PSYCHOTHERAPY PRE-TRAINING USING AN INTRODUCTORY
DOCUMENT OFFERING A CHOICE AS TO
THERAPEUTIC FRAMEWORK

DISSERTATION

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Previous attempts to alter client expectancy and behavior using brief therapy introduction documents have yielded mixed results. This paper reports on the clinical evaluation of such a document which presented individual therapy clients with suggested in-therapy behaviors and offered them a choice as to therapeutic framework. The document told clients that they would be allowed to choose between short term and long term therapy, but woven into the descriptions of these alternatives were repetitions of suggestions for in-therapy behaviors which were intended to positively alter the therapy process and the clients' attitudes toward it. A third choice, no therapy at all, provided the opportunity to present information about what therapy would not offer (medical treatment, direct advise, etc.).

Twenty-nine adult subjects (14 experimental, 15 control) were given either the experimental document or a control document (offering no suggested behaviors and no choices) immediately following their initial intake appointment at the North Texas State University Community Psychology Clinic.
Subjects reading the experimental document saw the clinic as more effective than subjects reading the control document ($P < .01$). Experimental subjects also seemed to attend therapy more regularly, although this finding only approached statistical significance ($P = .10$). Unexpectedly, experimental subjects placed a significantly lower dollar value on their therapy experience ($P < .01$). No other significant differences were found and choice of therapeutic framework did not prove to be a factor.

It was concluded that, while the document was effective at conveying some kinds of positive expectancy, and while it may have been effective at improving therapy attendance, it seemed to have also destroyed some of the mystery or "magic" associated with psychotherapy. It was suggested that the document's detailed instructions about goal setting, taking personal responsibility for change, and keeping therapy appointments may have caused subjects to see therapy as a tedious process and, therefore, place a lower dollar value on it.
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PSYCHOTHERAPY PRE-TRAINING USING AN INTRODUCTORY DOCUMENT OFFERING A CHOICE AS TO THERAPEUTIC FRAMEWORK

This paper describes and reports on the clinical evaluation of a written document intended to introduce new clients to individual psychotherapy. The document includes descriptions of therapy modalities, suggestions for effective in-therapy behavior and offers the prospective client some measure of choice as to therapeutic framework, all with the intent of benefiting and enhancing the therapeutic process.

Several contemporary schools of thought in psychotherapy including social learning theory (Bandura, 1969, 1977) and cognitive psychology (Rimm & Masters, 1979; Mahoney, 1977; Ellis, 1976) hold that one of the most effective ways to influence human behavior is to offer instruction. Supporters of these theories believe in the notion that human behavior is cognitively mediated. Among other things, this means that when a person has a clear cognitive understanding of a given task, he or she will perform that task better than he or she would otherwise. This same principle, according to these theories, should hold true for a client's task in psychotherapy. If a client has an accurate knowledge of what is appropriate behavior in the therapeutic situation, then he or she is in a much better position to derive benefit.
from the therapeutic process, elicit a positive response from a therapist, and make an informed choice about whether he or she wants to accept or reject the entire process.

Another important aspect of the social learning/cognitive model is the concept of expectancy. Many contemporary theorists (Bandura, 1969, 1977; Rotter, 1954) say that the degree to which an individual's expectations are met, determines how satisfying a given experience will be. For example, the psychotherapy client who has certain ideas and expectations about what the therapy experience will be like, will be more likely to appreciate the experience if a number of these expectations are met. The document presented here deals with the client's expectations in two ways. First, by instructing the client as to what to expect and describing appropriate behaviors, this document attempts to modify the client's expectations in the direction of actual therapeutic experience. Second, this document attempts to provide a situation in which the therapeutic experience itself can be modified, at least superficially, to meet the expectations of the client.

Research relating to the preparation of clients for psychotherapy although limited, has demonstrated some support of the concept. Some of the earliest studies include the work of Greenberg (1969) who showed that giving a client only minimal information about his therapist at the time of referral could significantly alter the client's response
to the therapist and his reaction to the therapeutic process. Thus, clients who were told that their therapist would be warm and supportive were more receptive than clients who expected a cold, detached therapist. Long (1969) found that showing young male counselees a 20-minute film that modeled therapy behavior could improve self exploration during therapy sessions.

Strupp and Bloxom (1973) had success with a film designed to present psychotherapy as an acceptable means of problem solving to lower class, unsophisticated clients. The film depicted a prospective client who was reluctant to enter psychotherapy. After a brief experience with a counselor, he dropped out only to find that his problem got worse. He returned for more help and was successful the second time. The authors found the film quite successful at increasing patient motivation to begin group psychotherapy, at increasing the patient's understanding of the therapy process and his or her role in it and at improving the patient's expectation of success in therapy. In addition, patients were more satisfied with the therapy process, more satisfied with their interpersonal relations and were rated by their therapists as showing more appropriate in-therapy behavior. Even therapy outcome was rated by therapists as better for patients who were shown the film.

In addition to the patients viewing the film in Strupp and Bloxom's study, another group was prepared for therapy
using the "anticipatory socialization" interview described by Orne and Wender (1968). The interview was as successful as the film in preparing clients for therapy, both groups differing similarly from non-treated controls. This interview has formed the nucleus of many role introduction techniques. It includes a rationale for therapeutic effectiveness, a brief description of appropriate therapeutic behaviors and an outline for the therapy process that creates a positive expectancy and anticipates possible problems. The specific behaviors emphasized in therapy preparation techniques may vary according to current trends in therapy and the preferences of the experimentors, but most contain Orne and Wender's basic points.

Hoehn-Saric et al. (1964) tested Orne and Wender's preparation interview using a population of 40 psychiatric out-patients who had minimal experience with psychotherapy. The authors found that patients who received the interview showed more appropriate behavior in therapy on five of seven measures, three of which reached significance at the .05 level. Clients who were prepared using the interview also showed significantly better outcome results than non-treated controls with respect to therapist's rating of improvement, client's rating of their own improvement and scales of social ineffectiveness. In a re-analysis of the same data, Nash et al. (1965) observed that the interview was particularly important for patients who were rated as "unattractive" by
their therapists. Persons judged unattractive by their therapist are often those who show the most inappropriate in-therapy behavior, who typically do the worst on outcome measures and who are actually avoided by therapists (Link et al., 1980). Hoehn-Saric et al. showed that this group, unattractive and inappropriate as they were, showed a positive response to therapy preparation, and stood to gain the most from the procedure.

An important part of Orne and Wender's preparation technique is the "faith induction" factor as described by Sloane et al. (1970). In addition to being taught appropriate behaviors, prepared patients are deliberately given a positive expectancy of therapeutic success. Sloane replicated Hoehn-Saric's study and examined the relative contribution of socialization and "faith" factors. It was concluded that faith was less important than the actual behaviors taught by the socialization process.

Dibner et al. (1963) tested a very practical and seemingly effective procedure to introduce clients to group psychotherapy. Clients on the waiting list for therapy were placed in a group designed to teach appropriate therapy behaviors. The procedure resulted in the elimination of the waiting list, enhanced in-therapy behavior and seeming therapeutic gains as measured by MMPI scales or neurosis.

It is important to note that control subjects in the studies cited thus far, were not given the same amount of
attention as experimental subjects. For example, Dibner's waiting list group cannot truly be said to have been free of therapeutic value beyond therapy pre-training. Likewise in the Hoehn-Saric study, control subjects were not given any sort of placebo treatment, but were merely sent home to await their first therapy session. In the meantime, experimental subjects were being interviewed and prepared for therapy in individual sessions. It is impossible to say with certainty, therefore, that obtained results were the result of the preparatory material, or merely the result of increased attention paid to experimental subjects (Ducro, 1979).

More recent studies have begun to employ the attention controls lacking in the early research. Although an actual attention control group was not employed, Heilbrun (1972) tested a role introduction procedure that briefed clients using only a short written document. In this design, experimental subjects did spend time reading material that was not spent by control subjects, but they received no more individual attention than the control subjects. Heilbrun's document stressed the importance of understanding the therapeutic ground rules and forming a "plan of action" with one's counselor. It goes on to describe therapeutic orientations that can be directive or non-directive and urges the client to make an effort to get along with whichever orientation his or her counselor displays. The document
was found to increase satisfaction with the therapy process among females who were judged to be high in counseling readiness. Interestingly, it also reduced the premature termination rate for both males and females in the low counseling readiness group.

Doster (1972) in a well controlled analogue investigation examined ways of preparing subjects to self disclose. He found that detailed instructions about self disclosure (considered an appropriate in-therapy behavior) were the most effective means of increasing the rate of that behavior in a subsequent interview. Other modes of presentation intended to enhance self disclosure (modeling and role playing) did not contribute significantly more than the instructions by themselves.

Holliday (1979) also used an attention control group and found limited support for the effectiveness of her therapy introduction procedure with community mental health center clients. A standard group discussion for all clients included instructions about appropriate therapy behavior for the experimental group. These subjects were urged through a group discussion format to attend therapy regularly, even if they did not feel like it, to be open and honest with their therapist and to think of therapy as a time of privacy when they could say what they wanted with confidence. Holliday found significant changes in client expectancy about therapy as a result of the discussion, but failed to find meaningful improvement in therapy outcome.
Very recently, Corder et al. (1980) reported that pre-training adolescents for group therapy through a set of guidelines presented in two one-hour group sessions was useful. Although a true experimental procedure was not employed, therapists reported that prepared youths showed faster development of group cohesion, increased expression of positive expectancies, reduced time spent in "pass time" discussions and improved skills for giving and receiving verbal feedback.

