THE EFFECT OF CLIENT PREPARATION UPON INVOLVEMENT AND CONTINUATION IN PSYCHOTHERAPY

By

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The present study was designed to assess the effect of pretherapy client preparation upon factors associated with the initial phases of psychotherapy. These dimensions included levels of client involvement and counseling readiness during the initial patient/therapist contact. The second set of dependent measures included attendance and dropouts rates of clients involved in this study.

The comparable groups of twenty incoming therapy clients at a community mental health center were exposed to an intake procedure that either included a pretherapy preparatory interview of the normal intake interview. Time and therapist contact were equal for both groups. Tapes of these sessions were made and analyzed for level of

client involvement by means of the Experiencing Scale. At the close of the intake session, all subjects were asked to fill out the Adjective Checklist in order to derive Counseling Readiness Scale scores. Attendance rates and dropout rates were recorded subsequent to the intake session for a period of six weeks and eight weeks, respectively.

Results indicate that attendance was significantly higher in the experimental interview group. Dropout rates were almost double in the control group although this did not achieve a statistically significant level. Furthermore, not only were level of involvement scores significantly higher in the experimental group but these scores also achieved a significant positive correlation with attendance in therapy for all subjects. Finally, Counseling Readiness Scale data failed to differentiate between subject groups and did not relate in a meaningful way to other measures obtained in this study.

Findings of this study attest to the importance of the initial patient/therapist contact in forming the therapeutic relationship. Here, as in previous studies of this kind, pretherapy client preparation seems to relate to improved attendance and continuation in therapy. Furthermore, level of involvement is seen as a significant factor related to continuation in therapy.

CHAPTER I
INTRODUCTION

While much research has been devoted to outcome measures of psychotherapy, a problem has been overlooked or underestimated which precedes that consideration. That is, according to Baekeland and Lundwall (1975), between 30% and 60% of patients in outpatient mental health clinics terminate prematurely. In community centered clinics these figures are the highest: Overall and Aronson (1963) reported figures of 57% of patients dropping out after the initial interview; Saltzman, Luetgert, Roth, Creaser, and Howard (1976) found that three quarters of the incoming clients they studied dropped out by the sixth session.

Studies generally have shown dropouts to occur at the highest rates at the start of treatment (Freedman, Engelhardt, Hankoff, Glick, Kaye, Buchwalk, and Stark, 1958; Rosenthal and Frank, 1958; Overall and Aronson, 1963; and Baekeland and Lundwall, 1975). Furthermore, the problem of patient dropouts is compounded by the finding that these people rarely seek treatment elsewhere, according to Garfield, Affleck and Muffly (1963) and Reiss and Brandt (1965). These people undoubtedly have a more negative attitude toward mental health treatment as a result. Hollingshead and Redlich (1958) point out that this is particularly

a problem with the growth of the community mental health movement and its lower socio-economic status clients.

One bit of evidence which testifies to the detriment of dropping-out is the numerous studies which relate duration of treatment to treatment outcome (Lorr, Katz, and Rubinstein, 1958; Bailey, Warshaw, and Eichler, 1959; Luborsky, Auerbach, Chandler, and Cohen, 1971; and Saltzman et al., 1976). Of course, it seems an obvious point that therapy certainly cannot help anyone who does not return after their initial visit. No matter what value researchers assign to therapeutic elements, the premature terminator will not be exposed to them.

In examining early terminators, we are faced with the consideration of those elements which are particular to the development of a therapeutic relationship. One such element which has received attention recently is that of client involvement. Client involvement can be thought of as the degree to which a patient is willing to invest and express himself in therapy as well as his self-awareness. This concept will be explored more fully in this paper.

Lennard and Bernstein (1960) were among the first to identify client involvement as a key to the formation of the therapeutic relationship. They observed in their research that the necessary precondition for therapy was the ability of client and therapist to be able to carry on

meaningful communication and to mutually perceive their roles in therapy. In their research among low socio-economic status patients. Overall and Aronson (1963) felt the greatest obstacle to psychotherapy is a patient's minimal involvement in the initial phases of treatment. Kirtner and Cartwright (1958) observed that patient involvement from the outset--for them acknowledging responsibility and examining feelings and experience--was related to improvement. Rice and Wagstaff (1967) concurred with this finding.

More recently, Saltzman et al. (1976) conducted in-depth research into the relationship between involvement, continuation, and improvement. With particular emphasis on uncovering features of the earliest sessions, these researchers used both client and therapist measures of the patient's experience. Using subscales of the Multiple Affect Adjective Checklist that they devised for clients, they were able to gain some measures of therapeutically important features such as understanding, openness, scrutiny, continuity, movement, uniqueness, and respect. They found that these scales were able to differentiate the continuers from the dropouts as early as the first session and most significantly at the third, for those subjects who remained in therapy that long. Additionally, the therapist reports of these same factors differentiated continuers from terminators also as early as the first session and slightly more clearly at the third, with the most significant variables

being their ratings of patient involvement, responsibility and movement. Interestingly, none of the variables gained any predictive strength after the third session in their ability to discriminate continuers from non-continuers. This research provided a great deal of testimony for the importance attached to patients' experience during the first few sessions of treatment, and the particular significance of client involvement in the continuation of treatment.

Another contribution to understanding the importance of client involvement to the therapeutic endeavor has come from the research of Klein, Mathieu, Gendlin, and Kiesler (1970). They became involved with this concept through the development of the Experiencing Scale (EXP). The Experiencing Scale is a process measure which evaluates a patient's level of involvement during any point in a therapy session. As shall be seen, this measure has been shown to be a reliable and valid tool in the assessment of patient involvement (Klein et al., 1970).

Among the findings provided by the Experiencing Scale research is that greater levels of patient involvement are associated with higher verbal productivity and expressiveness as well as better ratings of outcome (Rogers, Gendlin, Kiesler, and Truax, 1967). This study also provided evidence of the stability of the instrument and its sensitivity during short periods taken from therapy sessions. Other research has also shown the relationship of patient involvement

as measured by the EXP and a variety of positive process and outcome measures.

Kiesler (1969) was able to demonstrate an association between EXP ratings and outcome based on counselors' ratings of improvement. Subjects involved included schizophrenic as well as psychoneurotic samples. Van der Veen (1965) related EXP level to rapidity of the formation of the therapeutic relationship and patient motivation. Across the many studies employing the EXP scale, Kiesler notes that, "the most powerful and consistent finding is that successful therapy patients start, continue, and end therapy at a higher level of experiencing than do less successful patients" (p. 11). The research attesting to the usefulness, reliability, and validity of this scale shall be reviewed in greater detail later in this paper.

A similar line of research is that based on the positive relationship between patient emotional involvement and therapy readiness, first reported by Burham in 1952. Heilbrun and Sullivan (1962) conceived of therapy readiness as a necessary ingredient towards developing a therapeutic relationship. In light of this they developed a Counseling Readiness Scale (CRS) to help identify those clients who would be most likely to continue in therapy and derive some benefit from it. Over the course of several studies, they found this measure of therapy readiness (CRS) to be able to discriminate not only between successful and non-successful therapy outcomes, but also between continuers and non-continuers

in treatment (Heilbrun, 1962; Heilbrun and Sullivan, 1962). The concept of counseling readiness and its relationship to client involvement has provided researchers greater insight into the crucial early stages of the therapeutic relationship. The concept of counseling readiness and the Counseling Readiness Scale of the Adjective Checklist shall be discussed further in the following section.

