, Stress Related and Somatoform Disorders (N=126)**	**Sexual Disorders (N=3)**	**Personality Disorders (N=10)**	***p value***
BEP	3.41	1	4	2	3	5	0.490
MPEQ	8.00	3	5	4	2	1	0.091
MPEQ-role	7.03	3	5	4	1	2	0.134
MPEQ-outcomes	8.60	2	5	4	3	1	0.072
Brief Factor Inventory-10							
Openness	7.36	4	2	3	5	1	0.118
Conscientiousness	6.02	5	3	2	1	4	0.197
Extraversion	3.58	4	3	2	1	5	0.466
Agreeableness	1.12	3	4	2	5	1	0.890
Neuroticism	18.27	1	2	3	4	5	**0.001**
Coping Behaviour Assessment Scale							
Avoidant Coping	2.29	3	5	4	1	2	0.683
Problem Focused coping	5.89	5	2	3	4	1	0.207
Emotion Focused Coping	6.86	5	4	3	1	2	0.143
AAQ-II	8.50	1	5	2	4	3	0.075

Patients were also compared as per the presence of prior psychotherapy experience and whether they were structured or unstructured interventions. BEP scores (*p<0.001*), MPEQ-role subscale scores (*p=0.028*), openness (*p=0.027*) and AAQ-II scores (*p=0.013*) were found to be significantly different across these categories. Post Hoc Analyses revealed that people who had experience with structured interventions had significantly higher beliefs when compared with both unstructured interventions (*adjusted p=0.003*) as well as those who had no prior experience with psychotherapy (*adjusted p<0.001*). People who were exposed to unstructured interventions had higher role expectations (*adjusted p=0.048*) as compared to people with no prior experience. A higher degree of openness was found in people with exposure to unstructured interventions as compared to people with no prior experience (*adjusted p=0.033*). A higher degree of psychological inflexibility was found in people exposed to no prior psychological interventions as compared to people with exposure to unstructured interventions (*adjusted p=0.010*). (Table 3I)

Table 3I: Comparison of Variables according to Prior Experience with Psychotherapy (Mann Whitney U test)

		Mean Ranks (df=2)			
	$\chi 2$	**Structured Psychotherapy (N=72)**	**Unstructured Psychotherapy (N=141)**	**No Prior Experience (N=91)**	***p value***
BEP	3.41	3	2	1	**<0.001**
MPEQ	0.22	3	2	1	0.221
MPEQ-role	7.03	3	2	1	**0.028**
MPEQ-outcomes	8.60	3	1	2	0.528
Brief Factor Inventory-10					
Openness	7.36	2	3	1	**0.027**
Conscientiousness	6.02	1	3	2	0.124
Extraversion	3.58	2	1	3	0.906
Agreeableness	1.12	3	1	2	0.071
Neuroticism	18.27	3	1	2	0.051
Coping Behaviour Assessment Scale					
Avoidant Coping	2.36	1	3	2	0.306
Problem Focused coping	4.18	3	2	1	0.123
Emotion Focused Coping	1.65	3	2	1	0.438
AAQ-II	8.50	2	1	3	**0.013**

When compared by the type of professional who administered the prior psychotherapy, it was seen that people with exposure to a psychologist administered psychotherapy had higher BEP scores (*p=0.001*) , higher MPEQ-outcome subscale scores (*p=0.032*) and higher problem focused coping scores (*p=0.013*) compared to those who were exposed to a psychiatrist administered psychotherapy suggesting higher beliefs in the efficacy of psychotherapy, higher expectations of an active role during therapy and more usage of problem focused coping styles as compared to the other group. (Table 3J)

Table 3J: Comparison of Variables according to Prior Psychotherapy administered by

	Mean Rank		**Test Statistic**	***p value***
	Psychiatrist (N=194)	**Psychologist (N=19)**		
BEP	102.59	152.08	2,699	**0.001**
MPEQ	104.53	133.29	2432.5	0.051
MPEQ-role	104.79	129.53	2,271	0.095
MPEQ-outcomes	104.19	135.74	2,389	**0.032**
Brief Factor Inventory-10				
Openness	105.99	117.32	2,039	0.420
Conscientiousness	107.96	97.24	1657.5	0.461
Extraversion	104.77	129.82	2276.5	0.087
Agreeableness	108.09	95.89	1,632	0.403
Neuroticism	104.59	131.63	2,311	0.065
Coping Behaviour Assessment Scale				
Avoidant Coping	108.24	94.37	1,603	0.342
Problem Focused coping	103.78	139.87	2,467.5	**0.013**
Emotion Focused Coping	106.10	116.18	2,017	0.490
AAQ-II	107.02	106.84	1,840	0.991

As per family history, the study population was compared with a presence or absence of family history of mental illness along with the presence or absence of therapy experience in the family member. It was found that BEP scores (*p=0.007*), MPEQ-role subscale scores (*p=0.049*) and conscientiousness (*p=0.043*) differed significantly across the three sub-groups. It was seen that people with a positive family history but without therapy experience had a significantly higher belief in the efficacy of psychotherapy when compared to people with no family history (*adjusted p=0.020*). However, role expectations were not found to be significantly different on post hoc analyses between the three sub-groups. A higher conscientiousness was found in people with family members who had a mental illness and were not exposed to any psychotherapy as compared to those who had a mental illness but had an experience with any psychotherapeutic intervention (*adjusted p=0.043*). (Table 3K)

Table 3K: Comparison of Variables according to Family History of Psychiatric Illness

		Mean Ranks (df=2)			
		Family History of Psychiatric illness			
	$\chi 2$	Present- With Therapy Experience (N=13)	Present - Without Therapy Experience (N=43)	Absent (N=248)	*p value*
BEP	9.83	3	2	1	**0.007**
MPEQ	4.19	3	2	1	0.123
MPEQ-role	6.03	3	2	1	**0.049**
MPEQ-outcomes	0.75	3	2	1	0.686
Brief Factor Inventory-10					
Openness	3.36	3	1	2	0.186
Conscientiousness	6.31	1	3	2	**0.043**
Extraversion	1.33	1	3	2	0.514
Agreeableness	4.49	1	3	2	0.106
Neuroticism	1.16	2	1	3	0.560
Coping Behaviour Assessment Scale					
Avoidant Coping	2.35	1	2	3	0.308
Problem Focused coping	4.59	3	2	1	0.100
Emotion Focused Coping	4.67	3	2	1	0.096
AAQ-II	1.83	1	3	2	0.399

Correlation between the continuous variables

Table 4 summarizes the correlation between the continuous variables of the study. It was found that BEP scores were significantly positively co-related with MPEQ scores (*p<0.001*) along with MPEQ-role (*p<0.001*) and MPEQ-outcome (*p<0.001*) subscales, Extraversion (p=0.004), Agreeableness (p=0.001), AAQ-II scores (*p=0.044*), problem focused coping *(p=0.013),* Duration of illness (*p=0.022*), Duration of treatment (*p=0.008*), and number of follow ups. (*p<0.001*). There was significant negative correlation between avoidant coping and BEP scores *(p<0.001).*

MPEQ scores were found to be positively correlated with. Openness (*p=0.019*) and Agreeableness (*p<0.001*), problem focused coping (*p=0.002*), Age (p=0.013), Duration of treatment (*p<0.001*) as well as Number of follow ups (*p=0.005*).

Role expectations were positively correlated with Openness (*p=0.007*), Agreeableness (*p=0.001*), as well as duration of treatment (p<0.001) and number of follow ups (*p<0.001*). Outcome expectations on the other hand positively correlated with Extraversion (*p=0.022*), Agreeableness (*p<0.001*), and Age (*p<0.001*). Problem focused coping correlated positively with both role (*p=0.007*) as well as outcome expectations (*p=0.005*).

Avoidant coping correlated positively with age (*p=0.007*). Problem Focused coping correlated positively with Extraversion (*p=0.003*).

Table 4: Correlation between continuous variables (Spearman's correlation)