Turkat (1978) found that a variety of modes of communication could be effective at modifying subjects' expectancies. He also found that such expectancies would change, regardless of therapy preparation, after the subject had attended a few sessions. This finding points to a possible scenario for the effect of role preparation in general: It could be suggested that therapy role preparation does change client expectation and receptiveness to therapy, and that in some cases, in-therapy behavior can be modified by a therapy briefing procedure, but these effects are only noticeable in the beginning stages of treatment. Thus, when Heilbrun (1972) looked at behaviors in the intake interview and when Doster (1972) studied the effects of instructions to self disclose in an analogue interview immediately following the training session, significant results were found. But, when Holliday (1979) and Turkat (1978) looked for longer term outcome effects, they were not found to be significant.
In summarizing these background studies, it seems that support for consistent and exceptional improvement in therapy outcome as a result of brief, easily administered therapy introduction procedures has yet to be shown. Early successes of Orne, Hoehn-Saric and others must be viewed with caution since they did not really control for the effects of increased attention paid to the subject in experimental groups. Indeed, it would be difficult to make an operational distinction between what goes on in a therapy preparation group such as Dibner's and group psychotherapy itself. Likewise, an individual interview given to a subject prior to beginning therapy might not differ realistically from an extra therapy session. Experimental subjects in these studies may have simply received adjunct treatment compared to control subjects, and thus showed more improvement.

Although long range outcome therapeutic effects may not be expected to exceed those inherent in therapy proper, a role preparation procedure still has considerable merit for enhancing early therapy sessions. Such a procedure could be expected to make the therapy process more attractive, thus reducing the premature termination rate, as shown by Heilbrun (1972). It could help the client make an informed choice about the kind of therapy he or she would prefer, or whether to engage in therapy at all. Finally, it could save time and confusion during early therapy sessions. If a client could be simply and efficiently introduced to the
therapeutic process, then the therapist could cut through introductory stages faster and get on to building rapport and addressing the presenting problem. Indeed, Strupp (1980) emphasizes the need to establish a working relationship in therapy as soon as possible. He considers this to be a major factor in determining the success or failure of many cases. A formalized therapy introduction procedure would also ensure that certain key points were consistently made to all clients, even by inexperienced therapists.

Given that only short-term benefits are likely, cost effectiveness dictates that therapy introduction techniques be efficient while being simple, inexpensive, and easily administered. One of the most simple ways to prepare clients for therapy might be the briefing document tested by Heilbrun (1972). Such a document could accomplish the briefing task with minimal cost in dollars, professional time, and clerical inconvenience. As cited above, Heilbrun found such a document useful with high counseling readiness females and found it to improve "no show" rates among low counseling readiness subjects of both sexes. His results are encouraging even though he did not provide a control condition to balance the therapy briefing document. Fernback (1974) tested a similar document in a well controlled study with less success. Applicants to two university counseling centers were presented either a one-page typed general introduction to the facility (control condition) or a one-page typed therapy
role preparation document (experimental condition). This briefing document urged clients to be open in sessions, to make an effort to discuss emotion laden subjects, even if they found it difficult, and to take personal responsibility for their own improvement, without expecting a magical cure from their therapist. The idea was simple and provided a very inexpensive and simple way to prepare clients for therapy. Fernbach hoped that the prepared clients and their therapists would rate the sessions more favorably, and show a lower rate of premature termination. None of these predictions were borne out, however. As Fernbach pointed out, the likely cause was a lack of impact on the clients made by the brief document, as well as a lack of any assurance that the material was even read. The document was simply presented to the clients as another piece of routine material given out at intake. It is also possible, as Turkat (1968) might suggest, that Fernbach's measures were taken too late in the therapeutic process, and that the effects of the document were obscured by the therapy experience itself.

Assuming that a document like Fernbach's could be made to work in a controlled study, this writer devised a way to present the introductory material in a way that would encourage clients to read it. Smith (1982), using an analogue population, tested a therapy introduction document that offered clients information about psychotherapy in a choice format. Offering a choice is in line with Kelly's (1955)
suggestion that therapists should strive to meet a client's expectations, at least for the first few sessions. If a client finds that therapy is as he or she expected, they might remain in therapeutic contact long enough for other gains to materialize and keep them there. Along these lines, Goin et al. (1965) point out that therapeutic drop out rates often correspond to the rate of disconfirmed expectations. Similarly, Ersner-Hershfield et al. (1979) were able to drastically reduce the first sessions "no show" rate in a community mental health clinic by simply having secretaries describe directive versus non-directive psychotherapy over the phone to first time callers and offer them a choice.

The document tested by Smith offered a choice that was intended to place only minimal constraints on therapists. The client was asked to choose between short-term, crisis intervention and longer term therapy aimed at effecting more general change. Both choices provided a framework into which information about psychotherapy and suggested in-therapy behaviors could be woven. It was intended that, when the document was used with actual clients, the use of a choice would insure that the document was read. The choice format also allows the therapist to honor the client's wishes, thus meeting his or her expectations.

A third choice, that of no therapy at all, was also offered and provided an opportunity to explain how certain services (medicine, physical treatments, specific direct
advise) would not be offered. Silverman and Beech (1979) found that clinicians' fears about what happens to clients when they drop out of therapy are often unfounded. It was decided that offering a "no therapy" option would not endanger clients and that those who chose this option would likely have found help elsewhere, or solved their problem themselves.

In testing the effectiveness of this choice format with analogue populations, it was found that the document successfully communicated information about therapy, gave clients a clear idea of what to expect from therapy and gave them a feeling of confidence in the make believe clinic described in the study. The document was compared to a control document that presented the same material, but offered no choice. Both documents were superior to a no-treatment control on the above variables and did not differ from each other. Interestingly, the choice document seemed to create a slight, but non-significant increase in "eagerness to attend the first session" when compared to both other conditions.

Analogue investigation (Smith, 1982) has shown that a choice format introduction document can successfully communicate information and positive expectancy without undue confusion or aversion resulting from the choice format. It was hoped that the choice document would prove its real value, however, with actual clinical populations. If the choice format does have the ability to enhance the readability
of a preparation document, and if it does give clients a sense of involvement in the therapy process earlier than would otherwise happen, it will be a useful instrument. The present study proposes to evaluate the effectiveness of this document with clinical populations.

**Summary and research questions.** Social learning theory as proposed by Rotter, Bandura, and others suggests that instructing prospective psychotherapy clients about appropriate therapy behaviors will enhance their performance of those behaviors in therapy, and, thus have therapeutic value. Social learning theory also suggests that the degree to which a client's expectancies about therapy are confirmed by the therapy experience itself will determine, to a great extent, how satisfied the client will be with the entire process.

Attempts to demonstrate the therapeutic benefits from instructing or briefing clients about appropriate therapy behaviors seem to have been successful under three conditions. First of all, positive results are found if measures are taken very early in the course of therapy (measures taken later in the therapy process tend to reflect the effects of the therapeutic experience itself, and effects specific to the briefing are obscured). Secondly, success has been found when results were measured in controlled analogue situations, where specific target behaviors and attitudes could be isolated (Doster, 1972; Smith, 1982). Finally, it has been shown that procedures which provide
for extensive client participation in the briefing process through group or one-on-one interaction with a trainer are successful (Dibner et al., 1963; Hoehn-Saric et al., 1964; Orne & Wender, 1968). Most of these older studies lacked adequate attention controls, however, and attempts to obtain long-term outcome benefits from easily administered briefing procedures that required only passive client participation have met with little success (Fernbach, 1972; Holliday, 1978).

The studies cited here all tried to alter client expectations or behaviors so that they would not clash with a fixed model of the therapist's role. With the exception of Smith (1982), none of the briefing procedures reviewed here has provided a means whereby the therapist could change to meet client expectations. Kelly (1955) suggests, however, that the therapist should strive to meet a client's expectations, at least initially. Indeed, Ersner-Hershfield et al. (1979) found support for this notion when they significantly reduced a clinic's "no show" rate by offering prospective clients a choice as to therapy modality. Along these lines, Goin et al. (1964) suggest that clients drop out of therapy if they find that it is not what they expected, regardless of attempts to reshape their expectancies or behaviors.

The present study addressed both aspects of Social Learning Theory mentioned above. It provided a way to brief clients as to appropriate therapy behaviors, while, at the
same time, taking note of and dealing with the expectations they bring with them. The study tested whether a brief, written document could be effective in enhancing client expectancy and shaping appropriate behaviors (early on in the therapy process) if certain conditions were met.

First of all, it attempted to increase client involvement with the briefing document by presenting it in a choice format. Research by Smith (1982) showed that such a choice format was effective at communicating both information and positive expectancy to analogue subjects. This format was expected to encourage involvement because the client would read the document, it was hoped, in order to make the required choice. Secondly, the same choice format was intended to provide an opportunity by the client to express his or her wishes so that the therapist, at least initially, could deal with the choices made by the client. Granted, the nature of the choice was not intended to seriously constrain the therapist, but the client's input was solicited, and he or she was given the opportunity to choose between sets of very similar, therapeutically beneficial behaviors. Finally, the document was hoped to serve as a screen to eliminate clients who would have been expected to drop out of therapy on their own anyway. This is to say, by offering a choice of "no therapy at all," it directly addressed the issue of client drop out as a result of disconfirmed expectations, and attempted to provide an acceptable, positive way for
these individuals to withdraw after reading about the therapy alternatives available to them.

