THE EFFECTS OF A COUNSELING ORIENTATION VIDEOTAPE UPON CHILDREN'S KNOWLEDGE AND ATTITUDES REGARDING MENTAL HEALTH COUNSELING

By

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A DISSERTATION PRESENTED TO THE GRADUATE SCHOOL OF THE UNIVERSITY OF FLORIDA IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF DOCTOR OF PHILOSOPHY

UNIVERSITY OF FLORIDA

1990
ACKNOWLEDGMENTS

After countless hours, at both my word processor and behind the wheel of my pickup on Highway 441, it is with absolute pleasure to write these acknowledgments. Although technically I will be recognized for this dissertation, it could not have been completed without the assistance of some very excellent people.

First I would like to thank Dr. Bob Myrick, my committee chairperson, for his continued support throughout a dissertation process that will be remembered as much for its duration as its intensity. His professionalism, conceptual and editorial insights, and comprehension of the field continually inspired me and sharpened the final product.

I am thankful to my committee members: Dr. James Joiner from the Department of Rehabilitation Counseling for his seasoned encouragement and gentlemanly presence of the South; Dr. Max Parker of the Department of Counselor Education for his modeling of grace and style under pressure; and Dr. Robert Ziller of the Department of Psychology for a perfect sense of mystery he contributed to the drama of the process. I am especially thankful to Dr. Linda Crocker and Ms. Laura Price from the Foundations of Education Department. It was extremely helpful and encouraging to have their skills, energy, and enthusiasm, especially in that they were external of my department. Their shared talents with data analysis,
statistical treatment, and computer savvy was above and beyond the call of duty.

Next I would like to thank all of the people in the Marion County school system, especially the counselors that participated in the study: Ms. Patty Sadowski of Dunnellon Elementary School; Mr. Joe Hartman of Madison Street Elementary School; and Ms. Becky Wolf of Anthony Elementary School. Their energy and discipline with the research activities were essential to the overall success of the project. Additionally, I would like to thank Dr. Bill Edenfield, Director of Psychological Services for Marion County schools. His willingness to endorse the research opened the door to this project. To the principals and children of the participating schools, my sincere appreciation for sharing your schools and your enthusiasm. The cooperation of these people made this study possible.

Finally I would like to thank my family and friends for their emotional support, technical assistance, and secure places to sleep along the way. Rolayne Hooks, my tireless companion, supported me throughout the dissertation process with love, patience, understanding, and appropriate satire when necessary. My extended family in Gainesville did what good families do well. To Dr. Paula Lovett goes my special thanks for gracious TLC, and as well to Rob Hosford, who brings enhanced definition to the notion of friend and ally. And lastly, to the bush doctors of the Caribbean, the beat poets on the road, and all the Eden rangers tapping out the blues, my most enduring appreciation.
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Abstract of Dissertation Presented to the Graduate School of the University of Florida in Partial Fulfillment of the Requirements for the Degree of Doctor of Philosophy

THE EFFECTS OF A COUNSELING ORIENTATION VIDEOTAPE UPON CHILDREN'S KNOWLEDGE AND ATTITUDES REGARDING MENTAL HEALTH COUNSELING

By

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August 1990

Chairperson: Dr. Robert D. Myrick
Major Department: Counselor Education

The purpose of this study was to investigate the effectiveness of a mental health counseling orientation videotape as a developmental guidance unit with children. Additionally, the impact of the counseling orientation on high-risk and low-risk students was also investigated. Children's knowledge, attitudes, and state anxiety about mental health counseling were used as the variables for comparison.

The subjects were children from six fifth-grade classrooms in three Marion County, Florida, elementary schools. One hundred forty-three children participated in the study. A total of 70 children viewed the videotape orientation and participated in the developmental guidance unit. Seventy-three other children were used in control groups for comparative purposes.
This study was designed to determine whether a 19-minute videotape orientation and single-session guidance unit would positively affect children's perceptions and feelings about counseling. The videotape included information regarding the roles of counselor and client, the nature of the therapeutic relationship, and general expectations about the course of treatment and the rationale of counseling. Measures included a mental health counseling knowledge inventory, a mental health counseling attitude inventory, and a state-anxiety inventory.

Results indicated that children who viewed the orientation could acquire more knowledge and realistic expectations at a cognitive level. Further, these children were also likely to express more positive attitudes about counseling and mental health counselors in general. Results also indicated that knowledge and general attitudes about counseling may be independent of more personal motivation to engage in counseling. No significant differences in personal motivation to engage in counseling were found. Additionally, no differences in state anxiety were noted. Results of the study also indicated that the impact of the orientation was uniformly experienced by children from all risk-factor categories.

These results were discussed with reference to previous literature and with regard to the constraints of this study. Implications of this research were discussed, and recommendations for future studies were made.
CHAPTER I

INTRODUCTION

The tremendous growth and vitality of professional counseling have resulted in professional mental health counselors internally asserting themselves among other health service providers and externally seeking to convey to the public that they are effective providers of mental health services (Vacc & Loesch, 1987). Further, they assert that professional mental health counselors have knowledge, skills, and techniques specifically suited to the unique mental health needs of society.

Public attitudes about mental health counseling and therapy have changed markedly in the past two decades. There has been increased understanding of the counselor's role in the community and greater acceptance that consulting a mental health specialist is not considered different from seeking the services of other medical, psychological, or educational specialists. This is especially true for the counseling needs of children and adolescents (Furey, 1987).

There remains considerable confusion and misunderstanding about what a professional mental health counselor is and what a professional counselor does (Vacc & Loesch, 1987). This
identity crisis of role and function affects all counseling populations, including the mental health counseling of children. Because mental health services for this population have been identified as being in crisis (Furey, 1987), the need for accurate knowledge about the roles and functions of mental health counselors and the counseling needs of children is imperative.

Overview and Background

The Joint Commission on the Mental Health on Children (1969) estimated that 10% of American children suffer from "emotional disturbances" and require some form of treatment. A decade later, the President's Commission on Mental Health stated that up to 15% of all children require some type of mental health service. Additionally, 23% to 31% of children in elementary schools were judged by their teachers to have behavioral problems (Rubin & Barlow, 1978).

It is estimated that as many as 10% of children 6 to 12 years of age suffer from clinical depressive illness (McKnew, Cytryn, & Yahraes, 1978). Evidence to date suggests that depressive syndromes in children may persist into adolescence and adult life if not treated (Venzke, Farnum, & Kremer, 1987).

The American Mental Health Counselors Association reported that an alarming number of troubled youth remain
unrecognized and untreated (Furey, 1987). It is estimated that most of the children in the United States who need mental health services are not receiving them (Gibbs, 1982; Huntze & Grosenick, 1980; Knitzer, 1982; Langer et al. 1982).

The rate of child and teenage suicide in the United States has tripled in the last 20 years. Currently, 400,000 children and teenagers annually try to kill themselves, and in over one-third of the suicide attempts the person had gotten into trouble either at home with parents or at school a short time before (Chapell, 1987). The National Center for Health Statistics reported over 5,000 child and adolescent suicides in 1984, an acknowledged underestimate (Hawton, 1986). In addition, for each child who succeeds in suicide there are at least 50 more who attempt it (Tishler, McKenry, & Morgan, 1981) and perhaps hundreds more who give it serious consideration (Celotta, Jacobs, & Keys, 1987).

When the number of children in need is compared with the number of children who are receiving mental health services, the extent of the problem becomes more visible. Two-thirds of the estimated three to nine million children in need are receiving no mental health services (Knitzer, 1982). There is a consensus among professionals that the number of youth who require treatment far exceeds the number receiving such services (Huntze & Grosenick, 1980; Marcus et al., 1982).

A 1987 position paper in the Journal of the American Mental Health Counselors Association has pointed a two-
pronged solution to the crisis of children and mental health services: first, improving the methods for identifying children requiring mental health services, and second, enhancing the mental health system's ability to provide the services necessary to accommodate all children in need (Furey, 1987).

In attending to the first, the authors acknowledged that mental health counselors should not expect children to ask for help and that children's messages for assistance are often overlooked. Children do not have a clear perspective of themselves in relation to mental health counseling or the field of counseling in general (Gibbs, 1982).

The problem is compounded when viewed in terms of identifying what counseling elements lead to successful outcomes in treatment and, more specifically, what preconditions may affect counseling even before treatment begins. For most children uninitiated to the counseling experience, there is limited acknowledgement of counseling as an ameliorative resource for personal, school, or family problems (Jakes, 1982).

Mental health counselors who work with children note that among the more counter-productive conditions to progress in treatment are those related to the patient's preconceived expectations, as well as negative attitudes, biases, and uncertain feelings about the counseling experience (Olshaker, 1971; Strupp & Bloxom, 1973). Children are seldom self-
referred (Gibbs, 1982) and are usually directed to counseling by adults. It is also significant to note that there remains continued misunderstanding, and confusion as to the roles and processes of mental health counselors and counseling, especially in the eyes of children.

Specific impediments to successful counseling experienced by children include a lack of factual information regarding the content and process of mental health counseling, feelings of helplessness and uncertainty with respect to the decision to initiate counseling, and resistant attitudes marked by feelings of anxiety and apprehension about the counseling experience.

A patient's assumed knowledge of the counseling experience (Friedman, 1963), attitude (Sloane, Staples, Cristol, Yorkston, & Whipple, 1975) and feelings (Gomes-Schwartz, 1978) are of major significance to precounseling conditions. When expectations and attitudes are shaped by negative views and lack of factual information about counseling, anxiety and resistance to treatment increase.

It is not surprising that the knowledge, feelings, and attitudes of children about counseling and therapy are often marked by uncertainty, reluctance and even hostility. For the most part, schools, parents, and the mental health establishment have failed to educate children and adolescents toward what counseling is and how it is relevant to the
child. In most cases, a rationale for the content and process of counseling or an understanding of the role of counselor, client, and the counseling relationship itself has not been established.

Statement of the Problem

One major reason for unsuccessful counseling and psychotherapy experiences may be that clients often hold unrealistic expectations regarding the goals and processes of treatment, particularly with respect to the roles of client and counselor (Orne & Wender, 1968; Zwick & Attkisson, 1985). When clients' and counselors' expectations of their roles in counseling are incongruent, the therapeutic relationship and outcome of treatment suffer (Kelly, 1955).

