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THE EFFECTS OF CLIENT ROLE PREPARATION USING VIDEOTAPED INSTRUCTIONS AND MODELING ON CONGRUENCE BETWEEN CLIENT AND THERAPIST

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THE EFFECTS OF CLIENT ROLE PREPARATION USING VIDEOTAPED INSTRUCTIONS AND MODELING ON CONGRUENCE BETWEEN CLIENT AND THERAPIST

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THE EFFECTS OF CLIENT ROLE PREPARATION USING VIDEOTAPED INSTRUCTIONS AND MODELING ON CONGRUENCE BETWEEN CLIENT AND THERAPIST

Mental health practitioners often encounter clients who begin psychotherapy, yet who do not remain more than one or a few sessions. When a client drops out of treatment, there are three possible outcomes. The first is a spontaneous reduction in symptomatology and an increase in the person's level of functioning. A second alternative is that the person remains at his or her original level of functioning. Finally, the person may deteriorate psychologically. "Despite spontaneous improvement and entry or reentry into treatment, on the average the dropout seems to do worse than his counterpart who perseveres in treatment" (Baekeland and Lundwall, 1975, pp. 745-746).

There appears to be at least some relationship between improvement on the part of clients and the time spent in therapy. Orlinsky and Howard (1978) reviewed 33 studies which appraised the relationship between the number of sessions attended and outcome. Twenty of the studies found a positive linear relationship between amount of therapy and outcome. Luborsky, Chandler, Auerbach, Cohen, and Bachrach (1971) looked at twenty-two studies. In twenty of these studies, "the length of treatment was positively related to outcome; the longer the duration of treatment or the more sessions, the better the outcome" (Luborsky et al., 1971, p. 150).

Unfortunately, most persons do not stay in therapy long enough to realize this kind of outcome. Fiester and Rudestam (1975) found a termination rate of 37% to 45% within two sessions for adult outpatients. Garfield (1978) reported that half of the clients in fourteen studies he reviewed dropped out by the sixth session.

In view of the low average number of client contacts at many clinics, and the generally poorer outcomes of persons attending fewer sessions, several investigators have tried various methods to increase client benefits from therapy. The expectations which beginning clients have of therapy has been explored widely. Garfield and Wolpin (1963) questioned a largely middle-class sample of outpatient referrals, and found them to have basically accurate perceptions regarding therapy, with some distortion about the degree to which the therapist would offer advice. However, other researchers have not found their own samples to be as knowledgeable about psychotherapy.

Overall and Aronson (1963; Aronson and Overall, 1966) discovered that their clients expected the therapist to assume an active, medical role. Lower-class clients expected more activity, direction, and support from therapists than did middle-class clients. Bent, Putnam, Kiesler, and Nowicki (1975) found that their well-educated (median two years college) sample expected advice and medication, and expected some improvement "very soon". It appears that while in some cases higher social class or education increases the accuracy of client expectations, these variables are not consistent in their influence.

The first meeting between helper and client gives the client an opportunity to verify or disconfirm expectations. The initial interaction of client and therapist behaviors sets the stage for the ensuing attempt

to build a relationship which is helpful to the client. Garfield, Affleck, and Muffly (1963) noted "some tendency for patients who either overvalue or who are relatively critical of their therapist to leave therapy early" (p. 475). This evaluation was not tied to any specific therapist behaviors. Levitt (1966) interpreted this type of outcome in terms of an expectation-reality discrepancy, which stated that "there is a negative correlation between the effectiveness of any psychotherapeutic intervention and the discrepancy between the patient's expectation of the nature of the therapy process and the reality of the encounter... I refer not to his faith or lack of faith in the effectiveness of the process, but rather to his perception of specific characteristics of the process itself" (p. 164).

The congruence of client and therapist expectations has been a subject of interest for some time. In 1962, Goldstein reviewed the literature to that point and reported that mutual role expectations were an important consideration in therapy. A more recent review by Duckro, Beal, and George (1979) showed less positive findings, with some studies yielding no differences among clients, while other investigators had a higher dropout rate for clients with more discrepant expectations.

The effects of expectation manipulation on psychotherapy process has generally shown that discrepancies between role expectations and therapist behavior produced strains in the communication system, increasing anxiety and avoidant speech, and decreasing verbal productivity (Clemes and D'Andrea, 1965; Pope, Siegman, Blass, and Cheek, 1972).

The strongest relationship involving expectations has come from attempts to increase the congruence between client role expectations and therapist behaviors. Garfield (1978) wrote that three approaches have

been used to study expectations. Descriptive studies correlate pretherapy expectations with outcome. Most experimental studies establish congruent and incongruent therapy pairs and report the effects of confirmation or disconfirmation on various dependent measures. The approach taken in role preparation studies involves teaching the client what behaviors to expect in therapy, in effect establishing a new, more congruent set of expectations. These studies have shown the most consistent positive results in terms of duration and outcome of therapy.

Role Preparation for Clients

Sauber (1972) discussed different approaches used to systematically prepare clients for psychotherapy. Role induction training gives the client information about the goals and procedures of psychotherapy. Another method uses imitation learning and modeling to demonstrate the process of therapy.

The anticipatory socialization interview developed by Orne and Wender (1968) has been the basis of most of the literature concerned with the role induction interview. Essential information regarding the three major purposes of the interview is disseminated by the therapist or another party. These purposes are "1) to provide some rational basis for the patient to accept psychotherapy as a means of helping him deal with his problem... 2) to clarify the role of the patient and therapist in the course of treatment; and 3) to provide a general outline of the course of therapy and its vicissitudes" (p. 1207). This interview was tested by Hoehn-Saric, Frank, Imber, Nash, Stone, and Battle (1964), who reported more appropriate behavior and better outcome for clients exposed to the role induction interview. These results have been confirmed by several other researchers (Behrendt, 1978; Heitler, 1973, 1976; Jacobs et al., 1972; Larsen, 1978;

Sloane, Staples, Cristol, Yorkston, and Whipple, 1976; Yalom, Houts, Newell and Rand, 1967).

The second approach to preparing clients for therapy, vicarious therapy pretraining, was first investigated by Truax and his associates (Truax and Carkhuff, 1965; Truax, Shapiro, and Wargo, 1968; Truax and Wargo, 1969). This procedure used a 30-minute tape recording of "good" client behaviors which illustrated how clients explore themselves and their feelings. This procedure improved outcome with schizophrenic inpatients and neurotic outpatients, but had no effect with adolescent delinquents. Other authors have used videotape or audiotape preparation with favorable intherapy and outcome results (Johnson, 1978; Martin, 1975; Strupp and Bloxom, 1973). Strupp and Bloxom noted that a film presentation is more economical in terms of staff time, and that in their study it produced more favorable post-therapy ratings by patients than did a role induction interview.

Relative Effects of Modeling and Instructions

Only one study of psychotherapy has combined instructions and modeling. Martin (1975) exposed half his sample to an audiotape describing psychotherapy and containing two examples of actual therapy conversations. Significant results were found on therapist rating of problem expression, client self-reports, and mode of termination, with prepared clients showing greater gains and a lower dropout rate.

Several interview analogue studies have attempted to estimate the relative contributions of the two modes of preparation, instructions and modeling (Marlatt, 1971; Marlatt, Jacobson, Johnson, and Morrice, 1970; McGuire, Thelen, and Amolsch, 1975; Mendelsohn, 1978; Stone and Gotlib,

1975; Stone and Vance, 1976; Uhlemann, Lea, and Stone, 1976; Whalen, 1969). Inconsistent results from these studies point to the importance of contextual control of self-disclosing behavior. Whalen found modeling and instructions together were required for subjects in groups to engage in interpersonal openness. Stone and Vance reported a significant modeling effect but no effect for instructions on empathic communication. Stone and Gotlib obtained significant increases on self-disclosure for each method, with a combination of techniques nonsignificantly higher than either effect alone. Uhlemann, Lea, and Stone found significant effects for instructions and a combination of treatments but not for modeling alone, on a reflection of feeling scale.

Modeling appears to be more sensitive to different experimental manipulations than does instruction. Bandura (1978) wrote that "responsiveness to modeling cues is largely determined by three factors.... the characteristic of models, the attributes of observers, and the response consequences associated with matching behavior" (p. 88). Marlatt et al. (1970) found that problem statements increased in unstructured interviews when neutral or positive feedback was given, but not when negative feedback was offered. In a later study, Marlatt (1971) varied the ambiguity of instructions given to clients. Those receiving more ambiguous instructions matched a model's behavior more than clients whose instructions were relatively clear. Marlatt discussed these findings in terms of overall information available to the client. When instruction-based rules for behavior have high informational value, the client is less dependent on modeled behavior to generate rules for appropriate responding. He explained the interaction of instructions and modeling to facilitate performance

of desired behaviors:

> Instructions may serve to increase the relevance and discriminability of the model's performance; whereas the presentation of a model may serve to facilitate the informational directive of instructions through provision of examples and sequencing of responses. In addition, if the model receives reinforcement or informational feedback during the observation period, the O(bserver) can benefit from an overview of the response and the response consequences, an advantage not offered by the use of instructions alone. (pp. 274-275)

This study investigated the effects of preparing clients using modeling and/or instructions. Since modeling is highly dependent on context, preparation of actual clients rather than analogue participants was viewed as an effort to clarify the mixed results of laboratory studies, and establish useful guidelines for practitioners to use in introducing psychotherapy to their own populations. In addition, most of the studies using clinical samples have focused on lower-class clients at community mental health centers. The present study extended the use of systematic preparation to clients using a university counseling center. The specific hypothesis tested was whether such preparation would increase the congruence between client and counselor within the first session. Measures of both client verbal content and client-therapist interaction process (described below) were used to assess congruence. In addition, outcome measures using client and therapist ratings and dropout rates were obtained, to determine

if any initial benefits of preparation had a continuing effect on therapy.

Method

Subjects

Participants in this study were 32 persons applying for psychological services at Wichita State University Counseling Center. Persons who required emergency services, and persons requesting vocational counseling, were excluded from the sample. In addition, clients with previous experience in psychotherapy (more than four sessions) were not included in the study.

Two male counselors were used in the study. One of the counselors was a doctoral level intern, and the other counselor was a licensed psychologist with several years of experience. Counselors accepted new clients as their caseloads permitted. Clients were randomly assigned to treatments, with each counselor interviewing four persons within each condition.

Instruments

The Psychotherapy Expectations Inventory was used as a pretest. Within the first session, Primary System References and Problem Statements were used to measure content dimensions. Paralinguistic variables were assessed using Duration of Utterance and Reaction Time Latency. At the end of the first session, a Client Rating Form and a Therapist Rating Form were completed. At the end of therapy, Client and Therapist Termination Forms were collected, and Dropout Rate was determined.

The Psychotherapy Expectations Inventory is a 43 item scale which assesses client expectations of therapist behavior and attitudes. It was devised by Lorr (1965) and adapted by Martin, Sterne, and Hunter (1976) for use prior to counseling.

Primary System References are "patient or therapist propositions

that refer to their roles during treatment and the process of therapy, and to the purposes, goals, and accomplishments of therapy" (Lennard and Bernstein, 1960, p. 51). This is contrasted with references to oneself or others in roles other than patient or therapist. Lennard and Bernstein (1960) found that dissimilarities in patient-therapist expectation increased the frequency of primary role system communications. These communications were found to change within and between sessions, with the highest percentage occurring at the beginning of each session. Two raters scoring client and therapist responses obtained an interrater reliability of .89 for Primary System References.

Problem Statements were defined by Marlatt (1968, 1971) as the presence of conflict expressed in verbal form, statements of personal weakness, or statements prefaced by remarks such as "this bothers me" or "a difficulty I have". Scoring by Marlatt (1971; Marlatt, Jacobson, Johnson, and Morrice, 1970) of fifteen-second blocks yielded interrater reliabilities of .86 and .89 for twenty-minute samples. The present study used ten-second intervals and obtained a reliability of .87 over sixteen minutes.