The research questions asked, therefore, included the following.

1. Would clients who read the document show more appropriate therapy behaviors during early sessions than clients who did not read it?

2. Would clients who read the document and elected to remain in therapy be more likely to keep their scheduled appointments than clients who did not read it?

3. Would the document enhance the attitude of clients who read it toward their therapists?

4. Would the document enhance the attitudes of clients who read it toward the psychology clinic involved?

5. Would the document enhance the attitudes of therapists toward their clients who read it?

6. Would the attitudes and behaviors of clients who did not read the document come to more closely match the attitudes and behaviors of clients who did read it as therapy progressed?

7. Would the clients who read the document show more improvement at the end of therapy than clients who did not read it, or would the effects of the document become obscured by the therapy experience itself as treatment progressed?

8. Would the therapists of clients who read the document believe that they reached the "turning point" in therapy
Hypotheses To Be Tested

It was hypothesized that experimental and control groups would show differences on behavioral and attitudinal measures that fell into four logical groups that reflected the research questions to be answered:

Grouping one. It was hypothesized that subjects reading the experimental document would score higher than subjects reading the control document on ratings made by their therapists and included on a questionnaire given to their therapists following the subject's third visit to the clinic. These measures included the following:

1. Subjective rating of the client's attractiveness as a therapy candidate as measured on a 7-point Likert scale constructed a-priori for this study;

2. Psychological sophistication of the client as measured on a similar 7-point Likert scale, constructed a-priori for this study;

3. Quality of client's therapy goals and likelihood of the client's attaining those goals as measured on additional 7-point Likert scales constructed a-priori for this study.

Grouping two. It was hypothesized that subjects reading the experimental document would score higher than subjects reading the control document on ratings they themselves made
that were included on a questionnaire given to them following their third visit to the clinic. These measures included the following:

1. Subjective ratings of satisfaction with therapists and with the psychology clinic as well as ratings of therapist and clinic effectiveness as measured on 7-point Likert scales constructed a-priori for this study;

2. Worth of the therapeutic experience as measured by subject’s estimate of the dollar value of a single therapy session (based on a suggested cost of $70 per hour charged by clinicians in private practice).

Grouping three. It was hypothesized that subjects reading the experimental document would score higher than subjects reading the control document on ratings made by their therapists and included on a questionnaire given to the therapists following the subject’s tenth or final visit to the clinic. These measures were regarded as indications of outcome and included the following:

1. Subjective ratings of the client’s attractiveness as a therapy subject as measured on a 7-point Likert scale constructed a-priori for this study;

2. Psychological sophistication of the client as measured on a similar 7-point Likert scale constructed a-priori for this study;

3. Therapeutic improvement as measured by Likert scale estimates of improvement in overall function and interpersonal relations;
4. Speed of progress in therapy as measured by a Likert scale estimate of the "turning point" in therapy, or that point relative to other similar clients when the subject began to make real progress toward his or her goals.

**Grouping four.** It was hypothesized that subjects reading the experimental document would score higher than subjects reading the control document on measures of actual subject behavior. These measures included the following:

1. In-therapy goal setting behavior as evaluated by raters, blind to the experimental condition, who reviewed audio tapes of subjects' first therapy sessions. This behavior was defined as a score on the 5-point goal setting behavior scale constructed a-priori for this study (See Appendix H).

2. Acceptance of responsibility for change in therapy as evaluated by the same raters, blind to experimental condition, who reviewed the same audio tapes of subjects' first therapy sessions. This acceptance of responsibility for change in therapy was defined as a score on the 5-point responsibility scale constructed a-priori for this study (See Appendix G).

3. Measures of therapy attendance taken from clinic records. This measure was defined as the ratio of therapy sessions attended to total therapy sessions scheduled.

**Grouping five.** Finally, it was hypothesized that subjects reading the experimental document would score
higher than subjects reading the control document on a repeat of the same measures made under grouping two, but administered to subjects following the tenth or final therapy sessions, whichever occurred first.

In addition to these formal groupings of data, it was decided to collect follow-up information from subjects who read either the control or experimental document and who decided to drop out of therapy without completing the questionnaires. It was hoped that this information would add color to the data interpretation, but it was not anticipated that enough subjects would be contacted in this fashion to permit any hypothesis testing or analysis of data.

**Method**

**Facility and Therapists**

This study was carried out in the North Texas State University Psychology Clinic, a sliding fee facility serving the city of Denton and the surrounding north-central Texas area. The Clinic is operated as a part of the North Texas State University Psychology Department, but most of its clients are not university students. The majority of individuals served are lower and middle income residents of the community (students are routinely referred to the University Counseling Center).

The Clinic is staffed by graduate students in clinical and counseling psychology, under the supervision of licensed faculty psychologists. A range of services are provided,
but the function most relevant to this study is individual psychotherapy for adult out-patients. A variety of theoretical orientations and psychotherapy techniques are represented by the staff of the clinic, but clinic policy encourages therapists and clients to operate in a fairly structured, goal directed way. Therapeutic goals are routinely written down, and a record of a client's progress toward his or her goals is kept as a part of the case file.

New clients at the Clinic usually make an initial intake appointment by telephone. When they arrive for this appointment, they are received by a clinic secretary in a large room which serves as a clinic office and waiting area. Clients are then met in this room by a student clinician and escorted to one of several therapy rooms where a structured intake interview is done, and a clinic application (see Appendix I) is completed. Following this session, the assignment of a regular therapist (often different from the intake clinician) is made and the client is contacted by that therapist to schedule the first therapy session.

All therapy is done in the clinic therapy rooms and therapists routinely audio tape sessions for review by their fellow students and supervisors. It is made clear to clients by their therapists and in writing on the clinic application form that their case may be observed or reviewed by persons other than their actual therapist and it is explained that training and research are carried out in the clinic.
For the purposes of this study, clinic routine was disrupted as little as possible. Student clinicians and their supervisors were asked to participate on a voluntary basis only, and a total of 14 clinicians, supervised by licensed faculty psychologists agreed to do so. Although assignment of subjects to experimental conditions was random, only three therapists did not have clients in both experimental and control conditions. Of these, two dealt exclusively with control subjects and one exclusively with experimental subjects. The mean number of subjects per therapist was two.

Prior to the collection of data, therapists were given a brief description of the study and its requirements in terms of their time and effort. Permission of the clinicians' supervisors was obtained, and the clinic agreed to supply clerical support.

Subjects

New adult applicants (18 years or older) to the Clinic served as subjects in this study. Each new client was asked by the Clinic secretary if he or she was primarily interested in individual psychotherapy (as opposed to career counseling, group therapy, family therapy, etc.). Clients who responded affirmatively were tentatively considered part of the study sample. Prior to the analysis of data, however, tentative subjects whose case files indicated that they were experienced in psychotherapy, who could not read or who were forced to
participate in therapy by adult probation or other agency were eliminated. A total of 29 subjects, 15 control and 14 experimental were ultimately included in the study sample. Of these, 13 were male (5 experimental, 8 control) and the rest were female. The mean age of the experimental group was 24.31 years, ranging from 20 years to 38 years with a standard deviation of 10.14 years. The mean age of the control group was 29.20 years ranging from 19 to 63 years with a standard deviation of 4.85 years. The experimental group had completed an average of slightly more than two years of college (mean years education = 14.62 years with a standard deviation of 1.15 years). The control group had completed an average of two years of college (mean years education = 14.00 years, with a standard deviation of 1.83 years). The overall range of education in the study sample went from 12 years (high school) to 16 years (master's degree). The entire sample was caucasian American except for one black male.

Materials

Therapy introduction document. The therapy introduction document tested by Smith (1982) was revised and used as the experimental pamphlet in this study (See Appendix A). This document was typeset and offset printed on tan legal-size bond paper which was folded into the shape of a pamphlet. The pamphlet was entitled "Things Every Client Should Know" and contained a statement encouraging the prospective client
to read the material contained before his or her next visit to the Clinic. As an inducement to reading the pamphlet, the cover page also stated that the client's therapist would ask if the material had been read.

The next page of the pamphlet explained the "choice format" used and described how reading the pamphlet could give the client a "head start" in the therapy process. This statement was intended to further encourage the client to read and attend to the material presented.

The following pages were devoted to explaining the three therapy choices offered to the prospective clients. The choices were entitled, "Help With a Specific Crisis or Problem," "Help Making More Long Term, General Changes" and "No Therapy at This Time." Couched within the text that explained each of these choices were repetitions of essentially the same themes. Clients were encouraged, regardless of the choice they made, to keep therapy appointments, set manageable therapy goals that could be approached one step at a time, and to assume as much personal responsibility as possible for their own therapeutic change. In this regard, clients were encouraged to spend therapy time talking about issues they could change personally and were discouraged from spending time complaining about the behavior of other persons in their lives.

Finally, the choice entitled "No Therapy at This Time" cautioned clients not to expect a number of things that they
were not likely to find, including medical treatment and specific advice given by therapists.

It was the intent of this pamphlet to encourage appropriate, therapeutically beneficial behaviors that were roughly the same, regardless of the choice made by the client. The choice made by a client was not intended to seriously constrain the therapist, but was intended to encourage the client to read the pamphlet so that he or she would have enough information to make the choice.