	BEP	MPEQ	MPEQ-ROLE	MPEQ-OUTCOMES	Openness	Conscientiousness	Extraversion	Agreeableness	Neuroticism	Avoidant Coping	Problem focused Coping	Emotion focused Coping	AAQ-II	Age	DOI	DOT
MPEQ	0.386 **(<0.001)**	--														
MPEQ-ROLE	0.340 **(<0.001)**	0.956 **(<0.001)**	--													
MPEQ-OUTCOMES	0.391 **(<0.001)**	0.882 **(<0.001)**	0.717 **(<0.001)**	--												
Openness	-0.030 (0.604)	0.134 **(0.019)**	0.153 **(0.007)**	0.086 (0.134)	--											
Conscientiousness	0.050 (0.382)	-0.021 (0.717)	-0.049 (0.397)	0.010 (0.861)	-0.102 (0.075)	--										
Extraversion	0.163 **(0.004)**	0.085 (0.137)	0.040 (0.488)	0.131 **(0.022)**	0.006 (0.921)	0.208 **(<0.001)**	--									
Agreeableness	0.191 **(0.001)**	0.252 **(<0.001)**	0.198 **(0.001)**	0.294 **(<0.001)**	-0.035 (0.539)	0.132 **(0.021)**	0.222 **(<0.001)**	--								
Neuroticism	0.032 (0.580)	-0.056 (0.329)	-0.028 (0.626)	-0.079 (0.170)	-0.010 (0.868)	-0.274 **(<0.001)**	-0.149 **(0.009)**	-0.067 (0.245)	--							
Avoidant coping	-0.235 **(<0.001)**	0.003 (0.958)	0.010 (0.865)	0.026 (0.652)	0.045 (0.432)	-0.100 (0.081)	0.098 (0.087)	-0.159 **(0.005)**	0.033 (0.561)	--						
Problem focused coping	0.142 **(0.013)**	0.176 **(0.002)**	0.154 **(0.007)**	0.160 **(0.005)**	-0.084 (0.142)	0.130 (0.023)	0.168 **(0.003)**	0.190 **(0.001)**	-0.012 (0.841)	-0.124 **(0.031)**	--					
Emotion focused coping	0.010 (0.866)	-0.081 (0.158)	-0.101 (0.079)	-0.036 (0.532)	-0.107 (0.063)	0.123 **(0.032)**	0.067 (0.246)	0.013 (0.818)	-0.038 (0.513	0.220 **(<0.001)**	0.211 **(<0.001)**	--				
AAQ-II	0.166 **(0.044)**	0.069 (0.232)	0.068 (0.238)	0.077 (0.179)	-0.104 (0.71)	-0.230 **(<0.001)**	-0.108 (0.061)	-0.059 (0.308)	0.294 **(<0.001)**	0.050 (0.385)	-0.132 **(0.022)**	0.002 (0.979)	--			
Age	0.056 (0.322)	0.142 **(0.013)**	0.099 (0.084)	0.205 **(<0.001)**	0.081 (0.155)	0.123 (0.031)	0.075 (0.189)	0.103 (0.072)	-0.161 **(0.004)**	0.155 **(0.007)**	-0.105 (0.068)	-0.090 (0.881)	0.031 (0.584)	--		
DOI	0.130 **(0.022)**	0.013 (0.816)	0.064 (0.264)	-0.053 (0.348)	0.154 **(0.007)**	-0.078 (0.169)	-0.049 (0.390)	0.025 (0.658)	0.063 (0.273)	-0.070 (0.226)	0.004 (0.942)	-0.116 **(0.043)**	0.116 **(0.042)**	0.302 **(<0.001)**	--	
DOT	0.151 **(0.008)**	0.204 **(<0.001)**	0.268 **(<0.001)**	0.073 (0.199)	0.179 **(0.002)**	-0.155 **(0.006)**	-0.0425 (0.460)	0.001 (0.982)	-0.021 (0.714)	-0.032 (0.584)	-0.104 (0.069)	-0.112 (0.050)	0.097 (0.088)	0.132 **(0.021)**	0.438 **(<0.001)**	--
No of follow ups	0.199 **(<0.001)**	0.161 **(0.005)**	0.200 **(<0.001)**	0.079 (0.166)	0.102 (0.073)	-0.199 **(<0.001)**	0.034 (0.549)	0.025 (0.652)	-0.062 (0.275)	-0.075 (0.190)	-0.058 (0.316)	-0.067 (0.287)	0.177 **(0.001)**	0.177 **(0.002)**	0.379 **(<0.001)**	0.746 **(<0.001)**

REGRESSION ANALYSIS

Linear Regression:

Linear regression was conducted to examine the predictive value of all the variables which had a statistically significant association with Beliefs in the efficacy of Psychotherapy (BEP) scores ($p< 0.05$). Initially simple linear regression was used to assess which variables were significant predictors of BEP.

The AAQ-II scores were found to have significant positive correlation with BEP scores however, when the study population was analysed separately by dividing into groups as per prior experience with psychotherapy, this association did not hold true. Hence AAQ-II scores have not been included in the regression model. The other variables that had significant correlation with BEP scores were included in the regression model.

The results showed that Extraversion (B=0.650, t=3.17, p=0.002), Agreeableness (B=0.710, t=3.04, p=0.003), Avoidant coping (B=-7.637, t=-3.813, p<0.001), Problem Focused coping (B= 4.802, t=2.390, p=0.017), Duration of Illness (B=0.016, t=2.102, p=0.036) and Duration of treatment (B=0.092, t=2.026, p=0.044) were significant predictors of BEP scores. Hence these variables were used for multiple regression analysis.

Multiple Linear Regression:

The following step involved performing a multiple linear regression analysis using the entry method to determine the impact of each of the aforementioned significant predictors, taken collectively, on the outcome variable i.e., BEP scores. The following assumptions must be true in order to do a multiple linear regression analysis.

a) The dependent variable and independent variables have a linear relationship.

b) The data do not exhibit multicollinearity.

c) The residual values are independent.

d) The residuals' variance is constant (homoscedasticity).

e) The residual values have a normal distribution.

f) The model does not contain any significant case biases.

The association between each independent variable and the result variable was linear, as demonstrated by scatter plots. Collinearity diagnostics were carried out to make sure that multicollinearity wasn't present. This assumption was implied by the variance inflation factor (VIF) scores, which were all below 10 and tolerance scores, which were over 0.1. The results of the Durbin-Watson statistic, which was calculated to evaluate the assumption that the residuals' values are independent, were in the range of 1 to 3, suggesting that this assumption was not broken. To evaluate the presumption that the variance of the residuals was constant, scatterplots were developed (homoscedasticity). The assumption of homoscedasticity was satisfied because the plots did not exhibit any signs of funnelling. To evaluate the supposition that the residual values are distributed normally, a P-P plot was made. The plots showed no evidence of this presumption being broken. To make sure that no significant cases were skewed the model, Cook's distance values were calculated. All values were below 1, indicating that the model was not being overly affected by specific cases.

Multiple Regression Analysis

Table 5A: Model Summary

Model	R	R^2	Adjusted R^2	Std Error of the Estimate	Durbin Watson
1	0.337	0.114	0.096	7.260	1.718

Table 5B: ANOVA

Model	Sum of Squares	df	Mean Squares	F	*P*
Regression	2011.93	6	335.32	6.361	<0.0010
Residual	15655.48	297	52.71		
Total	17667.41	303			

The model as a whole was significant to predict beliefs in the efficacy of Psychotherapy (BEP): F (7,296) = 6.361, p-value < <0.0011 as shown by ANOVA table (Table 6B). The R^2 for the overall model was 11.4 % with an adjusted R^2 of 9.6 %, a small to medium effect size is reported by the model of variations in beliefs in

the efficacy of psychotherapy, which is accounted for by the linear combination of the predictor variables (Extraversion, Agreeableness, Avoidant Coping, Problem Focused Coping, Duration of Illness and Duration of Treatment).

Table 5C: Multiple Regression Coefficient

Variable	Unstandardized Co-efficient		Standardized Co-efficient	t	Sig.	95% C.I.	
	B	S. E	Beta			Lower Bound	Upper Bound
(Constant)	46.31	4.843		9.563	<0.001	36.787	55.852
Duration of Treatment (DOT)	0.037	0.022	0.106	1.678	0.094	-0.006	0.081
Duration of Illness (DOI)	0.009	0.008	0.073	1.172	0.242	-0.007	0.026
Extraversion	0.496	0.205	0.137	2.423	**0.016**	0.093	0.900
Agreeableness	0.386	0.235	0.094	1.645	0.101	-0.076	0.850
Avoidant Coping	-6.249	1.980	-0.175	-3.156	**0.002**	-10.146	-2.353
Problem Focused Coping	3.713	2.002	0.127	2.261	0.065	-0.227	7.654

In the final model, the independent variables that were statistically significant were Extraversion (B = 0.496, *t*-value = 2.423, *p*-value = 0.016) and Avoidant Coping (B = -6.429, *t*-value = -3.156, *p*-value = 0.002). (Table 6C)

Interpretation of the multiple linear regression for BEP scores:

a. The positive slope (B) for Extraversion (0.496) as a predictor of Beliefs in the efficacy of Psychotherapy indicated that there are 0.496 units higher mean BEP scores with one unit increase of Extraversion. In other words, the increase in Extraversion increases BEP scores. The Semi Partial Co-efficient (SR^2) of Extraversion was 0.017, indicating that 1.7 % of the variance in BEP scores is uniquely accounted for by Extraversion.

b. The negative slope (B) for Avoidant Coping (-6.429) as a predictor of Beliefs in the efficacy of Psychotherapy indicated that there are 6.429 units lower mean BEP scores with one unit increase in Avoidant Coping. In other words, the presence of Avoidant

Coping reduces BEP scores. The Semi Partial Co-efficient (SR^2) of Avoidant Coping was 0.029, indicating that 2.9 % of the variance in BEP scores is uniquely accounted for by Avoidant Coping.

Highest variance contributor: Avoidant Coping

Qualitative variables

Participants were asked various questions regarding their understanding of psychotherapy and their responses were recorded. Several themes were identified and have been reported here to add to the understanding of the results.

Q1: What do you think should be discussed during counselling/psychotherapy? (Like family issues, personal issues, and some confidential information)

Approximately 45 % of the respondents reported that "feelings and thoughts" should be discussed during psychotherapy or counselling. These patients understood psychotherapy as an endeavour to talk about what preoccupies their minds and as an outlet to their emotions. About 35 % of the study population felt that specific problems and stressors "what bothers them" at the moment or cross-sectionally in life should be discussed and explored at length while they are in counselling. About 15 % thought psychotherapy or counselling to be similar to an elaboration about "signs and symptoms" that afflict the patient, and an additional 1% thought it to be a process of history taking followed by generic advice given on lifestyle changes and perceived it to be synonymous with the word "counselling". (Table 5A)

Table 6A: Perceptions on the perceived components of psychotherapy/counselling

Perceptions	Frequency	Percentages
Discussion about feelings & thoughts	136	44.73
History taking, advice about lifestyle	11	3.61
No idea	4	1.31
Discussion about problems & stressors	107	35.19
Discussion about symptoms	46	15.13
Total	304	100

Q2: Which do you prefer medicine only/ talk therapy or counselling/ both for the treatment of your illness? Why?