Duration of Utterance is the total time it takes a person to emit all the words he/she is contributing in a particular unit of exchange (Matarazzo and Wiens, 1972). It may consist of only one word, such as "why", two words, or hundreds of words. It may also terminate in the middle of a sentence, if the other person interrupts. Pauses within this period are included as part of the duration of utterance. An utterance has a content dimension, containing a single basic theme or idea. When a pause precedes the introduction of new ideas or thoughts, without an intervening comment by the other person, this pause signals the onset of a new speech unit.

Another paralinguistic measure, Reaction Time Latency, is the time period between the end of one person's speech and the beginning of another person's speech (Matarazzo and Wiens, 1972). Reliability on these measures between observers was essentially 1.00 in a study conducted by Phillips, Matarazzo, Matarazzo, and Saslow (1957). Other researchers found reliability coefficients of .92 to .99 (Wiens, Molde, Holman, and Matarazzo, 1966) and .89 to .96 (Conger, 1971). The present study obtained reliabilities of .90 for reaction time latency and .94 for duration of utterance.

For this study, congruence measures were calculated on both the total and average time for duration of utterance and reaction time latency. Congruence is defined (Staples and Sloane, 1976) as the difference between the mean values for client and therapist on a given speech variable. Lower differences indicate greater congruity, and are associated with higher process levels within therapy.

The Client Rating Form and Therapist Rating Form were adapted by Holliday (1978) from the Therapist Rating Form presented by Strupp, Fox, and Lessler (1969). They are eight item parallel forms designed to elicit client and therapist perceptions of client participation and progress. Singer (1977) found that client perceptions and expectations after the first session were positively related to continuation in therapy. The Client Termination Form and Therapist Termination Form are extensions of the two rating forms. They contain the first seven items of these forms, plus items regarding present and former satisfaction. The termination forms are adapted from a longer form devised by Strupp, Fox, and Lessler (1969).

Procedure

Clients contacting the counseling center were asked if they would

participate in a research project being conducted through the counseling center. Those who agreed were asked to report to the counseling center approximately thirty minutes prior to their scheduled appointment time. Upon arrival, all clients completed the Psychotherapy Expectations Inventory. Clients in the Model, Instructions, or Instructions and Model conditions then viewed the videotape for that condition. Control clients were not exposed to a videotape. All clients then met with their assigned counselor. During the first session an audiotape recording was made. Following the session, both client and therapist completed their respective rating forms.

During the course of counseling, a record of scheduled appointments and actual interviews attended was kept. At the termination of counseling, each subject was asked to complete the Client Termination Form. Clients terminating unilaterally were contacted by mail. Therapists completed Therapist Termination Forms for all clients.

Design and Analysis

The study used a 2x2x2 factorial design. Presence or absence of Model and of Instructions were two factors. The third factor was which counselor was assigned to a participant. The Model condition was a twelve minute videotape of two simulated counseling sessions. In one vignette the client was male, and a female client was the model in the other scene. The same male therapist was used in both vignettes. Each taped client modeled a general exploration of problem areas typical of a first session, and exhibited a moderate level of self-disclosure. The Instructions condition was a twelve minute videotaped overview of counseling. The tape presented a general model of counseling, typical therapist and client behaviors, and

some problems which commonly arise during the counseling process. The Instructions plus Model condition was a combination of the two videotapes, beginning with the Instructions portion.

For the analysis of within-session behavior, an audiotape was used to record the client-therapist interaction. Two eight-minute segments of each tape were used in the collection of data for problem statements, primary system references, duration of utterance, and reaction time latency. The segments were the first eight minutes of the session, and from 30 to 38 minutes from the beginning. This was done to determine if any changes in interaction occurred within the first session.

A MANOVA procedure was used to analyze within-session data on four variables of problem statements, client primary system references, client-therapist congruence for average duration of utterance, and client-therapist congruence for average reaction time latency. Individual ANOVAs were computed on these and the other dependent measures.

Results

The MANOVA for problem statements, primary system references, average duration of utterance congruence, and average reaction time latency congruence was not significant for either the main effects or the interactions (Table 1). This lack of significance indicated that the overall results of the experimental manipulations did not change the therapy process during the first session. Individual analyses of the dependent variables were made to determine whether any trends in the data were evident, but these results must be considered tentative.

There was a significant difference among groups on the pretest, with groups viewing the model tape having more misconceptions regarding therapy, $F(1,24)=4.70$, $p<.05$ (Table 2). Most of this effect appears to be

due to one group which had twice as many differences as the average of the other groups.

There was a significant Model effect on expression of problem statements, $F(1,24)=4.94$, $p<.05$ (Table 3). Groups viewing the models made fewer problem statements than did groups not seeing the models.

Primary system references by clients had significant interaction effects for Instructions x Model, $F(1,24)=5.45$, $p<.05$; Counselor x Instructions, $F(1,24)=7.01$, $p<.05$; and Counselor x Model, $F(1,24)=6.16$, $p<.05$ (Table 4). Clients seeing both videotapes made nearly as many primary system references as did control clients, with persons having only one source of information making fewer references. One counselor had clients who made fewer references after viewing the tapes, while the other counselor's clients had more primary system references after exposure to the tapes (Table 14).

All of the treatments did have a positive effect on client-therapist congruence for average latency of response. There was a significant Instructions x Model interaction, $F(1,24)=4.28$, $p<.05$ (Table 6), with the three treatments clustered in the same direction. In these, client reaction time tended to be slightly less than the corresponding therapist reaction time, indicating a high level of client involvement in the interaction (Table 14). The average latency for clients had a significant Instructions effect, $F(1,24)=4.73$, $p<.05$ (Table 7), in which clients receiving Instructions had a faster reaction time.

There was a significant difference in counselor speech units between the two therapists, $F(1,24)=6.08$, $p<.05$ (Table 10). This was consistent throughout the therapy session. Each therapist spoke more

later in the session, but the relative increase in speech units remained fairly constant, so that the more active therapist at the beginning of the session remained highly active throughout the hour.

Three other measures of interaction in the first session were not significant. These were client-therapist average duration of utterance (Table 5), congruence for total duration of utterance (Table 8), and congruence for total reaction time latency (Table 9).

A number of measures were taken after the first session ended. On the Client Rating Form, a significant three-way interaction occurred, $F(1,24) = 7.79$, $p < .05$ (Table 11). The clients of one counselor who were exposed to Instructions only were the most satisfied with the first session, while the other counselor's clients in this condition were least satisfied (Table 14). None of the other measures of outcome were significant. A comparison of client and therapist ratings after the first session showed no difference among groups (Table 12). Upon termination, both clients and therapists completed rating forms for the entire period of therapy. Fewer than half the clients completed these forms, which precluded a statistical analysis of their replies. Therapist ratings of client improvement did not yield any differences among groups (Table 13). The number of clients who dropped out of therapy within each group was calculated. Groups were collapsed across Counselor to provide an adequate expected frequency. A chi-square of 1.44 (df=1) was obtained, which was not significant. Client percentage of attendance was anticipated to be affected by treatment, but the median number of sessions was two, and a meaningful percentage could not be calculated.

Discussion

The lack of significant results both in the MANOVA and many of

the individual ANOVAs leads to the conclusion that the treatments were ineffective in altering the initial session and the outcome of therapy. The significant difference among groups on the pretest may have skewed the subsequent measures enough to disguise any treatment effects. However, this appears to be likely only in the case of problem statements, which, like the pretest, had a significant Model effect. People whose expectations of psychotherapy were highly erroneous might be expected to produce fewer statements of problems, as they attempted to orient themselves to an unfamiliar situation.

The general effect on other measures had no specific pattern, however, except possibly some differences between the approaches of the two therapists. The two therapists viewed both videotapes prior to the beginning of the study, and filled out the Psychotherapy Expectations Inventory so that differences between client and therapist could be scored. The two therapists essentially agreed in their answers on the Inventory, and two questions they initially answered differently were clarified so that all their answers matched, establishing a single response pattern from which discrepancy scores could be measured. Both therapists also agreed that their general style of therapy was similar to that explained and portrayed in the videotape. In spite of this initial agreement, it appears that the two therapists had different styles, shown by their level of verbal activity. Therapist A, whose style in actual sessions was more similar to that on the Model tape, had fewer client primary system references during the first session, which indicated that clients were more oriented to the parameters of his counseling approach, than were the clients of therapist B, who had a greater departure from the modeled

counselor behavior of the videotape. Conversely, client satisfaction after the first session was substantially higher for therapist B's clients who had seen only the Instructions tape, than to a similar group counseled by therapist A. These results indicate that if expectations are grounded by experience, such as viewing a videotape, a significant departure from those expectations leads to higher client dissatisfaction and a disrupted interview process.

One difficulty not anticipated by this study was client heterogeneity. Use of two counselors with all four Model and Instructions conditions was designed to control for therapist effect. In addition, the use of two male counselors was designed to minimize interaction between therapist gender and client factors, although this limited the study's generalizability. However, both client diversity and differences in client-therapist counseling process were substantial. Client problems ranged from situational disturbances which could be resolved in one or two sessions, to serious characterological dysfunctions which required long term therapy. There seemed to be a difference between therapists on this dimension, in that more experienced therapist recognized that some persons he might diagnose as having characterological disturbances were interested only in short term management of crisis situations. The less experienced therapist attempted to engage many of these people in longer term therapy, and was relatively unsuccessful in this effort. Consequently, his client dropout rate was higher. In terms of the process of therapy, Lennard and Bernstein (1969) have suggested that more pathological systems are so because there is disagreement about the "ground rules" of interaction. If this is true, then more disturbed

clients should show less congruence with their therapists. Since no attempt was made to control for this variable, this hypothesis was not tested, although it may have decreased the treatment effect.

One interpretation of the lack of significance of results is that clients coming to a counseling center are more psychologically sophisticated than other populations. The Bent et al. (1975) study would disconfirm this idea, and the present study produced similar results. The median number of statements on which clients and therapists disagreed was six, mostly along the dimension of advice giving, with clients generally expecting this from therapists to a great degree. Another axis was reinforcement of client progress; many clients did not expect therapists to praise their positive steps. Although there were differences in expectation between client and therapist, only one client actually commented on this during the first session. This client also had the poorest self-rating at termination, and one of the poorest therapist ratings. It appears that only when expectations are grossly discrepant will a client verbalize his or her confusion, at least in the early stages of therapy.

The results of the study lend support to the contention by Duckro, Beal and George (1979) that preference moderates the effect of expectation. A client encountering a counselor who is more reinforcing than expected is likely to have a more positive response to therapy than a client whose therapist shows unexpected disinterest. Preference was not assessed in the present study, so a test of this assumption is not available. A consideration of preference raises the question whether a moderate discrepancy can be accommodated by most clients. The ability of the therapist to create with the client a therapeutic alliance may build a more positive set

than the client had anticipated, leading to an enhanced therapy experience. Conversely, a client who expects someone to give him or her all the answers will be disappointed in therapy unless those expectations are revised.

Further exploration of this question is needed. Future work in specifying what expectations, if any, are important, has been suggested by Duckro et al. (1979). One drawback of the present study was the lack of control for client type and severity of problem. For many clients who are functioning relatively well, differences in expectations may have little effect on the therapy process. Persons with difficulties in many areas may be less flexible along this dimension.

In summary, there was a lack of overall effect for the treatments designed to increase the congruence between client and therapist. The factor of client heterogeneity and its effect on expectations was discussed. A possible interaction among the direction and degree of expectation, client preference for treatment, and extent of client adaptability was not explored in the present study, and these variables should be considered in future research.