Another significant research program into the client involvement question was reported by Gomes-Schwartz in 1978. Thirty-five male counseling patients were assigned to therapists of varying levels of experience and either analytical or experiential in orientation. The process measure employed was the Vanderbilt Psycho-therapy Process Scale which was factored into seven derived scales that tapped dimensions hypothesized as predictors of outcome. These proved to be internally consistent and reliably rated throughout the project. The client factors which obtained significant validation consisted of patient exploration, patient participation, and patient hostility. These process factors were related to a variety of outcome measures that reflected the viewpoints of clients, therapists, and clinical observers. Gomes-Schwartz concluded that theoretical orientation and therapist experience did not have an impact on outcome. More importantly, all outcome measures including ratings by therapists, patients, and clinical observers were significantly predicted by "the patients'

willingness and ability to become actively involved in the therapy interaction" (1978, p. 1032). That is, patients' involvement during the early stages of interaction was the most consistently predictive measure of therapy outcome.

In her discussion of these findings, Gomes-Schwartz places a great deal of emphasis upon client involvement from the outset of treatment. She asserts:

> If the patient's willingness and capacity to participate in the therapy interaction are among the most important determinants of improvement in short-term therapy, one of the aims of future research should be to determine if and how positive involvement in therapy could be increased. (p. 1032)

She goes on to suggest role-induction procedures for just this purpose:

> If patients abilities to become involved in the therapy process were as much a product of inappropriate expectations about the psychotherapy enterprise as a lack of willingness to take responsibility for their own behavior, role induction procedures might be useful. . . . (p. 1032)

In line with this suggestion is an array of research testifying to the importance of client expectations for the formation of a beneficial therapeutic relationship. Also, research has provided abundant evidence for the merits of pre-therapy client preparation to overcome the obstacles supposedly created by inappropriate expectations. More specifically, studies have provided significant evidence that disconfirmation of participants' expectations may have adverse effects upon the formation of the therapeutic

alliance and continuation in therapy (Freedman et al., 1958; Lennard and Bernstein, 1960; Goldstein, 1960; Overall and Aronson, 1963; Horenstein and Houston, 1976). Lennard and Bernstein point out that dissymmetry of expectations between patient and therapist not only interferes with the therapeutic task, but can actually lead to the premature death of the therapy system, itself. Heine and Trosman (1960) concluded that a significant factor in predicting continuance in therapy is mutuality of expectations between patient and therapist.

It was the findings in this research exploring expectational factors which gave rise to the client preparation programs. These programs were aimed at correcting inappropriate expectations and providing a role orientation for clients entering treatment. Their success has been documented in many forms. Orne and Wender (1968) designed the Anticipatory Socialization Interview with the belief that providing patients with the correct set about their role in therapy would lead to a "more rapid engagement in the working alliance" (p. 1203). Hoehn-Saric, Frank, Imber, Nash, Stone, and Battle (1964) modified this Anticipatory Socialization Interview into their own Role Induction Interview which covered four topics: (1) a general discussion of what psychotherapy is; (2) the expected behaviors of both patient and therapist; (3) preparation for certain phenomena and topics in therapy, such as resistance; and

(4) expectations for duration of treatment. They designed a study using 40 subjects classified as "psychologically unsophisticated psychoneurotic patients." Half of the subjects randomly selected were administered the Role Induction Interview and compared to the half who received no pretherapy orientation. They found significant differences between treatment and control groups on three measures: the experimental group scored highest on the Therapy Behavior Scale in the third session, had a better attendance record, and received a better rating of the therapeutic relationship by the therapists. The findings of this research has been replicated in several different efforts involving individual adult incoming therapy clients (Nash, Hoehn-Saric, Battle, Stone, Imber, and Frank, 1965; Sloane, Cristol, Pepernik, and Staples, 1970; Lieberman, Frank, Hoehn-Saric, Stone, Imber, and Pande, 1972). This form of role induction interview has been employed with equal success in group therapy (Heitler, 1973, 1974; and Yalom, 1975).

Other forms of client preparation have also been attempted with positive results. Martin and Shewmaker (1962) used written instructions and found that their instructions fostered constructive patient behaviors, according to therapists. Strupp and Bloxon (1973), feeling that a more economical system was necessary, designed a role-induction film and compared it to a normal Role Induction Interview

as well as a no-treatment control situation. They found that both client preparatory procedures were significantly more effective than control in terms of contributing to patient behavior, attitudes, satisfaction, attractiveness, and progress. Venema (1972) found videotape role preparation to have a positive effect on the therapeutic process in the form of patient behavior and satisfaction. Truax and his co-researchers (Truax, Wargo, Carkhuff, Kodman, and Moles, 1966; Truax, Shapiro, and Wargo, 1968) used audiotapes of actual group sessions, comprised of desirable interactions, and found improvements on various measures of self-concept and therapy experience. Schlotthober (1975) employed a video-tape model and written instructions to prepare clients for a leaderless group. Finally, Whalen (1969) compared modeling versus modeling with instructions, measuring interpersonal openness as rated by independent judges, and found that modeling combined with instructions resulted in more interpersonal openness and feedback.

All of these studies have shown that client preparation is effective in helping patients to establish a therapeutic relationship and to derive benefits from treatment. While all of the client preparation studies have attempted to introduce some manipulation of intake procedures, they are lacking in measures of the particular effects of the manipulation. Gomes-Schwartz (1978) suggested the crucial ingredient to be client involvement. She felt that the reason

the client preparations were successful was in their ability to help patients understand therapy and their role in it, and as a result, to be able to become involved in treatment.

The present study is an attempt to shed more light on the role of client involvement as it relates to earliest stages of client therapy readiness and patient continuation. Research has shown a problem that leads to premature terminations is the inability to become involved in therapy. This is due, in large part, to the lack of understanding of the therapeutic process or the patient's role in it. Because it is up to the patient to "vote with his feet" on his commitment to the therapeutic relationship, it can be seen that the level of patient involvement could be a deciding factor in patient dropouts.

It has also been shown in research that there are methods which can help offset the barriers to patient involvement. There are several forms of special client preparation techniques which have all shown significant ability to improve patient continuation, (see Barnett, 1979). Those researchers who have employed process and outcome measures, as well as attendance and continuation assessments, have found positive relationships with client preparation.

The present method involves a comparison of a client preparation technique to a normal intake procedure in a community mental health center. This comparison was made

on the basis of client involvement and counseling readiness measures in addition to attendance and dropout rates. Client involvement is seen as the most salient of the intervening variables between intake and continuation in therapy. The primary hypotheses of this study were: (1) significantly higher rates of attendance and continuation expected in the experimental group; (2) significantly higher ratings of client involvement expected in the experimental group; and (3) a significant positive correlation between client involvement and continuation measures was expected. The secondary hypotheses of this study included: (1) significantly higher ratings of client counseling readiness expected in the experimental group; (2) a significant positive correlation expected between counseling readiness and continuation measures; and (3) a significant positive correlation expected between client involvement and counseling readiness measures.

CHAPTER II
METHODS

The goal of this study was to compare the usefulness of a client orientation interview to normal intake procedures at a community mental health center. It was designed to provide data concerning the role of client involvement and counseling readiness in the continuation of patients in therapy.

Subjects

Consecutive incoming adult clients at the North Central Florida Community Health Center designated for individual therapy were included in the subject population. There was a total of twenty subjects in both the experimental treatment group and the control group. Assignment to either condition was completed randomized. This was accomplished by designating assignment to either group on the basis of a blind drawing of sealed intake packets. This was performed by the therapist already assigned to the case at the beginning of the intake session. Assignment to therapists followed normal procedures. Six adult unit staff therapists participated in this study. Therapists were not aware of the research design, instead believing that an

ongoing evaluation of several intake procedures was occurring. The subject population did not include those clients designated for alcoholic rehabilitation of chemical therapy in that they were assigned to separate sections of the facility.