Around 43 % of the participants reported that they would prefer both medications and psychotherapy as they perceived that medicine has a role to play in controlling the

acute symptoms while talking would help reduce the burden of the mind and did not have a clear preference of one over the other. Similarly, around 21% of the study population felt that while medication resolves symptoms, talking will help achieve solutions to their "problems" and identified psychosocial issues as a primary cause of their symptomatology. Around 10 % felt that talking in counselling is a way of changing "thought patterns" so as to reduce "negative thinking", "unhelpful recurrent thoughts" or "worries". About 18% reported concerns about the side effects of medication and reported having a clear preference for "counselling" over medication as they considered that medication use can have "long lasting" or "permanent" side effects on their body. About 5 % considered counselling to be a long-lasting solution to their presenting problems while medication use was considered to be a short term or temporary solution. (Table 5B)

Table 6B: Perceptions on the perceived comparative preference between medication and psychotherapy

Perceptions	Frequency	Percentage
Both, medication helps in symptoms, talking helps in changing thought patterns	32	10.5
Both, medication helps in symptoms, talking helps in gaining solutions to problems	65	21.4
Both, medication helps in symptoms, talking helps in understanding of illness	3	1.0
Both, medication helps in symptoms, talking helps reducing burden in the mind	130	42.8
Counselling, due to concern for side effects with medication	56	18.4
Counselling, medication is short term solution, counselling is long term	14	4.6
I don't know	4	1.3
Total	304	100

Q3: What should be your role in counselling / psychotherapy?

A staggering 62.5 % of the study population reported that they expected to follow the advice given by their treating doctors as a part of psychotherapy/counselling. "I will follow whatever my doctor says or asks me to do" was the most consistent response

reflecting the above pattern. About 31 % reported that they expected to be able to express their thoughts and feelings freely during the counselling session as a way of "venting" or "letting out what bothers me" to be the primary role they would have to play as a part of psychotherapy. About 5% said they expected to elaborately talk about their problems and stressors freely as they felt "we can share what we can't tell anyone else" in the session. (Table 5C)

Table 6C: Perceptions of perceived expected role during psychotherapy/counselling

Perceptions	Frequency	Percentage
I will elaborate on problems and stressors freely	15	4.9
I will express thoughts & feelings freely	95	31.3
I will follow advice given by the doctor	190	62.5
I don't know	4	1.3
Total	304	100

Q4: How can a doctor help you in counselling? What are your expectations from the doctor?

About 42 % of respondents reported that they expected their doctor to provide them with easy and plausible solutions to their presenting problems and/or stressors. 30 % of the participants expected their doctor or counsellor to "listen with interest or patience," i.e., in a sense, practice active listening, which seemed to be an essential factor that provided them comfort as well as seemed to foster a positive therapeutic relationship as per the patients. About 26 % expected their doctor to "express empathy and be polite" which as per many was lacking in many of the clinical settings that the study participants had encountered. (Table 5D)

Table 6D: Pattern of perceived roles of the therapist/doctor in psychotherapy

Perceptions	Frequency	Percentage
Doctor should be empathetic & polite	80	26.3
Doctor should give solutions to problems	128	42.1
I don't know	4	1.3
Doctor should listen with interest & patience	92	30.3
Total	304	100

Q5: How was your past experience with therapy?

Thirty percent of patients did not have any prior experience with psychotherapy. Twenty-three percent of patients reported that they felt that psychotherapy or counselling helps them to "relax" and felt that it was a good recurring way to feel better. About 19% felt that counselling had helped them to deal or cope with their problems in a better way. Around 6% felt that they had better confidence after experiencing counselling, another 6% reported that they experienced lesser anxiety or worries due to the effects of counselling and an additional 6 % said they understood better about their illness as a result of being counselled. Three percent of participants also reported to have gained a "better understanding of self" as a result of psychotherapy. Two participants reported that counselling helped them to stay abstinent for substance use. (Table 5E)

Table 6E: Perceptions of perceived benefits of psychotherapy

Perceptions	Frequency	Percentages
Psychotherapy helped by improving the symptoms	17	5.6
Increased confidence as compared to previous self	19	6.3
Better coping with problems as compared to before	57	18.8
Therapy helps in gaining better understanding of self	9	3.0
Therapy helps in relaxation	70	23.0
Therapy helps by reducing the anxiety	18	5.9
No prior experience	93	30.6
No specific benefits	1	0.3
Understood better about illness due to counselling	18	5.9
Was able to stay abstinent from the drugs due to counselling	2	0.7
Total	304	100

DISCUSSION

The current study aimed to determine the association of Beliefs in the efficacy of Psychotherapy and Expectations from Psychotherapy and their correlation with Sociodemographic variables, Personality Traits, Coping Styles and Psychological Flexibility.

Role of sociodemographic variables

The current study found no differences between sexes when beliefs or expectations towards psychotherapy were compared. This is in contrast to what was found in a number of studies. [32, 33, 73] These studies found that women had better psychological help-seeking and more positive attitudes toward psychotherapy. These studies suggested that this difference is because women are more likely to engage in talking about their emotions as compared to men, who prefer quick solutions or practical ways to deal with their problems. These studies further highlighted that males might not seek help as often as women do because they are reluctant to participate in therapies when the main goal is emotional disclosure, even though men may benefit from emotional disclosure just as much as women. [73] Although a higher avoidant coping was found in men in our study, which supports the above hypothesis, this did not seem to affect their beliefs about the efficacy of therapy. The unique sociocultural background of the study population may be responsible for this finding. This may also be explained by the fact that 73 % of the males belonged to lower middle and lower socioeconomic categories, with higher beliefs and expectations as opposed to only 57 % of the females in the study population, which could have accounted for any gender variance. Further exploration is warranted to establish how the sex of the client affects these factors.

No correlation was found between age and beliefs in the efficacy of psychotherapy however, age correlated positively with role expectations. This is consistent with the literature. [10] This may be explained by the fact that older people expected to participate more in therapy than their younger counterparts from their experience of dealing with life issues and problems. Similarly, it has also been found that contrary to perceptions of older people being resistant to change, they want to change and feel

free to express and explore whatever they choose; a quality that has been described in the literature as their "personal agency" [74]

When compared between urban and rural groups, the people residing in urban areas seemed to have significantly higher beliefs in psychotherapy when compared to people from rural backgrounds. This could be explained by more access to and better awareness regarding psychological help in the urban population. People residing in rural areas have limited access to professional psychological help. Generally, they tend to depend on their immediate family members, friends, or the local village elders in times of stress. Bhargava et al. asserted that the limited resources, population size, and the widely prevalent stigma associated with seeking treatment for mental illnesses provide significant barriers to formal psychological therapies in rural populations.[65] Furthermore, 66.5% of the urban population had studied up to graduation or postgraduation in this study as opposed to 50% of the rural population. A higher education status might account for better awareness and possibly a higher psychological mindedness of the urban population which might have contributed to higher beliefs in the urban group.

Single people had a higher belief in the efficacy of psychotherapy than the married population. A higher avoidant coping in married people and a higher problem-focused coping in the single population could explain this finding. A higher avoidant coping contributed significantly negatively to the primary outcome variable (BEP scores) as per regression analysis and can explain the higher beliefs of single people. Besides, married people, from the virtue of having a partner, may have a lower perceived need for psychological help due to better social support provided by their spouse and family. The nature and importance of client's treatment expectations from couple therapy have been investigated in several qualitative studies. The majority of clients in these studies who were interviewed stated that they anticipated couple therapy to be helpful in achieving specific goals, had expectations for their behaviour that were well-defined, and anticipated delving deeply into personal issues while working together with their partners to address relationship issues. [75,76] However, no studies have been conducted comparing expectations between single and married people and between individual and couple therapy. Several barriers may exist to discussing marital issues, such as discordant initial expectations, role conflicts, or sexual

intimacy issues, especially in the Indian context, which may further contribute to the lesser beliefs and expectations from psychotherapeutic treatment in a married person.

Beliefs and expectations were higher in higher education categories, particularly in graduates and post-graduates and above. Highly educated people also had higher role and outcome expectations from psychotherapy. This finding contradicts the findings in a study by Vislă et al., which found no association between education and initial psychotherapy outcome expectations of the patients, and in another study by the same author, which found that lower pre-treatment outcome expectations were linked to higher educational status. [47, 77] A higher education status was also linked to a higher extraversion. It was also found that lower education was linked to higher use of avoidant coping. Both these findings highlight that individuals with a higher education status tend to be more confident, outgoing, and sociable than those who are less educated. On the other hand, lesser-educated people tend to use avoidant coping strategies, which include Self Distraction, Substance Use, Denial, and Behavioural Disengagement. These findings explain why people who have a higher education status hold more positive beliefs in the efficacy of Psychotherapy and also have higher role and outcome expectations, as they tend to be more extrovert and might accept "talking" as a method of psychological treatment more easily. Avoiding dealing with stress is more significant in people who are less educated in this study. This explains why they might not want to engage in psychotherapy or hold negative beliefs toward psychotherapeutic interventions. A higher education status has been found to be linked with better mental health literacy and attitudes toward psychological help-seeking. [78,79] On the other hand, a lower education status is found to be linked with a lower sense of mastery which also could be a contributory factor to the above findings. [80]

Higher outcome expectations were seen from Psychotherapy in People from Joint families, suggesting that people belonging to joint families have a higher expectation of achieving better outcomes with psychotherapy. They also had higher avoidant coping styles. However, people from nuclear families had a higher extraversion. This finding may be explained by the concept of the "transitional family" structure, which sociologists have defined as the defining feature of the current family structure in Indian society. According to Mullaiti, the family structure is a continuum, with

nuclear and joint families at each end. The transitional family sits in the middle of the spectrum and exemplifies the transformations in contemporary Indian culture. [81] Even if structurally nuclear, such transitional families may carry on as joint families. People belonging to joint families in this study can be considered transitional families in the modern context and this indicates a change from a highly hierarchical to a less hierarchical structure, from an emphasis on obedience to greater freedom and a greater emphasis on autonomy and self-identity. The advantages of a joint family system include tremendous emotional reliance on one another and a strong sense of closeness and commitment. However, the transition to a fully nuclear model is still in its early stages in Indian society, and the collectivistic attitudes of a transitional family may have contributed to the development of higher avoidant coping styles in such individuals.