Table 1

MANOVA Test for
Problem Statements, Primary System References,
Average Duration of Utterance Congruence,
and Average Reaction Time Latency Congruence

Source	Wilks' Criterion	F(1.24)
Instructions	.8362	1.03
Model	.7930	1.37
Counselor	.9581	.23
Instructions x Model	.7294	1.95
Instructions x Counselor	.6593	2.71
Model x Counselor	.7449	1.80
Instructions x Model x Counselor	.8416	.99

Table 2

Summary of Analysis of Variance for Psychotherapy Expectations Inventory

Source	df	Mean Squares	F(1,24)
Instructions	1	16.5313	1.35
Model	1	57.7813	4.70*
Counselor	1	38.2813	3.12
Instructions x Model	1	9.0312	.74
Instructions x Counselor	1	16.5312	1.35
Model x Counselor	1	16.5312	1.35
Instructions x Model x Counselor	1	38.2812	3.12

*$p<.05$

Table 3

Summary of Analysis of Variance for Problem Statements

Source	df	Mean Squares	F(1,24)
Instructions	1	40.500	.37
Model	1	544.500	4.94*
Counselor	1	50.000	.45
Instructions x Model	1	136.125	1.24
Instructions x Counselor	1	28.325	.26
Model x Counselor	1	.125	.00
Model x Counselor x Instructions	1	18.000	.16

*$p<.05$

Table 4

Summary of Analysis of Variance for
Client Primary System References

Source	df	Mean Squares	F(1,24)
Instructions	1	1.8528	.06
Model	1	5.5278	.18
Counselor	1	3.9903	.13
Instructions x Model	1	167.9028	5.45*
Instructions x Counselor	1	215.8003	7.01*
Model x Counselor	1	189.6378	6.16*
Model x Counselor x Instructions	1	11.8828	.39

*$p < .05$

Table 5

Summary of Analysis of Variance for
Client-Therapist Average Duration of Utterance

Source	df	Mean Squares	F(1,24)
Instructions	1	38.3469	.09
Model	1	209.1524	.50
Counselor	1	103.6440	.25
Instructions x Model	1	66.4992	.16
Instructions x Counselor	1	200.6505	.48
Model x Counselor	1	372.5768	.88
Model x Counselor x Instructions	1	16.3735	.04

Table 6

Summary of Analysis of Variance for
Client-Therapist Average Reaction Time Latency

Source	df	Mean Squares	F(1,24)
Instructions	1	17.8503	4.14
Model	1	6.1425	1.42
Counselor	1	.0276	.01
Instructions x Model	1	24.8160	5.75*
Instructions x Counselor	1	3.2896	.76
Model x Counselor	1	.0561	.01
Model x Counselor x Instructions	1	8.3436	1.93

*p<.05

Table 7

Summary of Analysis of Variance for
Client Average Reaction Time Latency

Source	df	Mean Squares	F(1,24)
Instructions	1	5.3465	4.73*
Model	1	2.4865	2.20
Counselor	1	.0450	.04
Instructions x Model	1	1.0878	.96
Instructions x Counselor	1	1.8915	1.67
Model x Counselor	1	.8001	.71
Model x Counselor x Instructions	1	2.2050	1.95

*p<.05

Table 8

Summary of Analysis of Variance for
Client-Therapist Total Duration of Utterance

Source	df	Mean Squares	F(1,24)
Instructions	1	19159.0313	.33
Model	1	32270.7013	.56
Counselor	1	193971.0613	3.38
Instructions x Model	1	40812.2450	.71
Instructions x Counselor	1	13563.0450	.24
Model x Counselor	1	25245.0450	.44
Model x Counselor x Instructions	1	1444.5313	.03

Table 9

Summary of Analysis of Variance for
Client-Therapist Total Reaction Time Latency

Source	df	Mean Squares	F(1,24)
Instructions	1	349.1403	.69
Model	1	1657.4403	3.28
Counselor	1	59.6778	.12
Instructions x Model	1	608.1328	1.20
Instructions x Counselor	1	479.7253	.95
Model x Counselor	1	281.4378	.56
Model x Counselor x Instructions	1	1374.1903	2.72

Table 10

Summary of Analysis of Variance for Therapist Speech Units

Source	df	Mean Squares	F(1,24)
Instructions	1	140.2813	.23
Model	1	935.2813	1.53
Counselor	1	3719.5313	6.08*
Instructions x Model	1	.7812	.00
Instructions x Counselor	1	34.0313	.06
Model x Counselor	1	1046.5313	1.71
Model x Counselor x Instructions	1	116.2813	.19

*p<.05

Table 11

Summary of Analysis of Variance for Client Rating Form

Source	df	Mean Squares	F(1,24)
Instructions	1	2.5313	.17
Model	1	3.7812	.25
Counselor	1	26.2813	1.76
Instructions x Model	1	1.5313	.10
Instructions x Counselor	1	9.0313	.61
Model x Counselor	1	.2813	.02
Model x Counselor x Instructions	1	116.2813	7.79*

*p<.05

Table 12

Summary of Analysis of Variance for Client-Therapist Rating Form

Source	df	Mean Squares	F(1,24)
Instructions	1	8.000	1.43
Model	1	15.125	2.71
Counselor	1	4.500	.81
Instructions x Model	1	15.125	2.71
Instructions x Counselor	1	8.000	1.43
Model x Counselor	1	6.125	1.10
Model x Counselor x Instructions	1	3.125	.56

Table 13

Summary of Analysis of Variance for Therapist Termination Form

Source	df	Mean Squares	F(1,24)
Instructions	1	22.7813	.37
Model	1	34.0313	.56
Counselor	1	30.0313	.49
Instructions x Model	1	225.7813	3.69
Instructions x Counselor	1	19.5313	.32
Model x Counselor	1	13.7813	.23
Model x Counselor x Instructions	1	7.0313	.11

Table 14

Means and Standard Deviations* for Psychotherapy Expectations Inventory, Problem Statements, Primary System References, Duration of Utterance, Reaction Time Latency, and Client and Therapist Forms

VARIABLE	COUNSELOR A				COUNSELOR B			
	Instructions + Model	Instructions	Model	Control	Instructions + Model	Instructions	Model	Control
Psychotherapy Expectations Inventory	7.75 (4.11)	4.75 (2.06)	11.75 (3.86)	6.50 (1.29)	7.75 (6.02)	3.25 (2.06)	4.50 (2.51)	6.50 (3.69)
Problem Statements	37.00 (9.76)	42.50 (7.85)	30.25 (18.50)	41.00 (9.49)	34.00 (7.70)	36.75 (6.07)	28.00 (12.94)	42.00 (5.35)
Primary System References	4.275 (2.217)	4.175 (3.185)	4.150 (2.310)	15.650 (12.150)	13.825 (6.596)	6.425 (2.428)	5.750 (5.073)	5.075 (1.767)
Client-Therapist Average Duration of Utterance	29.795 (25.592)	23.770 (14.475)	22.663 (20.519)	25.265 (15.914)	12.933 (5.731)	23.418 (18.979)	18.678 (27.975)	32.068 (25.716)
Client-Therapist Average Reaction Time Latency	-.300 (1.091)	-.273 (1.052)	-.390 (.309)	-.163 (.427)	-.600 (.610)	-1.150 (1.416)	-.628 (.892)	+1.368 (1.139)
Client Average Reaction Time Latency	1.238 (.565)	1.635 (.852)	1.725 (.205)	1.810 (.769)	.885 (.266)	.865 (.528)	1.295 (.940)	3.063 (2.476)
Client-Therapist Total Duration of Utterance	602.050 (197.936)	524.525 (155.447)	427.075 (273.763)	519.275 (301.094)	335.550 (125.089)	397.250 (271.422)	269.800 (273.392)	447.475 (257.588)
Client-Therapist Total Reaction Time Latency	11.700 (28.260)	-1.150 (28.579)	8.450 (10.454)	4.375 (9.472)	15.000 (16.785)	16.500 (22.337)	22.475 (36.182)	-19.675 (11.762)

* Standard deviations in parentheses.

Table 14 continued

VARIABLE	Counselor A				Counselor B			
	Instructions + Model	Instructions	Model	Control	Instructions + Model	Instructions	Model	Control
Therapist Speech Units	34.25 (13.67)	39.00 (15.51)	40.50 (23.67)	37.00 (13.74)	69.00 (19.17)	43.25 (21.23)	71.75 (33.94)	53.00 (41.77)
Client Rating Form	45.75 (3.30)	41.00 (1.63)	42.00 (2.16)	45.75 (6.85)	45.00 (4.90)	47.50 (2.65)	46.75 (.96)	42.50 (4.73)
Client-Therapist Rating Form	4.50 (2.65)	4.75 (.96)	7.25 (1.71)	6.00 (2.94)	6.50 (2.52)	6.25 (3.56)	8.50 (2.08)	4.25 (1.26)
Therapist Termination Rating	45.25 (6.99)	53.00 (11.83)	49.50 (7.55)	48.50 (5.80)	45.25 (6.40)	52.25 (.96)	48.25 (10.18)	42.75 (8.06)

* Standard deviations in parentheses.

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Appendix A

Prospectus

THE EFFECTS OF CLIENT ROLE PREPARATION USING VIDEOTAPED INSTRUCTIONS AND MODELING ON CONGRUENCE BETWEEN CLIENT AND THERAPIST

Mental health practitioners often encounter clients who begin psychotherapy, yet who do not remain more than one or a few sessions. Three courses are possible as a result of dropping out of treatment. The first is a spontaneous reduction in symptomatology and an increase in the person's level of functioning. A second alternative is that the person remains at his or her original level of functioning. Finally, the person may deteriorate psychologically. "Despite spontaneous improvement and entry or reentry into treatment, on the average the dropout seems to do worse than his counterpart who perseveres in treatment" (Baekeland and Lundwall, 1975, pp. 745-746).

Bergin and Lambert (1978) have reviewed the literature concerning spontaneous remission. Contrary to Eysenck's (1952) early estimate of a 65% remission rate for untreated subjects, their survey of seventeen followup studies revealed an average spontaneous remission rate of 43%, with a range of 18% to 67%. They further note that many previous studies of spontaneous

remission did not take into account other psychotherapy sources besides the institution at which the study was done. Even the average for the studies cited, 43%, means that the majority of untreated persons continue without relief.

The question arises whether psychotherapy can attain a higher improvement rate than that of spontaneous remission. There appears to be at least some relationship between improvement on the part of clients and the time spent in therapy. Orlinsky and Howard (1978) reviewed 33 studies which appraised the relationship between the number of sessions attended and the outcome of psychotherapy. Twenty of the studies found a positive linear relationship between amount of therapy and outcome. Luborsky, Chandler, Auerbach, Cohen, and Bachrach (1971) looked at twenty-two studies, with some overlap with the Orlinsky and Howard (1978) data. In twenty of these studies, "the length of treatment was positively related to outcome; the longer the duration of treatment or the more sessions, the better the outcome!" (Luborsky et al., 1971, p. 150).

Unfortunately, most persons do not stay in therapy long enough to realize this kind of outcome. A nationwide survey of mental health clinics (Bahn and Norman, 1959) revealed a median stay of three sessions, with 22% of the clients attending only once. Garfield (1978) reported that half of the clients in fourteen studies dropped out by the sixth session. Fiester and Rudestam (1975) found a termination rate of 37%

to 45% within two sessions for adult outpatients.

It may be assumed that persons who drop out in one or a few sessions are not receiving the kind of services they had anticipated. Various approaches have been used to orient the client to important variables in treatment, with generally positive results (Baum and Felzer, 1964; Behrendt, 1978; Crews and Melnick, 1976; Goldstein and Shipman, 1961; Heitler, 1976; Hoehn-Saric, Frank, Imber, Nash, Stone, and Battle, 1964; Holliday, 1978; Holmes and Urie, 1975; Larsen, 1978; Nash, Hoehn-Saric, Battle, Stone, Imber and Frank, 1965; Orne and Wender, 1968; Strupp and Bloxom, 1973; Truax and Carkhuff, 1965; Truax, Shapiro, and Wargo, 1968; Truax and Wargo, 1969; Yalom, Houts, Newell, and Rand, 1967).