Use of systematic role orientation with accurate knowledge of the counseling experience is noted to be the most powerful way to bring clients' pretreatment readiness and expectations in line with those of mental health counselors (Duckro, Beal, & George, 1979). These role orientations explain the purpose of counseling, provide clients with accurate information about counseling, and describe appropriate roles for both client and counselor.

Role induction orientations to counseling and therapy for specific adult populations have proven significant to positive involvement and outcome in treatment (Hoehn-Saric, Frank, Imber, Nash, Stone, & Battle, 1964; Orne & Wender,
Videotape productions designed to prepare specific adult populations to counseling and therapy have also been effective in decreasing resistance in treatment involvement and increasing motivation to participate (Friedlander & Kaul, 1983; Jakes, 1982; Strupp & Bloxom, 1973).

Video productions have been used with children to increase knowledge, improve attitudes, and diminish negative feelings and concerns has been utilized in a variety of settings (Henry, 1983; Keogh, 1983; Raskind, 1982). The use of modeling and guided expectations within the context of social learning theory has been shown to be effective with target populations across a variety of settings. New behavior is learned vicariously after viewing a model's behavioral demonstration. Hospital, medical clinics, dental facilities, professional athletic programs and school personnel are increasingly utilizing media presentations to introduce children to specific treatments, procedures, or skill development and enhancement (Smead, 1981; Thompson, 1984).

It is not known, however, if the development and administration of a counseling orientation videotape designed to introduce children to counseling can be effective. Additionally, it is not known if a counseling orientation will improve attitudes and feelings about treatment as well
as increase the accurate knowledge by children of the
counseling experience and its relevancy to them.

**Need for the Study**

There is a need to introduce and positively orient
children to the counseling experience. The rising incidence
of disruption of the family system by divorce and separation,
as well as the single-parent and blended families, has been
accompanied by a shift in the burden of nurturing children to
the schools. Traditional means of family rearing and coping
with developmental problems are in flux. Mental health
professionals are increasingly becoming emotional caretakers
(Gardner, 1982). Domestic upheavals have shaken the ability
of parents, schools, and children alike to deal with what
were once regarded as ordinary growing pains (Gardner, 1977).

With greater numbers of children and adolescents in need
of mental health services, it has become necessary for
counselors and therapists to refine the therapeutic elements
leading to successful outcome in treatment. Concommittantly,
counselors must identify those elements that enhance
pretreatment understanding of counseling. Further, children
need to be educated as to the role of counseling in their
lives to dispel myths and stigmas which lend to a negative
view of counseling and added resistance to treatment.

The most favorable conditions for success in counseling
and therapy exist when clients feel ready to seek assistance
for their problems and concerns. The treatment variables which most strongly and consistently predict positive involvement in therapy are client/patient variables rather than therapist variables (Sloane et al., 1975; Gomes-Schwartz, 1978). These client/patient variables can be grouped into three categories: (a) expectations concerning the nature of the counseling content and process; (b) client/patient motivation to engage in treatment; and (c) involvement, as measured by positive participation and reduced patient hostility (Gomes-Schwartz, 1978).

In as much as the typical reactions of children presented for counseling include uncertainty, apprehension, and self-consciousness, and the negative stigma of counseling being for the sick, crazy, weird, or retarded, the use of an induction-type orientation to counseling and mental health services could provide children with more accurate information with which to engage in counseling. Additionally, such an orientation may contribute to more positive attitudes about counseling services for children and an increased willingness to self-disclose problems and work with a counselor.

The treatment readiness of children and the positive perceptions of counseling by children could be enhanced through an orientation videotape that introduces the content and process of counseling, the roles of the client and
counselor, and the universal needs for counseling in society. Additionally, the counseling orientation videotape could establish the rationale for talking about feelings and taking responsibility for behaviors as a means of working through personal problems.

More realistic and accurate knowledge about the content and process of counseling, combined with a rationale for positive and disclosing involvement, could lead to diminished negativity and apprehension about the counseling experience, as well as to an improved attitude of the client for participation and contribution (Strupp & Hadley, 1977).

Therefore, there is a need to study counseling orientation programs as precounseling preparation for children. More accurate information about the roles of participants, and the "normalness" of being involved in counseling could lead to greater willingness to see counseling as a viable means of assistance with problems of home, school and person. Such an orientation could lead to greater disclosure of problem areas in children's lives as they understand and see counseling in a more positive manner.

**Purpose of the Study**

The purpose of this study was to investigate the effectiveness of a mental health counseling orientation as a
guidance unit with fifth-grade elementary school students. More specifically, this study examined the differences between an experimental group of students who received the guidance unit and a control group. Additionally, between-group differences of high-risk and low-risk students were also examined. The dependent variables of the students' knowledge of mental health counselors and counseling, attitudes about counselors and counseling, and an index of children's state anxiety were used for comparison.

Research Questions

The following research questions received attention:

(1) Does a guidance unit about mental health counseling affect children's knowledge of mental health counseling roles, process, and content?

(2) Does a mental health counseling orientation affect children's attitudes about mental health counseling?

(3) Does a mental health counseling orientation affect children's disclosure motivation regarding personal involvement in counseling?

(4) Does a mental health counseling orientation affect the global attitude and disclosure motivation of children about counseling involvement?

(5) Does a mental health counseling orientation affect children's state anxiety levels as they address the issues of mental health counseling in society?
(6) Will the mental health counseling orientation guidance unit affect high-risk and low-risk children's knowledge of mental health counseling differently?

(7) Will the mental health counseling orientation guidance unit affect high-risk and low-risk children's attitudes about mental health counseling differently?

(8) Will the mental health counseling orientation guidance unit affect high-risk and low-risk children's disclosure motivation differently?

(9) Will the mental health counseling orientation guidance unit affect high-risk and low-risk children's global attitude and disclosure motivation differently?

(10) Will the mental health counseling orientation guidance unit affect high-risk and low-risk children's state anxiety levels as they address the issues of mental health counseling in society?

Definition of Terms

A Mental Health Counseling Orientation Guidance Unit is a production that provides accurate and specific information about the process, content, and roles of mental health counseling and, additionally, attempts to dispel misconceptions, stigmas, and prejudices about mental health counseling.
A Developmental Guidance Unit is a form of guidance available to all students as part of an organized and planned curriculum that is both sequential, flexible, and part of the total educational process. Developmental guidance aims to help students learn more effectively and efficiently, emphasizing personal growth and individual potential.

Knowledge of counseling is the awareness and understanding of counseling content and process presented in the mental health counseling orientation videotape.

Attitudes are a system of beliefs held by an individual about a subject area including the manner of acting, feeling, or thinking that shows one's emotional and/or behavioral disposition.

Anxiety is the apprehension, tension, or uneasiness that stems from anticipation of a threatening experience, the source of which is largely unknown or unrecognized.

State anxiety is a transitory anxiety state that is subjective in nature. It includes consciously perceived feelings of apprehension, tension, and worry that vary in intensity and fluctuate over time. In this study, only state anxiety was examined.

Trait anxiety is a relatively stable anxiety proneness as a generally presented emotional state over a wide range of behavioral and affective experiences.

A high-risk child is a child, identified by teachers and/or guidance counselor, who meets criteria of academic,
behavioral, and/or developmental precariousness. Specifically identified concerns are absenteeism, poor academic performance, disturbed peer, family, and school relationships, and behavioral disturbances.

A low-risk child is a child, identified by teachers and/or guidance counselor, who meets criteria of satisfactory academic, behavioral, and developmental task performance.

A counselor is a professional person knowledgeable in human development, interpersonal skills, and problem-solving who acts as a helper to persons experiencing personal or environmental difficulties.

Mental health counseling includes knowledge, skills, and techniques applied by mental health counselors to help clients enhance their lives. It may involve personal, social, familial, or vocational concerns, with the common goal of helping people "cope" and find effective solutions to their problems.

Mental health counseling developmental guidance units are a series of activities that provide information regarding the roles of clients and counselors within the context of a mental health counseling relationship. The rationale and validity of "talk" therapy, the course of counseling and therapy, and the universality of people and problem areas attended to within the context of mental health counseling are addressed. Additionally, attitudes associated with
involvement in mental health counseling are discussed. In this study, a videotape was used as the primary source of information for students.

**Organization of the Remainder of the Study**

The remainder of the dissertation is organized into four additional chapters. A review of the related professional literature is presented in Chapter II. Methodology of the study is addressed in Chapter III, with attention to the dependent and independent variables, design of the study, description of the treatment groups, research procedures, analyses of data, and methodological limitations. Chapter IV contains the research findings and data analyses. The findings, discussion, implications, limitations and recommendations are discussed in Chapter V.
CHAPTER II

REVIEW OF THE RELATED LITERATURE

This chapter contains a further delineation of precounseling orientation to mental health counseling for children. An overview of counseling's evolution and the relationship to the growing mental health needs of children is discussed. Major research, including the development of mental health counseling orientation and induction studies, induction and orientation studies with children, and the mediums of developmental guidance units and video formats are also presented. The research literature addressing the variables of interest in this study (i.e., children's knowledge, attitudes, and anxiety regarding mental health counseling) is discussed in depth.

Mental health counseling for people with normal conflicts and anxieties represent a rapidly emerging profession (Nugent, 1981). Most authors discussing the growth and evolution of counseling attribute it to increasing conflicts and stress in normal life that have resulted from rapid social, cultural, and economic change. Factors such as changing family patterns, the infusion of alternative
lifestyles, the changing role of work, the new perceptions of women's roles, and the increasing drug and alcohol use are all believed to contribute to increased value conflicts in the general population (Belkin, 1975; Tolbert, 1978; Van Hoose & Pietrofessa, 1970). These sociocultural and economic conditions have undoubtedly contributed to a growing demand for counseling from the public at large.

However, it was not until professionals trained in psychology and counseling recognized the need for normally functioning persons to get help with problems that professional counseling expanded to the elementary and secondary schools and, more recently, children in the community at large. This recognition became apparent when early counseling theorists developed techniques and rationales for working with the prevailing concerns of normally developing individuals (Nugent, 1981).