The text of the pamphlet was evaluated using the formula for determining readability suggested by Grunder (1972) and was found to fall in the "easiest" category.

Control document. The control document used in this study was intended to look exactly like the experimental document before it was opened and read (See Appendix B). It was printed in exactly the same style and on the same paper as the experimental document, but contained none of the same information. Instead, the control document contained only a paragraph describing the "sliding fee" nature of the Clinic's billing procedure and an explanation of supervision practices in the Clinic.

Questionnaires. The majority of data collected in this study came from four questionnaires, two given to therapists, two given to subjects. These forms were completed at two points in the therapy process. The first two, one for subjects, one for therapists, were completed after the
subject's second therapy session following intake; the final two were completed after the termination of therapy or the tenth session, whichever occurred first.

The two questionnaires given to subjects were quite similar in content (See Appendices C & E). Each was entitled, "Confidential Feedback" and contained similar instructions. Subjects were asked to respond to nine Likert scale items (repeated on both questionnaires), constructed a-priori for this study and intended to assess subjects' reactions to and opinions of the Clinic, their therapists and the progress of their own case. A few of these items asked directly for a subject's reaction to or opinion about an aspect of his or her case. A number of items, however, asked how likely the subject would be to recommend the Clinic to someone else or how effective the subject thought his or her therapist was with other clients. Research by Smith (1982) suggested that persons are often more willing to answer this kind of indirect question with more candor and more objectively than when the same question is asked, but with reference to the respondent, personally.

All Likert items used on these questionnaires as well as on the questionnaires intended for therapists were based on a 7-point scale in which "1" represented "the very worst possible condition" and "7" represented "the very best possible condition." The specific dimensions addressed by each item are essentially self explanatory (See Appendices C,
D, E & F) and will be discussed in more detail as the results are presented and discussed.

Other than the Likert scale items, the questionnaires for subjects asked if the document given at intake had been read and asked clients to estimate a dollar value for the therapy they had received. This item suggested that an average cost of therapy in private practice was $70 per session in order to give respondents some idea of what range their responses should fall within. It was hoped that the open-ended nature of this item would eliminate a possible ceiling effect created by the limited 7-point Likert scales.

A final item, included on the second questionnaire only, asked the subjects which therapy session, in their opinion, did real progress begin to be made.

No formal "informed consent" agreement was given to subjects since the procedures of this study did not differ significantly from routine delivery of service in the Clinic. Each questionnaire, however, contained a statement informing subjects that they were in no way required to complete the form, and stating that if they did complete it, the experimenters would assume that they were thereby giving their permission for their answers to be examined. The questionnaires also told subjects that their responses would be considered confidential and would not be shared with their therapists.
The two questionnaires for therapists (See Appendices D & F) differed from each other in that the first was intended to assess the therapist's reaction to and opinion of the client, while the second was intended essentially as a therapy outcome measure. The first questionnaire for therapists asked whether, in the opinion of the therapist, the subject had read the document given at intake and asked which choice, if any, the subject had made as a result of having read it. As with the questionnaires for subjects, the actual content of the items is essentially self explanatory, and will be discussed more fully in the results section.

Procedure

For a period of eight months lasting from September, 1982 through April, 1983, data were collected for this study. Before the normal intake interview of a tentative experimental subject (as described above), his or her intake clinician was given randomly, either an envelope containing the experimental document or the control document as well as all of the other questionnaires and materials required for this study. A routine intake interview was then carried out, except that the client was given the document contained in the envelope and instructed by the clinician to read it carefully before his or her next therapy session.

On the subject's next visit to the clinic, he or she was seen by a regular therapist (in most cases not the same person as the intake clinician). As was usual Clinic
procedure, this session was audio taped and the tapes were saved by the therapist for later review by the experimentors. During this first session as well, the therapist asked the subject if he or she had read the document given to them at intake and noted the subject's response in the appropriate space on the experimental questionnaire for therapists.

Following the next therapy session (the subject's third visit to the Clinic), the therapist asked the subject to complete a questionnaire entitled "Confidential Feedback." Subjects were instructed to return these questionnaires to the Clinic secretary so that the therapist would not know how the subject responded. These questionnaires (as well as all additional questionnaires were turned over by the secretaries to the experimentors\(^1\) for review. At the same point in therapy (following the second therapy session), the therapist completed a form entitled "Questionnaire for Therapists Following Session 3" and turned it in to the Clinic secretary who kept it for the experimentors.

A similar procedure involving questionnaires for both therapists and subjects was carried out following the final therapy session, or the tenth session, whichever occurred first. These questionnaires were distributed and collected the same as the earlier versions.

Subjects who dropped out of therapy prematurely were contacted by telephone (where possible) by the experimentors\(^1\) Albert Smith, David Bowman, Becky Orchard.
and given a structured interview intended to assess their reasons for dropping out and to obtain their opinion of the Clinic and their therapist on a number of dimensions. Forms for these interviews were constructed a-priori for this study and were intended to simplify and standardize the interview procedure (See Appendix J).

Finally, the case folders of subjects were reviewed for additional data and demographics. Attendance records were quantified by dividing the number of sessions attended as shown in the files, by the total number of sessions scheduled forming a ratio for each subject. Notes in the chart such as "failed to keep appointment . . . no show . . . cancelled by client" were considered missed sessions. Notes such as "regular therapy" were considered attended sessions. Data for subjects who attended no more than five sessions were not counted.

Review of therapy tapes. The experimental document suggested that subjects try to set manageable goals for themselves in therapy, and that they attempt to take most of the responsibility for changing in-therapy upon themselves. In order to assess whether these behaviors would be demonstrated in actual therapy sessions, audio tapes of the second therapy session following intake were rated according to criteria established a-priori for this study (See Appendices G & H). Two senior undergraduate psychology majors at North Texas State University were given research
course credit for serving as therapy tape raters and assisting with the collection of data. These raters were kept blind to the experimental condition of the tapes rated. Two non-experimental tapes were rated conjointly by these raters to help establish a consensus about the meaning of the five rating levels used. Following this, six experimental tapes were rated by both raters. The ratings assigned by both correlated perfectly on both scales (r = 1.0), so the remainder of tapes were rated by only one rater each. These ratings were then analyzed as part of the experimental data for each subject.

Results

Excluding telephone follow-up data, the dependent variables (DV's) examined in this study fell into four groupings that paralleled the experimental hypotheses.

1. Grouping one consisted of therapists' responses to the first questionnaire (T1) given to them following the subjects' third visit to the Clinic. These data, based on four Likert scales, were analyzed in two ways. First, experimental and control group means for all four were compared using the t-statistic. Second, a stepwise discriminate analysis was performed on these same four DV's.

2. Grouping two consisted of subjects' responses to the first questionnaire (S1) given to them following their third visit to the Clinic. These data were based on nine

1David Helton, Michael Phillips.
Likert scales and one question asking subjects to set a dollar value on their therapy experience. Just as with grouping one, these DV's were examined independently using the t-statistic and as a group using a stepwise discriminate analysis.

3. Grouping three consisted of therapists' responses to six Likert scale items on a questionnaire given to them following the subjects' tenth or final visit to the Clinic (T2). These DV's were analyzed the same as the others using the t-statistic and stepwise discriminate analysis.

4. A final grouping to be statistically analyzed consisted of three DV's measured independently and based largely on subject's behavior rather than subject's responses to questions. These DV's consisted of two ratings of in-therapy behavior taken from audio tapes of therapy sessions and one estimate of subject attendance taken from Clinic records. These variables were examined independently using the t-statistic only.

Data obtained from a second questionnaire for subjects (S2) (Grouping 5) will be reported, but an insufficient number of questionnaires were returned to make statistical analysis or interpretation meaningful. Likewise, data from telephone follow-up interviews will be reported but will not be analyzed statistically or interpreted.

It was felt that because of the large number of DV's examined in this study, great caution in interpretation was
required owing to the possibility of spurious findings due to family wise error rate. It was decided, therefore, that only DV's approaching a significance level of alpha = .01 would be seriously interpreted. Lesser significance levels would be discussed as trends in the data only.

Demographic data. Demographic data were examined to assure that the experimental and control groups did not differ significantly from each other on these dimensions. Sex of subjects was distributed evenly between groups. There was only one Black subject; the rest were Caucasian, so the groups were considered essentially homogeneous with regard to race. The groups were compared statistically as to age of subjects and educational level of subjects, and were found to be essentially similar. Table 1 shows these results (See Appendix J).

First therapist questionnaire. The individual Likert scale items associated with this questionnaire (T1) are as follows.

1. How much do you think you will enjoy working with this client? (Therapist 1-1)

2. How clearly do you think this client understands the process of therapy? That is, how clearly do you think he or she understands what a client should do to obtain maximum benefit from therapy? (Therapist 1-2)

3. In your opinion, how likely is this client to arrive at his or her goals? (Therapist 1-3)
4. In terms of being realistic and attainable, how appropriate are this client's therapy goals? (Therapist 1-4)

Table 2 shows the results of t-calculations for the variables associated with the first questionnaire given to therapists (T1). None of the differences observed on these DV's were statistically significant (See Appendix K). Table 3 shows an intercorrelation matrix for these data (See Appendix L). Table 4 summarizes the results of a discriminate function analysis performed on these DV's (See Appendix M).