No differences were seen in beliefs and expectations when compared as per employment status. However, a higher extraversion was seen in the employed group, while higher neuroticism was seen in the unemployed group.

A higher belief in the efficacy of psychotherapy was found in the lower socioeconomic strata compared to the upper socioeconomic categories. A higher extraversion, openness, and higher agreeableness in the lower socioeconomic categories may be contributory in this regard. Rosenstreich et al., in their review, highlighted that a significant cognitive dysfunction is brought on by financial restrictions, which may influence the failure or success of psychological therapy. Such problems show themselves as increased stress, a lack of self-control, and cognitive inflexibility. [82] In turn, these cognitive problems may impair the patient's capacity to engage in introspective self-examination, to identify and locate the resources needed to attain therapeutic goals, and to support adaptive behaviours. A higher problem-focused coping was found in the upper socioeconomic category in the current study, which supports this notion however, on the contrary, people from lower socioeconomic categories had a higher belief in the efficacy of psychotherapy along with indicators of being more extrovert, more open to experiencing new things as well as more cooperativeness in this study. This contrary finding can be explained by the fact that while only 6% of the study population belonged to the lower or lower middle socioeconomic categories, 69.7 % of the study population belonged to the urban

population and might have had better awareness and access to mental health services than anticipated and nearly 50% of the population was educated up to graduate or post-graduate level. This may reflect the dynamic shift modern Indian society is undergoing regarding urbanization and better access to education and the internet.

When compared across different diagnostic categories, no difference was seen in the beliefs or expectations of the patients towards psychotherapy which is consistent with existing literature. [41]

Prior psychotherapy experience significantly influenced the participant's beliefs and role expectations. People who had experience with structured interventions had significantly higher beliefs when compared with both unstructured interventions as well as those who had no prior experience with psychotherapy. People who were exposed to unstructured interventions had higher role expectations as compared to people with no prior experience. Both of these findings reflect that patient's experience of being in a therapy session significantly enhanced their positive beliefs and increased their expectations to participate more actively in therapy in the future. Constantino et al., in their study of socially anxious people, found that greater treatment satisfaction in people with prior psychotherapy experience was linked with higher outcome expectations in the participants.[11] Similar results were found in other studies. [83,84] A higher degree of openness in people with exposure to unstructured interventions compared to people with no prior experience explains a higher role expectation, as openness was found to have a significant positive correlation with role expectations in this study.

In this study, when compared as per the family history of psychiatric illness and exposure to psychotherapy in the family member, it was seen that people with a positive family history but without therapy experience had a significantly higher belief in the efficacy of psychotherapy when compared to people with no family history. It has been seen in a few studies that feedback regarding prior experiences and opinions, or attitudes from friends and family members, also influences expectations toward psychotherapy in a significant manner.[13] Thus, it may be hypothesized that people with family members who had a positive experience following therapy are likely to hold more positive beliefs as any reservations they

may hold against therapy might have been allayed by the positive experience their family member had and might encourage them to take up therapy.

Beliefs and Expectations towards Psychotherapy and its correlates

In our study, it was seen that BEP scores were significantly positively correlated with MPEQ scores along with MPEQ-role as well as MPEQ-outcome subscales. This parallels the statistically significant positive relationship between BEP and MPEQ ($r = .52$, $p < .001$) found by Volpe. Similarly, a significant positive correlation was found between BEP scores and Extraversion ($r = .16$, $p < .05$) and agreeableness ($r = .27$, $p < .001$) by Volpe, which was replicated in this study. [67]

Role of Personality

When the five-factor model of personality was considered in the study population, it was seen that extraversion and agreeableness correlated positively with beliefs in the efficacy of psychotherapy. It was also seen that people with a higher openness and agreeableness had higher overall expectations, as well as higher role expectations, and people with a higher extraversion and agreeableness had higher outcome expectations. This means that people who have these traits have a higher belief that psychotherapeutic interventions work. People that exhibit the aforementioned traits also anticipate becoming actively involved in the counselling process. This is consistent as found by Hatchett and Han, [20] Roland[85]and Schaub and Tokar.[86] Extraversion has been found to be linked to being sociable, fun-loving, affectionate, friendly, and talkative. These adjectives show that extraversion significantly increases a person's motivation for social interaction and may explain why these people may have higher beliefs and expectations from psychotherapy because they may find it easier to "talk" about their thoughts and feelings and to interact more actively with the therapist. [87] Similarly, agreeableness has been connected to being compassionate, kind, forgiving, and helpful. A higher agreeableness has also been found to be linked to higher cooperativeness. [88] According to Roland, agreeableness was associated with higher personal commitment, expectations of facilitative circumstances, counselling expertise, and nurturing behaviour by the therapist. [85] Such people can be hypothesized to be more diligent towards the therapy process. They may harbour higher beliefs in the efficacy of therapy as well as outcome expectations due to a

possibility of a higher level of individual responsibility. Openness has been defined as having a tendency towards a vivid imagination and fantasy life, being more receptive to inner emotional states and feelings, and having a higher level of intellectual curiosity. [89] The trait of openness, thus is likely to increase expectations from psychotherapy as it increases the inclination for exploring and learning new things. Such people might be curious about the possibilities therapy can offer them. They may want to play a central or active role in this exploration which explains higher role expectations.

Role of Coping Styles

There was a significant negative correlation between avoidant coping and BEP scores and a significant positive correlation with problem-focused coping. Problem-focused coping also correlated positively with expectations, i.e., role and outcome expectations.

This finding means that people who dealt with their problems using tactics such as self-distraction, substance use, denial, or behavioural disengagement had significantly lesser beliefs in the efficacy of psychotherapeutic interventions. This can reflect the tendency of such individuals to "avoid" dealing with their problems altogether. Such individuals may thus either deny that there is a problem to be discussed in therapy or may not believe that going to therapy or counselling is a valid method of dealing with the problem at hand. On the other hand, people with a higher problem-focused coping usually tend to believe that actively coping with an issue, using the information as a means of building support, positively reframing the problem, or planning on how to tackle the issue are better means of coping. These coping styles also reflect the methods various psychological interventions employ to help the patients deal effectively with their problems, for example generating alternative thought patterns or collaborating with the patient to develop an action plan to deal with their issues. Thus, such individuals are a good fit for psychological therapies as they already come from a demographic which believes in and uses these techniques in their lives and expect to enhance the same when they enter the therapy.

This finding has been inconsistent in literature, with limited studies directly assessing the role of coping styles on expectations and beliefs towards psychotherapy. For

example, Simon et al. found that people with active coping styles had higher recovery with CBT and attributed the same to higher homework compliance and better engagement in therapy. [50] However, Burns and Nolen-Hoeksema did not find this difference and emphasized that the coping styles of the client may not affect the suitability for CBT. Further studies may be required to explore the role of coping styles on client's beliefs and expectations for psychotherapy. [51]

The contribution of avoidant coping in belief in psychotherapy was significant in this study, with 2.9 % of the variance of BEP scores explained by avoidant coping when controlled for other correlates in regression analysis.

Role of Psychological Flexibility

AAQ-II scores correlated positively with BEP scores in this study. This means that people with higher psychological inflexibility had higher beliefs in the efficacy of psychotherapy. However, when people with no prior psychotherapy experience and people with prior psychotherapy experience were analysed separately, no such correlation was found in people who were not exposed to psychotherapy before. Contrary to what was found by Yasinski et al. [57] and Brandon et al. [54] in their studies, only a small difference was seen between the people who did not have any prior experience and people with exposure to unstructured interventions in this study. Moreover, the illness severity may also be a contributing factor toward psychological flexibility and has not been accounted for in this study.

Studies suggest that rigidity towards emotional experience reduces with higher psychological flexibility. [56] This means that people with greater psychological flexibility must have a greater capacity to endure intense or negative emotional experiences. However, the correlation between this aspect and the beliefs and expectations of people towards psychotherapy has not been studied. This hypothesis did not hold in our study.

Role of clinical variables

BEP scores correlated positively with the duration of illness, duration of treatment as well as the number of follow-ups at the study facility. The three factors also correlated positively with each other. This means that people with a longer duration of illness,

who were under treatment for longer periods and were under regular follow ups had higher beliefs in the efficacy of psychotherapy. A longer duration of treatment and a greater number of follow-ups was also found to be linked with a greater client role and outcome expectations, meaning that such individuals also expected to play a more active role during therapy and achieve better outcomes at the end of treatment as compared to people with a shorter duration of treatment or who were in the initial follow-ups at our facility. This may be reflective of a higher chance of being exposed to a psychological intervention when a patient is under treatment for a greater duration than someone who drops out of the treatment and thus also having more chances of their prior experiences contributing to their positive beliefs and expectations towards psychotherapy as discussed earlier.

Similarly, a higher belief in the efficacy of psychotherapy and higher expectations from therapy may also cause better client retention and contribute to a greater duration of treatment and number of follow-ups.

Qualitative data

The findings from the response to the open-ended questions add to the understanding of the beliefs and expectations of Indian patients towards psychotherapeutic treatment.

When asked about what they thought should be talked about in psychotherapy or counselling, a significant number of respondents expressed that "feelings and thoughts" should be discussed during psychotherapy or counselling. These patients saw psychotherapy as an opportunity to discuss their concerns and express their emotions. According to some participants, counselling sessions should include extensive discussion and exploration of the specific issues and stressors that trouble them right now or generally in their lives. A substantial number of people said they would prefer both medication and psychotherapy because they felt that talking would help ease their mental burdens while talking would help regulate their acute symptoms. They did not have a clear preference for one over the other. Similarly, some participants believed that while medication reduces symptoms, talking will help find answers to their "problems" and identified psychosocial problems as the primary contributor to their symptomatology. Remarkably, more than half of the participants

in the study said they anticipated following the recommendations or advice given by their doctors as part of psychotherapy or counselling. Similarly, a significant number of respondents said they expected their doctor to offer them quick, logical solutions to whatever difficulties or stressors they were now experiencing. A significant number reported counselling as a way of achieving relaxation or unburdening the mind of difficult thoughts and emotions. Those with prior experience with therapy reported that they perceived benefits such as reduced anxiety, improved confidence, and a better understanding of self due to psychotherapy.