These promising results have relied chiefly on one of two methods, either a discussion of roles and expectations, or exposure to a modeled counseling session. Several therapy analogue studies have shown that the relative effectiveness of these approaches is highly dependent on the context of the experiment. (Heller, 1969; Marlatt, 1971; Marlatt, Jacobson, Johnson, and Morrice, 1970; McGuire, Thelen, and Amolsch, 1975; Mendelsohn, 1978; Stone and Gotlib, 1975; Stone and Vance, 1976; Uhlemann, Lea, and Stone, 1976; Whalen, 1969).

This study will investigate the effects of modeling and instructions on the interaction of the therapist and client during the first interview, and how this affects outcome of counseling.

Review of Related Literature

The relationship between number of sessions and outcome is generally positive, although the results of some studies indicate that simple correlational procedures may be inadequate for the detection of transition points within therapy. Three major reviews have focused on duration of treatment or number of sessions as a therapy variable (Luborsky et al., 1971; Meltzoff and Kornreich, 1970; Orlinsky and Howard, 1978). Orlinsky and Howard (1978) reported 20 of 33 studies having a linear relationship between sessions and outcome, while Meltzoff and Kornreich (1970) found over half their studies had a linear relationship. In addition, six studies reviewed by Orlinsky and Howard (1978) showed a curvilinear relationship. One of these (Cartwright, 1955) discovered a "failure zone" from the 13th to the 21st interview. Clients terminating within this period had less successful outcomes than those with fewer (5-12) or more (22-) sessions, according to therapist reports. Johnson (1965) also found a failure zone, but his differed from Cartwright's and between his two samples. The zone was 5 to 7 interviews in one sample and 6 to 8 interviews in a second sample. Both of these authors attributed the appearance of a "failure zone" to the discovery or anticipation of discovery of threatening aspects of self. These threats were not sufficiently explored to become resolved, giving the poorer outcome for those persons terminating at this point. However, most of the studies reviewed by

Orlinsky and Howard (1978) did not show any consistent transition period during which more failures occurred. The discrepancy among these results may mean that the failure zone was an artifact of the Cartwright and Johnson samples, or, as Johnson suggests, that client samples which are not differentiated on relevant client variables may mask significant aspects of the counseling process.

Meltzoff and Kornreich (1970) comment that:

> These studies are from diverse sources and are characterized by different therapeutic approaches with different patient groups and different treatment goals. Two things are apparent, however. The first is almost self-evident - sooner or later in psychotherapy there is a point of diminishing returns....These varied studies suggest that it takes place sooner than most therapists imagine. The optimal point has been found to range anywhere from the fifth to the sixty-fifth interview, depending on the type of patient and the type of therapy. The controversial issue comes about from the discovery in some studies of a failure zone followed by successful continuation on the part of some patients who are able to weather it. Other studies report a constant decline after reaching the optimal point. This is an issue of substantial implications that requires careful reappraisal. It is quite possible

> that neither the failure zone nor the optimal point was found in many investigations because the experimenter did not treat the data with this in mind but simply looked at the correlation between the total number of interviews and outcome. (Pp. 351-352)

In addition to the problems of interpretation noted above, another methodological problem is presented by Garfield (1978). Those studies in which the therapist's rating was used as the criterion measure of improvement may be biased against the early terminator. Garfield states many therapists assume:

> That a certain (frequently unspecified) amount of contact with a therapist must be made if progress in psychotherapy is to be attained. If a client discontinues therapy before the therapist believes there has been sufficient time to affect change, then such discontinuance directly influences and limits the amount of change to be expected. It is for this reason that early or premature termination on the part of the client is frequently viewed as a failure in psychotherapy. (P. 210)

It is possible that a significant amount of temporary symptom reduction occurs after assessment but before formal psychotherapy begins (Sloane, Staples, Cristol, Yorkston,

and Whipple, 1975). Clients may be satisfied with this improvement and not feel any need to continue. Other clients may find the psychotherapeutic experience to be less rewarding than anticipated, and drop out without significant improvement. Both Baekeland and Lundwall (1975) and Bergin and Lambert (1978) indicate that a more favorable outcome is obtained by those persons who remain in therapy. Unfortunately a large percentage of those who request treatment do not stay in therapy more than one or a few sessions. Garfield and Kurz (1952) reported that 42% of the clients they studied had less than five interviews. Gallagher and Kanter (1961) found that 23% of their sample dropped out after one session, while only 44% remained for four or more interviews.

In view of the low average number of client contacts at most clinics, and the generally poorer outcomes of persons attending fewer sessions, several investigators have examined various facets of the dropout problem, such as client variables, therapist variables, and the interaction of client and therapist.

Client Characteristics

Two types of client variables have been used in the effort to identify persons likely to drop out of treatment. Demographic information has generally been a poor indicator of dropout, except for social class. Personality attributes show a somewhat stronger relationship to premature termination, although in many cases there appeared to be an

interaction between client characteristics and the type of treatment offered.

One reviewer (Brandt, 1966) examined twenty-five drop-out studies of long-term individual adult psychotherapy. The cutoff point for dropping out ranged from three to nine sessions, most of them five or less. Brandt wrote that these studies consistently found an effect for "personality factors", but the specific factors changed from study to study. This points out the problem in using standardized tests as predictors without cross-validating results with additional client samples. Taulbee (1958) used selected measures from both the Rorschach and MMPI and found a difference between those staying beyond the thirteenth session and those terminating before then. Sullivan, Miller, and Smelser (1958) could not replicate these results on the MMPI.

One battery which appeared to provide a better than chance prediction was the Terminator-Remainer Scale, developed by Lorr, Katz, and Rubinstein (1958). In this paper and later studies (McNair, Lorr, and Callahan, 1963; Rubinstein and Lorr, 1956), dropouts had greater sociopathic tendencies and low anxiety, and held rather rigid authoritarian views. They also had poor impulse control. Kirk and Frank (1976) found that persons making appointment but not attending any sessions had greater impulse expression.

A review of previous research by Stern, Moore, and Gross (1975) raised the question of whether social class was

confounded with the personality characteristics assessed by the Terminator-Remainer Scale. They divided clients according to social class, and found that within each class, the Scale was not a good predictor, with the notable exception of the anxiety portion of the scale. They concluded that prediction with the Terminator-Remainer Scale was primarily due to social class.

The sole criterion of diagnosis has also been applied to the study of what kind of client is likely to terminate. Diagnostic category appears to be a rather poor indicator of dropping out. Four of nine studies cited by Baekeland and Lundwall (1975) did not find a relationship between diagnosis and duration of treatment. Five other studies did. The diagnostic indicators of dropping out were a low level of anxiety and/or depression, paranoid symptoms, sociopathic features, or alcoholism. Of the latter two Baekeland and Lundwall write "it is ... understandable that so few studies should have found these factors relevant since most mental hygiene clinics are reluctant to accept sociopathic or alcoholic patients for treatment" (1975, p. 756). Only one study found paranoid symptoms to be a factor in dropping out (Hiler, 1959). Of the studies which related anxiety or depression to discontinuance, two found severely depressed persons more likely to drop out, while in three studies those with lower levels of depression or anxiety dropped out more often.

The use of diagnosis in addition to other predictors

has not shown any greater promise than prediction through actuarial data. Affleck and Garfield (1961) used ratings obtained in a group staff meeting to predict the duration of stay in therapy. Forty-six patients were dichotomized with a median of eight interviews. Differences for sex, age, education, and diagnosis were not significant. "There was no evidence that patients rated more positively in terms of therapeutic assets actually remain longer in psychotherapy" (Affleck and Garfield, 1961, p. 136).

Extensive reviews of client factors in dropping out are available (Baekeland and Lundwall, 1975; Garfield, 1978; Luborsky et al., 1971). Age has been found to be related in some studies, and Baekeland and Lundwall (1975) concluded that younger persons were more likely to drop out. Garfield (1977) pointed out that the studies cited by Baekeland and Lundwall conflicted, with one study finding older persons dropping out more frequently. He could find no trend to indicate that age was a factor in dropping out.

Four studies reviewed by Baekeland and Lundwall (1975) found females more likely to drop out of treatment. Garfield (1978) cites six other reports in which sex of client was specifically investigated and in which no differences were found. Garfield (1977b) concluded that sex was not an important predictor of continuation in psychotherapy.

Education was found to be positively related to continuation in several studies reviewed by Garfield (1978), although

some investigations did not find this correlation. Rosenthal and Frank (1958) indicate that education below ninth grade may be a handicap working against continuation.

One client characteristic which is associated with a greater tendency to terminate psychotherapy prematurely is lower socioeconomic status (Bailey, Warshaw, and Eichler, 1959; Frank, Gliedman, Imber, Nash, and Stone, 1957; Gallagher and Kanter, 1961; Heitler, 1973, 1976; Jacobs, Charles, Jacobs, Weinstein, and Mann, 1972; Orne and Wender, 1968; Yamamoto and Goin, 1965). Baekeland and Lundwall (1975) cited eighteen studies in which socioeconomic status was a factor in dropping out. Garfield (1978) notes there is a likely relationship between social class and length of stay. Lorion (1973) reviewed several studies in which low socioeconomic status was negatively correlated with acceptance for and the length of psychotherapy.

In spite of the tendency for lower socioeconomic status persons to drop out more quickly than others, those who do remain have a success rate comparable with other groups. Katz, Lorr, and Rubenstein (1958) found that success in treatment was not a function of social class. Lerner (1972) showed that substantial numbers of inner city patients benefitted from psychotherapy, the main difference in outcome due to therapist attitude. Gould (1967) reported good results with analytic therapy among autoworkers. Lorion (1973) concludes that therapy outcome is not necessarily related to socioeconomic status. Several authors have suggested that therapist

prejudices are a major factor in premature client termination (Frank, 1959; Goldstein, Heller, and Sechrest, 1966; Truax and Carkhuff, 1967). Goldstein, Heller and Sechrest (1966) write:

> In broader terms, the basis of this exclusion process seems to be therapist inability or anticipation of inability to, as Freud put it, "clear away the resistances that crop up in the beginning". Thus, by a sort of fiat based on an admixture of clinical reports and therapeutic traditions, persons labeled psychopathic, sociopathic, delinquent, antisocial, unmotivated, unsuitable, nonverbal, or "involuntary" in other ways rarely find their way into psychotherapeuric participation. (P. 82)

To summarize the findings on client characteristics, generally socioeconomic status and related educational level have affected dropout rates. Low anxiety in clients is also associated with a greater likelihood to terminate prematurely.

Client Expectations

While social status is an enduring trait among clients, other characteristics may be unique to the counseling situation. Clients come to counseling seeking relief from the problems which confront them. Usually they have tried to solve these problems on their own, with little success. They turn to professional helpers with expectations of assistance. The nature of these expectations is seldom explored or even

acknowledged, and clients are confused with the new role they are supposed to adopt.

Goldstein (1962) differentiated between two types of expectancies. The first, expectancy of therapeutic gain, deals with the attitude that improvement will result as a function of participating in therapy. The second, role expectancy, concerns the actual behavior of client and therapist in counseling. Meltzoff and Kornreich (1970) have noted that clients can see themselves as the locus of change, or can place their trust in the therapist or the therapy process itself. These various orientations can lead to different behaviors which may or may not be suited to progress in therapy.