These results suggest that the best discrimination between control and experimental groups is a weighted formula which uses data from variable Therapist 1-3 and variable Therapist 1-4. The maximal predictability based on this formula, however, is limited (P = .12).

Questionnaire for subjects. The individual Likert scale items associated with this questionnaire are as follows.

1. How happy are you with the treatment, information and service you have received from this clinic so far? (Subject 1-1)

2. How effective do you think your therapist is with other people? (Subject 1-2)

3. If a friend asked you about this clinic, how would you rate it? (Subject 1-3)

4. How effective do you think this clinic is with other people? (Subject 1-4)
5. How clearly do you think you understand the process of therapy? That is, how clearly do you understand what you should do to get the maximum benefit? (Subject 1-5)

6. You were probably given a pamphlet to read when you first came to the clinic. Did you read it? If you read it, how useful did you find the information in it? (Subject 1-6)

7. How well do you think this client respects the wishes of its clients? (Subject 1-7)

8. How likely do you think you are to achieve what you want in therapy? (Subject 1-8)

9. If you were to take just what you know now and try to solve your problems on your own, without the help of a therapist, how would you rate your chances for success? (Subject 1-9)

A final item on this questionnaire (subject-value) asked for a dollar value rather than a Likert scale rating: "Finally, most psychologists in private practice charge about $70.00 per hour for their service. How much do you think the service and information you have received so far is worth?"¹

Table 5 shows the results of t-calculations for the DV's associated with the first questionnaire given to subjects (See Appendix N). These results suggest that two DV's

¹Responses indicating that therapy was too valuable to be measured in dollars were coded as the mean of the three highest actual dollar values given or $160.
approached statistical significance; the rest did not. The
dollar value placed by subjects on their therapy seemed to
be significantly lower for subjects in the experimental group
than for subjects in the control group ($P = .02$). Subjects
in the experimental group, however, seemed more likely to
rate the Clinic as effective with other people ($P = .02$).

An intercorrelation matrix for these variables is shown
in Table 6. It is of interest that neither variable approaching statistical significance is highly correlated with any
other variable (See Appendix 0).

Table 7 summarizes the results of a discriminate func-
tion analysis performed on these DV's (See Appendix P). These
results suggest that the best discrimination between control
and experimental groups is a weighted formula which uses
data primarily from the subject-value variable and the
subject 1-4 variable. Data from the subject 1-7 variable
was considered but to a lesser extent. It should be noted
that the probability of these data having generated a formula
with this predictability by chance alone is quite small ($P
= .001$), thus these results were considered rather significant.

**Questionnaire for therapists following termination or
tenth session.** The individual Likert scale items associated
with this questionnaire are as follows.

1. How well did this client reach his or her therapy
goals? (Therapist 2-1)
2. Did this client's interpersonal relations improve as a result of therapy? (Therapist 2-2)

3. How well did this client achieve overall improvement? (Therapist 2-3)

4. How easy was it for you to work with this client? (Therapist 2-4)

5. How psychologically sophisticated do you think this client is? (Therapist 2-5)

6. Compared to other clients in your experience with similar problems, how soon did this client catch on to the therapy process? That is, relative to others, how soon did this client begin to show signs of making progress, or give evidence of reaching a "turning point" in therapy? (Therapist 2-6)

Table 8 shows the results of t-calculations for these DV's (See Appendix Q). These results suggest that none of these variables approached statistical significance.

Table 9 shows the intercorrelation matrix for these DV's (See Appendix R).

Finally, no discriminate function analysis could be performed on these DV's because none of the variables discriminated between groups sufficiently. It must be concluded, therefore, that these data were essentially equivocal.

Questionnaire for subjects following termination or tenth session. Table 10 summarizes the responses of subjects to a final questionnaire given to them after their tenth
therapy session, or after termination of therapy if it occurred before 10 sessions. Only seven questionnaires were returned (three control, four experimental) so statistical analysis was not attempted. Group means are reported for purposes of illustration only (See Appendix S).

Behavioral data. The DV's for this grouping of data were as follows:

1. Behavioral rating of goal setting, based on 1-5 scale developed a-priori for this study and made from a review of audio tapes of therapy sessions (Behavior-Goal) (See Appendix H);

2. Behavioral rating of subject's ability to take personal responsibility for change in therapy, based on 1-5 scale developed a-priori for this study and made from a review of audio tapes of therapy sessions (Behavior-Responsibility) (See Appendix G);

3. Subject's attendance at therapy sessions, taken from Clinic records and expressed as a ratio of sessions attended/total sessions scheduled. (Behavior-Attendance)

Table 11 shows the results of t-calculations for these data (See Appendix T). Neither DV based on a rating of therapy tapes (Behavior-Goals, Behavior-Responsibility) approached statistical significance. Experimental subjects, however, seemed to attend therapy more often than control subjects, although the difference in group means only approached significant levels (P = .10).
Indications that pamphlet was read. All subjects in the experimental group indicated that they had read the pamphlet given them at intake. One control subject indicated that he had not read it.

Telephone follow-up data. A total of seven subjects (four control, three experimental) were successfully contacted by the experimentors. Each was given the following instruction: "Our records show that you stopped coming to therapy at the psychology clinic. Tell me what led you to do that." Of the respondents, two control and one experimental subject replied that they had moved away from the area. One control responded that he had achieved success and one reported that she decided therapy was not what she expected. One experimental subject reported that he had decided to attend another clinic, and another reported that he was dissatisfied with the therapist.

Respondents were then asked the following questions which were coded as numerical Likert scales.

1. If you were to assign a grade, like in school, to your therapist, what would it be? (Telephone 1)
2. What grade would you give the clinic itself? (Telephone 2)
3. Was the clinic what you expected? (Yes, probably, maybe, probably not, no) (Telephone 3)
4. If the need arose, would you come back again? (Yes, probably, maybe, probably not, no) (Telephone 4)
Finally, each respondent was asked if he or she had based their decision to leave therapy on the pamphlet given them. All responded negatively.

Table 11 shows the individual subject response to questions 1-4. For purposes of calculation, a grade of "A" was coded as 12, "A-" as 11 and so on down to "F" which was coded as 1. On items 3 and 4, a response of "Yes" was coded as 5, and "No" was coded as 1 (See Appendix U).

Questions omitted. Questionnaires given to therapists contained questions about subject diagnosis but therapist compliance with this item was poor. Many therapists declined to diagnose their clients and many diagnoses when given were incomplete. For these reasons, these data were not reported.

Therapists were also asked to describe the therapy framework used with each client and to describe any strategies used in treating the client. Compliance with these items was also poor so these items were similarly disregarded.

It was disappointing that these questionnaire items were not usable, but it was felt that therapist compliance was generally good and that the omission of these few items was not worth further imposition on the therapists or the Clinic.

Discussion

Among the advantages gained by the design of this study is the opportunity to test the therapy introduction document with an actual clinical population in an on-going psychological
clinic. This design permits the evaluation of both process and outcome variables and the examination of large amounts of information. Many of the questions this study addresses could not have been answered by research using analogue subjects; indeed this study is intended to be as a clinical follow-up to an analogue investigation of the same introduction document (Smith, 1982). The disadvantages of this design, however, include the difficulties and limitations which are usually found when large numbers of subjects are involved in a study without the controls provided by analogue procedures. Actual clinical subjects, for example, forget to return questionnaires, and tend to misunderstand experimental instructions, resulting in lost or missing data. In addition, the very fact that large numbers of experimental variables are examined increases the possibility that some results seem significant when they actually are not, simply as a result of chance or familywise error rate. For these reasons, great caution is used in interpreting the results of this study. Although a number of observed differences between groups appear to reach statistical significance, these are interpreted with great caution pending future replication. In spite of these difficulties and cautions, however, it is felt that this investigation proved to be worth while. Although the findings do not permit the formulation of an accurate model of the effects of the introduction document with all populations, they do provide an interesting
overview of its effects. A number of trends emerged from this investigation which point the way for future research and allow for speculation about some unexpected findings.

The overall pattern of results for this investigation suggests that one grouping of data (Grouping two) yields meaningful results while the other groupings yield trends at best. In spite of the interpretive limitations inherent in this study, this clustering of significant findings in one area can be taken as supportive of the overall validity of the experimental design. While there is risk in this kind of speculation, it is interesting to note that only the questionnaires given to subjects immediately after they read the document resulted in significant differences between experimental and control groups. If the experimental design is prone to yielding spurious results, such results would be expected to crop up throughout the data base. On the contrary, only one area stands out and shows differences reaching meaningful significance.

If, then, the results of the first questionnaire for subjects (Grouping two) are meaningful, a number of questions are raised. It is suggested by these data that experimental subjects differ from control subjects in two important ways. According to both t-calculations ($P = .02, P = .02$) and step-wise discriminate function analysis ($P < .01$), experimental subjects are more likely to see the psychology clinic as effective with other people, but they are also more likely
to devalue psychotherapy in terms of dollars. The subjects' view of the effectiveness of the Clinic was expected and was an intended effect of the document, but subjects' tendency to devalue therapy was not expected. If the typical experimental subject believes the Clinic is effective with others, why does he or she place a significantly lower dollar value on the process of psychotherapy as practiced in the Clinic.