Procedures

The half of the subjects who were assigned to the treatment condition were administered the "Client Preparatory Interview." This interview was based on the Role Induction Interview developed by Orne and Wender (1968) and Hoehn-Saric et al. (1964) and is shown in Appendix A. The instructional set designed for the therapists is included in Appendix B. The therapist spent between ten and fifteen minutes with the subject going over this form and reviewing the essential points. This interview form has been adopted by several other researchers with positive results mentioned previously in this paper--most notably Yalom (1975) and Heitler (1973, 1974). The interview was designed to cover four main topics: (1) a general discussion of what psychotherapy is; (2) the expected behavior of both the patient and therapist; (3) preparation for certain phenomena and topics in therapy, such as resistance; and (4) expectations for duration of treatment.

The orientation interviews were conducted by therapists who were assigned automatically to subjects on a rotating basis. In this way, the normal intake interview timing was not interfered with and, therefore, there was no problem with

the confounding effect of extra attention in the experimental group. Control subjects engaged in normal intake procedures for the same amount of time--one hour--with therapists who went on to become the patients' regular therapists. The control intake procedure included obtaining identifying information such as age, sex, marital status, race, and education. It also included having the patient describe his presenting problem along with specific symptoms, when they began, precipitating factors, how they affect his life, and why he decided to come to the clinic at this time. This procedure may have included an evaluation of the patient's mental status and formal testing to derive this information although this was rarely performed. Finally, an effort was made to obtain relevant history including psychiatric history, medical history, family background, and personal history such as social, sexual, and employment adjustment. While this intake format was included for both treatment and control group subjects, it was simply extended for the control subjects not receiving the orientation interview for the first few minutes of intake.

In order to test the hypothesis that the client preparatory interview has an immediate effect upon level of client involvement, all subjects were measured on this variable during their initial session by means of the Experiencing Scale (EXP). This process measure is designed to be especially sensitive to levels of patient involvement and was used to rate audiotapes of short therapy segments taken

from the last half of the intake hour. Two three minute segments were obtained from these samples for each subject. All of these segments were taken from the identical moments during the intake session.

In order to attain data reflecting counseling readiness, the Counseling Readiness Scale (CRS), which is a subscale of the Adjective Checklist was also administered. All subjects filled out this checklist at the very end of the intake interview session. A list of the adjectives contained in the Counseling Readiness Scale are contained in Appendix D.

The second set of dependent measures involved discriminating measures of continuation and attendance. One measure consisted of the complete attendance records of all subjects for the six weeks subsequent to the intake procedure, that is, the total number of sessions attended during that period based on once a week standard scheduling. In this way, between group comparisons of attendance were possible after the first six weeks of treatment. Another measure consisted of the number of subjects in each group who dropped out by the fourth session. This was designated as those clients who are not present for their fourth session and who made no contact with the center for another four weeks, measured at the eight-week follow-up period. This particular criterion was arrived at through the results of pilot research conducted at the Community Mental Health Center which showed that 50% of all patients drop out by the second session and that 70% drop out by the fourth session (Barnett, 1979). By the fourth session, most dropouts are

accounted for and beyond this point other factors of treatment have become salient in the decision to drop out.

Instruments

The Experiencing Scale (EXP) provides a measure for evaluating patient involvement in psychotherapy directly from tape recordings or transcripts of the therapy session. The concept of Experiencing, and for the purposes of this study, involvement, refers to "the quality of an individual's experiencing of himself, the extent to which his ongoing, bodily, felt flow of experiencing is the basic datum of his awareness and communication about himself, and the extent to which this inner datum is integral to action and thought," (Klein et al., 1970, p. 1).

The scale designed to give an estimate of level of experiencing on a continuum broken down into seven stages. These distinct levels are scored on a one to seven scale. An outline of each level is provided in Table 1. At low levels of experiencing, the patient's discourse is superficial and impersonal. As one moves up the scale there is a progression towards inwardly elaborated descriptions of feelings and away from simple, limited, or externalized self-references. At higher levels of experiencing, feelings are explored more deeply and new perspectives are achieved. Klein et al. (1970) state:

TABLE 1
THE SEVEN LEVELS OF THE EXPERIENCING SCALE

Stage	Content
1	Abstract, superficial discussion of external events; content not about the speaker.
2	External events are described; behavioral or intellectual self-description. There is association between content and speaker but no feelings attached.
3	Association between content and speaker including some feelings; personal reactions to specific events; limited self-description; behavioral descriptions of feelings.
4	Content is a clear presentation of speaker's feelings and personal experience. Experience rather than events are subject of discourse--but, interior events are not interrelated or used as basis for systematic self-examination.
5	Purposeful exploration of speaker's feelings and experiencing. Must include defining a problem about himself explicity in terms of feelings plus exploring the problem in a way which leads to expanded awareness of it.
6	Synthesis of realized feelings and experiences to produce personally meaningful structures or to resolve issues. Present or emergent experience is part of content.
7	Same synthesis as Stage 6 with the addition that the speaker's new ideas be applied to an expanding range of inner events or give rise to new insights. Speaker sees his solution as a process that he can apply to new situations.

> Independent of specific pathology or problem content, and apart from details of therapists technique, this scale attempts to assess the degree to which the patient communicates his personal, phenomenological perspective and employs it productively in the therapy session. (p. 1)

Most importantly, for data collection in this particular context, the authors go on to point out that:

> It is sensitive to shifts in patient involvement, even within a single interview session, making it useful for microscopic process studies, for example, to evaluate the effectiveness of therapist interventions, . . . to appraise different patterns of interaction between patients and therapists, or to establish a profile of patient performance within the therapy hour. (p. 1)

The unit typically scored by judges (two to four are recommended) is a two to eight minutes tape segment. These segments are, of course, edited for names and identifying material. In a study to determine the ideal unit length, EXP ratings were compared for two, four, eight, and sixteen minute intervals by Kiesler, Mathieu, and Klein (1964). They found that "the reliabilities, the range and the discriminatory power of the ratings were independent of the length of the segments" (p. 34). In this study, two three-minute segments were taken during the last third of the intake session hours. Specifically, three minute segments were obtained at the fortieth and fiftieth minute of the intake session. Three judges were trained in the form prescribed by the Manual of the Experiencing Scale to rate these tapes. This training consists of practice sessions

in which a total of sixteen hours of random segments from therapy sessions are rated.

Interrater reliabilities obtained on this scale have been high. The statistical approach has been to both estimate the reliability of the means of the judges rating (r_{kk}) and to estimate the average intercorrelation of all possible judge pairs (r_{ii}). The r_{ii} values obtained in various studies have ranged from 0.44 to 0.67 while the more crucial r_{kk} coefficients have ranged from 0.76 to 0.91 (see Klein et al., 1970, p. 45).

Extensive research has gone into the attempt to validate the Experiencing Scale. Detailed summaries of these studies can be found in the Research and Training Manual (Klein et al., 1970) as well as in Rogers et al. (1967). This section will review some of the studies contributing to the validity of the Experiencing Scale.

In the most extensive study to date, using schizophrenic inpatients as subjects, Rogers et al. (1967), compared EXP ratings to data from testing (WAIS, TAT, and others), ratings of therapists, and behavior evaluations. EXP level was associated with an initial absence of depression, high verbal ability, and high verbal productivity and expressiveness. EXP level was also related to independent judges ratings of the therapist accurate empathy, and to patients' perceptions of favorable therapist attitudes. The EXP level was associated with the following indices of change and outcome: MMPI Sc scale, Hs scale, and Pd scale improvement; self rated Q-sort adjustment; clinician evaluation of change; and percent of time out of the hospital.

Also in this study, the more successful patients had smoother trends on EXP level, "with less backsliding and more consistently maintained their initial levels." The study most clearly revealed that the EXP scale, "taps differences in patients' verbal behavior, which is a function of initial expressive capacity of motivation for therapy" (Rogers et al., 1967, p. 136). It also made clear the sensitivity of the scale during short periods of therapy.