Regarding expectancy of therapeutic gain, Wilkins (1973) has written a comprehensive review article. He describes the emergence of this construct from the "placebo effect" in medical literature. Despite several studies reporting predictive validity for expectancy, Wilkins noted that those giving positive results relied solely on client self-reports of expectancy and outcome, without verifying improvement using other measures. Studies having positive results also failed to keep therapists experimentally blind. Wilkins stated that this suggests that therapeutic gain may be determined by therapist expectancies. He concludes that expectancy of gain is a collection of unidentified effects which need to be empirically related to improvement in psychotherapy.

Role expectations have been explored with equal vigor. Those expectancies are more easily identified, and various

procedures have been used either to change client expectations or to adapt therapeutic techniques to meet the expectations.

What expectations do people have about psychotherapy? Garfield and Wolpin (1963) questioned a largely middle-class sample of outpatient referrals. The respondents regarded emotional factors as important in their difficulties. Lack of will power was viewed as a prime cause of their problems. Treatment was pictured as involving a dialogue, with the client making decisions regarding subject matter. Nearly half the subjects thought that a large part of the therapist's time would be spent giving advice and guidance. The results indicate that the sample of clients basically had accurate perceptions regarding therapy, with a few distortions.

Other researchers have not found their own samples as knowledgeable about therapy. Overall and Aronson (1963; Aronson and Overall, 1966) gave prospective clients a questionnaire concerning expectations of psychotherapeutic procedures. These clients expected the therapist to assume an active, medical role, much as a medical doctor. Overall and Aronson also found that the greater the discrepancy between client expectations and perceptions of the interview, the less likely clients were to return for treatment. The methodology of this study may have influenced the first finding about expectations, since the questionnaire was administered orally. An acquiescence set could have resulted in many falsely positive statements. Aronson and Overall (1966)

compared this original group to a group of middle-class clients. Their lower-class clients expected more activity, direction, and support from the therapists than did middle-class clients. "The greatest discrepancy between the classes results from a difference in anticipating the therapeutic techniques to be utilized, not from a divergence of opinion concerning the content of therapy" (Aronson and Overall, 1966, p. 40).

Two more recent studies recorded expectancies of clients at community mental health centers (Bent, Putnam, Kiesler, and Nowicki, 1975; Hornstra, Lubin, Lewis, and Willis, 1972). Hornstra et al. actually asked what treatment was desired, rather than expected, and found half the people selected "talking therapy." Of these, most preferred supportive therapy. Even though most of the clients had at least a partial or full high school education, "the level of sophistication among applicants is low and their knowledge of the array of treatment programs at the center is poor. This is all the more remarkable in that 60.5% have had direct experience with a psychiatric-treatment system, i.e., have had either outpatient or inpatient care at least once during the past five years. In this case, experience does not seem to add information that affects expectations" (Hornstra et al., 1972). Hornstra et al. conclude that the services offered do not reflect the mental health consumer's needs and expectations. As a result, only 15% of clients at this center kept more than three appointments.

Bent et al. (1975) reached the same general conclusion regarding client expectations. Their well-educated (median 2 years college) sample expected advice and medication, and expected some improvement "very soon." The authors offered two options; a) correct inaccurate and unrealistic expectancies, or, b) modify treatment procedures and goals to meet client expectations.

Interaction of Client and Therapist

The first meeting between helper and client gives the client an opportunity to verify or disconfirm expectations. The initial interaction of client and therapist behaviors sets the stage for the ensuing attempt to build a relationship which is helpful to the client. The novice client must ask two questions: "Is this relationship what I had hoped for?", and "If not, can what is offered help me?".

Garfield, Affleck, and Muffly (1963) investigated some behaviors and perceptions of the client and therapist within the first interview. Although the results of this study were largely negative, they noted "some tendency for patients who either over-value or who are relatively critical of their therapist to leave therapy early" (p. 475). This evaluation was not tied to any specific therapist behaviors. Levitt (1966) interprets this type of outcome in terms of an " expectation-reality discrepancy," which states that "there is a negative correlation between the effectiveness of any psychotherapeutic intervention and the discrepancy between

the patient's expectation of the nature of the therapy process and the reality of the encounter....I refer not to his faith or lack of faith in the effectiveness of the process, but rather to his perception of specific characteristics of the process itself" (p. 164).

Heine and Trosman (1960) first called attention to the importance of congruent therapist and client expectations. They found that the initial hopes for improvement of continuers and terminators were similar, but that continuers "apparently conceptualized the experience in a manner more congruent with the therapists' role image" (p. 278). Conversely, Wallach and Strupp (1960) theorized that confirmation of client expectations by the therapist would enhance client participation. Lennard and Bernstein (1960) discussed discrepant role expectations in terms of the psychotherapeutic system. When therapist and client expectations were not congruent, this introduced strain into the communication system, which could lead to dissolution of the relationship. Freedman, Engelhardt, Hankoff, Glick, Kaye, Buchwald, and Stark (1958) concluded that the therapist needed to establish a relationship consistent with client expectations, to avoid dropout among clients.

In 1962, Goldstein reviewed this early literature and reported that mutual role expectations were an important consideration in therapy. A recent article by Duckro, Beal, and George (1979) updates this review, with less positive

findings. Numerous experimental studies have been conducted on the effects of disconfirmed client expectations. Significant differences in dropout rate (Borghi, 1968; Sandler, 1975; Overall and Aronson, 1963) are balanced by studies reporting no differences (Fiester, 1974; Horenstein, 1974; Goin, Yamamoto, and Silverman, 1965; Vail, 1974).

On the dimension of client satisfaction, Mendelsohn (1964) reported that clients were more critical of therapists failing to meet their role expectations. Goin et al. (1965) found a higher percentage of clients reported satisfaction when their expectations of therapist advice-giving were confirmed than if no advice was given. Gladstein (1969) indicated that expectations were multidimensional, and that satisfaction declined if none of the dimensions was provided. Martin, Sterne, and Hunter (1976) used the dimensions of nurturant and critical expectations to match clients and therapists. They found that mutuality of client-therapist expectations produced greater satisfaction only when high nurturant, low critical expectations were combined. These studies indicate that disconfirmation of one dimension of the therapist role is not strong enough to produce adverse effects.

The effects of expectation manipulation on psychotherapy process has generally shown that discrepancies between role expectations and therapist behavior produced strains in the communication system, increasing anxiety and avoidant speech,

and decreasing verbal productivity (Clemes and D'Andrea, 1965; Pope, Siegman, Blass, and Cheek, 1972). Duckro et al. (1979) cite Warren's (1973) lack of effect on relationship quality as a result of disconfirmed expectations, a finding contrary to the previous studies.

The strongest relationship involving expectations has come from attempts to increase the congruence between client role expectations and therapist behaviors. Garfield (1978) writes that three approaches have been used to study expectations. Descriptive studies correlate pretherapy expectations with outcome. Most experimental studies establish congruent and incongruent therapy pairs and report the effects of confirmation or disconfirmation on various dependent measures. The approach taken in role preparation studies involves teaching the client what behaviors to expect in therapy, in effect establishing a new, more congruent set of expectations. These studies have shown the most consistent positive results in terms of duration and outcome of therapy.

Role Preparation for Clients

The effects of role training in psychotherapy have been extensively investigated (Baum and Felzer, 1964; Bednar, Weet, Evenson, Lanier, and Melnick, 1974; Behrendt, 1978; Birnbaum, 1975; Cartwright, 1976; Crews and Melnick, 1976; Fernbach, 1975; Fernandez, 1975; Heitler, 1973, 1976; Hoehn-Saric et al., 1964; Holliday, 1978; Holmes and Urie, 1975; Isenberg, 1975; Jacobs, Charles, Jacobs, Weinstein, and Mann, 1972;

Johnson, 1977; Larsen, 1978; Martin, 1975; Martin and Shewmaker, 1962; Nash et al., 1965; Orne and Wender, 1968; Sauber, 1972, 1973; Shannon, 1974; Sloane, Cristol, Pepernik, and Staples, 1970; Strupp and Bloxom, 1973; Truax and Carkhuff, 1965; Truax, Shapiro, and Wargo, 1968; Truax and Wargo, 1969; Urie, 1974; Yalom et al., 1967).

Sauber (1972) writes that three basic approaches have been used to systematically prepare clients: 1) role induction training, which explains the goals and procedures of psychotherapy; 2) vicarious therapy pretraining, using imitation learning and modeling; and 3) therapeutic readings which orient the client toward salient therapy factors. This review focuses on the first two procedures, which have been used most widely.

The anticipatory socialization interview developed by Orne and Wender (1968) has been the basis of most of the literature concerned with the role induction interview. Essential information regarding the three major purposes of the interview is disseminated by the therapist or another party. These purposes are "1) to provide some rational basis for the patient to accept psychotherapy as a means of helping him deal with his problem... 2) to clarify the role of the patient and therapist in the course of treatment; and 3) to provide a general outline of the course of therapy and its vicissitudes, with particular emphasis on the clarification of negative transference" (p. 1207). This interview was tested by

Hoehn-Saric et al. (1964), who reported more appropriate behavior and better outcome for clients exposed to the role induction interview. These results have been confirmed by several different researchers (Behrendt, 1978; Heitler, 1973, 1976; Jacobs et al., 1972; Larsen, 1978; Sloane et al., 1970; Yalom et al., 1967). However, Holliday (1978) and Holmes and Urie (1975) did not find a differential treatment outcome. Holmes and Urie did note a substantial reduction in client dropout. In general, studies with differential treatment outcomes did not report a difference in dropout rate, while studies which did have a dropout effect showed insignificant treatment effects. It is possible that many clients who are not prepared gain less from therapy. Those who remain in therapy may show poorer outcomes, which would decrease the average improvement for nonprepared clients. If these same clients dropped out, the clients less in need of preparation would exhibit an artificially positive outcome for the control group. Some assessment of dropouts should therefore be included to properly evaluate the effects of the role induction interview.

The second approach to preparing clients for therapy, vicarious therapy pretraining, was first investigated by Truax and his associates (Truax and Carkhuff, 1965; Truax, Shapiro, and Wargo, 1968; Truax and Wargo, 1969). This procedure used a 30-minute tape recording of "good" client behaviors which illustrated how clients explore themselves and

their feelings. This tape successfully improved outcome with schizophrenic inpatients and neurotic outpatients, but had no effect with adolescent delinquents. Other authors have used videotape or audiotape preparation which led to more favorable intherapy and outcome results (Johnson, 1977; Martin, 1975; Strupp and Bloxom, 1973). Strupp and Bloxom noted that a film presentation is more economical in terms of staff time, and that in their study it produced more favorable post-therapy ratings by patients than did a role induction interview.

Effects of Modeling and Instructions

Only one study of psychotherapy has combined instructions and modeling. Martin (1975) exposed half his sample to an audiotape describing psychotherapy and containing two examples of actual therapy conversations. Significant results were found on therapist rating of problem expression, client self-reports, and mode of termination, with prepared clients showing greater gains and a lower termination rate.

Several interview analogue studies have attempted to estimate the relative contributions of the two modes of preparation, instructions and modeling. (Marlatt, 1971; Marlatt et al., 1970; McGuire et al., 1975; Mendelsohn, 1978; Stone and Gotlib, 1975; Stone and Vance, 1976; Uhlemann et al., 1976; Whalen, 1969). Inconsistent results from these studies point to the importance of contextual control of self-disclosing behavior. Whalen found both modeling and instructions

were required for subjects in groups to engage in interpersonal openness. Stone and Vance reported a significant modeling effect but no effect for instructions on empathic communication. Stone and Gotlib found significant effects for both modeling and instructions on self-disclosure, with a combination of techniques nonsignificantly higher than either effect alone. Uhlemann, Lea, and Stone obtained significant effects for instructions and a combination of treatments but not for modeling alone, on a reflection of feeling scale.