Community Mental Health Clinics in the United States originated in the early 1900s. At that time a psychiatrist, a clinical psychologist, and a social worker typically constituted the staff. The major concerns of these mental health practitioners focused on working with delinquents and disturbed children and their families. School counseling programs and counseling psychology stem from similar historical roots and emphasized the social needs identified by the vocational and community mental health counseling movements (Nugent, 1981).
The first community clinic was started in Chicago by William Healy. The Juvenile Psychopathic Institute was established to provide services to juvenile delinquents. Treatment was predominantly a modified psychoanalytic model, and funding was provided by philanthropic sources concerned with the juvenile crime rate (Levy, 1971).

Lightner Witmer developed the first psychological clinic at the University of Pennsylvania primarily to diagnose and treat children with learning and behavioral problems. The treatment service was used by schools when children experienced academic, behavioral, or social problems. Similar clinics at other universities were established to focus on the emotional and behavioral issues of children. Later these influences led to fueling the development of the school psychologist movement, to assess and treat children's learning and behavioral problems. The conceptualization of counseling students or families with the normal problems of living was as yet not entertained (Nugent, 1981).

In the 1920s continued concern about problem children brought about funding for the Child Guidance Demonstration Clinics. These treatment services modeled the methods and strategies of Healy and helped create a seedbed for a broadening interest away from strictly a juvenile delinquency orientation to more general childhood problems (Levy, 1971). The focus on work with children and families continued into
the 1940s and 1950s, but as Levy notes (1971), services gradually expanded to include emotionally disturbed adults. At that time, psychotic patients were not seen in community clinics but rather were warehoused in mental hospitals for extended periods.

In the 1950s, interest increased in counseling for people's normal concerns. Carl Rogers' client-centered theory, geared to these concerns, gained popularity. Counselor training programs broadened the base of counseling from strictly vocational concerns to the conflicts in personal and social areas. Nugent (1981) noted, however, that these new counseling approaches had little impact on the counseling needs of children.

In response to advances by the Soviet space program, the United States Congress pushed through the National Defense Education Act (NDEA) in 1958. The major purpose was to discover scientific and academic talent in schools and encourage its development. Funds were provided to upgrade secondary school counseling programs and train counselors through counseling and guidance institutes. Later the NDEA was extended to include the enhancement of elementary school counseling programs.

In 1963 Congress passed the Kennedy Comprehensive Community Mental Health Act. This ambitious program turned the corner on the historic focus of unidimensional treatment of delinquency. Under this act, outpatient clinics, halfway
houses for transitional care, crises clinics, and hotlines were proposed. The Community Mental Health Act of 1963 was designed to include treatment for normal people with a broad range of problems, as well as to develop prevention programs, including specific attention the mental health needs of children (Randolf, 1978).

In practice, however, community mental health clinics were unable to establish significant counseling programs for many clients due to their focus on severely emotionally disturbed, psychotic, and postpsychotic patients. The neglect of counseling being extended to the normal population was primarily the result of insufficient funding. Although the intention of the Act was to decrease federal monies gradually each year to allow state and local funding to take over, federal monies were insufficient to begin with and became more inadequate with deep state legislature cutbacks (Nugent, 1981).

Counseling needs in schools and the community increased rapidly in the 1970s. The difficulty in getting quality counseling programs launched in the schools continued. While professional counseling was having difficulty gaining credibility in schools and the community, a renewed interest in guidance activities in educational settings came about. Progressive, developmental educational activities for children that had been extinguished in the 1940s and 1950s began to resurface. The term "humanistic education" was used
in the literature more frequently, and curriculums based upon affective components of education were published (Patterson, 1973).

Attention to the normal and developmental concerns of children and counseling strategies focusing on these needs increased with the growth and professional standardization of the counseling profession itself. Strengthened professionalism in mental health counseling and the concern regarding unqualified persons handling counseling led the governing body of counselors to propose guidelines for professional licensure in 1976.

The American Mental Health Counselors Association (AMHCA) now represents over 12,000 counselors nationwide and has reported growth of approximately 10% per year over the last 10 years. A counselor is certified as having competency to assist individuals in achieving optimal mental health through personal and social development and adjustment, and counseling is defined as the process of assisting individuals through a helping relationship to achieve optimal mental health (American Mental Health Counselors Association, 1979).

**Induction Studies: Historical and Developmental Context**

Mental health counseling and psychotherapy are both systems of role relations in which complementarity is largely absent. The process of orientation to treatment is one of
the crucial and necessary tasks in the construction and maintenance of a psychotherapeutic system (Lennard & Bernstein, 1960). The delineation of role and process of therapeutic relationships is a major concern and point of focus for counselor and client alike (LaTorre, 1977).

Prototype orientations to counseling and therapy began as systematic attempts to provide a pretreatment framework for the client (Hoehn-Saric et al., 1964; Orne & Wender, 1968). These "role induction interviews" involved giving the client an explanation of what will take place in treatment before it actually begins. The rationale underlying this effort focused on increasing congruence between counselor and client with respect to treatment expectations and reducing anxiety of the client, while concurrently seeking to enhance the client's attitudes about treatment involvement. Hoehn-Saric et al. (1964) found that, when compared to a control group, patients who received role induction interviews scored significantly higher on scales that measured appropriate therapy behaviors. Role-induction patients also had better treatment attendance, were rated by therapists as having better therapeutic relationships, and showed greater improvement in target symptoms.

Hoehn-Saric et al. (1964) realized that less sophisticated clients might be bewildered by a procedure (psychotherapy) that differs considerably from both usual medical treatment and customary social interactions. In
examining the systematic preparation of clients who were applying for treatment, the original role induction procedures were designed to arouse and strengthen appropriate expectations of treatment involvement. The induction interviews consisted of four prominent components: (a) the roles of both client and therapist; (b) the nature of psychotherapy; (c) preparation for typical phenomena within treatment (e.g., resistance); and (d) induction of a realistic expectation of improvement during treatment.

Role induction, as currently used, is believed to function as an advanced organizer of information, in that it presents material about therapy and counseling that the clients do not already possess. In the 25 years since the original Hoehn-Saric et al. (1964) study, induction procedures and media have mutated to address a variety of counseling settings and populations; however, the contents of role induction procedures have remained consistent with the prototype.

Current induction procedures to counseling and therapy are designed to (a) clarify the role of client and therapist in the context of treatment; (b) provide a rational basis for the client to accept therapy as a means of helping with problems, recognizing that talking is not seen by most clients as a treatment modality; (c) provide a general outline of the course of treatment, including particular
emphasis on the client's hostile and negative attitudes; and, (d) convey information to create more positive and realistic attitudes concerning the therapeutic enterprise (Lambert & Lambert, 1984).

Induction and orientation studies that have been conducted vary greatly, and no study has directly replicated any other. Most are not comparable because critical variables differ from study to study (Jakes, 1982). These variables include the following: mode of treatment, individual or group; type of SES; type of induction (film vs. interview vs. script); type of subject (normal vs. neurotic vs. psychotic); whether the therapist is blind to the treatment conditions; types of measures used to assess therapeutic change and effects of the inductions; process vs. outcome; types of scales, etc. (Jakes, 1982). Role induction procedures to mental health treatment for children have not as yet been designed or compared with previous studies.

Despite the variations in outcome measures and the limitations in both process and outcome measures in most of the studies, all have obtained strong main treatment effects for the induction procedure utilized (LaTorre, 1977). As a summary review of the literature by Jakes (1982) indicated, with respect to the contemporary field of counseling and therapy inductions procedures, regardless of the type of pretreatment presentation or its methodological limitations,
inductions can have a strongly positive effect upon the client's level and style of participation in treatment and upon the client's perceptions, attitudes, and feelings about the treatment experience.

Induction Studies Research

Truax, Wargo, Carkhuff, Kodman, and Moles (1966) took a different approach to inducing appropriate client role expectancies when compared to the original Hoehn-Saric et al. (1964) study. Because a vicarious pretraining facilitated learning in some areas of human behavior, Truax et al. conceived a vicarious pretraining for therapy. Their goal was to enhance the client's willingness to engage more quickly in the self-exploratory process. This vicarious therapy introduction consisted of having clients listen to a tape recording of portions of therapy interviews that illustrated "good" client therapy behavior. Pretraining information focused on exploration of feelings and beliefs and on the kinds of personally relevant materials that are suitable topics.

Truax et al. (1966) examined eight groups of 10 clients each, four groups of hospitalized psychiatric patients and four groups of institutionalized juvenile delinquents. Self-concept and ideal self-concepts were assessed with Q sorts prior to and upon conclusion of therapy. Those receiving
vicarious therapy pretraining significantly increased the correlation between their self-concept and what experts think is ideal adjustment, significantly increased the correlation between their ideal self-concept and the experts' ratings, and significantly changed their ideal self-concepts in the direction of greater adjustment. LaTorre (1977) notes however, that the lack of process measures coupled with the absence of measures from other populations leaves the source and validity of these changes questionable.

Focusing more on the Hoehn-Saric et al. (1964) study than on the Truax et al. (1966) study, Yalom, Houts, Newell, and Rand (1985) decided to apply the basic principles of pretherapy role induction via an interview to a group therapy situation. Although geared to group therapy, the presentation of the orientation lecture was much like the Hoehn-Saric et al. (1964) role induction interview. Yalom et al. (1967) examined the effects of preparation for therapy on the behavior and attitudes toward both the group and its benefits. The most significant finding was that prepared clients tend to discuss those issues which seem to be more appropriate for effective therapy. Additionally, the experimental group necessitated a significantly shorter time necessary to obtain benefit of treatment.

Two historically significant induction studies that prepared subjects for individual therapy used a procedure based on an induction process identified as "Anticipatory
Socialization Interview." This interview was adapted from Orne and Wender's (1968) original model and later provided the guidelines for many future induction studies. Orne and Wender's (1968) original induction was designed to prepare subjects for individual, dynamically oriented therapy. It has also been adapted to group therapy pretreatment induction procedures.