In order to answer this question, it is necessary to engage in a bit of speculation. Sloan, et al. (1970) describes the "faith induction factor," believing it to be an important part of the success of therapy induction procedures. According to Sloan, it is necessary to build an expectancy of personal success in the mind of the subject so that he or she will have the confidence to engage in the actual behaviors which will bring about that success. In examining the content of the experimental document, no such "faith factor" is found. This is to say that no mention is made of any rationale for the efficacy of psychotherapy and no words of encouragement are given to subjects suggesting that they can expect to find success. Thus, as the data suggests, subjects may see how the Clinic could be successful with some persons (perhaps persons who can easily engage in the suggested behaviors), but they may not see the Clinic as likely to help them personally. Thus, they see psychotherapy as a process that is less likely to help them, and they rate it as less valuable than control subjects rate it.
Another and perhaps more interesting speculative explanation of these results involves a possible tendency of the document to make the process of psychotherapy seem mundane and tedious. The document goes to great lengths to describe the difficulties and pitfalls of psychotherapy. It even encourages subjects to rely on themselves when they were probably expecting to rely on their therapist. It is quite possible that a number of positive expectations which subjects might have had about psychotherapy were destroyed by the document. After all, why would a subject want to pay a great deal of money for a service which makes him or her do most of the work? Granted, the same subject might be able to see how such a service could help others, but after reading how much personal effort is expected, might be less willing to pay a great deal of money for it.

Although the most significant results of the study seem to have been those described above, a number of trends emerged in the other areas. Among these are the results of Grouping one data, which were intended to reflect the therapists' reactions to and impressions of subjects who read or did not read the document. Although the significance level is quite weak ($P = .12$), stepwise discriminate function analysis suggests that the therapists of the experimental subjects see their clients as having set less appropriate goals and as being less likely to arrive at those goals than control subjects. It must be pointed out, however, that neither
of these variables reach significance when experimental and control groups are compared individually using the t-statistic ($P = .14$, $P = .44$). This finding is, therefore, only a weak trend in the data which requires replication before it can be taken too seriously.

A possible explanation of this weak but unexpected trend, however, could be that the experimental document introduces the idea of goals to subjects who would otherwise not think of them at all. The document, perhaps, starts subjects thinking in terms of goal setting, but does not succeed in actually improving their goal setting skills. Therefore, when the experimental subjects bring up the idea of goals in therapy, they seem to the therapist to be thinking in terms of inappropriate therapy goals. The control subjects, on the other hand, bring no such goal setting intent into the therapy session so any goals they discuss are a product of interaction with the therapist, and, therefore, seem more appropriate to the therapist.

The results of analysis of data from Grouping four were expected to show behavioral changes caused by the experimental document. Only one behavioral measure, attendance, approaches statistical significance, however ($P = .10$). This finding is quite weak and is best regarded as a trend in the data, but it suggests that the admonitions in the experimental document about keeping appointments may have been effective.
ratings of goal setting and responsibility taking, but it does not. A possible explanation for this variability in behavioral measures could be that instructions to attend therapy are much more concrete and easily followed than vague instructions about taking responsibility and setting goals.

Insufficient data is available from Grouping five to permit any interpretation or discussion. It will be recalled that this grouping was intended to reflect attitudes at the end of the therapy process.

The document was written in a choice format and distributed in the form of a professionally printed pamphlet in an attempt to encourage subjects to actually read the material. This intent seems to be realized with this study sample as only one person (control group) indicates that he or she had not read the document. It should be pointed out, however, that the sample in this study is quite literate (mean number of years of education exceeded two years of college) and might be expected to make a habit of reading most things given to them.

Finally, the choice format of the document which was intended primarily as a device to encourage reading of the document seems to be largely ignored. Only three therapists report any choice at all made by a subject. This finding was largely anticipated and is of little concern since the choices were not intended to effect the actual course of therapy.
In examining the findings of this study, and the lack of significant findings in some areas of investigation, an important question arises: Were the measuring scales used sensitive enough to detect all of the actual differences between groups that may have been present? Calculations to show the statistical power of the various Likert rating scales suggest that a difference between means of $D = 1.06$ scale points for Grouping one data and $D = 1.04$ for Grouping two data would have yielded results significant at the $P = .05$ level. It is felt that these differences could have been obtained on a seven point scale, as they were in certain cases, and, therefore, these rating scales should be considered adequately sensitive.

The same calculations performed on the scales used for Grouping three data, however, suggest that in order to reach statistical significance at the $P = .05$ level, a difference between means of $D = 2.05$ would have to have been obtained. It is felt that such a difference would be hard to achieve on a seven point scale, and that perhaps a more sensitive measuring technique would have detected effects.

Along these lines, the five point rating scale of goal setting behavior would have required a difference between means of $D = 1.52$ to reach the $P = .05$ level of significance. Likewise, the five point scale of responsibility taking would have required a difference between means of $D = 1.00$. It is felt that five points may not have represented enough
gradations of discrimination for these measures. Perhaps differences were masked by relatively few options available to raters in measuring these dimensions. This is to say, differences may have existed between groups on these dimensions, but the measuring scales were too coarse to detect them.

In speculating about the overall effect of this document, it seems to produce somewhat mixed results. On the one hand, it probably communicates the idea to subjects that the psychology clinic is effective, at least with other clients, and although the results are not as strong, it may improve the attendance rates of subjects who read it. On the other hand, the document has the unexpected effect of causing subjects to devalue the psychotherapy process.

While these results are puzzling, and in a sense self-contradictory, they provide an opportunity to speculate about the effects of therapy introduction documents. It may not be stretching the point too far to conclude that documents such as this are good at communicating mundane facts and procedures to clients (keeping appointments, understanding how the Clinic could be effective), but are apt to destroy a little of the "magic" of psychotherapy in the process. The psychotherapist has been compared to the tribal "shaman" or magical healer. His or her effectiveness has been said to depend, in part, on the client's belief in the therapist's ability to "cure." It is, in fact, difficult to discount
the role played by expectancy, non-specific-effects, placebos or even "magic" in psychotherapy. People come to a therapist with all kinds of expectations, some of which are accurate, but some of which are based on the hope that they can tell their troubles to the "shaman" and be "cured." Perhaps it is the document's discounting of this magic which causes subjects to devalue the therapy process after reading it. After all, would we pay as much to see a stage magician if we knew exactly what he or she was going to do and how he or she was going to do it?

Whether or not the metaphor of the shaman is applicable in this case, the document's effect of causing the therapy process to be devalued remains puzzling. It is hoped that future research will attempt to replicate this finding and, if successful, attempt to isolate the factors in the document which lead to this unexpected result.

It is assumed for purposes of this investigation that psychotherapy is a homogeneous concept and that psychotherapy clients are a homogeneous population. Clearly this is not the actual case, but perhaps if the document's effects are evaluated with different populations, meaningful findings will emerge. It may well be, for example, that there are groups of clients that need to have some of the magic removed from their expectations about therapy. The marriage counselor, for example, might want his or her clients to have the most down-to-earth understanding of the therapy process possible
and might want to eliminate any undue positive expectancy from the beginning. In such a situation, a document such as the one tested here might prove very useful. On the other hand, the hypnotherapist who wants to eliminate pain through hypnotic suggestion would want to rely on all of the positive expectancy he or she could muster. Such a therapist would probably want to avoid the present document, but might want to substitute one that avoids specific descriptions of therapy behavior in favor of building client faith and positive expectancy.

Finally, since the data do suggest some positive results in the form of attendance and belief in the effectiveness of the clinic, it is hoped that different versions of the document will be investigated. It is hoped that a version of the document, perhaps one that pays more attention to the "faith induction factor," will be tried. Perhaps it is still possible to communicate useful information about therapy without destroying the "magic" at the same time.
THINGS EVERY CLIENT SHOULD KNOW:

Please read this pamphlet very carefully before your next appointment.

Your therapist will ask you if you have read and understood this information; it is important and may help you very much.

You will want to keep this pamphlet and refer back to it as your treatment progresses.
YOUR CHOICES IN THERAPY

Here in this clinic, the first session or two is usually spent setting some ground rules and beginning to define your problem. This pamphlet is designed to give you a "head start" and point out in advance some choices that you have and some things that you can do to help the process along. After all, the sooner you and your therapist can get the first steps out of the way, the sooner you will begin to make real progress.

PLEASE READ AND THINK OVER THIS PAMPHLET VERY CAREFULLY SO THAT YOU CAN TALK OVER THESE CHOICES WITH YOUR THERAPIST.

THE KIND OF SERVICE WE CAN OFFER YOU INCLUDES THESE THREE CHOICES—
CHOICE ONE

HELP WITH A SPECIFIC CRISIS OR PROBLEM.

This kind of therapy is designed to help you with one or two problems that are very serious to you, right now. The purpose is to find a way to "get back on your feet" or get control of a situation that has gotten out of hand.

IF YOU AND YOUR THERAPIST DECIDE THAT THIS IS THE KIND OF THERAPY FOR YOU, THEN THIS IS WHAT YOU SHOULD DO:

A Starting right now, try to think of a few very simple, concrete "goals". When you reach these goals, you can move on to others in a step-by-step manageable way. For example, think of something simple and direct that you can do before your very next session. A goal can be a small step—it doesn't have to be large to be in the right direction. Your therapist will help you see that difficult problems are best worked out a little bit at a time.