Modeling appears to be more sensitive to different experimental manipulations than does instruction. Bandura (1978) wrote that "responsiveness to modeling cues is largely determined by three factors....the characteristics of models, the attributes of observers, and the response consequences associated with matching behavior: (p. 88). Marlatt et al. (1970) found that problem statements increased in an unstructured interview when neutral or positive feedback was given, but not when negative feedback was offered. In a later study, Marlatt varied the ambiguity of instructions given to clients. Clients with more ambiguous instructions matched a model's behavior more than those whose instructions were relatively clear. Marlatt discussed these findings in terms of overall information available to the client. When instruction-based rules for behavior have high informational value, the client is less dependent on modeled behavior to generate rules for appropriate responding.

McGuire et al. (1975) found that modeling was more sensitive to time of exposure than were instructions. They discussed the disinhibitory effects of both modalities and concluded that instructions have a maximum effect within a brief exposure time. Modeling effects depend on the length of exposure to the model, gradually exerting a cumulative disinhibitory effect on self-disclosure.

Marlatt (1971) discusses the interaction of instructions and modeling to facilitate performance of desired behaviors:

> Instructions may serve to increase the relevance and discriminability of the model's performance; whereas the presentation of a model may serve to facilitate the informational directive of instructions through provision of examples and sequencing of responses. In addition, if the model receives reinforcement or informational feedback during the observation period, the O(bserver) can benefit from an overview of the response and the response consequences, an advantage not offered by the use of instructions alone. (Pp. 274-275)

To study the relative effectiveness of these modalities in preparing clients for counseling, modeling of behavior should last long enough to provide a representative sample of in-therapy behavior. While an hour long modeling tape would likely meet this specification, as a practical aid to therapists, a shorter segment should adequately cover the salient features of initial interviews.

Purpose

This study will investigate the effects of preparing clients for psychotherapy on the interaction between the client and therapist in the initial interview, and on subsequent client outcome. The modalities of verbal instructions and modeling will be used, singly and in combination, to teach clients appropriate in-therapy behaviors. This study should help clarify the relative effectiveness of modeling and instructions in client role preparation. It should also support the conceptualization of psychotherapy as a learning process which benefits from clearly expressing its goals and procedures. The general hypothesis to be tested is as follows: Does client preparation for psychotherapy increase the congruence between client and therapist, and is this congruence related to a more successful client outcome? Specific tests of this hypothesis are presented below.

H 1. Prepared groups will make fewer primary system references.

H 2. Prepared groups will make more problem statements.

H 3. Prepared groups will show greater client-therapist congruence for total speech time.

H 4. Prepared groups will show greater client-therapist congruence for total pause time.

H 5. Prepared groups will show greater client-therapist congruence for average duration of utterance.

H 6. Prepared groups will show greater client-therapist congruence for average latency of response.

H 7. Prepared groups will have a smaller average client latency of response.

H 8. Prepared groups will have fewer therapist speech units.

H 9. Prepared groups will have higher ratings on the Client Rating Form.

H 10. Prepared groups will have greater congruence between Client and Therapist Rating Forms.

H 11. Prepared groups will have a higher percentage of attendance at scheduled sessions.

H 12. Prepared groups will have a lower dropout percentage.

H 13. Prepared groups will have a higher client rating of improvement at termination.

H 14. Prepared groups will have a higher therapist rating of improvement at termination.

Method

Subjects

Subjects for the study will be persons applying for services at a university counseling center. Participation will be voluntary and persons will be informed that availability of services is not contingent on participation. All subjects will be informed of the limits of confidentiality for the experiment. Subjects will be limited to those expressing concerns of a social-emotional nature, rather than persons seeking career counseling solely. Persons requiring emergency services will not be included in the study. Persons with previous experience in psychotherapy (five or more sessions) will also be excluded from the study.

A total of 32 subjects will participate in the study. Subjects will be assigned to one of four conditions using a random assignment procedure for each counselor. Clients will be assigned to one of two counselors as each counselor accepts new counselors.

Treatments

Three treatment conditions (Instructions, Model, Instructions and Model) and one control condition will be used. All treatments consist of exposure to a videotape related to counseling. The Instructions condition consists of five minute

videotaped overview of counseling. The person on the tape will present a general model of counseling, typical therapist and client behaviors, and some problems which commonly arise during the counseling process.

The Model condition is exposure to a five minute simulated counseling session on videotape. The client in the videotape will model a general exploration of problem areas with a moderate level of self-disclosure. The therapist will model appropriately warm and emphatic behaviors.

The Instructions & Model condition is a combination of the two videotape segments. The Instructions part will be presented first, followed by the Model.

The Control condition will not be exposed to a videotape.

All videotapes will be rated by a panel of judges to determine that the tapes portray the specifications mentioned above.

Procedure

Approximately a half hour before their first counseling session, clients will be given a consent form (Appendix I) explaining the purpose of the research project. If they agree to participate, they will be given the Survey of Expectations (Appendix B).

Persons in the three experimental conditions will then be told, "We have found that when people understand the basic principles of counseling, they can talk more easily without

worrying about how they should act. This videotape will give you an idea of what will happen when you talk with the counselor." They will then be seated in a private viewing area to watch one of the videotapes.

Subjects in the control group will wait for their scheduled appointment. All groups will then meet with one of the counselors. During the first session, an audiotape will be made for later analysis. Following the first session, each subject will complete a Client Rating Form for the session. Each therapist will complete a Therapist Rating Form.

During the course of counseling, each therapist will keep a record of scheduled appointments and the number of appointments kept.

Upon termination, each subject will be asked to complete an outcome evaluation. Those subjects terminating unilaterally will be contacted by mail. Persons terminating by mutual agreement with their therapist will complete the form after their final session.

Instruments

Psychotherapy Expectations Inventory. (Appendix B). This is a 43-item scale which assesses client expectations of therapist behaviors and attitudes. It was devised by Lorr (1965) and adapted by Martin, Sterne, and Hunter (1976) for use prior to counseling. Factor analysis was used in both studies, and five clusters were identified. Martin et al. (1976)

identified two factors which were associated with the greatest satisfaction with treatment. A combination of high nurturant and low critical expectations was correlated with most satisfaction from therapy.

Client and Therapist Rating Forms. (Appendices C and D). These forms were adapted by Holliday (1978) from the Therapist Rating Form presented by Strupp, Fox, and Lessler (1969). They are eight-item parallel forms designed to elicit client and therapist perceptions of client participation and progress. Items are arranged along a five-point scale. Singer (1977) found that client perceptions and expectations after the first session were positively related to continuation in therapy.

Client and Therapist Termination Forms. (Appendices E and F). These are an extension of the client and therapist rating forms, containing the first seven items (excluding expectations) plus items regarding present and former satisfaction. These forms are adapted from a longer form devised by Strupp, Fox, and Lessler (1969). The client form contains 23 items. The therapist form contains 10 items.

Primary System References. Lennard and Bernstein (1960, 1969) define this as "patient or therapist propositions that refer to their roles during treatment and the process of therapy, and to the purposes, goals, and accomplishments of therapy" (1960, p. 51). This is contrasted with references to oneself or others in other than their roles as patient or therapist. Transference is an example of a reference directed to the therapist but not dealing with the therapist role. Lennard and

Bernstein (1960) found that dissimilarities in patient-therapist expectation increased the frequency of primary role system communications. These communications were found to change both within and between sessions. The beginning of each session contains most of the primary system references. The percentage of these references declines over sessions, from 17% of therapist and 14% of client communications during the first four sessions to an average of 7% and 6% respectively in later sessions.

Problem Statements. These are defined by Marlatt (1968, 1971) as the presence of conflict expressed in verbal form, statements of personal weakness, or statements prefaced by remarks such as "this bothers me" or "a difficulty I have". Scoring of fifteen second blocks yielded an interrator reliability of .89 for a twenty minute session. For shorter time periods, Marlatt (1968) recommended decreasing the rating blocks to ten seconds to maintain adequate reliability.

Paralinguistic Measures. Duration of utterance is the total time it takes a person to emit all the words he/she is contributing in a particular unit of exchange. It may contain only one word, such as "Why," two words, or hundreds of words. It may also terminate in the middle of a sentence, if the other person interrupts. Pauses within this period are included as part of the duration of utterance. An utterance has a content dimension, containing a single basic idea. When a pause precedes the introduction of new ideas or thoughts, without an intervening comment by the other person, this pause

signals the onset of a new speech unit (Matarazzo and Wiens, 1972, pp. 7-8).

Latency consists of two kinds of silences. The first, initiative time latency, occurs when one person finishes an utterance and the other person does not respond. The first person then begins speaking again, and the time between the two utterances is the initiative time latency. The second type of latency is reaction time latency. This is the time between the end of one person's speech and the beginning of the second person's utterance.

Total speech time is the total duration of all utterances of one person. Total pause time is the total reaction time latencies for one person. Average latency is the total pause time divided by the number of reaction time latencies. Number of speech units is the total number of utterances for one person.

Reliability on these measures between observers was essentially 1.00 in a study conducted by Phillips, Matarazzo, Matarazzo, and Saslow (1957). Other researchers found reliability coefficients of .92 to .99 (Weins, Molde, Holman, and Matarazzo, 1966) and .89 to .96 (Conger, 1971). Test-retest reliability was .90 for a five minute interval.

Attendance and Dropout Rates. Attendance is the percentage of scheduled appointments which are kept by the client. Dropout is the number of persons terminating therapy unilaterally on or before the fifth session.

Experimental Design and Proposed Analysis

The experimental design is a 2 x 2 x 2 factorial arrangement (Kirk, 1968). The presence or absence of Model and of Instructions are two factors. The other factor is which counselor meets with the subject. Using 32 subjects in this experiment, this design yields a power coefficient of .81 for a difference of 1.5 sigma.

Use of the Psychotherapy Expectations Inventory precedes the treatments, and its function is to control for expectations. It is anticipated that the eight groups will not differ significantly on this measure.

Primary system references, problem statements, and paralinguistic measures will be scored from an audiotape of the first session. Two raters will be used and a reliability coefficient will be calculated for each of these measures.

The client and therapist rating forms will be completed immediately after the first session by the respective parties. After the first session, client and therapist will again complete these rating forms. Upon termination, the therapist will complete the therapist termination form. If termination has been agreed upon mutually, the client will complete the client termination form at this time. If the client drops out, a form will be mailed with a cover letter. If no response is obtained, a follow up telephone call will be made.

Percentage of attendance will be kept by the counselor and collected upon termination.

Primary system references, problem statements, and paralinguistic measures from the audiotape will be analyzed together using multivariate analysis of variance. If this test is significant, univariate analyses will be performed on the individual dependent variables. Client and therapist rating and termination forms will be analyzed separately for each time they are collected. Number of clients dropping out and percentage of attendance will be analyzed using chi-squares.

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Appendix B

Psychotherapy Expectations Inventory

PSYCHOTHERAPY EXPECTATIONS INVENTORY

I expect that my therapist will:

yes no

1. seem to know exactly what I mean.
2. show a real interest in me and my problems.
3. be full of advice about everything I do.
4. expect an individual to shoulder his/her own responsibilities.
5. become impatient when I make mistakes.
6. seem to understand how I feel.
7. be easy to talk to.
8. tell me what to do when I have difficult decisions to make.
9. think people should be able to help themselves.
10. act smug and superior as though he/she knew all the answers.
11. realize and understand how my experiences feel to me.
12. act as though we are co-workers on a common problem.
13. offer me advice on my everyday problems.
14. encourage me to work on my own problems in my own way.
15. act as though he/she is trying to outsmart me.
16. understand me even when I don't express myself well.

yes no

17. make me feel that he/she is one person I can really trust.
18. seem to try to get me to accept his/her standards.
19. try to get me to make my own decisions.
20. give me the impression that he/she doesn't like me.
21. miss the point I am trying to get across.
22. be quick to praise and commend me when I am doing well.
23. expect me to accept her/his ideas and opinions.
24. talk down to me as if I were a child.
25. have a hard time seeing things as I do.
26. give generously of her/his time and energy to others.
27. try to get me to think as she/he does.
28. ignore some of my feelings.
29. have difficulty understanding what I am trying to express.
30. understand my problems and worries.
31. make me feel that I don't have to agree with him/her.
32. Be critical and not easily impressed.
33. be protective of and really concerned about my welfare.

yes no

34. show a real liking and affection for me.
35. tell me what I should talk about.
36. act as though I am dull and uninteresting.
37. make comments that are right in line with what I am saying.
38. seem to have a very real respect for me.
39. be a difficult person to warm up to.
40. make me feel better after talking about my worries with her/him.
41. seem glad to see the interview finished.
42. make me feel free to say whatever I think.
43. relate to me as though I am a companion.