Kiesler's study (1969) associating EXP and outcome included ratings of fourteen schizophrenic and twenty-six psychoneurotic patients. Counselors ranged widely in technique and orientation. The outcome criterion was the counselor rating of improvement made on the Kogan-Hunt Movement Scale. Two different sets of four judges rated four-minute segments drawn from each of the first thirty interviews for each patient. Results were consistent and reliable: for one to thirty interviews there were significant main effects for outcome and no significant interaction effects either for outcome and diagnosis or outcome and time.

In a study of the effectiveness of psychoanalytic psychotherapy with schizophrenics Karon and VandenBos (in Klein et al. 1969) used EXP along with other scales of process and condition including Relationship, Problem Expressions, and Personal Constructs. With reliabilities of the four judges ranging from .54 to .72, correlation among all four process scales were extremely high. Researchers suggested that it is the consistency of therapists' behavior in all areas that is

correlated with EXP. EXP was also strongly related to ratings of mental health made from the Clinical Status Interview and to the length of hospitalization.

Other studies have been consistent with the above findings and contribute to its construct validation. Van der Veen (1965) found ratings of EXP level were associated with the "speed (in days) with which the patient took advantage of the therapy offered and the frequency of his contact, factors reflecting patient motivation" (p. 24). Gorney (in Klein et al., 1969) tested the relationship between EXP scores and a rating of focusing ability, which are thought to be measures of the same construct (see Gendlin, Beebe, Cassens, Klein, and Oberlander, 1968). A positive correlation was formed and provided evidence of the validity of the measure of experiencing. Mintz (in Klein et al., 1969) compared the information gathered from ratings of the whole hour of sixty sessions to briefer four-minute segments. Correlations ranged from .62 to .99 and so Mintz concluded that, "ratings of brief segments tap the same experiencing quality as ratings over the whole sessions" (p. 67). In a factor analysis of the same material, "EXP saliently loaded a factor interpreted as Patient Involvement that also included Patient Receptiveness, Therapist Impact on Patient, Patient Evaluation, and Patient Dependency" (p. 67). EXP can be seen as being particularly

sensitive to the degree of patient involvement and his capacity to engage in therapy, based on these studies.

A second instrument that was used in this project is the Counseling Readiness Scale developed by Heilbrun and Sullivan (1962), a subscale of the Adjective Checklist. This scale is designed to provide a measure of client preparedness for treatment and is filled out by the patient. The Adjective Checklist Manual (Gough and Heilbrun, 1965) identifies the main function of the CRS as "identifying counseling clients who are ready for help and who seem likely to profit from it." Heilbrun and Sullivan felt one purpose in developing the CRS was to provide a tool which would identify the client who would remain in treatment long enough to benefit from it as well as the premature terminator. It was intended for use as early in treatment as was feasible and much of the data involving the CRS was gathered during initial sessions of therapy. The developers felt an important use of this tool would be to take immediate steps to deal with factors leading to premature termination with those clients who show poor counseling readiness.

The use of the Counseling Readiness Scale in this research study was to provide a secondary source of data for the concept of patient involvement in therapy. In the literature, counseling readiness has been discussed as a factor associated with client involvement. Burham (1952)

first conceived of therapy readiness as an initial set, and found significant positive relationships between therapy readiness and emotional involvement, as measured by the therapists, for clients in short-term therapy. In this context, CRS is being employed to provide more detailed information on the relationship between client preparation, client involvement and continuation in therapy.

The Counseling Readiness Scale was developed to discriminate between continuers and non-continuers in treatment. Heilbrun and Sullivan (1962) attempted to validate their scale on vocational counseling clients. With this sample they found counseling readiness to successfully differentiate successful from non-successful outcomes among male subjects. Heilbrun (1962) was able to provide improved scale predictions for women clients as well. These studies have also provided evidence that "therapy-ready clients" remain longer in therapy, were therapy-minded, and less self-accepting.

The CRS provides a raw score which, using separate conversion tables for male and female subjects, is converted into a T-score ranging in numbers from 2-107. The mean T-score is set at 50, and the standard deviation at 10. Reliability of these scores have been assessed in two ways. Test-retest correlations are as follows: college males over ten weeks = .71, adult males over six months = .65, medical students over five and one-half years = .54. Interrater reliability was obtained by having ten judges

fill out the checklist to describe one hundred assessees. Five of these cases were scored for inter-group reliability coefficients (and corrected by the Spearman-Brown prophecy formula) and yielded scores of .70, .63, .61, .75, .61. Futhermore, social desirability was assessed for its influence upon this measure using Edward's Social Desirability Scale. It was found to have a median correlation of +.16 with a range from -.41 to +.45. Thus, the social desirability factor is not as prominent in CRS scores as it is in most personality tests.

Analysis

The design of this research study was suggested by Campbell and Stanley (1963) as the most clear procedure for measuring the central question of whether treatment does have an effect. They point out:

> While the pretest is a concept deeply embedded in the thinking of research workers, it is not actually essential to true experimental designs. For psychological reasons, it is difficult to give up "knowing for sure" that the experimental and control groups were "equal" before the differential experimental treatment. Nonetheless, the most adequate all-purpose assurance of lack of initial biases between groups is randomization. (p. 25)

The design is as follows:

Experimental Treatment Group	R	X	$O_{1a}O_{1b}$	Continuation measures
Control Group	R		$O_{2a}O_{2b}$	Continuation measures

where R=randomization, X=experimental treatment, and 0_1-0_2=simultaneous measures of client involvement and counseling readiness.

One reason this design is desirable is due to its amenability to clear statistical analysis. Once again this is pointed out by Campbell and Stanley (1963) who recommend a between-groups t-test--"this design is perhaps the only setting for which this test (the t-test) is optimal."

So analysis took the form:

I. between-groups t-tests of:

   A) client involvement scores (EXP);

   B) therapy readiness scores (CRS);

   C) continuation and attendance measures;

II. Pearson Product-Moment correlations of all subjects' scores on:

   A) client involvement X continuation measures;

   B) therapy readiness X continuation measures;

   C) therapy readiness X client involvement.

Finally, data were analyzed for any differential therapist effect or subject group differences. In this way, analysis produced information relating to treatment effects on client involvement, therapy readiness, and continuation. It also provided evidence of the relationship between client involvement and continuation, as well as between counseling readiness and continuation. Lastly, this analysis was to reveal

any relationship between the measures of client involvement and client therapy readiness.

While training of the three raters was in the form prescribed in the Experiencing Scale Training Manual, it was also necessary to check the reliability of their ratings during the rating process, itself. This was also performed in accordance with the manual. Six samples from among the forty rating segments were submitted to a reliability test of the means of the judges scores (r_{kk}) and the average intercorrelation of all possible judge pairs (r_{ii}).

CHAPTER III
RESULTS

The treatment group and the control group were compared on attendance, dropout rates, Experiencing Scale ratings, and Counseling Readiness Scale data. These raw data are all contained in Appendix B. This was performed by t-test comparisons between means (see Table 2) as well as by Pearson Product-Moment correlations between all three possible groups (See Table 3). These measures seemed to support the primary hypotheses involving the significance of attendnace and Experiencing Scale data. However, the analyses failed to provide any meaningful support for the secondary hypotheses involving the Counseling Readiness Scale measures.

T-tests comparing attendance data showed the tendency for treatment group subjects to attend therapy significantly more often than the control group subjects. All clients were scheduled weekly for sessions for at least six weeks immediately subsequent to the intake session. In fact, total attendance for the treatment group was twice that of control group subjects during the six-week follow-up period. Additionally, the number of dropouts recorded after the eight-week follow-up period numbered 13 out of 20 for the control group and only 8 out of 20 for the treatment group.