The Orne and Wender (1968) interview was conducted individually by the therapist and had three major goals: (a) to provide a rational basis for the patient to accept psychotherapy as a means of helping to deal with personal problems; (b) to clarify the role of the patient and therapist in the course of treatment; and (c) to provide a general outline of the course of therapy and its vicissitudes (Orne & Wender, 1968). Benefits of this procedure are that it can be conducted either by a therapist or a trained outside person prior to the beginning of therapy, and that it can be modified to include examples from the individual client's own history. One significant problem with this procedure is that it requires more individual therapist time per client than would a film (Strupp & Bloxom, 1973) or a videotape (Jakes, 1982; Zwick & Attkisson, 1985).

LaTorre (1977) identified a study by Sloane, Cristal, Pepernick, and Staples (1970) as the next significant role preparation study as having a more impressive design. Using
the same Hoehn-Saric et al. (1964) interview, Sloan et al. (1970) devised treatment conditions that would assess separately the two factors implicitly examined in the original study. They hypothesized that the induction of both appropriate role behaviors and expectation of improvement would produce better attendance and more improvement in patients than would the induction of either of these factors alone or no induction at all.

Second, Sloane et al. (1970) also hypothesized that a pretherapy induction would affect the therapist's perceptions of the patient, as did Hoehn-Saric et al. (1964) under the heading "therapeutic relationship." While Hoehn-Saric et al. (1964) assessed this effect by obtaining global therapist ratings at the end of treatment, Sloane et al. (1970) predicted that induction effects would show up earlier and, consequently, obtained therapist ratings after the first therapeutic interview.

The Sloane et al. prediction that the anticipatory socialization interview might be enhanced by inducing expectation of improvement within a specific period of time was not confirmed. The researchers obtained no significant results from the therapist ratings, while in the Hoehn-Saric et al. (1964) study the experimental group performed significantly better in all areas. Jakes (1982) postulated that Sloane et al. (1970) may have obtained no significant results because the therapist rating was premature in the
course of therapy or because the simplistic rating measure of client attractiveness did not address the specific effects of the induction orientation. It was indicated, however, that the anticipatory socialization interview is most effective with naive patients--those having no previous therapy experience or understanding.

Warren and Rice (1972) utilized an induction procedure to prepare subjects for individual therapy and termed their approach "stabilizing and structuring." This approach involved four half-hour, outside-of-therapy sessions, conducted by a nontherapist investigator. Stabilizing refers to encouraging the client to bring up any problems that might be happening in terms of the client's feelings with the therapist or therapy itself, clarifying them, and encouraging the client to bring them up with the therapist (Warren & Rice, 1972). Structuring is an approach designed to teach the client to participate productively in the therapy process and assist the client through practice feedback to learn to use the ways of relating to experiences that have proven to be the most helpful (Warren & Rice, 1972).

The design of the stabilizing portion focused on increasing the congruence of patient-therapist expectations by encouraging the client to bring up problems incurred in the therapy process and clarify discrepancies of expectations. The structuring portion of the induction procedure sought to increase the level of motivation for
participation. The advantage of this procedure was the extended opportunity (four sessions in two weeks) for the client to integrate and apply the knowledge.

Warren and Rice (1972) used attrition and attendance as a major index of a successful induction procedure. It was further hypothesized that experimental clients would engage in therapy in a more productive manner and would have a more favorable outcome within the context of treatment. Additionally, Warren and Rice (1972) were the first investigators to direct their efforts specifically toward poor-prognosis clients.

Results showed that the stabilizing portion decreased attrition, but only those with both stabilizing and structuring interviews completed significantly more therapy sessions than did the controls (Warren & Rice, 1972). These findings support the belief that congruence in patient and therapist expectations would encourage the client to remain in treatment, and that this is the result of the clients' being more comfortable and more productive.

Two historically and developmentally significant induction studies that addressed subject groups in need of role induction or anticipatory socialization focused on low-socioeconomic-class individuals. Heitler, (1973) sampled consecutive first admissions to an open ward of a Veteran's Administration Hospital. All subjects were male between 20
and 40 years old. Typically, subjects were nonpsychotic, of average intelligence, had less than a high school education, held semi-skilled or unskilled jobs, and were from low socioeconomic classes.

Every other patient was given an individualized participatory interview, while the remainder of subjects received, instead, an equivalent amount of time that contained warmth, concern, and information about hospital life exclusive of therapy. The socialized individuals demonstrated significantly better therapy behavior during early therapy sessions.

Therapist ratings of each patient favored the socialized group with respect to degree of participation, desirability of style of participation, quality of working alliance, and anticipated benefit from therapy. The main conclusion, was that socialized patients exhibit more desirable therapy behavior than control groups, but that this effect dissipates over time.

Strupp and Bloxom (1973) also addressed the therapy needs of the lower socioeconomic class. Their clients were obtained through community agencies and had been identified as lower-income individuals needing psychological counseling but having minimal motivation to seek and accept it. Clients were assigned to one of three treatment conditions. One treatment group observed a role induction film. Another group was given a role induction interview similar to that
given by the Hoehn-Saric et al. (1964) group. The third group observed a film on early marriage that served the purpose of equalizing interest and attention devoted to each client.

The socialization film offered clear and positive outcome expectancies to subjects in contrast to the role-induction interview group, who were encouraged to "expect no miracles" and to understand that change takes time. In-therapy effects of the induction procedures were assessed by therapist and client ratings made following every other session.

Patients' ratings showed that a role induction increases satisfaction with therapy sessions, with progress in therapy, and interacting with others. Therapists' ratings indicated that role induction produced positive benefits regarding appropriateness, and desirability of in-therapy behavior.

Further refining the medium of filmed pretherapy role induction, Jakes (1982) developed a videotape presentation for women seeking counseling services from a University Counseling Center. The general purpose of the experimental induction was to provide a client with information concerning the nature and process of psychotherapy in order to facilitate change through active participation and collaboration with the therapist.

The induction videotape consisted of a 20-minute, informal expository dialogue between a "client" who
approximated the characteristics of the subject population and a "clinician." The client asked basic questions concerning all aspects of therapy. Topics included the therapist's and client's behaviors and roles in therapy (e.g., initiation of discussion, taking responsibility, not censoring one's speech); the course of therapy (e.g., length of time, ups and downs, resistance, reasonable goals); the nature of the client-therapist relationship (e.g., transference, trust); and common myths about therapy. The clinician responded with answers to these questions as well as to concrete suggestions for the best means of participating in a therapy session.

The goals of the induction videotape were to provide a client with realistic expectations about the process and goals of therapy that are congruent with those of a therapist, to increase a client's motivation to engage in therapy, and to teach appropriate, productive ways of participating in individual therapy sessions. More specifically, the goal of the study was to alter attitudes and behaviors of subjects that have been shown to correlate significantly with a positive therapy outcome.

Results of the Jakes (1982) study indicated that the induction procedure was able to alter some observed affective states and participatory behaviors. The research endeavor demonstrated that a brief, videotape psychotherapy induction was capable of altering nonpatients' knowledge and
expectations concerning therapy in a realistic and positive manner. Further, the videotape induction was able to provide non patients with a cognitive framework within which to conceptualize the process of psychotherapy.

Zwick and Attkisson (1985) focused on the effectiveness of an adult client pretherapy orientation induction on videotape. The primary goal was to determine whether a videotaped orientation that was chiefly informational in nature would enhance client response to therapy. The effects of the orientation on client knowledge about therapy, satisfaction with services, and therapist ratings of client attractiveness with respect to appropriate therapy behaviors were also investigated.

The 11-minute videotape described the relationship between client and therapist, encouraged clients to attend appointments, and stated that although progress is rarely immediate, most clients find that therapy can lead to a reduction in anxiety and depression. Results showed that (a) oriented clients were able to understand and recall the information in the videotape, (b) the oriented group showed greater decrease in self-reported symptoms than the control group, and (c) client feedback regarding the videotape was favorable. A key finding was that videotape orientations can be readily standardized as a pretreatment medium and are easily and inexpensively administered. In contrast with person-to-person orientations that are expensive and time-
consuming to administer, the procedure demonstrated that videotape orientations could be useful to the intake procedure in a wide variety of settings, including community mental health centers, private practices, and college counseling settings.

Induction and orientation procedures appear to be capable of producing positive, observable changes in client behavior within counseling and therapy conditions and to correlate highly with favorable evaluations of the therapy experience made by clients, therapists, and outside clinicians. Types of inductions and orientations vary greatly. Written scripts (Garrison, 1978), films (Strupp & Bloxom, 1973), audiotapes (Friedlander & Kaul, 1983), videotapes (Jakes, 1982), and, the most commonly used procedure, a role induction interview (Orne & Wender, 1968), have been examined. All have achieved highly positive results.

In a direct comparison of a verbal script with a role induction interview, in which both communicated the same material, both formats achieved identical positive results (Garrison, 1978). Similar data, in combination with results from modeling studies, suggest that film and videotape could be both highly efficient and highly effective in pretreatment induction and orientation procedures (Jakes, 1982; Strupp & Bloxom, 1973).
Application of Inductions and Orientations with Children

The concept of assisting clients to form realistic expectations, attitudes, and roles in counseling and therapy is not new. A number of studies were found in the counseling, psychotherapy, and education literature that addressed precounseling orientation or preparation of clients as a means of positively affecting counseling outcomes. For example, Davidshofer and Richardson (1981) examined the effects of a videotape orientation on client's increased knowledge of the counseling process, attitudes and motivation toward counseling, and anxiety levels about treatment involvement. This form of induction research has not as yet been applied to the counseling and therapy needs of children.

Efforts to use systematic induction and orientation procedures to effect changes in children's knowledge, attitudes, and anxiety about mental health counseling have not as yet been addressed. Applications of mental health counseling or therapy orientations (Hoehn-Saric et al., 1964), induction interview (Orne & Wender, 1968), filmed-modeling induction (Strupp & Bloxom, 1973), and target-subject induction video (Jakes, 1982) have not been clarified in the realm of mental health counseling with children. The clear majority of induction and orientation research studies with children have been the products of medical and educational communities.
Information induction and anxiety reduction are the prominent goals of orientation procedures by Siegel (1975), Hernandez-Portuguez (1983), and Henry (1983), all with medical applications for children. Investigations focused on the problem of newly arrived child patients, studying whether seeing an audio-visual orientation program affects how children perceive various aspects of their forthcoming hospitalization, and to what extent level of anxiety affects these perceptions, including the patient's willingness to see an orientation about his/her particular health condition (Thompson, 1984).