Appendix C

Client Rating Form

CLIENT RATING FORM

1. How appropriate was the therapist's behavior during the therapy session, i.e., did he or she act the way you expected a therapist to act?

*	*	*	*	*
Opposite to expected	Not at all	A few times	Sometimes	Most of the time

2. How does your therapist compare to what you believe is the ideal therapist?

*	*	*	*	*
Not at all	A little	Slightly	Moderately	Very well

3. How satisfied were you with the therapist's participation in the session?

*	*	*	*	*
Very dissatisfied	Moderately dissatisfied	Neutral	Moderately satisfied	Very satisfied

4. How satisfied were you with your participation in the session?

*	*	*	*	*
Very dissatisfied	Moderately dissatisfied	Neutral	Moderately satisfied	Very satisfied

5. How would you rate your general condition since starting therapy?

*	*	*	*	*
Much Worse	Slightly worse	Same	Slightly better	Much better

6. How satisfied are you with your progress during therapy?

*	*	*	*	*
Very dissatisfied	Moderately dissatisfied	Neutral	Moderately satisfied	Very satisfied

7. How much improvement have you noticed in yourself for (check one box in each row):

	Much worse	Worse	None	Some	Very Much
Discomfort	*	*	*	*	*
Self-awareness	*	*	*	*	*
Interpersonal behavior	*	*	*	*	*
Symptoms	*	*	*	*	*

8. How do you expect your condition to be at the end of treatment?

*	*	*	*	*
Much worse	Slightly worse	Same	Somewhat improved	Very improved

Appendix D

Therapist Rating Form

THERAPIST RATING FORM

1. How appropriate was the client's behavior during the therapy sessions, i.e., did he or she act the way a client is supposed to act?

*	*	*	*	*
Opposite to expected	Not at all	A few times	Sometimes	Most of the time

2. How does this client compare to what you believe is the ideal client?

*	*	*	*	*
Not at all	A little	Slightly	Moderately	Very well

3. How satisfied were you with this client's participation in the session?

*	*	*	*	*
Very dissatisfied	Moderately dissatisfied	Neutral	Moderately satisfied	Very satisfied

4. How satisfied were you with your participation in the session?

*	*	*	*	*
Very dissatisfied	Moderately dissatisfied	Neutral	Moderately satisfied	Very satisfied

5. How would you rate this client's general condition since starting therapy?

*	*	*	*	*
Much worse	Slightly worse	Same	Slightly better	Much better

6. How satisfied are you with the client's progress during therapy?

*	*	*	*	*
Very dissatisfied	Moderately dissatisfied	Neutral	Moderately satisfied	Very satisfied

7. How much improvement has there been in the client for (check one box in each row):

	Much Worse	Worse	None	Some	Very Much
Discomfort	*	*	*	*	*
Self-awareness	*	*	*	*	*
Interpersonal behavior	*	*	*	*	*
Symptoms	*	*	*	*	*

8. How do you expect the client's condition to be at the end of treatment?

*	*	*	*	*
Much worse	Slightly worse	Same	Somewhat improved	Very improved

Appendix E

Client Termination Form

CLIENT TERMINATION FORM

1. How appropriate was the therapist's behavior during the therapy session, i.e., did he or she act the way you expected a therapist to act?

_____Opposite to expected
_____Not at all
_____A few times
_____Sometimes
_____Most of the time

2. How does your therapist compare to what you believe is the ideal therapist?

_____Not at all
_____A little
_____Slightly
_____Moderately
_____Very well

3. How satisfied were you with the therapist's participation in the session?

_____Very dissatisfied
_____Moderately dissatisfied
_____Neutral
_____Moderately satisfied
_____Very satisfied

4. How satisfied were you with your participation in the session?

_____Very dissatisfied
_____Moderately dissatisfied
_____Neutral
_____Moderately satisfied
_____Very satisfied

5. How would you rate your general condition since starting therapy?

_____Much worse
_____Slightly worse
_____Same
_____Slightly better
_____Much better

6. How satisfied are you with your progress during therapy?

_____Very dissatisfied
_____Moderately dissatisfied
_____Neutral
_____Moderately satisfied
_____Very satisfied

7. How much improvement have you noticed in yourself for

(Check one box in each row):

	Much worse	Worse	None	Some	Very Much
Discomfort	*	*	*	*	*
Self-awareness	*	*	*	*	*
Interpersonal behavior	*	*	*	*	*
Symptoms	*	*	*	*	*

8. If you had only one period of therapy, did you ever feel a need for further therapy?

_____Never
_____Very rarely
_____A number of times
_____Often
_____Very often

If you felt a need for further therapy, but did not seek it, what were your reasons?

9. How much in need of further therapy do you feel now?

_____No need at all
_____Slight need
_____Could use more
_____Considerable need
_____Very great need

10. What led to the termination of your therapy?

_____My decision
_____My therapist's decision
_____Mutual agreement
_____External factors (Describe briefly)

_____Other (Describe briefly)

11. Everything considered, how satisfied are you with the results of your psychotherapy experience?

_____Extremely dissatisfied
_____Moderately dissatisfied
_____Fairly satisfied
_____Moderately satisfied
_____Extremely satisfied

12. What impression do you have of your therapist's level of experience?

_____Extremely inexperienced
_____Rather inexperienced
_____Fairly experienced
_____Highly experienced
_____Exceptionally experienced

13. How well did you feel you were getting along at the befinning of therapy?

_____Very well
_____Fairly well
_____Neither well nor poorly
_____Fairly poorly
_____Very poorly

14. How long before entering therapy did you feel in need of professional help?

_____Less than one year
_____1-2 years
_____3-4 years
_____5-10 years
_____More than 10 years

15. How severely disturbed did you consider yourself at the beginning of your therapy?

_____Extremely disturbed
_____Very much disturbed
_____Moderately disturbed
_____Somewhat disturbed
_____Very slightly disturbed

16. How much anxiety did you feel at the time you started therapy?

_____A tremendous amount
_____A great deal
_____A fair amount
_____Very little
_____None at all

17. How great was the internal "pressure" to do something about these problems when you entered psychotherapy?

_____Extremely great
_____Very great
_____Fairly great
_____Relatively small
_____Very small

18. How much do you think you have changed as a result of psychotherapy?

_____A great deal
_____A fair amount
_____Somewhat
_____Very little
_____Not at all

19. How much of this change do you think has been apparent to others?

(a) People closest to you (husband, wife, etc.)

_____A great deal
_____A fair amount
_____Somewhat
_____Very little
_____Not at all

(b) Close friends

_____A great deal
_____A fair amount
_____Somewhat
_____Very little
_____Not at all

(c) Co-workers, acquaintances, etc.

_____A great deal
_____A fair amount
_____Somewhat
_____Very little
_____Not at all

20. On the whole how well do you think you are getting along now?

_____Very well
_____Fairly well
_____Neither well nor poorly
_____Fairly poorly
_____Very poorly

21. How adequately do you think you are dealing with any present problems?

_____Very adequately
_____Fairly adequately
_____Neither adequately nor inadequately
_____Somewhat inadequately
_____Very inadequately

22. To what extent have you complaints or symptoms that brought you to therapy changed as a result of treatment?

_____Completely disappeared
_____Considerably improved
_____Somewhat improved
_____Not at all improved
_____Got worse

23. How strongly would you recommend psychotherapy to a close friend with emotional problems?

_____Strongly recommend it
_____Mildly recommend it
_____Recommend it but with some reservations
_____Not recommend it
_____Recommend against it

Appendix F

Therapist Termination Form

THERAPIST TERMINATION FORM

1. How appropriate was the client's behavior during the therapy sessions, i.e., did he or she act the way a client is supposed to act?

*	*	*	*	*
Opposite to expected	Not at all	A few times	Sometimes	Most of the time

2. How does this client compare to what you believe is the ideal client?

*	*	*	*	*
Not at all	A little	Slightly	Moderately	Very well

3. How satisfied were you with this client's participation in the sessions?

*	*	*	*	*
Very dissatisfied	Moderately dissatisfied	Neutral	Moderately satisfied	Very satisfied

4. How satisfied were you with your participation in the session?

*	*	*	*	*
Very dissatisfied	Moderately dissatisfied	Neutral	Moderately satisfied	Very satisfied

5. How would you rate this client's general condition since starting therapy?

*	*	*	*	*
Much worse	Slightly worse	Same	Slightly better	Much better

6. How satisfied are you with the client's progress during therapy?

*	*	*	*	*
Very dissatisfied	Moderately dissatisfied	Neutral	Moderately satisfied	Very satisfied

7. How much improvement has there been in the client for (check one box in each row):

	Much worse	Worse	None	Some	Very much
Discomfort	*	*	*	*	*
Self-awareness	*	*	*	*	*
Interpersonal behavior	*	*	*	*	*
Symptoms	*	*	*	*	*

8. What was the overall success of therapy with this client?

*	*	*	*	*
Very little	Some	Moderate	Fairly great	Very great

9. How would you characterize your working relationship with this client?

*	*	*	*	*
Extremely poor	Fairly poor	Neither good nor poor	Fairly good	Extremely good

10. How satisfied do you think the client was with the results of therapy?

*	*	*	*	*
Extremely dissatisfied	Fairly dissatisfied	Neutral	Fairly satisfied	Extremely satisfied

Appendix G

Instructions Script

Instructions Script

In the next few minutes I would like to go over the counseling process and what you can expect to happen in counseling. We at the Counseling Center think that it is important that you understand what is going on in your sessions, so that your experience in counseling will carry over into your everyday life.

I will cover four areas of counseling, which should help you gain a perspective of the counseling process. By understanding how counseling works, you can devote your time to working on what is bothering you, instead of wondering what is going on. The four areas are, first, the counseling relationship in general; second, what you can do to make your counseling time most productive; third, what your counselor will do to facilitate your progress; and fourth, common problems that arise in counseling, and how they can be handled.

Counseling is a unique relationship, unlike other relationships with your family or friends. It exists for the purpose of helping you better understand your problems, to change how you are living so your life becomes more satisfying and fulfilling.

To accomplish this, counseling sets aside many of the rules which guides our actions in everyday life. The philosophy of counseling is that we are all trying to maximize the positive aspects of ourselves. However, what was most satisfying to us earlier in our lives may not fit now. We are always growing, and as we learn more about ourselves, we also learn new ways of integrating our experiences. If we do not, tension grows between what

we have been doing, and what we know we can do. People often experience this tension, and many people seek counseling because of this.

Tension can be expressed in many ways, and often we do not recognize it, only its results. You may feel anxious, or depressed, or not really feel at all. You may have disturbing thoughts which seem beyond your control, you may act in strange ways which you do not understand. All of these are reflections of tension, within us, or between us and others.

Recognizing that you are unhappy or that you could be enjoying life more is really the first step in counseling. You probably have tried working things out by yourself, or with friends. This may have helped, but you still feel dissatisfied, so you have come here for help.