TABLE 2
T-TEST COMPARISONS OF CONTROL AND TREATMENT GROUPS

	Mean Control	Mean Treatment	Mean Difference	df	t	
6-week attendance	1.35	2.70	1.35	38	3.29	$p < .005$*
Experiencing Scale	2.69	3.21	.52	38	2.26	$p < .025$*
Counseling Readiness Scale	58.00	57.30	.70	38	.74	
Dropouts 1-week	.55	.10	.45	38	2.25	$p < .025$*
Dropouts 8-weeks	.65	.40	.25	38	1.14	$p < .15$*

*one-tailed

TABLE 3
PEARSON PRODUCT-MOMENT CORRELATIONS
BETWEEN DEPENDENT MEASURES

Measure	r Value	
Experiencing Scale Data X 6-week attendance rates	+.54	$p < .001$*
Counseling Readiness Scale Data X 6-week attendance rates	+.078	
Experiencing Scale Data X Counseling Readiness Scale Data	+.134	

*two-tailed

The difference in attendance achieved a statistical significance of .005 (one-tailed). The difference in group dropout rates does not reach the conventional statistical significance level of .05, but does reach a probability level of .15.

An interesting aspect of the attendance measures was the fact that 11 subjects in the control group failed to attend even one therapy session after intake as compared to only 2 subjects in the treatment group. This difference is statistically significant at the .025 level (one-tailed).

Comparisons of the Experiencing Scale means between-groups show the treatment group to have a significantly higher level of interaction than did subjects in the control group. This seems to reveal a higher level of participation on the part of clients involved in the experimental orientation program. Furthermore, when Experiencing Scale measures were correlated with attendance data, a positive relationship ($r = +.54$, $p < .001$) was demonstrated.

In order to determine the reliability of the three raters involved in the Experiencing Scale ratings, inter-rater reliabilities were obtained for six randomly selected samples among the forty protocols. As in cases where more than two raters are employed, it was preferable to use Ebel's intraclass method which produces not only an estimate of the reliability of the means of the judges' ratings

(r_{kk}), but also the more stringent estimate of the average intercorrelation of all possible judge pairs (r_{ii}). This second measure reveals the amount of variance present for each rater versus every other rater. Results of this analysis yielded ratings that are considered quite high when three raters are employed (see Table 4). Interrater reliabilities averaged .83 for r_{kk} and .64 for r_{ii} for mode scores and .95 for r_{kk} and .87 for r_{ii} for peak scores. This would provide support for those findings involving the Experiencing Scale data.

Data obtained for the Counseling Readiness Scale provided no significant information along any of the dimensions involved in this study. Comparison of the means of treatment and control groups provided no differentiation according to Counseling Readiness Scale measures. A correlation between Counseling Readiness Scale scores and attendance for all subjects achieved on a +.03 relationship which is insignificant by an standard. The correlation between Counseling Readiness Scale and Experiencing Scale scores was only slightly higher at +.13. All in all, this scale seems unrelated to factors which relate either to the client's level of interaction as measured by the Experiencing Scale or those that lead to increased participation in therapy as measured by attendance and dropout rates. Given this finding, this study could only provide negative support for the validity of the Counseling Readiness Scale.

TABLE 4
REPRESENTATIVE INTERCLASS RELIABILITIES
FOR EXP SCALE RATINGS

	Rating Reliabilities	
	r_{kk}	r_{ii}
Sample 1 (treatment group)	.78	.54
Sample 2 (treatment)	.90	.75
Sample 3 (treatment)	.92	.83
Sample 4 (control group)	.81	.59
Sample 5 (control)	.74	.48
Sample 6 (control)	.85	.66
TOTAL (modes)	.83	.64
Peak Scores	.95	.87

As part of data examination, several Adjective Checklist subscales other than the Counseling Readiness Scale were calculated in order possibly to shed more light on factors related to this study. It must be noted that what became apparent during these calculations was the limitations of the Adjective Checklist, itself. The very nature of a checklist lends itself to many interfering elements such as reading ability, perceived time pressure, and so on.

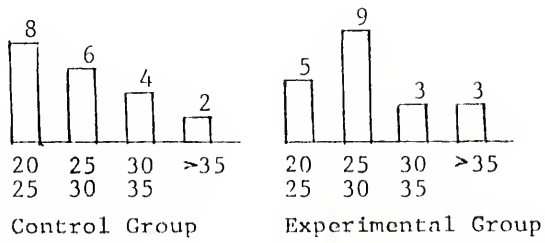
Adjective Checklist subscale measures of defensiveness and need for succorance failed to achieve any statistical differences between groups or any meaningful relationships to either attendance or Experiencing Scale data. One subscale which consisted of the total number of adjectives checked, was difference between groups. Subjects in the experimental group tended to check a significantly greater number of adjectives than those subjects in the control group (69.5 versus 83.0, $p < .05$, one-tailed test). According to the Adjective Checklist Manual, "checking many adjectives seems to reflect surgency and drive, and a relative absence of repressive tendencies . . . the man with low scores tends more often to be quite and reserved, more tentative and cautious in his approach to problems, and perhaps at times unduly taciturn and aloof" (p. 5). While the groups did differ on this characteristic, there was no relationship found between number of adjectives checked and either attendance or Experiencing Scale data.

As part of the analysis, the two groups of subjects were compared on a number of relevant demographic variables in order to see if the groups were comparable. The variables consisted of age, color, sex, income, education, and diagnosis. It was found that the control and experimental groups were almost identical along all of the mentioned variables. As is expected in an outpatient community setting, the subjects were young, with little education and low income, mostly white, and mostly female. Table 5 provides a complete breakdown and description of the subject composition. Appendix C contains this raw data in its entirety. It should be noted that comparisons were made between groups on therapist effects and that no differences could be attributed to this factor.

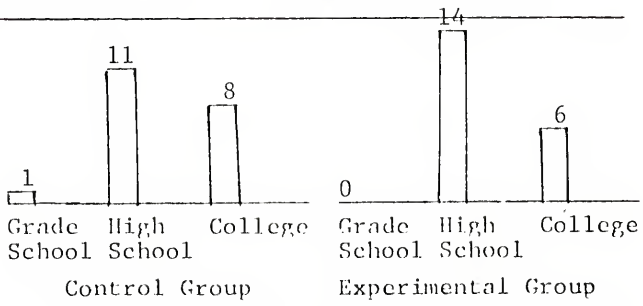
In conclusion, data analyses of measures obtained in this study provide support for the hypotheses that the experimental treatment leads to increased attendance and higher levels of involvement in therapy. Additionally, the hypothesis that predicted a significant positive relationship between level of experiencing and attendance was supported.