The purpose of the Siegel (1975) study was to investigate the efficacy of filmed modeling, based on social learning theory, in reducing the emotional reactions of children hospitalized for surgery. Subjects were 60 children between the ages of 4 and 12 with first-time hospitalizations. Prior to hospital admission, subjects in the experimental group viewed a peer-type modeling film that depicted a young child experiencing the various events, from admission to discharge, that most children encounter when hospitalized. The format of the film included a child whose behavior and verbal remarks were characteristic of a "coping" model, whereby the peer-model child overcomes initial fears and completes each event in a successful and nonanxious manner.

Siegel (1975) utilized a multidimensional assessment approach to evaluate the effectiveness of the treatment
conditions in reducing anxiety of the children throughout their hospitalization. Measures of trait anxiety, state anxiety, hospital attitudes, and observer-rated anxiety were used.

Statistical analysis of the data revealed a significant reduction in preoperative and postoperative anxiety for the subjects who viewed the hospital orientation film. The state anxiety measures consistently reflected differences between the experimental and control groups, showing fewer self-reported hospital/medical fears, fewer anxiety-related behaviors, and less observed anxiety.

Siegel (1975) noted that although the success of the hospital orientation film in reducing anticipatory and situational anxiety was demonstrated beyond that of typical preoperative instruction, the preliminary nature of the study did not permit a delineation of the specific components that resulted in the orientation's effectiveness. The investigators speculated that the orientation film may have served as a more dramatic and explicit procedure for providing children with accurate and anxiety-reducing information about the hospital and medical procedures, and thereby reduced uncertainty, diminished negative attitudes, and increased children's knowledge of the actual experience.

Reducing the anxiety of Costa Rican surgical pediatric patients by filmed information and relaxation treatments (Hernandez-Portuguez, 1983) utilized the peer-modeling/coping
model format. Eighty-five children between the ages of 6 and 13 admitted for elective surgery were assigned to one of three treatment conditions or to a placebo intervention:

(a) specific information about hospital procedures and surgery was provided by a peer-modeling videotape depicting a child from admission to discharge;

(b) two sessions of relaxation exercises that included suggestions of comfort, self-control, and quick recovery;

(c) a combination of both the videotape orientation and relaxation; and

(d) a placebo condition that consisted of general information about surgical ward organization.

As the investigator hypothesized, measures of anxiety, including self-report, behavioral observations, and psychological reactions, revealed that children who received the combination orientation and relaxation exercises showed significantly fewer indications of anxiety arousal (psychological and physiological) while undergoing hospitalization and after discharge than children in the orientation group or control group. The results of this research indicated that information alone does not ameliorate the impact of situational stress-induced anxiety. In addition to general information and reassurance, psychological preparation for hospital procedures should include practical suggestions about roles and process to help
the patient cope effectively with the situation (Hernandez-Portuguez, 1983).

Henry (1983) observed that the effects of hospitalization and surgery have been studied for the past 50 years. During that time, a general consensus has been reached that few children undergo hospitalization without some adverse effects. Acknowledging the pioneering work of Siegel (1975) in the use of filmed modeling as a method of preparing children for hospitalization and surgery, and the research of Bandura (Bandura & Walters, 1963; Bandura & Barab, 1973), who showed that anxiety can be reduced through vicarious extinction, Henry (1983) examined the effect of structuring information on a filmed modeling orientation.

Thirty children between the ages of four and nine were prepared for surgery in one of three treatment conditions: filmed modeling, filmed modeling plus structuring (orientation on how best to participate), or control group. Methodological limitations and the speculated confounding of the filmed material by the structuring orientation led to the failure of the orientation to bring about the expected decrease in anxiety. Additionally, self-selection of the subjects for the experimental and control groups may have resulted in the findings, as only 38% of the contacted referrals participated in the final subject pool.

Within educational settings, test anxiety has been viewed as a source of systematic bias in test scores. Since
modeling and induction orientations have demonstrated success in reducing fearful behaviors in children, Raskind (1982) hypothesized that exposure to a modeling film would effectively and economically reduce test anxiety and prevent a decrement in test scores. Raskind (1982) extended previous research which acknowledged filmed orientations utilizing a coping model to raise the intelligence scores of high-test-anxious college students and culturally different children.

Subjects were 48 boys and 48 girls, all middle class and all in the fifth grade. Randomly selected subjects were assigned to one of three treatment groups: a filmed test session with test-anxious children receiving supportive assistance from the examiner; a coping peer-model child in the same test session, verbalizing anxiety feelings and receiving coping techniques from the examiner; and a control group who saw an unrelated film. The major hypothesis predicted higher WISC-R scores for children viewing the coping film. The secondary hypotheses concerned the interaction of anxiety level and film content. Multivariate analysis of covariance indicated that filmed orientations differentially affect WISC-R scores, but were most effective with children extremely anxious as well as significantly deficient in school success skills (Raskind, 1982).

Smead (1981) compared two methods of presenting relaxation training with a control group for the purpose of
decreasing test-related anxiety in elementary school children. Thirty-nine sixth-grade students selected as target subjects with high anxiety by the State-Trait Anxiety Scale for Children were randomly assigned by sex to two treatment groups and one control group, with 13 children per group. Treatment group A received the orientation training in-vivo by the school counselor. Group B received a videotape orientation of the identical training, while the control group received no exposure to the training. Smead used one-way analysis of variance to compare means among the groups on each dependent variable considered separately. When one-way analysis of variance indicated significant treatment effects, a post hoc analysis using the Scheffe test was conducted to locate specific differences among the means of the groups. Both forms of treatment were demonstrated to be more effective in reducing test anxiety and state anxiety than the control group.

One of the fundamental means by which an observer can acquire new attitudes and behaviors vicariously from the demonstrating person's presentation of those attitudes and behavior is by modeling. Bandura (1969) pointed out that a wide variety of response patterns have been transmitted through modeling orientations and that these procedures can be effective with adults and children. Such modeling orientations have been shown to be effective with children over a variety of situational considerations including
aggressive behaviors, prosocial behaviors, frustration reactions, response patterns to new situations, etc. (Cuthbert, 1986).

Thelen, Fry, Rehrenbach and Frautschi (1979) pointed out that cognitive processes that are important components of in vivo modeling can also occur from watching filmed and videotape presentations. Filmed modeling has been used extensively to teach social skills to isolated or withdrawn children in the preschool age range. O'Conner (1969) designed a 23-minute orientation film in which 6 nursery school peer-models demonstrate social competencies and, at the same time, help to reduce fear of peer interaction. The experimental group increased in social interaction rate after the filmed modeling procedure.

O'Conner (1972) included follow-up data in a subsequent study where the same modeling film and control film were shown to 33 children identified as socially isolated or withdrawn. Included in this study was the added feature of external reinforcement procedures to shape appropriate social interaction and involvement behaviors. Follow-up data showed that conditions for filmed modeling orientations and orientations with the added feature of specific reinforcement procedures both maintained appropriate target behaviors with no significant differences between procedures, thus indicating no additional benefit from the external reinforcement conditions.
In an attempt to more precisely identify specific social interaction behaviors and thereby further clarify the process by which interaction increases, Keller and Carlson (1974) developed videotapes depicting the specific social behaviors thought to be components of positive social interaction. Tapes were shown to isolated preschoolers in the experimental group, while the control group saw nature tapes. Results revealed increases in all hypothesized social interaction behaviors for the experimental group. The control group remained the same.

As was shown by early studies, modeling orientations have been used extensively and successfully to teach skills to isolated or withdrawn preschool children. Miller, Gum, and Bender (1972) found that modeling orientations, where peer models oriented low-social-skill behavior subjects, was a worthy method for working with young children. Applications of induction and orientation procedures with children to reduce anxiety in medical and educational settings and, additionally, to induce appropriate knowledge, attitudes, and behaviors in these settings, have been extensively researched. What is not known is the effectiveness of an orientation on children's knowledge, attitudes, and anxiety about mental health counseling.
**Developmental Guidance**

Developmental guidance units in the classroom are a form of group guidance counseling, and are distinct from group counseling which places emphasis on remediation and is problem oriented. Developmental guidance is also distinct from group psychotherapy, where the main thrust is reconstructive or reeducative and aims toward personality change (Cuthbert, 1986).

Brammer and Shosstrom (1976) characterized group guidance as (a) preventative, (b) developmental, (c) emphasizing personally relevant information, (d) being cognitive, (e) having environmental emphasis, (f) being delivered through presentation and discussion, (g) leader directed, (h) topic oriented, (i) using planned and structured materials and activities, (j) emphasizing skills, and (k) using common goals.

Duncan and Gaumaer (1980) succinctly stated that "developmental classroom guidance is a systematic, planned educative program that provides an environment for integrating affective and cognitive learning experiences" (p. 91). This emphasis in guidance is now being implemented in school systems throughout the nation (Cuthbert, 1986).

Faust (1968) acknowledged that the approach to children in the school setting should be of a developmental focus for all children rather than for children in crisis. He further
urged that the school counselor and teacher work with students during the developmental stage when their life is centered in classroom and academic activities. This view lends further support to the present study since the counselor and teachers worked with the students in a developmental capacity.

Cuthbert (1986) noted that developmental guidance had its roots--and incorporates into its basic principles today--the idea that appropriate information should be taught to all children within appropriate developmental stages so that they can realize their fullest potentials academically and socially. Developmental guidance is a valid media through which specific skills can be delivered to children.

Classroom guidance units have been shown to be effective and efficient vehicles to use with large groups of students. Myrick, Merhill, and Swanson (1986) demonstrated that school-counselor-led classroom guidance units resulted in improvements in school attitudes in fourth-grade students initially targeted as both high- and low-risk. Students from 67 schools were randomly assigned to a treatment group that received the guidance unit and to a control group. Likert-type scales were used to rate the students' attitudes, and the results indicated that there were significant positive changes in school attitudes as a result of the intervention.