These findings are consistent with those hypothesized by several authors. [62,63,65,66,] These findings suggest that although the study population preferred to keep a "problem or emotion-focused" discussion as a part of therapy or counselling, they expected their roles to be passive and expected their therapist to offer them advice and solutions rather than encourage discovery of the deep-rooted thought patterns and guide in modifying them as is ideally practiced.

Reddy conducted a study assessing the beliefs of Indian patients regarding the treatment of mental illness, keeping cultural aspects in mind, and found that psychotherapy was the least preferred treatment. Both patients, as well as their relatives, preferred drug or "electrical" treatments more as compared to psychotherapy. They also emphasized that people had a poor understanding of the psychoanalytic concepts and magico-religious and cultural beliefs heavily influenced the understanding of the participants about mental illness. [90]

Similarly, in a qualitative study on Indian immigrants and their therapists in Australia, Mathisen and Ledingham found that clients perceived that their understanding of counselling improved when they started their therapy, from almost no understanding of the concept to understanding that counselling involved talking to someone who listens to you without judgment. They reported that they found significant benefits from counselling in terms of gaining more strategies and changes in thoughts and feelings about themselves. They also reported that their culture represented a significant barrier in help-seeking and gender roles, language, stigma, and a mismatch between the client's culture and the therapist's awareness about it further impacts the therapeutic relationship. [91]

In another comparative study by Syed et al., it was found that Indians living in the UK had favourable attitudes towards western psychotherapy approaches than their counterparts living in India as well as the British participants. Participants with prior counselling experience reported, on the whole, more favourable attitudes about counselling. Furthermore, compared to the other two participant groups, Indians in India appeared to be less knowledgeable about Western counselling techniques. They emphasized that Indians living in Western nations may have greater opportunities to observe the effects of counselling and its methods and contrast them with those used in India. [83]

Due to a variety of reasons, such as the communal nature of the society, the availability of traditional support like visiting religious gurus, conducting religious rituals, and visiting holy sites, as well as a lack of knowledge about professional psychological treatment and a shortage of specialized mental health professionals to meet their needs, Indians rely on one another.[92] Moreover, Indians have a deep faith in mythology, superstitions, rituals, and the concepts of actions and duties, as is expected by sociocultural norms and religious doctrines. They also tend to look elsewhere for answers to their problems. This further maintains the belief that vocal expressiveness and the overt display of emotions are bad because they weaken interpersonal relationships and are indicators of weakness. It might be difficult for them to conduct an emotional investigation. This was called a "cultural defense" by Indian therapists in the past when they noticed it in their patients. [65,92,93]

Furthermore, in more collectivistic societies like our own, the self is defined in reference to others, with an emphasis on dependency, empathy, and reciprocity. It is challenging to use western psychotherapy in the setting of collectivism in India because it typically focuses on dynamic models, ego structure, and individual people. [64,94]

These factors may cause dependency on the authoritarian figures in the society for advice which may have translated into the expectations of playing passive, obedient roles and expecting psychological treatments to be more didactic in nature, as has been found in this study.

This is in line with the previous hypotheses in the literature that Indian patients might not be suitable for western psychotherapeutic approaches and effective indigenous approaches need to be developed for them. [60,62]

Neki gave one such approach. He called this a 'Guru Chela' relationship. As per this concept, the guru embarks on an in-depth journey of self-discovery with his Chela (his student) in order to liberate the student from all misery. The Guru-Chela relationship is different from the transference relationship in western psychotherapy. The Guru shows the way to liberation and makes himself available for use, unlike a therapist who might worry about transferences. [60]

Similarly, authors have compared the Gita to modern psychotherapies with components similar to both psychodynamic and cognitive behavioural approaches used by Krishna (Therapist), leading to psychic transformations in Arjuna (Patient). [95,96] Another approach from mythology that has been recommended is the "hanuman complex," in which the patient "Hanuman," who had lost his ability to fly owing to a curse after being reminded by Jambavan (the therapist), was able to realize his powers and is a widely prevalent belief in the Indian psyche. However, these approaches have not been explored empirically as part of research studies.[97]

Some suggestions have also been made in the literature for adapting the traditional CBT model to serve better Indian clients, including a philosophical or spiritual outlook inherent in the culture, the need for a holistic view, the inclusion of family and other close people in the treatment, and more elements of support and direction rather than Socratic dialogue or self-discovery. [98]

The cultural adaptation of western or traditional models of psychotherapy has been supported by several studies however most of these studies have been conducted in the migrant or non-indigenous population of developed countries, and original studies on such adaptations from the developing world are sparse. [99]

In India, the availability of professional services like counselling is still in its infancy and is limited to those who can afford them and reside in big cities. [100,101] Hence it is imperative to adapt the existing psychotherapeutic approaches to suit and cater to the Indian psyche, which can make the patients more receptive to psychological treatment in our resource-limited clinical settings.

Further research is warranted to explore the role of sociocultural determinants on the expectations and beliefs of Indian patients towards psychotherapy.

CONCLUSION

This study found that belief in the efficacy of psychotherapy was significantly higher in people with a higher extraversion and agreeableness and a problem focused coping style. On the other hand, it was significantly lesser in people with avoidant coping styles. This study also found that people belonging to urban areas, who are more educated, are single, have prior experience with psychotherapy and with a family history of mental illness have higher beliefs in the efficacy of psychotherapy. Extraversion and Avoidant Coping styles were found to have major contributions to these beliefs and the maximum variance was found to be because of avoidant coping.

Older population, those with higher openness and agreeableness, those who used problem focused coping styles, those who had a greater duration of treatment as well as number of follow ups had higher expectations from psychotherapy. Those with more openness had higher role expectations while those with more extraversion had higher outcome expectations. Higher agreeableness was found to increase both role as well as outcome expectations. People with exposure to unstructured interventions in the past, and those with family history of psychiatric illness with exposure to therapy had higher role expectations. People belonging to Joint families, older people and who had therapy experience administered by a psychologist had higher outcome expectations. Those with a higher education status had higher role as well as outcome expectations.

The aforementioned findings give an insight into a clinical and socio-demographic profile that maybe well suited for psychotherapeutic interventions in the Indian settings. Modifying the pre-treatment beliefs and expectancies of the client remains an important step towards possibly achieving better results in therapy and needs to be explored further in future research studies. Keeping sociocultural context in mind is a pre-requisite when selecting a patient for a particular psychological intervention and future research needs to explore these aspects further.

Strengths of the study

1. The study provides insight into the Indian client's psyche with respect to what they think about psychotherapy and its correlates.

2. The study had a large sample size and had equal representation from either of the sexes
3. The study was done in clinical settings where psychotherapeutic services are actively practiced and psychotherapy training is available
4. The study highlights the need to develop indigenous psychotherapy approaches that are suitable for the Indian population keeping the complex sociocultural contexts in mind

Limitations of the study

1. The study population had the majority of the people belonging to urban and educated backgrounds, which might not be representative of the majority of the demographic the clinical settings cater to.
2. Study population was heterogeneous regarding the duration of treatment and exposure to a psychiatric setting, which might have influenced the outcome.
3. Definition of psychotherapy was operationalized to include all types of structured and unstructured interventions.
4. The widely limited access, as well as lack of awareness about counselling services and psychotherapy, might have been a covariate that was not explored in this study
5. The questionnaires used in this study for assessing the beliefs and expectations towards psychotherapy have not been validated for use in the Indian population

Clinical Implications

1. Beliefs and expectations towards psychotherapy is an important therapeutic common change factor that needs to be assessed prior to intake in psychotherapeutic interventions
2. These factors correlate well with personality, coping styles as well as several socio-demographic factors that need to be kept in mind while taking up clients for therapy
3. Modifying these factors may enhance the client-therapist therapeutic relationship and increase the chances of achieving better outcomes following psychotherapy
4. Development of indigenous psychotherapy approaches and keeping sociocultural context in mind is an essential future step in the practice of psychotherapy in Indian settings

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APPENDIX - I

ETHICAL CLEARANCE CERTIFICATE

अखिल भारतीय आयुर्विज्ञान संस्थान, जोधपुर
All India Institute of Medical Sciences, Jodhpur
संस्थागत नैतिकता समिति
Institutional Ethics Committee

No. AIIMS/IEC/2021/3466 Date: 12/03/2021

ETHICAL CLEARANCE CERTIFICATE

Certificate Reference Number: **AIIMS/IEC/2021/3301**

Project title: **"Beliefs and Expectations from Psychotherapy and its association with Personality traits, Coping styles and Psychological flexibility"**

Nature of Project:	**Research Project Submitted for Expedited Review**
Submitted as:	**M.D. Dissertation**
Student Name:	**Dr. Harsh Khandelwal**
Guide:	**Dr. Mukesh Kumar Swami**
Co-Guide:	**Dr. Naresh Nebhinani & Dr. Tanu Gupta**

Institutional Ethics Committee after thorough consideration accorded its approval on above project.

The investigator may therefore commence the research from the date of this certificate, using the reference number indicated above.

Please note that the AIIMS IEC must be informed immediately of:

- Any material change in the conditions or undertakings mentioned in the document.
- Any material breaches of ethical undertakings or events that impact upon the ethical conduct of the research.

The Principal Investigator must report to the AIIMS IEC in the prescribed format, where applicable, bi-annually, and at the end of the project, in respect of ethical compliance.