TABLE 5
SUBJECT GROUPS COMPOSITION

I - Age (Average = 28.9) (S_D=7.4)



II - Education



III - Race

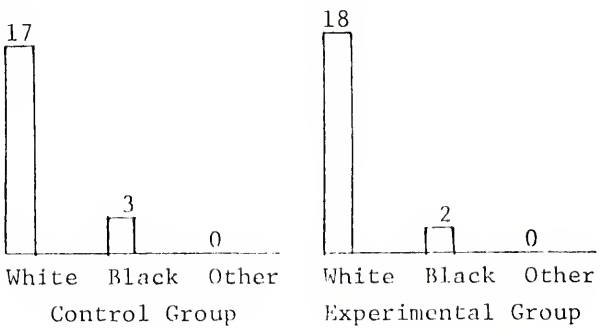
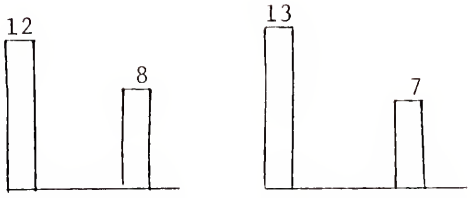


Table 5 - continued

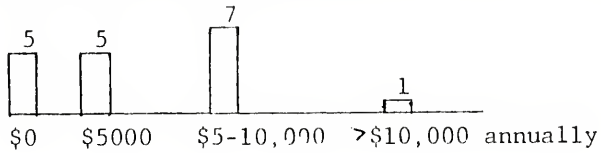
IV - Sex



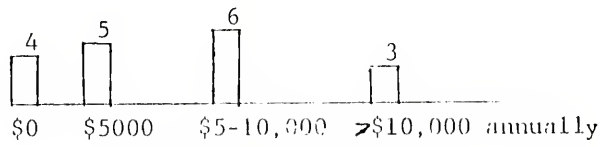
V - Income

(Average = $4,575/yr)

(S_D=$4,415)

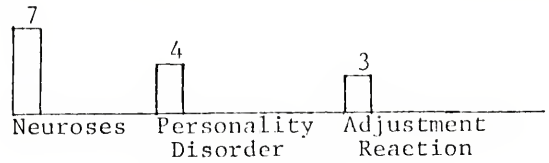


Control Group

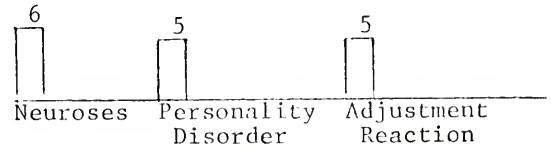


Experimental Group

VI - Diagnoses



Control Group



Experimental Group

CHAPTER IV
DISCUSSION

This study was conceived and designed to elucidate the factors involved with client preparation and how they relate to continuation and involvement in therapy. The major hypotheses of this research were, primarily, that client preparation would have a significant effect on client continuation and involvement and that continuation would be positively related to involvement. The secondary hypothesis predicted that counseling readiness would be higher in the experimental group and would be positively related to the continuation and involvement measures employed in this study.

The present study employed a client preparation technique consisting of a personal interview since the literature has consistently pointed to the superiority of this technique across many types of research designs. Client involvement was assessed by means of Experiencing Scale and counseling readiness by means of the Counseling Readiness Scale contained in the Adjective Checklist. These measures are described in detail in the Method section of this paper.

Data obtained from this experimental program tend to support the major hypotheses. However, the secondary hypotheses received no support. Continuation measures, consisting of attendance rates over six weeks and dropout rates after eight weeks were both significantly better in the experimental treatment group than in the control group. Level of involvement as measured by the Experiencing Scale also was higher in the experimental treatment group. Also, a positive correlation was found to exist between level of involvement and continuation in therapy.

The secondary hypotheses involving counseling readiness measures achieved no significant levels. That is, Counseling Readiness Scale scores were not different between groups and were unrelated to either attendance measures or level of involvement. These experimental findings will all be discussed in more adequate detail.

The finding that client preparation did seem to have an effect upon attendance and dropout rates falls very much in concordance with other studies previous to this one. Specifically, in this study, attendance was doubled in the experimental group and dropout rate was almost half (7 versus 13) of that in the control group. Other studies employing a live interview very similar to this one have had the most significant effect on continuation measures and therapy variables.

The most significant of these studies was the research program initiated by Hoehn-Saric et al. (1964). Their interview was based on the Orne and Wender model, as was the present study, which was finally published in 1968. Subjects in that study were remarkably similar to those utilized in this study: 40 psychoneurotic patients with a mean age of 30 and a mean education of 11 years. There were 17 males and 23 females, 35 white and 5 black subjects. The major differences between their design and the present one were to employ a separate therapist to perform the Role Induction Interview instead of the subjects' therapists and, for some reason, to replace subjects who dropped out by the fourth session. This last element seemed inexplicable in that they were measuring attendance rates. Even though their main assumption was that their procedure would provide appropriate expectations of therapy for new clients, their dependent measures consisted of attendance records, therapy behavior ratings, and client/therapist ratings of client improvement--omitting expectational data completely.

As predicted, they found significant differences which favored the experimental treatment group: better attendance over a four month period, higher scores on the Therapy Behavior Scale in the third session, and they received a better rating of the therapeutic relationship as perceived by the therapists. These findings seem to

parallel those obtained in the present study. While attendance rates were obtained for six weeks and client involvement was measured during the first session, similarities are obvious. Attendance was improved for the experimental group in both studies, and the comparable process measures were also more favorable in the group prepared for therapy.

This same research group replicated this study and found that in addition to better attendance records, the treatment group had better ratings for improvement from both clients and therapists (Nash et al., 1965). This form of individual interview prior to therapy has been replicated with similar findings by: Baum and Felzer (1964) who reduced dropout rates from 60% to 35% in five sessions; Sloane et al. (1970) who found the same results with or without giving prospective clients an expectation for a cure in four months; and Lieberman et al. (1972). What the present study has added to this research field was to standardize the interview procedure including a written form in addition to verbal and to add a specific measure designed to elucidate the particular factor mediating client preparation with continuation, that is, client involvement.

One important factor in all of these studies was the use of low Socio-Economic Status subjects who were considered to be most likely to have unrealistic expectations. In

assuming that these clients had the most to gain from pre-therapy orientation procedures, studies in this area have overlooked the possible benefits to other socio-economic classes. Future studies may wish to have several SES classes represented in their research in this area.

Other studies employing various client preparatory techniques have met with similar but somewhat less significant findings. As seen in the introduction section of this paper, various forms of pre-therapy orientation such as videotape, audiotape, and even in written forms have had positive results. While not identical in their dependent measures, many are parallel to the present findings. This would point to the conclusion that while some effect can occur while the client is prepared alone, he will probably respond more positively when the technique is interpersonal. Of particular importance in supporting this conclusion is the study performed previous to this one in the identical setting (Barnett, 1979). Using most of the same therapists, in fact, conditions were very similar to the present study with the difference being the orientation procedure. In the first study, a videotape procedure covering the same topics was presented to incoming clients. While there was improvement in attendance in the first study, it did not compare to the increase seen in the present study. This would indicate that studies in the future, hoping to employ the optimal client preparatory technique, should consider the live interview methods outlined here.

Data obtained from the Experiencing Scale during this study have led to other significant findings. The Experiencing Scale proved to be a clear and accessible measure in this study. As indicated in the EXP Manual, it is easy to rate because the differences between EXP scale levels are easy to understand. Raters felt that during the six minute segments they listened to, they were able to obtain a clear idea of subjects' EXP level which seemed stable for this period. This, then is why high inter-rater reliabilities were possible.

One less desirable aspect of this scale during this particular study was that most clients seem to fall onto the lower parts of this scale. In fact, not one statement was rated over Level 5 during the entire period, and subjects were fairly similar in ratings of their scale levels. This, of course, leaves us unable to learn if higher scores on EXP lead to higher degrees of continuance or whether a "threshold" exists beyond which higher EXP scores are irrelevant. This study can only conclude that those with a score of 3 or 4 on EXP are more likely to continue in therapy than those with an EXP score of 2.

What is important, though, in using this scale, is understanding what it measures, that is, what is level of Experiencing. During this study, this tool was employed to provide some idea of the level of involvement. But, this concept is not defined identically by all those who consider it. This leads to the most essential aspect of

this scale--it is very clear about what it is measuring. As seen in the description of each level on the EXP Scale in the Method section of this paper, there is excellent face validity for those aspects of communication which relate to the closeness of the subject, the sense of emotion experienced, and the degree to which a person is able to integrate the different aspects of his or her experience. To put it another way, when a client describes his feelings, the distinction between impersonal (you, people, etc.) and personal subject is one that reflects something that is seen to be important in therapy. If the client is able to discuss his feelings or only the weather, this also is a difference that will possibly reflect his ability to enter into a productive therapeutic relationship. These elements are what is meant by "Level of Experiencing" and what is functionally defined as involvement for the purposes of this research. From what has been seen in this research study, this concept seems to be related to continuation measures in therapy. Furthermore, and quite importantly, this factor seems accessible to manipulation in the form of client preparation.