B Unless there is another person involved in therapy with you, most of the work of changing is going to fall on you. For this reason, try to think of goals and steps that you can take yourself. Your therapist will give you a lot of help with these things, but you will have to do most of the changing yourself. Most people's problems involve another person. When that person is not involved in therapy, however, they are not likely to change their ways very much. For this reason, trying to make someone else change is not a good goal for you. Stick to things you can do yourself, or make a goal of bringing that person in to therapy with you.

C Finally, keep your appointments. When you feel like skipping one or dropping out altogether, you are probably close to an important step. Come in and talk about the hesitation you are feeling. don't give up.
CHOICE TWO

HELP MAKING LONG TERM, MORE GENERAL CHANGES.

Unlike choice one, this kind of therapy focuses on more long term patterns or chains of events in your life. If the trouble you are having seems to be part of a long series of problems, this may be the right choice. You may wish to save this choice for later, however, if there is an immediate, "Choice One" type problem that you want to solve first.

IF YOU AND YOUR THERAPIST DECIDE THIS IS THE KIND OF THERAPY FOR YOU, THEN THIS IS WHAT YOU SHOULD DO:

A Make an effort to look at the way troublesome situations have developed over time. Your problems of the day are best dealt with as examples of larger patterns or chains of events, so try not to dwell on every day annoyances and irritations. "Goals" are still best when they are kept simple and manageable, but the one-step-at-a-time solution might begin with giving your therapist a detailed history of your problem or simply beginning to develop a trusting relationship between the two of you. As you can see, "choice two" is for more long term problems.

B Just as in choice one, this kind of therapy might get into problems that seem to center around another person in your life. At some point, a goal in therapy might be to have that person come in with you, but as long as it is just you, stick to goals that you can do something about. Again, trying to force change in someone else is not a good goal.

C You may find that as you begin to change long standing patterns in your life, the work of changing becomes harder. Your friends and family may have liked things better the way they were, even if they weren't the best for you. Even you might feel more comfortable if you didn't have to change. When you feel like quitting, or skipping an appointment, don't! Come in and talk it over, you may have only been moving a little too fast!
CHOICE THREE

NO THERAPY AT THIS TIME.

After reading a pamphlet like this, or coming to a session or two, some people decide that therapy is not really what they had in mind.

For example, you may have expected more direct, simple to follow, "expert advice" than we are likely to give. After all, your therapist is not going to tell you exactly what you should do. He or she can only help you find your own solutions.

If you expected medicine or medical treatment, you may be disappointed as well. With only a few exceptions, we must refer you to someone else for these things.

Finally, many people find that they only needed to talk to someone briefly, and one session was enough. Likewise, many people decide that a better source of help for them is their clergy, helpful friends or their family.

IF YOU DECIDE NOT TO CONTINUE—

We ask only that you be certain that neither you nor anyone involved with you is in danger if you don't have the support of a therapist. Talk over this decision with your therapist before you leave, and remember, if your needs change, we'd be glad to see you again.
THINGS EVERY CLIENT SHOULD KNOW:

Please read this pamphlet very carefully before your next appointment.

Your therapist will ask you if you have read and understood this information; it is important and may help you very much.

You will want to keep this pamphlet and refer back to it as your treatment progresses.
The North Texas State University Psychology Clinic is a non-profit organization that exists for two basic reasons:

1. A SERVICE TO YOU AND THE DENTON AREA COMMUNITY—

First of all, the clinic is here to provide a service to the community of Denton and the surrounding areas. Psychological testing, counseling, individual therapy and group therapy are provided to children, adults and families on a "sliding fee" scale. Our clients are asked to pay what we consider a fair fee, based on their amount of income, family size and other special circumstances. The purpose of the fee is to cover our expenses, not to make a profit.

Psychological service can be invaluable to those who need or want it, and we feel strongly that such service should be available to people, regardless of their ability to pay.

As a client of the clinic, feel free to ask questions about your case and about those persons involved with it. You may certainly know the qualifications of any person connected with your case and the rationale for any technique that is used. The clinicians that you will come in contact with will be at various levels of training but they are all carefully supervised.
2. THE CLINIC IS A TRAINING FACILITY AS WELL—

The second major function of this clinic is to train psychologists and psychological associates. More than likely, your therapist will be a student in his or her third year of graduate education. He or she has had considerable training in the classroom, and is now putting that learning to work under careful supervision.

Since this is a teaching facility, your case will be monitored by your therapist's fellow students as well as his or her supervisor. This monitoring may include listening to tapes of your therapy sessions or sometimes direct observation through a "one way" window. We assure you that we take your right to privacy very seriously, however, and our interest in your case is purely professional in nature. You may be certain that details of your case will not be discussed outside of a professional clinical setting.

Finally, if you have any questions about your case, or the way the clinic functions, please feel free to ask your therapist; he or she will be glad to help.
North Texas State University
Denton, Texas
Appendix C

Confidential Feedback

It would be a great help to us if you would answer a few questions about the service you have received from this clinic. If you do not want to answer these questions, it will not effect the way you are treated by the clinic, but you would be doing us a great favor if you did answer them. This form is for research only and not even your therapist will know how you responded. We will assume if you answer the questions, that you have given your permission for the researchers only to see how you responded.

Thank you very much for your cooperation.

For questions 1 through 9 circle one number under each question. Assume that the numbers mean the following:

1 - Terrible, the worst you can imagine
2 - Poor
3 - Fair
4 - Average, about what you expected
5 - Good
6 - Very Good
7 - Excellent, the very best you can imagine

1. How happy are you with the treatment, information and service you have received from this clinic so far?

- 1 2 3 4 5 6 7

2. How effective do you think your therapist is with other people?

- 1 2 3 4 5 6 7

3. If a friend asked you about this clinic, how would you rate it?

- 1 2 3 4 5 6 7

4. How effective do you think this clinic is with other people?

- 1 2 3 4 5 6 7
5. How clearly do you think you understand the process of therapy? That is, how clearly do you understand what you should do to get the maximum benefit?

1  2  3  4  5  6  7

6. You were probably given a pamphlet to read when you first came to the clinic. Did you read it? ___Yes ___No If you read it, how useful did you find the information in it?

1  2  3  4  5  6  7

7. How well do you think this clinic respects the wishes of its clients?

1  2  3  4  5  6  7

8. How likely do you think you are to achieve what you want in therapy?

1  2  3  4  5  6  7

9. If you were to take just what you know now and try to solve your problems on your own, without the help of a therapist, how would you rate your chances for success?

1  2  3  4  5  6  7

Finally, most psychologists in private practice charge about $70.00 per hour for their service. How much do you think the service and information you have received so far is worth?

____________________dollars per visit

If you have any comments or suggestions about these questions or any matter related to your experience with this clinic, please make them below.
Questionnaire for Therapists Following Session Three

Client Name: __________________________

Therapist Name: _______________________

Please rank this client on the following dimensions. Assume a score of "1" to represent the very worst case in your experience, "4" to represent the average or expected case and "7" to represent the very best case in your experience. The idea is for you to give very few "1's" or "7's" so that the end points of the scale will represent only extreme cases. Thank you very much.

1. How much do you think you will enjoy working with this client?
   1  2  3  4  5  6  7

2. How clearly do you think this client understands the process of therapy? That is, how clearly do you think he or she understands what a client should do to obtain maximum benefit from therapy?
   1  2  3  4  5  6  7

3. In your opinion, how likely is this client to arrive at his or her goals?
   1  2  3  4  5  6  7

4. In terms of being realistic and attainable, how appropriate are this client's therapy goals?
   1  2  3  4  5  6  7

5. According to this client, did he or she read the pamphlet given them at intake? __Yes __No

6. Diagnostic Impression (DSM III):
   Axis I __________________________
Appendix D--Continued

Axis II

Axis III

Axis IV

Axis V

Comments:
Appendix E

Confidential Feedback

It would be a great help to us if you would answer a few questions about the service you have received from this clinic. You may have filled out a questionnaire like this a few weeks ago, but we are interested in how your opinions might have changed. Again, if you do not want to answer these questions, it will not effect the way you are treated by the clinic, but you would be doing us a great favor if you did answer them. This form is for research only and not even your therapist will know how you responded. We will assume if you answer the questions, that you have given your permission for the researchers only to see how you responded.

Thank you very much for your cooperation.

Your name: ____________________________

For questions 1 through 8 circle one number under each question. Assume that the numbers mean the following:

1 - Terrible, the worst you can imagine
2 - Poor
3 - Fair
4 - Average, about what you expected
5 - Good
6 - Very Good
7 - Excellent, the very best you can imagine

1. How happy are you with the treatment, information and service you have received from this clinic so far?

   1  2  3  4  5  6  7

2. How effective do you think your therapist is with other people?

   1  2  3  4  5  6  7

3. If a friend asked you about this clinic, how would you rate it?

   1  2  3  4  5  6  7
4. How effective do you think this clinic is with other people?
   1 2 3 4 5 6 7

5. How clearly do you think you understand the process of therapy? That is, how clearly do you understand what you should do to get the maximum benefit?
   1 2 3 4 5 6 7

6. You were probably given a pamphlet to read when you first came to the clinic. Did you read it? Yes No If you read it, how useful did you find the information in it?
   1 2 3 4 5 6 7

7. How well do you think this clinic respects the wishes of its clients?
   1 2 3 4 5 6 7

8. How well did you reach the goals you had for yourself in therapy?
   1 2 3 4 5 6 7

9. Over the course of therapy, did you notice any change in your relationships with other people? (Let "1" mean they got much worse, "4" mean they stayed about the same and "7" mean they got very much better.)
   1 2 3 4 5 6 7

10. How would you rate your overall improvement as a result of therapy?
    1 2 3 4 5 6 7
11. During which session (if any) do you think you began to make real progress toward your goals or aims in therapy? That is, when did you begin to really catch on to the change process and realize what it would take to accomplish what you wanted? (1st session, 2nd session, 3rd session, etc.)