AIIMS IEC retains the right to withdraw or amend this if:

- Any unethical principle or practices are revealed or suspected
- Relevant information has been withheld or misrepresented

AIIMS IEC shall have an access to any information or data at any time during the course or after completion of the project.

Please Note that this approval will be rectified whenever it is possible to hold a meeting in person of the Institutional Ethics Committee. It is possible that the PI may be asked to give more clarifications or the Institutional Ethics Committee may withhold the project. The Institutional Ethics Committee is adopting this procedure due to COVID-19 (Corona Virus) situation.

If the Institutional Ethics Committee does not get back to you, this means your project has been cleared by the IEC.

On behalf of Ethics Committee, I wish you success in your research.

Dr. Praveen Sharma
Member Secretary
Member secretary
Institutional Ethics Committee
AIIMS,Jodhpur

Basni Phase-2, Jodhpur, Rajasthan-342005; **Website:** www.aiimsjodhpur.edu.in; **Phone:** 0291-2740741 Extn. 3109
E-mail : ethicscommittee@aiimsjodhpur.edu.in; ethicscommitteeaiimsjdh@gmail.com

APPENDIX II: PATIENT INFORMATION SHEET

Beliefs and Expectations from Psychotherapy and its association with Personality traits, Psychological flexibility and Coping styles

Name of the patient: **Patient ID:**

Psychotherapy, also known as talk therapy or counselling is a form of treatment modality that is used to treat psychiatric disorders that involves treatment through use of various psychological techniques that modify the way people think, perceive and believe various things in life.

People suffering from depression, anxiety, addiction, bereavement and other various types of psychiatric problems can benefit from psychotherapy/counselling.

Psychotherapy/counselling can be done by a clinical psychologist, a psychiatrist, trained counsellors, and sometimes psychiatric social workers and psychiatric nurses can also administer it after training.

APPENDIX II: PATIENT INFORMATION SHEET

1. **Aim of the study:** To study the beliefs and expectations towards psychotherapy as a treatment modality for the treatment of psychiatric disorders in patients attending psychiatry OPD and their correlates.
2. **Study site:** Out Patient services of Department of Psychiatry, All India Institute of Medical Sciences, Jodhpur, Rajasthan.
3. **Study procedure:** Sociodemographic and a clinical data sheet will be filled for collection of sociodemographic and clinical data and open-ended questions will be asked to assess beliefs and expectations from psychotherapy as a treatment modality. Question Answer session will be audio recorded. BEP scale will be applied to measure the belief system regarding the efficacy of psychotherapy, MPEQ scale will be applied to measure the expectations, AAQ-II scale will be applied to measure the psychological flexibility, Coping Behaviour Assessment Scale (Indian Adaptation) will be used to assess coping styles and BFI-10 scale will be used to assess personality traits.
4. **Likely benefit:** Study will help identifying various factors that determine the engagement of the patients in psychotherapy/counselling and help towards working on the same for improving their variable clinical outcomes.
5. **Confidentiality:** All the data collected from each study participant will be kept highly confidential.
6. **Risk:** Enrolment in above study poses no substantial risk to any of the study participant and if any point of time participant wants to withdraw himself/ herself, he/ she can do so voluntarily at any point of time during the study.

For further information / questions, the following personnel can be contacted:

Dr. Harsh Khandelwal, Junior Resident, Department of Psychiatry, All India Institute of Medical Sciences, Jodhpur, Rajasthan. Ph: +91 8769567361

रोगी सूचना पत्र

साइकोथेरेपी मे विश्वास और अपेक्षाएं और व्यक्तित्व, तनाव का सामना करने की शैलियों और मनोवैज्ञानिक लचीलेपन के साथ इसका सम्बन्ध

साइकोथेरेपी, जिसे टॉक थेरेपी या काउंसलिंग के रूप में भी जाना जाता है, उपचार पद्धति का एक रूप है जिसका उपयोग मनोवैज्ञानिक विकारों के इलाज के लिए किया जाता है, जिसमें विभिन्न मनोवैज्ञानिक तकनीकों के उपयोग के माध्यम से लोगों के सोचने, समझने और जीवन में विभिन्न चीजों पर विश्वास करने के तरीकों को परिवर्तित किया जाता है।
अवसाद, चिंता, व्यसन, शोक और अन्य विभिन्न प्रकार की मनोरोग समस्याओं से पीड़ित लोग साइकोथेरेपी /काउंसलिंग से लाभान्वित हो सकते हैं।

साइकोथेरेपी /काउंसलिंग एक नैदानिक मनोवैज्ञानिक द्वारा किया जा सकता है, एक मनोचिकित्सक, प्रशिक्षित कोउन्सेलर, कभीकभी मनोरोगी सामाजिक कार्यकर्ता और - मनोरोग नर्स भी प्रशिक्षण के बाद इसका प्रबंधन कर सकते हैं।

1. अध्ययन का उद्देश्य: मनोचिकित्सा ओपीडी में भाग लेने वाले रोगियों में मनोचिकित्सा संबंधी विकारों के उपचार के लिए साइकोथेरेपी के प्रति विश्वास और अपेक्षाओं का अध्ययन करना।
2. अध्ययन स्थल: मनोरोग विभाग, अखिल भारतीय आयुर्विज्ञान संस्थान, जोधपुर, राजस्थान की रोगी सेवाएं।

3. अध्ययन प्रक्रिया: सोशियोडेमोग्राफिक और क्लिनिकल डेटा शीट को सोशियोडेमोग्राफिक और क्लिनिकल डेटा के संग्रह के लिए भरा जाएगा और ओपन एंडेड प्रश्नों-का उपयोग साइकोथेरेपी से उपचार के रूप में मान्यताओं और अपेक्षाओं का आकलन करने के लिए किया जाएगा। प्रश्न उत्तर सत्र ऑडियो रिकॉर्ड किया जाएगा । मनोचिकित्सा की प्रभावकारिता के बारे में विश्वास प्रणाली को मापने के लिए पैमाने को लागू किया जाएगा □ □, □म्मीदों

को मापने के लिए स्केल लागू किया जाएगा □ □ □, मनोवैज्ञानिक लचीलेपन को मापने के लिए **AAQ-II** स्केल लागू किया जाएगा, कोपिन्ग् स्किल्ल् का आक्लन करने के लिये कॉपिंग बिहेवियर असेसमेंट स्केल भारतीय अनुकूलन)) जाएगा, व्यक्तित्व का आकलन करने के लिए का उपयोग किया □ □-□10 पैमाने का उपयोग किया जाएगा।

4. संभावित लाभ: अध्ययन साइकोथेरेपी /काउंसलिंग में रोगियों की भागीदारी को निर्धारित करने वाले विभिन्न कारकों की पहचान करने में मदद करेगा और उनके परिवर्तनशील नैदानिक परिणामों में सुधार के लिए काम करने में मदद करेगा।
5. गोपनीयता: प्रत्येक अध्ययन प्रतिभागी से एकत्र किए गए सभी डेटा को अत्यधिक गोपनीय रखा जाएगा।
6. जोखिम: उपरोक्त अध्ययन में नामांकन से अध्ययन के किसी भी प्रतिभागी को कोई भारी जोखिम नहीं होता है और यदि किसी भी समय प्रतिभागी स्वयं / खुद को वापस लेना चाहता है, तो वह अध्ययन के दौरान किसी भी समय स्वेच्छा से ऐसा कर सकता है।

अधिक जानकारी / प्रश्नों के लिए, निम्नलिखित कर्मियों से संपर्क किया जा सकता है:

डॉ हर्ष खंडेलवाल, जूनियर रेजिडेंट, मनोरोग विभाग, अखिल भारतीय आयुर्विज्ञान संस्थान, जोधपुर, राजस्थान। **Ph: +**91 8769567361

APPENDIX -III

All India Institute of Medical Sciences

Jodhpur, Rajasthan

Informed Consent Form

Title of Thesis/Dissertation: Beliefs and Expectations from Psychotherapy and its association with Personality traits, Coping styles and Psychological flexibility.

Name of PG Student : Dr. Harsh Khandelwal

Patient/Volunteer Identification No.: _____

I, _____ S/o or D/o _____

R/o _____

give my full, free, voluntary consent to be a part of the study **"Beliefs and Expectations from Psychotherapy and its association with Personality traits, Coping styles and Psychological flexibility"** the procedure and nature of which has been explained to me in my own language to my full satisfaction. I confirm that I have had the opportunity to ask questions.

I understand that my participation is voluntary and am aware of my right to opt out of the study at any time without giving any reason. I understand that the information collected about me and any of my medical records may be looked at by responsible individual from AIIMS Jodhpur or from regulatory authorities. I give permission for these individuals to have access to my records.

Date: _____ _____

Place: _____ Signature/Left thumb impression

Date: _____ _____

Place: _____ Signature of PG Student

This to certify that the above consent has been obtained in my presence.