In direct contrast to the clearness of the EXP Scale is the Counseling Readiness Scale. The present study found there to be no relationship whatsoever between Counseling Readiness scores and either involvement or attendance data. This is surprising in that the Counseling Readiness Scale was derived to differentiate between continuers and

non-continuers in therapy. In this study there was no difference between experimental and control group scores even though these groups had significantly different attendance rates. This tool attempts to quantify a measure that is possibly too vague for it ever to be properly validated. As noted in the Results section, this scale and other Adjective Checklist scales had too many limitations to instill any confidence in their use. Calculations seemed to produce only random numbers in arbitrary patterns. Scatter charts of scale frequencies in relation to any meaningful variables testified to this.

In addition to the Counseling Readiness Scale, other subscales of the Adjective Checklist were calculated with the intention of providing some other related characteristics to the variables measured in this study. Defensiveness, need for succorance, and total number of adjective checked were among those studied. Defensiveness and the need for succorance displayed the same kind of arbitrary pattern as did Counseling Readiness. These scales failed to organize themselves into any meaningful pattern whatsoever on their own or in relationship to any other measure. While total number of adjectives was found to yield a higher average in the experimental group, it also failed to relate meaningfully to other factors measured. While this might support the notion of more openness in the experimental group and more repression in the control group as suggested by the Adjective Checklist Manual, it can only be considered a vague testimony.

The Adjective Checklist in its present form does not seem to provide a stable, meaningful tool. Scale derivations and calculations are inadequate and cannot be validated properly. Limitations in the use of the Checklist range from methodological problems such as subject vocabulary and administrative controls to computational formulas which fall far short of their ability to offset confounding subject variables. Present clinical research cannot be advanced with a tool such as this because it fails to provide a measure which relates realistically to the already vague concepts which are identified. It can be of more use as a qualitative clinical tool, to be interpreted as such.

While providing support for client preparation, the main focus of this study was to identify some elements that are associated and possibly predictive of client continuance. Many studies have provided support for any number of different client preparatory techniques, and many have shown the positive effects of these techniques upon continuance and other positive therapy factors. But, the gap in this research area has been identifying any variables that mediate client preparation and positive outcome. Most studies have simply assumed this factor to be induced appropriate expectations. The belief has been that when a prospective client is provided with appropriate expectations for the therapy experience, he will be able to participate more comfortably and thus, productively.

The limited research into the expectational factor has provided no evidence as of yet that would account for the large effect produced by client orientation techniques. Of particular significance is the lack of any validated tool to assess patient expectations. An attempt was made in a previous study (Barnett, 1979) to determine the interaction of client expectations with client preparation and continuance in therapy. Using the only client expectation questionnaire available (derived from Overall and Aronson, 1962), results failed to yield any meaningful relationship between expectational conditioning and continuance in therapy. There was, however, a significant rise in attendance subsequent to this orientation procedure. In light of this, the expectational variable has to be discounted as a meaningful factor until further tools are developed which could possibly indicate otherwise.

The present study certainly supports the concept of client preparation for therapy. It seems to lead, according to this study, to higher levels of involvement and more continuance in therapy. While client involvement remains a less than optimally specified factor, it does seem to relate meaningfully to client preparation. As such, it is one of the few factors which have been isolated to relate client preparation to improved therapy attendance and fewer drop outs. It would seem that there is finally a cloudy yet significant area being identified to elucidate this particular relationship.

In recent years, this concept of client involvement has received more attention and empirical support. As research has focused our attention on the initial therapeutic interaction, it has also identified client involvement as a key factor during this critical period. Gomes-Schwartz wrote in 1978:

> More striking data on the importance of patient attitudes come from studies of behavior in early therapy sessions. Patients who were involved in the therapy process from the outset of treatment--acknowledging their own responsibility for changing their behavior and actively examining their feelings and experiences--were most likely to improve. (See Kirtner and Cartwright, 1958; Rice and Wagstaff, 1967; Saltzman et al., 1976) (p. 1025)

Gomes-Schwartz's concept of client involvement as stated above is nearly identical to that as conceived and measured in this study. As seen in the present study and in the previously mentioned descriptions of the studies by Gomes-Schwartz and Saltzman et al., the concept of involvement during the initial client-therapist contact related positively with improved attendance. Gomes-Schwartz and Saltzman et al., also were able to show a relationship between involvement and improved process and outcome measures.

In this study, the relationship between preparation, involvement, and continuation appeared tightly woven. Not only was there a significant positive relationship between Level of Experiencing and attendance, but there was also a significant difference in Level of Experiencing between

control and experimental groups. This last point provides strong support for the ability to manipulate level of involvement by means of appropriate client orientation.

What makes this preparatory technique and others so effective has only been tentatively speculated. Given the experience of the present study, it seems that Truax and Carkhuff (1967) had the most accurate assessment of this effect. They used learning theory terms to generalize about the value of pre-therapy preparation procedures and felt that the evidence on the values of experiential and cognitive structuring fit well with what was known about human learning.

> If psychotherapy or counseling is indeed a process of learning and relearning, then the therapeutic process should allow for structuring what is to be learned rather than what amount to "incidental learning," where the client does not have clearly in mind from the outset what it is he is supposed to learn. (Truax and Carkhuff, 1967, p. 363)

During the course of the present study, the element identified as client involvement has shown itself to be a meaningful factor in the relationship between client preparation and continuance in therapy. In the larger frame of reference, interpersonal elements in the early therapeutic encounter seem to be more predictive of continuance and a more positive therapeutic relationship than do any intrapersonal variables. One early example of this idea in the literature is the finding that patient and

therapist expectational congruence is more predictive of positive outcome than is the patient's own confirmed or disconfirmed expectations (Lennard and Bernstein, 1960; Heine and Trosman, 1960; Goldstein, 1960; Garfield et al., 1963).

What this means is that, instead of trying to select the optimal clients for therapy in the hope of diminishing dropout rates, therapists may be rewarded more by providing a proper foundation for therapy in their initial sessions. While no specific content or format has been positively identified, the preparatory techniques discussed in this paper have already proven their significance in this endeavor. It is hope these techniques will be further refined in the future. This will probably come about only when it is understood more clearly and specifically what therapeutic variables at what times are critical towards the formation of the beneficial patient-therapist alliance.

APPENDIX A
ROLE INDUCTION INTERVIEW

I. What is therapy about?

A. It is active participation by both members.
B. It is not just cheap advice.
C. It is not someone telling you what to do, or what is right.
D. It is to help you to find out for yourself how you are going to solve your problem.
E. It is to help you understand why you do things the way you do.
F. It is to help you find alernatives that satisfy your needs.

II. What goes on in treatment itself?--What do you talk about, what do you do?

A. You can talk about anything--wishes, dreams, thoughts or feelings--from now or in the past.

1. Your therapist will not judge what you say.
2. He will help you get at what you really want.
3. He will not try to make decisions for you but help <u>you</u> make decisions.

B. Your therapist will help you understand when you are kidding yourself--how two things you are saying just don't fit together.
C. He will help you keep in mind all of the important facts and feelings so that you can come to a solution that takes them all into account.
D. He will hlep you to understand all of your feelings that sometimes seem confused.

1. Understanding the causes of your feelings helps you understand why you are the way you are.
2. By becoming aware of this, you can treat them more realistically.