________________________ session

12. Finally, most psychologists in private practice charge about $70.00 per hour for their service. How much do you think the service and information you have received so far is worth?

________________________ dollars per visit

If you have any comments or suggestions about these questions or any matter related to your experience with this clinic, please make them below or on the back.
Appendix F

Questionnaire for Clinicians
Following Termination or Tenth Session

Client: ______________________
Clinician: ____________________

Assume a score of "1" to be the worst outcome of a case in your experience, a score of "4" to be the average or expected outcome and a score of "7" to be the very best outcome of a case in your experience.

1. How well did this client reach his or her therapy goals?
   1 2 3 4 5 6 7

2. Did this client's interpersonal relations improve as a result of therapy?
   1 2 3 4 5 6 7

3. How well did this client achieve overall improvement?
   1 2 3 4 5 6 7

4. How easy was it for you to work with this client?
   1 2 3 4 5 6 7

5. How psychologically sophisticated do you think this client is?
   1 2 3 4 5 6 7

6. Compared to other clients in your experience with similar problems, how soon did this client catch on to the therapy process? That is, relative to others, how soon did this client begin to show signs of making progress, or give evidence of reaching a "turning point" in therapy? (Assume a "1" to be never, "4" to be an average amount of time and "7" to be very early).
   1 2 3 4 5 6 7
7. Current DSM III diagnosis. (This may have changed over the course of treatment)

Axis I ________________ Axis IV ________________

Axis II ________________ Axis V ________________

Axis III ________________

8. Briefly describe the therapy modality you used with this client. (Often a few words will be enough, for example, "RET," "Behavioral contracting," "Insight therapy," "Didactic therapy," etc.)

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

9. Did this client choose a therapy framework (short term, long term or no therapy at all) based on having read the therapy introduction pamphlet? yes no. Framework chosen: ________________________________

Please comment on to what extent you followed that framework or suggested other options.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
Appendix G

Instructions to Raters: Responsibility Rating

The target dimension for this scale is the client's acceptance of personal responsibility for change in therapy. It is the degree to which what a client says reflects an understanding that the therapeutic process will require them to take steps personally. It is the degree to which they understand that expecting other people to change or expecting magical "cures" from the therapist is not appropriate.

Level 1 - This level describes a client who is primarily concerned with changing someone else. This person believes that their problems would be solved if someone else would only do things differently. They seem to believe that an outside person or agency is the source of their trouble. Score this level if there is no evidence that this person understands that he or she can take action to help himself or herself.

Level 2 - This level describes the client who believes that the therapist will be the agent of change. He or she may believe that they need to change, but they expect the therapist to take responsibility for that change. They expect the therapist to take over or do something to them to make them better. Do not score this level if the client brings in ideas of his or her own for ways to change, but wants the therapist's opinion.
Level 3 - This level is intended to be more or less neutral. The material on the tape does not seem relevant to behavior change or responsibility taking. Tapes of this level may be concerned with history, descriptions of problems, client and therapist getting to know each other, etc.

Level 4 - This level is for clients who seem to have considered the possibility that they could do something to help themselves but decided that such a course of action would not work. For example: "I know that I'm the one who needs to do the changing, but if my husband would just . . . ."

Level 5 - This is the client who seems to have thought in terms of taking responsibility personally and who has some idea of what to try. Do not judge the quality of their ideas, only if they have thought of some.

Just as on the other scale, score the highest appropriate level on a tape.
Appendix H

Instructions to Raters: Goal Setting

The target dimension for rating therapy tapes is client understanding of appropriate therapy goals. The key factor is the client's behavior, not the therapist's. The degree to which a client seems to already have an understanding of goals, as defined here, the degree to which he or she can accept suggestions made by the therapist with respect to goals and the appropriateness of the goals themselves are to be the deciding factors. Please score the client's goal setting behavior with respect to the levels listed below. If different goals seem to fall in different levels, score the highest attainment of appropriate goal behavior.

Definition. A good therapy goal is one that can be accomplished by the client, personally. It may have a long range quality to it, but steps are identified that can be taken immediately.

Level 1 - Absolutely no mention of goals were made. The client showed no understanding that therapy would involve working toward something. He or she may have spent the entire time explaining a problem, complaining about other people or simply making conversation. Do not score this level if the therapist brings the conversation around to goals and the client goes along. If the therapist brings goals up and the client ignores it, however, score this level.
Level 2 - The client seems to understand that something must be accomplished in therapy, but does not have an idea that goals should be set and kept manageable. Score this level if the client talks about vague, general directions like "Not being depressed" or "Learning to get along with people better," but is unable to understand the idea of breaking the process down into small steps. If the therapist brings up the idea of more appropriate goals, and the client goes along with it and seems to understand, do not score this level. If the therapist brings it up and the client still can only grasp vague general directions, score this level.

Level 3 - The client is able to understand and accept reasonable goals, but only after the therapist brings them up. Do not judge the quality of goals suggested by the therapist; if he or she brings them up and the client readily accepts them, score this level.

Level 4 - The client seems to already have some idea of what an appropriate goal might be. Score this level if they seem to understand that they need to work in a direction, and that they will need to set reasonable goals along the way. Score this level also if the goal suggested by the client is not accepted by the therapist, but shows some understanding of a step-by-step process. For example, if the client suggests something he or she would like to do before the next session that is related to solving his or her problem, but the therapist makes modifications, score this level. Score this
level if the client seems to know that therapy should involve goals, but needs help setting his or her own. The main difference between this and Level 3 is that the client seems to know about goals for Level 4. For Level 3, they are receptive to the idea, but it was clearly a new idea to them. Score Level 4 if the therapist mentions goals first, but the client's response indicates that they have thought about the idea before.

**Level 5** - This level is reserved for clients who almost seem to know more than the therapist. They come in with well thought out goals in mind and merely need to check with the therapist. Score this level if the therapist readily approves whatever the client wants to do, or if in your opinion, the goals suggested by the client are clearly superior to those of the therapist. Remember, an ideal therapy goal is something that can be accomplished by the client and that can in some way be begun immediately. It does not involve changing other people unless that change can be reasonably carried out by the client. For example, a good goal could be to change a spouse's behavior through positive reinforcement (something the client has control over). A good goal might also be approaching a long standing problem with a small manageable step. For example, "I want to be divorced by next week" is not as good as, "I plan to discuss divorce with my husband by next week."
Appendix I

Telephone Interview for Dropouts:
Instructions to Callers

1. Identify yourself and explain why you are calling. Be somewhat persistent if they are reluctant to comply. (Stop short of offending the client, however)

2. "Our records show that you stopped coming to therapy at the psychology clinic. Tell me what led you to do that."

3. "If you were to assign a grade, like in school, to your therapist, what would it be? Example: A, A-, B+, B, B-, C+ . . . F."

   grade_____

4. "What grade would you give the clinic itself?"

   grade_____

5. "Was the clinic what you expected?"

   yes probably maybe probably not no

   "Explain:"

6. "If the need arose, would you come back again?"

   yes probably maybe probably not no

   "Explain:"

7. "Did the pamphlet you were given when you first came have anything to do with your decision to stop, and if so, please explain?"
### Appendix J

#### Table 1

**T-Statistic Comparison of Demographic Data**

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<tr>
<th>Variable</th>
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<th>Mean</th>
<th>Standard Deviation</th>
<th>T Statistic</th>
<th>Prob. of T</th>
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*Note.* Data was available for 28 subjects, 15 control, 13 experimental.
Appendix K

Table 2

T-Statistic Comparison of Grouping One Data

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Note. Data was available for 27 subjects, 12 experimental, 15 control.
Appendix L

Table 3

Intercorrelation Matrix of Grouping One Data

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Appendix M

Table 4
Stepwise Discriminate Function Analysis of Grouping One Data

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Note. Based on 47 observations, 4 variables.
### Appendix N

Table 5

T-Statistic Comparison of Grouping Two Data

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Note. Data was available for 21 subjects, 13 experimental, 9 control.
### Table 6

**Intercorrelation Matrix of Grouping Two Data**

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Appendix 0
Appendix P

Table 7

Stepwise Discriminate Function Analysis of Grouping Two Data

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Note. Based on 22 observations, 10 variables.
Appendix Q

Table 8

T-Statistic Comparison of Grouping Three Data

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Note. Data was available for 17 subjects, 8 experimental, 9 control.
Appendix R

Table 9
Intercorrelation Matrix of Grouping Three Data

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Appendix S

Table 10

Raw Scores of Grouping Four Data

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Appendix T

Table 11
T-Statistic Comparison of Grouping Five Data

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Appendix U

Table 12

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References


Fernbach, R. Preparation of clients for individual psychotherapy using a written document to orient expectations


Heilbrun, A. Effects of briefing upon client satisfaction with the initial counseling contact. *Journal of Consulting and Clinical Psychology*, 1972, *38*(1), 50-56.