1. Witness 1

Signature

Name: _____

Address: _____

2. Witness 2

Signature

Name: _____

Address: _____

अखिल भारतीय आयुर्विज्ञान संस्थान, जोधपुर, राजस्थान

सूचित सहमति पत्र

थीसिस / शोध प्रबंध का शीर्षक: "साइकोथेरेपी मे विश्वास और अपेक्षाएं और व्यक्तित्व, तनाव का सामना करने की शैलियों और मनोवैज्ञानिक लचीलेपन के साथ इसका सम्बन्ध"

पीजी छात्र का नाम: हर्ष खन्डेलवाल

टेलीफोन नंबर : +91 8769567361

रोगी / स्वयंसेवक पहचान संख्या: _____

मैं,

_____पुत्र/पुत्री_____

निवासी_____

मेरी पूर्ण, मुक्त, स्वैच्छिक सहमति को "साइकोथेरेपी मे विश्वास और अपेक्षाएं और व्यक्तित्व, तनाव का सामना करने की शैलियों और मनोवैज्ञानिक लचीलेपन के साथ इसका सम्बन्ध" का एक हिस्सा बनने के लिए दें, जिसकी प्रक्रिया और प्रकृति ने मुझे अपनी पूर्ण संतुष्टि के लिए अपनी भाषा में समझाया है। मैं पुष्टि करता हूं कि मुझे सवाल पूछने का अवसर मिला है।

मैं समझता हूं कि मेरी भागीदारी स्वैच्छिक है और बिना किसी कारण के किसी भी समय अध्ययन से बाहर निकलने के मेरे अधिकार से अवगत हूं।

मैं समझता हूं कि मेरे और मेरे किसी भी मेडिकल रिकॉर्ड के बारे में एकत्रित जानकारी को **AIIMS, Jodhpur** या नियामक अधिकारियों के जिम्मेदार व्यक्ति द्वारा देखा जा सकता है। मैं इन व्यक्तियों को अपने रिकॉर्ड तक पहुंचने की अनुमति देता हूं।

हस्ताक्षर / बाएं अंगूठे का निशान पीजी छात्र के हस्ताक्षर

यह प्रमाणित करने के लिए कि मेरी उपस्थिति में उपरोक्त सहमति प्राप्त हुई है।

1. साक्षी	2.साक्षी
हस्ताक्षर	हस्ताक्षर
नाम	नाम
पता	पता

APPENDIX - IV

SOCIODEMOGRAPHIC DATA

- **NAME:**
- **AGE:**
- **SEX:**
- **RESIDENCE:**
- **MARITIAL STATUS:**
  (single/married/divorced/separated)

- **RELIGION:**
- **FAMILY TYPE:**
  (nuclear/joint/transitional)

- **EDUCATION:**
  (school/graduation/post-graduation/doctorate/uneducated)

- **EMPLOYMENT STATUS AND TYPE/OCCUPATION:**

  (professional/semiprofessional/skilled/semiskilled/unemployed/household/ student)

- **SOCIOECONOMIC STATUS:**
  (According to modified kuppuswamy scale 2019)

CLINICAL DATA

DIAGNOSIS:

DURATION OF ILLNESS:

TOTAL DURATION OF TREATMENT/NO OF FOLLOW UPS:

(At AIIMS/other setups)

PRIOR EXPERIENCE WITH COUNSELLING/PSYCHOTHERAPY:

- **Structured psychotherapy**
- **Scheduled counselling**
- **Behavior intervention including lifestyle intervention**
- **Psychoeducation session and pharmacological treatment**

PSYCHOTHERAPY/COUNSELING ADMINISTERED BY:

- **Psychologist**
- **Psychiatrist**
- **Others**

FAMILY H/O PSYCHIATRIC ILLNESS (1st degree relative/others):

(Including history of psychotherapy/counseling)

ANSWER THE FOLLOWING QUESTIONS:

a. **What do you think should be discussed during counselling/psychotherapy? (Like family issues, personal issues, some confidential information)**

b. **Which do you prefer medicine only/ talk therapy or counselling/ both for the treatment of your illness? Why?**

c. **What should be your role in counselling / psychotherapy?**

d. **How can a doctor help you in counselling? What are your expectations from the doctor?**

e. **How was your prior experience with psychotherapy?**

- आपको क्या लगता है कि काउंसलिंग / साइकोथेरेपी के दौरान किस बारे में चर्चा की जानी चाहिए**?** (जैसे पारिवारिक मुद्दे, व्यक्तिगत मुद्दे, कुछ गोपनीय जानकारी)

- आप अपनी बीमारी के इलाज के लिए दवाई / टॉक थेरेपी या साइकोथेरेपी / दोनों पसंद करते हैं**?** क्यों**?**

_____

_____

- साइकोथेरेपी / काउंसलिंग में आपकी भूमिका क्या होनी चाहिए**?**

_____

_____

- एक डॉक्टर आपकी काउंसलिंग में कैसे मदद कर सकता है**?** डॉक्टर से आपकी क्या उम्मीदें हैं**?**

_____

_____

- मनोचिकित्सा के साथ आपका पूर्व अनुभव कैसा था**? (**पूर्व अनुभव मौजूद है तो लागू)

_____

APPENDIX - V

Milwaukee Psychotherapy Expectations Questionnaire (MPEQ)

Below is a list of statements describing expectations about therapy that you may have. These statements cover expectations regarding your own behaviour in therapy, your future therapist, and the therapy setting. Read each statement carefully and circle the number that indicates the strength with which you find yourself expecting what it is described in the statement.

Statements	Not at all	somewhat	very much so
1. I expect my therapist will provide support.	0 1 2 3	4 5 6 7	8 9 10
2. My therapist will provide me feedback.	0 1 2 3	4 5 6 7	8 9 10
3. I will be able to express my true thoughts and feelings.	0 1 2 3	4 5 6 7	8 9 10
4. I will feel comfortable with my therapist.	0 1 2 3	4 5 6 7	8 9 10
5. My therapist will be sincere.	0 1 2 3	4 5 6 7	8 9 10
6. My therapist will be interested in what I have to say.	0 1 2 3	4 5 6 7	8 9 10
7. My therapist will be sympathetic.	0 1 2 3	4 5 6 7	8 9 10
8. I expect that I will come to every appointment.	0 1 2 3	4 5 6 7	8 9 10
9. Therapy will provide me with an increased level of self-respect.	0 1 2 3	4 5 6 7	8 9 10
10. After therapy, I will have the strength needed to avoid feelings of distress in the future.	0 1 2 3	4 5 6 7	8 9 10
11. I anticipate being a better person as a result of therapy.	0 1 2 3	4 5 6 7	8 9 10
12. After therapy, I will be a much more optimistic person.	0 1 2 3	4 5 6 7	8 9 10
13. I expect that I will tell my therapist if I have concerns about therapy.	0 1 2 3	4 5 6 7	8 9 10

Milwaukee Psychotherapy Expectations Questionnaire (MPEQ)

नीचे उन बयानों की एक सूची दी गई है, जो साइकोथेरेपी के बारे में अपेक्षाओं का वर्णन करती हैं। ये कथन साइकोथेरेपी में आपके स्वयं के व्यवहार, आपके भविष्य के चिकित्सक और थेरेपी सेटिंग के बारे में अपेक्षाओं को कवर करते हैं। प्रत्येक कथन को ध्यान से पढ़ें और उस संख्या को सर्कल करें जो आपके अपेक्षाओं को सही प्रकार से वर्णित करती है ।

	हर्गिज नहीं				कुछ हद तक			बहुत ज़्यादा			
1. मुझे उम्मीद है कि मेरा चिकित्सक सहायता प्रदान करेगा।	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
2. मेरा चिकित्सक मुझे फीडबैक (प्रतिपुष्टि) प्रदान करेगा।	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
3. मैं अपने वास्तविक विचारों और भावनाओं को व्यक्त कर सकूंगा।	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
4. मैं अपने चिकित्सक के साथ सहज महसूस करूंगा।	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
5. मेरा चिकित्सक निष्ठावान होगा।	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
6. मैं जो कुछ भी कहना चाहता हूँ, मुझे उम्मीद है की मेरे चिकित्सक को उसमे दिलचस्पी होगी	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
7. मेरा चिकित्सक सहानुभूतिपूर्ण होगा।	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
8. मुझे उम्मीद है कि मैं हर अपॉइंटमेंट पर आऊंगा।	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
9. थेरेपी मुझे आत्म-सम्मान का बढ़ा हुआ स्तर प्रदान करेगी।	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

10. थेरेपी के बाद, मेरे पास भविष्य में कष्ट की अनुभूति से बचने के लिए जरूरी क्षमता होगी	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
11. मुझे थेरेपी के परिणामस्वरूप एक बेहतर व्यक्ति बनने की उम्मीद है।	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
12. थेरेपी के बाद, मैं बहुत अधिक आशावादी व्यक्ति बनूंगा।	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
13. मुझे उम्मीद है कि अगर थेरेपी को लेकर मुझे कुछ चिंताएं होंगी तो मैं अपने चिकित्सक को बताऊंगा।	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

APPENDIX - VI

Belief in the Efficacy of Psychotherapy (BEP) Items

Below is a list of statements that measure the belief system in the efficacy of psychotherapy as a treatment modality for mental illness. Choose the option that best coincides with your beliefs.