III. What kinds of things might I expect over time?

A. As you begin to change, friends and family may be puzzled or troubled by this difference.

1. It isn't a bad sign--it just means you are changing.
2. It helps to take the time to make them understand what you are going through.

B. You may feel worse or discouraged at some stages of treatment.

1. These very feelings are often good indications that you are working and that it's uncomfortable.
2. It's very important that you don't give in to these temporary feelings when they come up.

C. A funny thing happens when things are getting rough for you in therapy--suddenly you have trouble keeping your appointments.

1. What this means is that you are getting down to something difficult and important--some sensitive issues.
2. These are the most important times to bring yourself to your therapy meetings. Decide beforehand that you will make your appointment.
3. You can postpone a session for good reason, if you discuss it with your therapist beforehand.

IV. Therapy can help you find the solution to your problems that suit you best. Sometimes it's hard to do this--if it were not hard you wouldn't be here. Don't expect overnight miracles--give yourself the time to work things out the right way!

APPENDIX A - continued

Procedure for Intake Program

1. At the very beginning of the intake, look inside the manilla envelope to determine whether the client is to be assigned to an experimental procedure or the normal procedure.

2. Write down the client's name, your name, and the date.

3. If the client is in the experimental group, administer the Preparatory Interview. Remember to cover each point carefully in the interview outline and to be open to client questions.

4. For all clients in intake, tape record the last 30 minutes of the sessions--if you might forget, turn on the recorder early.

5. At the end of the session, have each client fill out the Adjective Checklist in the envelope.

6. Make sure the cassette and the Adjective Checklist and the identifying page are all in the packet when you seal it.

THANK YOU!!!

APPENDIX B
EXPERIENCING SCALE AND COUNSELING READINESS SCALE DATA

Control Group Results

Subject Number	Therapist	Attendance 6-weeks	EXP Score	CRS Score
1	A	0	2.2	56
2	B	0	3.0	49
3	C	0	2.1	52
4	B	0	2.3	66
5	D	4	3.4	83
6	E	2	3.0	56
7	C	2	2.7	54
8	D	0	3.1	56
9	B	0	2.4	52
10	B	2	2.3	51
11	A	5	3.5	62
12	F	0	2.8	56
13	F	0	1.9	52
14	E	0	2.8	57
15	A	4	3.5	67
16	E	4	2.3	49
17	F	0	2.3	59
18	F	0	2.6	63
19	C	2	2.8	66
20	E	2	2.8	54
	TOTAL	27	53.8	1160
	MEAN	1.35	2.69	58

APPENDIX B - continued

Treatment Group Results

Subject Number	Therapist	Attendance 6-weeks	EXP Score	CRS Score
1	D	2	4.3	62
2	C	4	4.0	56
3	F	1	3.0	62
4	C	4	3.8	56
5	B	3	2.6	66
6	E	4	3.2	53
7	E	2	2.6	57
8	F	4	3.0	59
9	F	5	3.0	53
10	D	3	3.2	61
11	B	1	3.8	56
12	A	1	2.4	47
13	A	3	3.0	35
14	E	4	3.5	78
15	F	0	3.1	67
16	B	0	2.6	57
17	E	3	2.5	51
18	B	1	3.1	49
19	C	3	3.2	56
20	A	6	4.3	56
	TOTAL	54	64.2	1146
	MEAN	2.7	3.21	57.3

APPENDIX C
SUBJECT GROUP COMPOSITION

AGE

Controlled	Experimental
31	31
31	40
53	24
23	21
29	28
32	29
32	32
29	24
26	32
21	38
23	26
27	20
21	21
21	26
25	28
25	36
23	27
27	28
54	23
23	36
MEAN 29	28.8

APPENDIX C - continued

	EDUCATION	
	Controlled	Experimental
	HS	HS
	COL	HS
	COL	HS
	HS	HS
	HS	COL
	HS	COL
	COL	COL
	GRD	COL
	HS	HS
	HS	HS
	HS	HS
	COL	HS
	HS	HS
	HS	HS
	COL	HS
	COL	HS
	HS	HS
	COL	HS
	COL	COL
	HS	COL
TOTALS	HS = 11	HS = 14
	GRD= 1	GRD= 0
	COL= 8	COL= 6

APPENDIX C - continued

RACE

	Controlled	Experimental
	W	W
	B	W
	W	W
	W	W
	W	W
	W	W
	W	W
	W	W
	B	W
	W	W
	W	W
	W	W
	B	B
	W	B
	W	W
	W	W
	W	W
	W	W
	W	W
	W	W
TOTALS	W = 11	W = 18
	B = 3	B = 2

APPENDIX C - continued

	SEX	
	Controlled	Experimental
	F	F
	M	F
	F	F
	F	M
	F	M
	F	F
	M	M
	M	F
	F	F
	M	F
	F	M
	F	M
	F	F
	M	M
	M	F
	F	F
	M	M
	F	F
	M	F
	F	F
TOTALS	F = 12	F = 13
	M = 8	M = 7

APPENDIX C - continued

	WEEKLY INCOME	
	Controlled	Experimental
	143	263
	00	115
	00	89
	121	147
	196	64
	195	00
	92	00
	66	00
	161	118
	38	00
	00	208
	68	41
	00	115
	25	69
	318	70
	00	191
	110	135
	150	295
MEAN	96.33	107.0

APPENDIX C - continued

DIAGNOSES

Controlled	Experimental
319.0	300.4
307.0	307.3
300.0	300.0
301.5	301.89
300.4	301.0
300.4	301.89
300.3	319.0
301.2	301.81
301.3	300.4
301.3	307.3
301.3	300.0
301.9	300.2
300.0	319.0
301.89	300.4
300.4	302.3
301.3	296.9
296.3	300.4
301.89	316.0
319.0	301.1

Neuroses = 6	Neuroses = 7
Personality Disturbance = 5	Personality Disturbance = 4
Adjustment Reaction = 5	Adjustment Reaction = 3
Miscellaneous = 4	Miscellaneous = 6

APPENDIX D
INDICATIVE AND CONTRAINDICATIVE ADJECTIVES FOR COUNSELING READNESS SCALE

MALES		FEMALES	
+ Items	- Items	+ Items	- Items
awkward	active	aggressive	energetic
cautious	adventurous	assertive	honest
cold	affectionate	autocratic	jolly
commonplace	ambitious	bossy	
complicated	boastful	cold	patient
dull	capable	cynical	peaceable
fussy	cheerful	dignified	slow
inhibited	clever	discreet	suggestible
meek	confident	effeminate	trusting
moderate	courageous	enterprising	wholesome
peculiar	determined	formal	
quite	egotistical	independent	
rigid	emotional	individualistic	
self-seeking	energetic	inhibited	
sensitive	enthusiastic	intelligent	
serious	headstrong	moody	
shy	humorous	noisy	
silent	initiative	opportunistic	
slow	jolly	painstaking	
soft-hearted	original	rigid	
spineless	robust	self-centered	
submissive	sociable	stingy	
timid	spontaneous	tense	
unrealistic	strong	thorough	
withdrawn	temperamental	unaffected	
	tough	unemotional	
	uninhibited	unrealistic	
	witty		

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BIOGRAPHICAL SKETCH

Mark Barnett was born in New York in 1952. He moved to the Miami area in 1957 and remained there until graduating from high school in 1970. He attended Princeton University as an undergraduate and developed there an interest in his major field of study--psychology. His exposure to volunteer work in counseling as an undergraduate led him into pursuing a graduate degree in clinical psychology. After graduating from Princeton in 1974, he was accepted into the Graduate School of the University of Florida. He obtained his master's degree in clinical psychology in 1979 and completed his internship at the Miami VA in 1980. His research has been focused particularly on the critical aspects of patient-therapist interaction in psychotherapy. He hopes to work with the psychological components of medical problems after graduation.

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

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