Cuthbert (1984) also found developmental guidance units to be appropriate in teaching communication skills to fourth
graders. The treatment group received training in specific communication skills delivered through a counselor-directed unit based on the procedures of Myrick et al. (1986). Results showed that students significantly improved in school behavior on the teacher-rated scales.

Cuthbert (1985) utilized a developmental guidance unit to enhance students' feelings about self. Results of this research showed a positive impact on the self-ratings of children in the treatment group, with greater pleasure, less excitement, and more self-control being indicated.

There is support in the literature to show that developmental guidance units are effective ways to teach children new ideas. The use of such a unit for an orientation to mental health counseling will be supported if a guidance unit has a significant effect on outcome measures for children in a fifth-grade classroom.
CHAPTER III

METHODOLOGY

The purpose of this study was to investigate the effectiveness of a mental health counseling orientation for children which was presented as a developmental guidance unit to fifth-grade elementary school students. A guidance unit, featuring information about mental health counseling via a videotape, was presented to an experimental group of students. These students were compared with a control group of students on several outcome measures. In addition, high- and low-risk children among these students were compared with respect to their knowledge and attitudes about mental health counseling. Levels of state-anxiety were also examined.

The experimental treatment (El) consisted of a 19-minute mental health counseling orientation videotape presented as a guidance unit by school guidance counselors. A control group (Cl) was then used for comparisons. Four dependent variables were studied: a) children's knowledge of mental health counseling; b) attitudes about mental health counseling and counselors; c) children's willingness to self-disclose problems and concerns; and d) state-anxiety levels associated
with environmental and/or situational apprehension surrounding presentation of the guidance unit.

**Population**

The population for this study consisted of children in regular fifth-grade classrooms in Marion County, Florida. Marion County is situated in the north-central portion of Florida, 70 miles north of the major tourist industry in the Orlando area and 40 miles south of Gainesville. Tourism, light manufacturing, agriculture, and thorough-bred horse breeding are the major industries in the county.

The county population includes over 200,000 residents. The 34 public schools service approximately 25,000 public school students. There are 10,300 students enrolled in the 20 elementary schools. All of the elementary schools are composed of grades K through 5. The population for this study consisted of approximately 1900 fifth-grade students.

The county's mental health services needs are addressed by public and private delivery systems. In the public sector, the West Central Florida Human Resources Center is a community mental health center which provides comprehensive mental health services including crisis intervention, daycare, outpatient therapy, children's services, community outreach, and emergency services. The private sector for delivery of mental health services includes two psychiatric
treatment centers geared to child and adolescent populations and approximately 16 licensed private practitioners from the disciplines of mental health counseling, social work, marriage and family therapy, counseling psychology, and psychiatry.

**Sampling Procedures**

The sample was drawn from 20 Marion County, Florida, elementary schools. All of the 20 schools that had regular fifth-grade classrooms were invited to participate in the study. Three schools were randomly selected from the seven schools that accepted the invitation and met research criteria. Because intact classrooms were the settings in which the guidance unit was presented, they comprised the unit of sampling in this study.

The fifth-grade classrooms in each of three participating schools were randomly assigned, using a table of random numbers, to one of two experimental conditions. Each classroom had approximately 20-25 students. All students from whom data were obtained were present for pre- and postobservations and for the 21-day time period over which the guidance unit and observations were presented. Allowing for absences and incomplete data, each of six randomly selected classrooms from three randomly selected schools provided from 21 to 27 students, for a total of 143 students.
Within each of the six classrooms, five "high-risk" target students (n=30) and five "low-risk" students (n=30) were identified by teachers and counselors. Using a class roster, teachers rated the degree of risk for all students according to a list of criteria on a scale from one to five. Low-risk students were those children with little or no academic, behavioral, or developmental problems. Students rated as high risk were identified as those children having academic, behavioral, and/or developmental problems. The five students in each fifth-grade with the lowest ratings were termed the low-risk subjects and the five children with the highest ratings were the high-risk subjects. The High Risk/Low Risk Student Inventory - Teacher Form (see Appendix A) was used to establish risk-factor criteria.

Permission to conduct the study in Marion County Public Schools was first obtained. A detailed description of the study was submitted to the Director of Student Services along with a copy of the videotape orientation and copies of the assessment instruments. The Supervisor of Counseling Services and Supervisor of Media Services were also included in establishing the appropriateness of the orientation's content and production suitability for use as a classroom developmental guidance unit. Final school board approval came after approval by the Director of Student Services. Secondly, a detailed summary of the study was forwarded to the University of Florida Institutional Review Board to
obtain approval for research in which experimental procedures with human subjects are outlined.

Following these procedures, the elementary school principals were informed of the nature of the study and invited to volunteer their schools for participation. Each principal received a copy of the Application for Research in Marion County Public Schools form which explained the purpose of the research, summarized of the procedures, stated the population needs, and delineated the amount of time involved to complete the study. The seven schools that agreed to take part in the study were then assigned random numbers from which three schools were selected.

Resultant Sample

The final sample was composed of students from three elementary schools from Marion County, each with a minimum of two regular classrooms of fifth graders (approximate total N=143). Within each classroom, five high-risk students (n=30) and five low-risk students (n=30) were also identified. The selected schools had certified school counselors with a minimum of two years direct experience in implementing classroom developmental guidance activities. The experimental conditions were administered by the school counselors in accord with specifically outlined research procedures.
Research Design

The research design was a pretest-posttest control group design with two experimental conditions (Issac & Michael, 1981). The fifth-grade classes in their respective elementary schools were randomly assigned to one of two treatment conditions by using a table of random numbers. The design is shown in Table 1. Because intact classes in three elementary schools were assigned to receive the guidance unit, the design was a nested or hierarchial design such that the classrooms were nested in treatment conditions (see Table 2).

The basic assumption in the hierarchical design is that in addition to treatment effects and error, each student's score is influenced by the class to which he/she belongs. Therefore, the class needs to be accounted for in the statistical model (Myers, 1979). In this research design, a separate factor is included for the effect of the intact groups, which reduces the size of the residual variance and provides an appropriate and unbiased test of the treatment effect.
Table 1
Pretest-Posttest Control Group Design

<table>
<thead>
<tr>
<th></th>
<th>Pretest</th>
<th>Posttest</th>
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<tbody>
<tr>
<td>E1 (Guidance Unit) (R)</td>
<td>01</td>
<td>02</td>
</tr>
<tr>
<td>E2 (Control) (R)</td>
<td>01</td>
<td>02</td>
</tr>
</tbody>
</table>

01 = Mental Health Counseling Knowledge - Student Form
02 = Mental Health Counseling Attitude Scale - Student Form
03 = State-Trait Anxiety Inventory for Children-A-State Scale
Table 2
Hierarchical Design: Subjects Within Classes Within Treatments

<table>
<thead>
<tr>
<th>Experimental Conditions</th>
<th>Treatment Group</th>
<th>Control Group</th>
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<tbody>
<tr>
<td></td>
<td>C1  N=24</td>
<td>C4  N=21</td>
</tr>
<tr>
<td></td>
<td>C2  N=27</td>
<td>C5  N=27</td>
</tr>
<tr>
<td></td>
<td>C3  N=22</td>
<td>C6  N=22</td>
</tr>
</tbody>
</table>

Total Subjects 73 70 (N=143)

From Myers (1979)

The pretest-posttest control group design controls for most of the threats of internal validity. Because all groups of subjects were assigned at random to treatment and control groups, it was assumed that the groups were equal at the beginning of the study. Any threat of history or maturation should have affected both groups equally. Because the intact classes were not selected because of extreme or idiosyncratic needs, the phenomenon of statistical regression to the mean should not be a threat to internal validity because it should have been present in both groups equally. Similarly, testing was not considered a cause of observed differences between the groups, since it was unlikely that the pretest alone
could be responsible for differences between groups. Instrumentation was not a threat to internal validity in the pretest-posttest control group design since the same procedures and instruments were used for each of the two groups at the pretest and posttest time periods. By having both groups measured at the same time and on the same scales, any defect or deterioration of the observation should have impacted both groups equally.

The threat to internal validity that was not controlled in this design was mortality. It was expected that the dropout rate would be equal for the two groups between the pretest and posttest. The numbers of subjects who dropped out during the study were only one treatment-group subject and two control-group subjects. This effect of mortality seemed minimal.

**Description of the Experimental Treatment**

The experimental treatment consisted of a 19-minute videotape orientation to mental health counseling implemented as a single-session guidance unit to children by their school counselors. The unit was presented to fifth-grade classrooms of children as part of existing guidance counseling activities within each of three elementary schools and consisted of two elements: (a) the guidance unit information and facilitation presented by the guidance counselor during
the introduction to the videotape and during the summary and closure opportunity after the videotape, and (b) the videotape itself.

The Guidance Unit

The rationale of the single-session guidance unit was to present an introduction to the videotape orientation and summary/closure information following the videotape presentation. The school counselors introduced themselves to the children and helped the children shift from an academic orientation to self and peer awareness with a brief relaxation technique.

The counselors then introduced the children to the topic area of mental health counseling as well as to the characters and storyline of the videotape. For example, "Today we're going to see a videotape about counseling. What's special about this videotape is that it's been made from a kid's point of view...not by professional actors, or adults, but by regular children." The introduction also included brief descriptions of what to expect from the videotape. For example, "Since one of the characters has already been to counseling and then shares honest information with her two best friends, the two boys find out what really happens in counseling, what counseling looks and feels like, and who goes to counseling." After the introduction the videotape was shown to the children.
The guidance unit summary consisted of closure statements by the guidance counselor reflecting the main points from the videotape and an opportunity for the children to ask questions and make comments. For example, one child said, "We found out that counselors can help kids understand their feelings and solve problems," and another said, "We also learned what happens between a counselor and a client and how things talked about are confidential and private." The guidance counselors were instructed to respond to feelings and clarify ideas in leading a group discussion about the videotape. An outline of the guidance unit is presented in Table 3.