	Strongly Disagree	Disagree	Neutral/don't know	Agree	Strongly agree
1. Psychotherapy can help people get through difficult times in their lives.	1	2	3	4	5
2. In general, I don't believe that talking to a therapist is an effective way to deal with problems.	1	2	3	4	5
3. Psychotherapy can be an effective way to improve one's quality of life.	1	2	3	4	5
4. Talking with a therapist is a poor way to resolve emotional conflicts.	1	2	3	4	5
5. Talking to a therapist is a good way to become more comfortable with oneself.	1	2	3	4	5
6. Psychotherapy can help people learn to function better at school.	1	2	3	4	5
7. Psychotherapy seems pretty pointless to me.	1	2	3	4	5
8. Psychotherapy can help people learn to function better at work.	1	2	3	4	5
9. Talking to a therapist cannot enhance one's satisfaction with life.	1	2	3	4	5
10. People don't get actually better as a result of psychotherapy.	1	2	3	4	5
11. Psychotherapy can help people have more satisfying relationships.	1	2	3	4	5
12. Weighing the possible benefits against the cost, psychotherapy just doesn't seem worth the money.	1	2	3	4	5
13. Psychotherapy can enhance one's ability to be insightful.	1	2	3	4	5

नीचे उन बयानों की एक सूची दी गई है जो मानसिक बीमारी के लिए उपचार के तौर पर साइकोथेरेपी की प्रभावकारिता में विश्वास प्रणाली को मापते हैं। वह विकल्प चुनें जो आपके विश्वासों के साथ सबसे अच्छा मेल खाता हो।					
	बिलकुल असहमत	असहमत	तटस्थ / पता नहीं है	सहमत	बिलकुल सहमत
1. साइकोथेरेपी लोगों को अपने जीवन में कठिन समय से जीतने में मदद कर सकता है।	1	2	3	4	5
2. सामान्य तौर पर, मेरा मानना है कि किसी थेरेपी चिकित्सक (थेरेपिस्ट) से बात करना समस्याओं से निपटने का एक प्रभावी तरीका है।	1	2	3	4	5
3. जीवन की गुणवत्ता में सुधार के लिए साइकोथेरेपी एक प्रभावी तरीका हो सकता है।	1	2	3	4	5
4. भावनात्मक संघर्षों को हल करने के लिए एक चिकित्सक के साथ बात करना एक खराब तरीका है।	1	2	3	4	5
5. एक चिकित्सक से बात करना अपने आप के साथ अधिक सहज होने का एक अच्छा तरीका है।	1	2	3	4	5
6. साइकोथेरेपी लोगों को स्कूल में बेहतर कार्य करने में मदद कर सकती है।	1	2	3	4	5
7. साइकोथेरेपी मुझे बहुत निरर्थक लगती है।	1	2	3	4	5
8. साइकोथेरेपी लोगों को काम पर बेहतर कार्य करने में मदद कर सकती है।	1	2	3	4	5
9. एक चिकित्सक से बात करने से जीवन से संतुष्टि नहीं बढ़ सकती है।	1	2	3	4	5
10. साइकोथेरेपी के परिणामस्वरूप लोग वास्तव में बेहतर नहीं होते हैं।	1	2	3	4	5

11. साइकोथेरेपी लोगों को अधिक संतोषजनक रिश्ते रखने में मदद कर सकती है।	1	2	3	4	5
12. अगर लाभ-हानि की तुलना की जाये, तो साइकोथेरपी पैसा खर्च करने लायक नहीं है	1	2	3	4	5
13. साइकोथेरेपी अपनी अन्तर्ज्ञान (स्वयं की समझ) की क्षमता को बढ़ा सकती है।	1	2	3	4	5

APPENDIX - VII

Instructions: How well do you think the following statements describe your personality?

A Brief Version of the Big Five Personality Inventory -Big Five Inventory-10 (BFI-10)

	Disagree strongly	Disagree a little	Neither agree nor disagree	Agree a little	Agree strongly
1. … is reserved	(1)	(2)	(3)	(4)	(5)
2. … is generally trusting	(1)	(2)	(3)	(4)	(5)
3. … tends to be lazy	(1)	(2)	(3)	(4)	(5)
4. … is relaxed, handles stress well	(1)	(2)	(3)	(4)	(5)
5. … has few artistic interests	(1)	(2)	(3)	(4)	(5)
6. … is outgoing, sociable	(1)	(2)	(3)	(4)	(5)
7. … tends to find fault with others	(1)	(2)	(3)	(4)	(5)
8. … does a thorough job	(1)	(2)	(3)	(4)	(5)
9. … gets nervous easily	(1)	(2)	(3)	(4)	(5)
10. … has an active imagination	(1)	(2)	(3)	(4)	(5)

A Brief Version of the Big Five Personality Inventory -Big Five Inventory-10 (BFI-10)

निर्देश: आपके हिसाब से किस हद तक निम्नलिखित कथन आपके व्यक्तित्व का वर्णन करते हैं?

	बिलकुल असहमत	असहमत	तटस्थ / पता नहीं है	सहमत	बिलकुल सहमत
1.... अंतर्मुखी/संकोची हूँ	(1)	(2)	(3)	(4)	(5)
2.... आम तौर पर लोगों पे भरोसा कर पाता हूँ	(1)	(2)	(3)	(4)	(5)
3.... आलसी हो जाता हूँ	(1)	(2)	(3)	(4)	(5)
4.... निश्चिंत रहता हूँ, तनाव को अच्छी तरह से संभालता हूँ	(1)	(2)	(3)	(4)	(5)
5. ... कुछ कलात्मक रुचियाँ रखता हूँ	(1)	(2)	(3)	(4)	(5)
6. ... बहिर्मुखी, मिलनसार हूँ	(1)	(2)	(3)	(4)	(5)
7. ... दूसरों में गलतियां ढूंढता हूँ	(1)	(2)	(3)	(4)	(5)
8.... काम अच्छे से पूरा करता हूँ	(1)	(2)	(3)	(4)	(5)
9.... आसानी से घबरा जाता हूँ	(1)	(2)	(3)	(4)	(5)
10.... एक सक्रिय कल्पना रखता हूँ	(1)	(2)	(3)	(4)	(5)

APPENDIX - VIII

Coping behaviour assessment scale Indian version (Hindi)

तनाव समायोजन मापनी

कथन	हाँ	नहीं
मै समस्या से ध्यान हटाने के लिएअन्य कार्यो या गतिविधियों में शामिल हो जाता हूँ|		
मैं समस्या से सम्बंधित ,परिवर्तन में केन्द्रित होने का प्रयास करता हूँ|		
मै अपनेआप से कहता हूँ कि यह वास्तविकता नही हैं|		
मै शराब या अन्य मादक पदार्थो का सहारा लेता हूँ ,अपने आपको बेहतर महसूस करने के लिए|		
मै दुसरो से भावनात्मक समर्थन प्राप्त करता हूँ|		
मै समस्या समाधान के लिए कोई प्रयास नहीं करता हूँ|		
मै परिस्थिति को बेहतर बनाने के लिए आवश्यक कार्यवाही करने के लिए प्रेरित होता हूँ|		
समस्या हैमै ऐसा विश्वास नही करता हूँ|		
अप्रिय भावनाए निर्मित न हो इसके लिये मैअपने आपमें धनात्मक दृष्टिकोण रखता हूँ|		
समस्या समाधान के लिए दुसरो से सहायता/सलाह माँगा हूँ|		
मै समस्या से उबरने के लिए नशे का सहारा लेता हूँ|		
मै समस्या को धनात्म परिप्रेक्ष्य में देखता हूँ|		
मै अपने समस्या समाधान का आलोचना करता हूँ|		
समस्या के समाधान के सन्दर्भ में कुछ योजना बनाकर उस पर कार्यवाही करता हूँ			
समस्या के समाधान के संदर्भ में मुझे दुसरे से समझत था आराम मिलता हैं|		
मैं समस्या समाधान के लिए स्वयं को असहाय पाता हूँ|		
मै समस्यात्मक परिस्थिति में धनात्मकतत्वोंके ऊपर ध्यान केन्द्रित करता हूँ|		
मै समस्या को एक मजाक के रूप में लेता हूँ|		
मैं समस्या के बारे में कम सोचता हूँ और दुसरो कार्यो में लग जाता हूँ जैसे टीवी देखना ,पढना आदि|		
मै समस्या को स्वीकार कर लेता हूँ|		
मैं अपने ऋणात्मक भावनाओ को प्रकट करता हूँ|		
मैं धर्म एवं आध्यात्मिक से आराम पाता हूँ|		
मैं क्या करू इस संदर्भ में दुसरो से सलाह मांगते हैं|		
मैं समस्या के साथ जीवन जीना सीख लिया हूँ|		
मैं समस्या समाधान के संदर्भ में क्या कदम उठाया जाये इस बारे में निरंतर सोचता हूँ|		
मैं समस्या के लिए स्वयं को दोषी मानता हूँ|		
मैं प्रार्थना या ध्यान करता हूँ|		
मै परिस्थिति का मजाक उड़ाता हूँ|		

APPENDIX - IX

AAQ-II

(Acceptance and Action Questionnaire-II)

Following statements describe how you feel about your emotions. Choose the response that applies to you best.

	never true	very seldom true	seldom true	sometimes true	frequently true	very frequently true	always true
My painful experiences and memories make it difficult for me to live a life that I would value.	1	2	3	4	5	6	7
I'm afraid of my feelings.	1	2	3	4	5	6	7
I worry about not being able to control my worries and feelings.	1	2	3	4	5	6	7
My painful memories prevent me from having a fulfilling life.	1	2	3	4	5	6	7
Emotions cause problems in my life.	1	2	3	4	5	6	7
It seems like most people are handling their lives better than I am.	1	2	3	4	5	6	7
Worries get in the way of my success.	1	2	3	4	5	6	7

निम्नलिखित कथन वर्णन करते हैं कि आप अपनी भावनाओं के बारे में कैसा महसूस करते हैं। उस प्रतिक्रिया को चुनें जो आप पर सबसे अच्छी तरह लागू होती है।							
	कभी सच नहीं	बहुत ही कम सच है	शायद ही कभी सच है	कभी-कभी सच	अक्सर सच	बहुत बार सच	अटल सत्य
मेरे दर्दनाक अनुभव और यादें मेरे लिए एक ऐसी ज़िंदगी जीना मुश्किल बना देती हैं जिसकी मैं कदर करू	1	2	3	4	5	6	7
मैं अपनी भावनाओं से डरता हूं।	1	2	3	4	5	6	7
मैं अपनी चिंताओं और भावनाओं को नियंत्रित नहीं कर पाने के बारे में चिंता करता हूं।	1	2	3	4	5	6	7
मेरी दर्दनाक यादें मुझे एक परिपूर्ण जीवन जीने से रोकती हैं।	1	2	3	4	5	6	7
मनोभाव मेरे जीवन में समस्याएँ पैदा करते हैं।	1	2	3	4	5	6	7
ऐसा लगता है कि अधिकांश लोग अपने जीवन को मुझसे बेहतर संभाल रहे हैं।	1	2	3	4	5	6	7
चिंताएँ मेरी सफलता के रास्ते में आ जाती हैं।	1	2	3	4	5	6	7