Your counselor is trained to assist you in exploring your problems. Some people feel comfortable right away discussing personal matters with their counselor. However, for most of us it takes some time to really be able to talk about what is happening within us. Remember, though, your counselor is here to help you, not to judge you.

Generally, people begin by discussing what brought them here. You may decide to talk about several different topics, or concentrate on one area which is bothering you. During this first period, your counselor will attempt to understand your world as you do. As you begin to explore your world, he or she may ask you to clarify certain statements, to get a better idea of how you

perceive different events. As you and your counselor talk, the nature of your problems will become clearer to you both: For example, how often you experience difficulties, how severe they are, and what situations or people they are associated with, as well as how long you have had these problems. In addition, your counselor will help you identify your strengths and the resources you use to cope with and resolve problems.

Once you have decided what you want to work on with your counselor, you will begin to explore each topic in depth. Your counselor will help you focus on the relationships among seemingly isolated parts of yourself, to make sense of your different attitudes and behaviors. You will also begin to develop realistic goals of how you would like to act.

The next stage of counseling is the translation of these goals into a series of steps through which you change how you act and feel. These steps are based on a thorough exploration of your feelings, attitudes, and abilities. Your counselor will then help you develop or improve the skills you need to reach your goals.

As you begin to incorporate these new strategies for living, you should attain a better ability to translate your goals into actions. Your increasing understanding of yourself, and the development of new skills should decrease the strains which caused you to enter counseling. At this point you will discuss termination with your counselor, and how to maintain the gains you have made without further counseling.

To summarize the counseling process, it consists of three

stages. The first stage is a general survey of feelings, thoughts, and behaviors. The second stage is a deeper exploration of different aspects of yourself and how these fit with each other to make you a unique person. The third stage is the development of concrete goals and the skills to reach your goals.

The second area I will cover involves how you can get the most out of your counseling. The counseling relationship exists for your benefit. Your counselor wants to work with you to help you reach your goals. To do this effectively, the counselor must get to know you as an individual. Therefore, the first part of counseling involves you talking about yourself. As you do this, your counselor will help you explain your problems in a way that begins to point to a solution. For this to happen, you must begin to share those parts of yourself you normally do not discuss with others. This is not easy to do, but your counselor will help you in moving through these emotionally troubling areas to a more comfortable state. Your counselor will not condemn you or think you are a terrible person for what you have done or said. He or she will help you resolve your feelings about these areas that are painful to you.

In addition to talking about your problems, counseling requries a lot of work to change how you act. If you act differently, you will feel differently. This is difficult to do. We get used to acting certain ways, and even if we realize our behaviors are not constructive, their familiarity is comfortable. Working with your counselor, you will develop new, more satisfying behaviors to

replace those that do not work for you.

To summarize, the two most important things you as a client can do, are to talk freely about your problems, and to make a commitment to change.

The role of your counselor is to help make your progress through counseling as easy as possible. In the beginning, you and your counselor will establish a relationship in which you can feel free to discuss personal matters. Later, as your counselor gets to know you better, he or she can offer you another perspective on your behavior. With this information, you can decide which of your actions fit your goals, and which you would like to change. Once you have decided what you want to change, your counselor will help you develop tools for how to change. Your counselor has worked with many people, and is skilled in identifying effective strategies for different situations. Of course, your circumstances are unique, and a combination of procedures may be necessary for you to reach your goals.

Your counselor accepts you as you are now, and extends himself or herself as a willing co-worker on your problems. The counselor also provides a framework for changing, while you work within that structure.

The final area I will discuss regards common problems in counseling. Sometimes people feel lost and do not know what is happening in counseling. To a certain extent, this is due to being in a new situation, but it can be overwhelming. If your progress is blocked by feelings of being lost, be sure to discuss

these feelings with your counselor. By doing this, you will clarify where you are going.

Another problem arises early in counseling. As you begin to explain how you feel, a sense of relief is often experienced. At this time you may feel no need for furthering counseling. However, relief is only temporary, because you have not changed the conditions which brought you to counseling. Changing requires work, and one session of counseling is not likely to give long-term improvement. If you do experience an exhilaration when beginning counseling, accept its benefits, but realize that counseling takes time and effort to produce changes that last.

People often experience intense negative emotions as they are working through counseling. At this point it is easy to become discouraged, to feel that counseling is hopeless, or to blame your counselor for not giving you what you need. This is a trying period, but your counselor is there to support your struggle. The main point is to be aware that this is a difficult but necessary part of the counseling process.

Finally, as you begin to implement actions, you may find they do not work exactly as you had planned. When this occurs, be sure to discuss with your counselor exactly what you did and what the results were. You and your counselor can then reevaluate your situation and modify your change strategies so that they are more effective for you.

In general, problems which arise in counseling can best be solved by frankly and openly discussing them with your counselor.

Counseling has many times that are difficult, but by working through these, you can develop new skills and an increased understanding and appreciation of your changing self.

Appendix H

Modeling Scripts

Modeling Script I

(The first portion of this script is adapted from M.R. Goldfried and G.C. Davison, Clinical Behavior Therapy, New York: Holt, Rinehart, & Winston, 1976, pp. 40-42.)

Client: It's just that I feel nervous most of the time.

Therapist: What's that feeling like?

C: Oh, I mean it's kind of hard to describe... I just feel nervous.

T: So you know what the feeling is like, but it's difficult for you to describe it in words.

C: Yes, it is. It's kind of like a feeling of uneasiness and apprehension. It's like you think something bad may happen, or you're afraid that is might.

T: So emotionally, and perhaps physically, there's a fear that something might happen, although you may not be certain exactly what.

C: Yes.

T: When you feel like that, what do you experience physically?

C: Well, my heart starts to pound and I feel myself tense up all over. I mean it's not always bad; sometimes it's only mild.

T: In other words, depending upon the circumstances, you may feel more or less anxious.

C: Yes.

T: Could you tell me something about the sitautions that make you feel most anxious?

C: Well, it's usually when I'm around other people.

T: I would find it particularly helpful to hear about some typical situations that might upset you.

C: It's hard to come up with something specific.

T: I can understand how it may be hard to come up with a specific example right on the spot. That's not at all uncommon. Let me see if I can make it a little easier for you. Let's take the past week or so. Think of what went on at work or school, or at home, or when you were out at a social gathering that might have upset you.

C: Okay. Something just occurred to me. Last weekend we went out to a big party and as we were driving to the place where the party was to be held, I felt myself starting to panic.

T: Can you tell me more about that situation?

C: I knew it was a big party, and that I would not know a lot of people that were there. I usually feel uncomfortable about events like that.

T: In what way?

C: Well, it's hard to be natural in situations like that.

T: Do you typically become nervous when you go to social gatherings?

C: It depends on the situation.

T: In what way?

C: It depends on the people, how I feel about the people.

T: Okay. So there are certain situations and certain types of people that make you more apprehensive.

C: I mean it's not a problem most of the time.

T: What was it like when you reached the party?

C: Well, I didn't have a bad time. I stood around talking with people that I knew.

T: You felt comfortable when you were talking with them.

C: Yeah, we just talked about things we always talk about. It's like I already know what they're going to say.

T: Did you talk to anyone to didn't know?

C: A couple of times. We'd be standing around talking and sometone I didn't know would come over and start talking to us.

T: How did you feel then?

C: Fine.

T: Did you feel any differently when someone came over and said something to you?

C: Yes, one time a girl came over and made a little joke, and then I noticed she was looking at me, and I felt really awkward, I just didn't have anything to say.

T: What does that feel like physically, being awkard?

C: It's like I don't know what to do with my hands. They just hang there and sort of twitch...

T: Anything else?

C: Yeah, it's kind of hard to swallow.

T: So you felt pretty comfortable when you were standing around talking with your friends, but when this girl came up, and said something to you, you thought you should respond and when you didn't, you got a message form your hands and your throat.

C: They were saying, "let me out of here!"

T: What happened then?

C: Well, I noticed she was looking at somebody else, and so I went into the kitchen. I thought it was time to move around a little.

T: Here's one situation where you become anxious and you get rid of the anxiety by leaving the entire scene.

C: Yeah, I didn't want to stick around after I'd already blown it.

T: How had you blown it?

C: Well, uh, I didn't know what to say, I felt like an idiot. I feel really awkward is situations like that. I didn't know what to say, so I split.

T: What do you think would have happened it you had stayed there, even though you felt uncomfortable?

C: I suppose that feeling would have passed. I can't be uptight all the time.

T: So you're pretty sure you would have calmed down if you had stayed.

Modeling Script II

T: A little earlier you were talking about school and the sacrifices you have to make to get an education. Could you tell me more about that?

C: Well, I come from a small town about twenty miles from here. When I was in high school I worked in a department store part-time, like I'm doing now. I did a really good job for the people there, and they wanted me to come to work full-time after I graduated. The pay was pretty good, but I decided to come here instead. I guess I did the right thing, but it hasn't been easy here.

T: You had a good job opportunity when you graduated. You passed that up to come here, and life's been satisfying in general, but you've had to give up some things you enjoy.

C: I think about how hard I have to work just to pay for school and a tiny apartment and all; sometimes I get really discouraged.

T: Like, is it really worth all the effort.

C: Most of the time it's okay, but sometimes I really feel down.

T: How does being down feel for you?

C: At certain times it just hits me. Some mornings I wake up, and it's such a bummer just getting out of bed. And when I start out like that, the day just doesn't get any better.

T: So one time you feel depressed is in the morning, and when you start out like that, you know the rest of the day will be bad, too.

C: I don't know how it works, but it's something like that.

T: When you wake up like that, how do you know you're depressed?

C: I just wake up, and I know.

T: Try to remember the last time this happened, and what specifically was running through your mind.

C: Well, I thought about all the things that I have to get done in the next week, and how I don't know where I'll find the time.

T: There just isn't enough time for you to do everything.

C: And most of the things that I'm doing are things I don't want to do, not really.

T: So most of your time is filled up with obligations to other people.

C: I'm always doing what other people want, not what I want. I feel like my identity depends on what other people want me to do, and I don't know where I fit in with all of that.

T: It's pretty confusing trying to meet other people's demands on you.

C: Well, I just need some time to be myself, and I don't get it.

T: You're feeling the need to have some time to get to know who you are.

C: How can I know what I want unless I know who I am?

T: Are there certain times when you feel like you do know who you are?

C: When I'm with people I know well, that helps. Or when I do get to be by myself, and do things that I enjoy.

T: What are some things you like to do by yourself?

C: I like to ride my bike, and just feel the wind blowing against me. I enjoy fixing up my apartment so it looks pretty.

T: How often do you do these things?

C: Not often enough. I hardly ever get the chance to ride without having to be someplace at a certain time. And I don't have the money to fix up my apartment.

T: How often do you ride your bike?

C: Oh, sometimes I have some time during the weekends. I usually have a little free time then.

T: Do you have any time during the week you could do this?

C: My weekdays are really pretty busy.

T: Are you important enough to yourself that you will make some time?

C: I guess I am.

Appendix I

Client Consent Form

STATEMENT OF CONSENT

In an effort to improve the quality of services at the WSU Counseling Center, the staff is involved in an ongoing evaluation of various counseling procedures. As part of this evaluation, clients are requested to provide some information about their expectations for treatment, and their satisfaction with the services provided. This evaluation is voluntary, and availability of counseling is not affected if a person declines to participate.

Clients who agree to participate will complete a Survey of Expectations before counseling, a Client Rating Form after the initial session, and a Client Termination Form at the end of counseling.

An audiotape recording is routinely made of sessions to aid in supervision. Clients in this project authorize a qualified staff member and/or assistant to review tapes for categorization of responses.

All information obtained for this project will be coded so that the identity of clients is not made public. Persons involved in the project retain the right to discontinue participation at any point during the project.

I have read the preceding explanation, and I agree to participate in this project.

_____ _____

Name Date