The Videotape

The rationale of the 19-minute videotape was to create an information vehicle which was an "audience-friendly" medium. Specific attention was paid to script development, presenting to children accurate and factual information about counseling. The videotape was designed to enhance knowledge and positive attitudes about counseling, while depicting an age- and issue-appropriate storyline (the counseling experience from a child's point of view). Within the script, specific references addressed knowledge and attitudes about mental health counseling. These specific references were vocalized by either the main characters or the narrator in the videotape. Simultaneously, the screen presentation then
depicted a written declarative statement in high-resolution format over the video action which confirmed the reference or point of information. For example, while the children discussed what a person is called who sees a counselor, a five-second, high-resolution display stated,"CLIENT = A PERSON WHO GOES TO A COUNSELOR."

Table 3
Guidance Unit: Mental Health Counseling Orientation

A. Introduction of Orientation to Students (3 minutes)
B. Videotape Orientation to Mental Health Counseling (19 minutes)
C. Group Discussion of Videotape (4 minutes)
D. Guided Summary and Closure (4 minutes)
Total Time of Guidance Unit (30 minutes)

The structural formula applied to the screenwriting, casting of the characters, and the video and audio work subscribed to the two prime directives of film making. First, effective films and videos have characters and issues which the audience identifies with; second, the flow and movement of the piece should capture attention and induce excitation by the creation of tension, the release of tension, and finally the recapitulation or resolution of the film's message.
With respect to identification with characters and issues, the videotape orientation about children in counseling emphasized age, sex, race, and developmentally appropriate characters, discussing issue-appropriate material within the context of a verbally and behaviorally appropriate presentation. More specifically in this study, three 12-year-old children, one white female and two males, one black and one white, act out a typical Saturday morning telephone conversation between friends. Both boys are soon to go to mental health counseling after referrals from their school counselors. They are apprehensive and uncertain of what to expect and have typical biases and misinformation about counseling. They decide to telephone a trusted friend (the white female) who had gone to counseling the previous year during a particularly difficult period in her life. As the female character discloses her own experiences with counseling, emphasis of the video orientation is focused on her feelings and the accurate information about counseling which she shares with her friends.

A discussion between the three children clarifies typical counseling process and content, counselor and client roles, attitudes about counseling, and, finally, a reassuring and positive outcome. The boys gain a refreshed view about counseling and appear less resistant to the idea of counseling in their own lives. In essence, more accurate and greater knowledge about counseling, coupled with a sense of
positive regard from a peer, lead each boy to think and feel differently about counseling.

The second component of the formula attended to the flow and movement of the script and subscribed to traditional tension/tension-release theory for audience attention and interest stimulation. The videotape was divided into three separate, yet integrated, elements.

In the first four minutes, the viewer is presented a typical Saturday morning home setting with a child character on screen using a television remote control unit to switch between morning television channels. A flow of brief clips from significant movies with an appeal to children (Wizards, The Karate Kid, E.T., Jaws, and surfing films) depict a variety of confusing situations, threatening predicaments, and problematic events. The audio narration overlay relates these events to children-oriented dilemmas. For example, "You know, sometimes life can be tough.....even in the fifth grade. You've got to make a lot of choices and sometimes you just miss.....and sometimes things can get really out of control." This constitutes the initial phase of identification with the issues while initiating the creation of character tension.

As the characters are presented and identified, the viewer is made aware of the storyline and plot development. The videotape then moves to a 13-minute main segment whereby
a telephone conversation ensues. The male characters disclose their concerns, attitudes, and questions about counseling while the female character reassures them by self-disclosing her own positive experiences with counseling. For instance, "But isn't it weird to talk to someone you don't know?" Her response was, "It was like making a new friend. Trust didn't happen right away, but slowly after we got to know each other we could really talk!" The video scenes switch between children's rooms in their homes and still shots of the three child actors.

The latter portions of this segment include views of the female character in actual counseling situations, using art and puppets with her counselor. They are shown playing the "Talking, Feeling and Doing Game" (Gardner, 1973) and casually sitting and talking in an animated fashion in the counselor's office. Another example of the dialogue is, "What else happens in counseling...do you lie on a couch and tell your dreams?" with the response being, "You don't lie on a couch...you sit in real comfortable chairs like in your living room...and you can talk about all sorts of things...sometimes you even sit right on the floor."

The 2-minute conclusion on the tape utilizes mini-scenes from the 13-minute main segment to review and summarize the main points. "Talking with a counselor about feelings and problems is sometimes a good way to get a grip on things!" and "We found out about counseling from our friend," and
"Going to counseling sounds like a pretty good idea, now that I know a little about it." These dialogue segments contributed to the recapitulation and resolution phase of the storyline.

**Treatment Group**

Information relevant to a mental health counseling orientation for children was depicted via videotape format. It also seems appropriate for fifth-grade students within the context of the developmental guidance unit. Developmental guidance units have been used successfully with Marion County Schools to present information on human growth and development, personal safety, self-esteem and personal responsibility, drug education, and coping with change in the family and school. These units were designed to assist children deal with the complexities of self and society.

The researcher used the format of the developmental guidance unit to examine the treatment effects (El). The experimental condition was incorporated into a 30-minute developmental guidance unit period. The mental health counseling orientation guidance unit was then presented to randomly assigned, intact classes of fifth-grade students by the school counselor in each school.
Control Group

Intact fifth-grade classrooms randomly assigned to the control groups did not see the videotape or receive the guidance unit until the study was completed. Members of this group responded to the same measures of attitudes and knowledge of mental health counseling at the same intervals for pretest and posttest as the treatment group. For the purpose of this study the pretest, treatment, and posttest occurred on three successive weeks. All other variables were held constant between both groups.

Assessment Techniques

In order to assess the effect of the treatment, the following measures were used: (a) Mental Health Counseling-Knowledge-Children's Form (MHC-K-CF), (b) Mental Health Counseling Attitude/Disclosure Motivation Scale - Children's Form (MHC-A/DM-CF), and the (c) State-Trait Anxiety Inventory for Children (STAIC). These measures were administered as part of the pretest-posttest research design.

Mental Health Counseling-Knowledge-Children's Form

The Mental Health Counseling Knowledge-Children's Form (see Appendix B) is a paper-and-pencil measure developed by the investigator. It contains 15 mixed-frequency items representing material presented in the guidance unit.
regarding knowledge of mental health counseling content, process, and roles.

The students marked each item true or false with an X or a check on a five-dimension, Likert-type scale. Each item was assigned a numerical score from one to five. A total score was then recorded for each student. The instrument had a maximum possible score of 75 (5 X 15), for a range of 60 points.

Items which received a value of 1 would reflect highly accurate knowledge about a specific counseling dimension. Those items which received a value of 5 would reflect that limited or inaccurate overall information about counseling was known by the subject. Conversely, the lower the overall score, the more accurate overall information about counseling is known by the subject. Therefore, any decrease of overall score between pretest and posttest suggests a positive treatment effect, and in essence, an increase in the subject's knowledge about counseling.

The instrument covered three general areas, each with five items which addressed client role, counselor role, and the nature of counseling. An example of a client role question is "A Client talks about feelings and problems." A counselor's role question is, "A Counselor judges good and bad in people." An example of a question about the nature of counseling is, "The important feelings a Client tells a Counselor are confidential and private."
Reliability refers to the consistency of test results. A frequently used measure of consistency recommended where consistency of the subjects' scores over time was of interest (Ary, Jacobs, & Razavieh, 1979), the test-retest technique was utilized for establishing reliability with this instrument. Test-retest scores from 20 age-appropriate subjects who were not involved in the research design and under similarly controlled testing conditions were paired, and a reliability coefficient was calculated using the Pearson correlation. Consistent with the research procedures implemented in the study, subjects received an initial test followed by a one week waiting period before receiving the retest. A reliability coefficient of .86 suggested appropriate limits of reliability.

Mental Health Counseling-Attitude/Disclosure Motivation-Children's Form

The Mental Health Counseling-Attitude and Disclosure Motivation-Children's Form (see Appendix C) is a paper-and-pencil measure, also developed by the investigator, in which the students respond to 10 mixed-frequency items representing attitudinal aspects of being involved in counseling. The students marked each item with an X or a check on a five-dimension, Likert-type scale. Each item was assigned a numerical score from one to five. A total score was then recorded for each student, with the instrument capable of generating a maximum possible score of 50 (10 X 5), and a
minimum possible score of 10 (10 x 1), for an overall range of 40 points.

Items which received a value of 1 would reflect strongly positive attitudes about counseling and willingness to self-disclose personal feelings about counseling. Items which received a value of 5 would reflect more negative attitudes about counseling and less willingness to self-disclose. The greater the overall score, the less positive attitude about mental health counseling or willingness to self-disclose is reflected by the subject. Conversely, the lower the overall score, the more positive attitude and/or willingness to self-disclose is felt by the subject. Therefore, any decrease of overall score between pretest and posttest suggests a positive treatment effect, and in essence, an increase in the subject's positive attitude and/or willingness to self-disclose about counseling.

The instrument covered two attitudinal areas: (a) client attitudes about mental health counseling in general, and (b) client self-disclosure and self-involvement motivation about counseling. Whereas the first area addressed more generalized attitudes about counseling, the second area focused specifically on the subject's personal attitudes about counseling involvement. Examples of items from the general attitude category are, "It is a sign of weakness for a person to see a Counselor about feelings and
problems," and "All people who go to counseling are crazy or weird." Examples of the self-disclosure/self-involvement category are, "I would be afraid to talk to a Counselor," and "If I talked to a Counselor I would probably worry less and feel better."

The test-retest technique was used as a measure of consistency to establish reliability for this instrument. The test-retest scores from 20 age-appropriate subjects under similarly controlled testing conditions were paired, and a reliability coefficient was calculated using the Pearson correlation. Table 4 shows the test-retest correlations for each of the submeasures and the global measure.

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<td><strong>Test-Retest for the Mental Health Counseling</strong></td>
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<td><strong>Attitude/Disclosure Motivation</strong></td>
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<td>(MHC-A, MHC-DM, and MHC-A/DM)</td>
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<td><strong>Mental Health Counseling Attitude/Disclosure Motivation</strong></td>
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<td><strong>Global Attitude/Motivation</strong></td>
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State-Trait Anxiety Inventory for Children-(A-State Scale)

The State-Trait Anxiety Inventory for Children (STAIC) was initially developed as a research tool for the study of
anxiety in elementary school children (Spielberger, Gorsuch, & Lushene, 1970). It is comprised of separate, self-report scales for measuring two distinct anxiety concepts: state anxiety (A-State) and trait anxiety (A-Trait) (Spielberger, Edwards, Lushene, Montouori, & Platzek, 1973). The STAIC is similar in conception and structure to the State-Trait Anxiety Inventory, which provides measures of anxiety for adolescents and adults (Spielberger et al., 1970). The STAIC is especially constructed to measure anxiety in 9- to 12-year-old children.

The STAIC A-State scale consists of 20 statements that ask children how they feel at a particular moment in time. The STAIC A-Trait scale also consists of 20 item statements, but subjects respond to these items by indicating how they generally feel. The format for children responding to the STAIC has been specifically simplified to facilitate its use with young children. Though the STAIC items have face validity as measures of anxiety, this term is not used during administration of the instrument, but rather in the "How-I-Feel" Questionnaire (see Appendix D).

The A-State scale is designed to measure transitory anxiety states; that is, subjective, consciously perceived feelings of apprehension, tension, and worry that vary in intensity and fluctuate over time receive attention. The A-Trait scale measures relatively stable individual differences in anxiety proneness.
For the purpose of this research the A-State scale was used exclusively as a measure of anxiety at a particular moment in time. Specifically, it was used as an index of anxiety by children who received the Mental Health Counseling Orientation for Children as a guidance unit in their elementary school. Research on the STAIC has consistently demonstrated that scores on the A-Trait anxiety scale are relatively impervious to the conditions under which the scale is given (Johnson & Spielberger, 1968; Lamb, 1969; Spielberger et al., 1970), but A-State anxiety scores are influenced by the immediate environment.

Elevations in the state anxiety scale are normally evoked in children exposed to stressful situations. As noted by Spielberger, et al. (1973), children who are higher in trait anxiety experience state anxiety more frequently and with greater intensity than low-trait-anxiety children because they perceive a wider range of circumstances as threatening. The state-anxiety scale is noted for determining actual levels of state anxiety induced by experimental procedures. Additionally, the state anxiety scale is noted as a useful indicator of the level of transitory anxiety experienced by children exposed to counseling situations, and especially as a measure of the effectiveness of anxiety-reduction procedures used to enhance counseling and therapy involvement (Spielberger et al., 1973).
Test-retest reliability coefficients for the STAIC A-State reflect the influence of unique situational factors existing at the time of testing, and low test-retest correlations are often reported, as would be expected, in measuring the changes over time with anxiety related to situational stress. Given the transitory nature of anxiety states, a measure of internal consistency more meaningful than test-retest, the alpha reliability of the STAIC-A Scale, was computed for the Leon County sample. Utilizing the Kuder-Richardson formula 20 as modified by Cronbach (1951), the reliability coefficient was .82 for males and .87 for females.

**Instrument Construction Rationale**

The purpose of this study was to investigate the effect of a systematic orientation of children to mental health counseling. The results of previous research has demonstrated that preparation of clients for counseling and psychotherapy using role induction orientations have been successful in facilitating improved treatment outcome, with change in client expectancies suggested as the means by which the effects of the orientation are exerted. The present study was implemented by the researcher to demonstrate changes in the variables of knowledge, attitude, and anxiety with children exposed to an orientation role induction for mental health counseling.
Because attempts to isolate the effective components of role-induction procedures have met with little success (Imber et al. 1970), it is noteworthy to address role induction orientations in terms of a general learning experience leading to more realistic expectations concerning the roles and process of counseling and therapy. Changed expectations produce complementary changes in attitudes, motivations, and behaviors, and enhance the likelihood of treatment success (Strupp & Bloxom, 1973).

In terms of this study, the rationale underlying instrument construction and selection necessitated addressing the developmental age of the subjects as well as the subjects' reading and vocabulary skill levels. Additionally, because role and process orientations to mental health counseling for children have not been developed as yet, dependent measures designed to address the learning experience required parallel and related development. Specific information regarding mental health counseling roles and process were appropriately tailored to the subject population, while maintaining the content integrity demonstrated valid and appropriate in the majority of adult orientation studies.

Dependent measures implemented to assess dimensions of children's knowledge (MHC-K-CF) (see Appendix B) and attitudes and disclosure motivation (MHC-A/DM-CF) (see Appendix C) with respect to mental health counseling were
developed specifically for this study by the author. The dependent measures were found content valid and appropriate for children by a selection of 8 licensed mental health counselors/marriage and family therapists of children and families.

The selection of the State-Trait Anxiety Index for Children (STAIC) was based specifically on its strengths in the area of instrument development and normative standardizations to the research population. It was especially constructed to measure anxiety in 9- to 12-year-olds with average reading ability and is influenced by immediate situations in the immediate environment. The STAIC in its current revised form was initially developed and normed to be given to fourth-, fifth-, and sixth-grade children in a semi-rural Florida area, with many of the children from lower-socioeconomic-class families. This area is similar to the region of this current research effort.

The STAIC, also referred to as the "How-I-Feel" Questionnaire, and its A-State scale have proven useful as indicators of the level of transitory anxiety experienced by children in counseling situations. Elevations in A-State anxiety are normally evoked in children exposed to stressful situations in general and to involvement in experimental conditions specifically.

Many of the attempts to produce or enhance change in counseling or psychotherapy have focused upon the role of the
therapist (Garfield & Bergin, 1978; Gomes-Schwartz, 1978; Strupp & Hadley 1977;), and the relationship of outcome and process issues. These studies have been designed and implemented to investigate those behaviors, characteristics, or techniques which the counselor can employ to facilitate improvement in the client and positive outcome for the course of treatment.

Recent watershed studies by Sloane et al. (1975) and Gomes-Schwartz (1977) indicated that the variables which most strongly and consistently predict positive engagement in psychotherapy and counseling are, in fact, client/patient variables rather than counselor/therapist variables.

These variables can be grouped into three areas. The first area is patient expectation concerning the nature of therapeutic process, including roles of client and therapist, and specific knowledge with respect to the mechanics of being in treatment. The second area is that of client/patient involvement and includes two attitude dimensions: positive participation and negative hostility. The third area is motivation to engage in counseling/psychotherapy.

These three variables have been shown by Gomes-Schwartz (1977) to be highly predictive of outcome in treatment. Further, these three variables are of sufficient strength to influence the outcome of counseling or psychotherapy regardless of the personality characteristics, techniques, or
therapeutic orientations of the therapists involved in the studies (Gomes-Schwartz, 1977; Sloane et al., 1975).

Expectation/Knowledge

With respect to the expectation category, Goldstein (1962) identified two primary dimensions relevant to counseling and psychotherapy: prognostic expectancy and participant role expectancy. Prognostic expectancy refers to a belief that a certain type of treatment will happen and, additionally, offers a specific concept as to the particular form which the course of treatment will take. Participant role expectancy denotes the belief that the client/patient and counselor/therapist will behave in certain ways during the actual course of treatment.

Congruence within the category of prognostic expectation would include a discussion of the following:

1. course in treatment: projected number of sessions (time), setting realistic goals, ups and downs to be expected, anticipation and interpretation of resistance; and

2. rationale for counseling and psychotherapy: validity of talk therapy, or how talking can help improve a bad life situation.

The category of participant role expectation includes three dimensions of client-counselor expectation mutuality:
1. client/patient's role in counseling/therapy: needs to be active rather than passive; initiates discussion of important concerns; needs to talk openly and freely; needs to take part in mutual goal setting with the counselor; needs to share ideas and express feelings.

2. counselor/therapist's role in counseling/therapy: primarily listens, clarifies, and avoids judging; helps client/patient to better understand self; does not take responsibility for finding solutions to problems; and

3. therapeutic relationship: trust develops gradually over time; an explanation of transference; a special person with whom to discuss and understand self.

The dimensions presented above are a consolidation of a variety of significant expectation studies; however, guidelines presented by Orne and Wender (1968) and Gomes-Schwartz (1977) are prominent with regard to the above component configuration.

**Attitude and Disclosure Motivation**

The involvement dimension, composed of a positive participation factor and a negative hostility factor, is identified as the single most useful predictor of outcome in studies with adult individual therapy (Gomes-Schwartz, 1978).
These two attitudinal dimensions are the most predictive of outcome, independent of other sources of variance such as ego strength, satisfaction with therapist, or patient motivation. A client's motivation to begin counseling or therapy and devote energy and effort (disclosure motivation) to growth and change has been frequently designated as a factor which is predictive of success in treatment (Gomes-Schwartz, 1977; Malan, 1976; Strupp & Bloxom, 1973). Because so many different measures and definitions have been used to address the category of motivation, the results as related to prediction of outcome are mixed and vary with the measures used (Meltzoff & Kornreich, 1970). It is evident that a client's level of motivation to engage in treatment is often related to the degree of treatment success.

High-Risk/Low-Risk Student Inventory

The first step in the development of the High-Risk/Low-Risk Student Inventory was the identification of variables relating to children's academic and behavior problems. These variables were chosen through review of the literature, consultation with educators and counselors, and the researcher's experience with children.

The significant variables of student risk which were identified correlated highly with prominent dimensions of the Walker Problem Behavior Identification Checklist (WPBIC). This measure was developed to identify children with behavior
problems (Walker, 1983). On the construct of behavior disturbance, five factors were identified as highly correlated with student risk:

1. acting-out (disruptive, aggressive, defiant);
2. withdrawal (restricted functioning, avoidance behavior);
3. distractibility (short attention span, inadequate study skills, non-attendance);
4. disturbed peer relations (poor social skills, negative self-image); and
5. immaturity (dependent, developmental lag, regressive).

For the purpose of this research these five factors were assigned as criteria for a general index of high-risk and low-risk students. These factors were viewed collectively and assigned numerical strengths based on a five-point Likert-type scale; the classroom teachers used class rosters to assign each student with a global risk index from one (low-risk) to five (high-risk). After using this method of risk assignment, the five high-risk and five low-risk students from each class were then randomly selected from each class' total population.
Hypotheses

The following hypotheses were tested in this study:

1. There is no significant difference between treatment and control groups (El & E2) on children's knowledge of mental health counseling, as measured by the Mental Health Counseling-Knowledge-Children's Form (MK).

2. There is no significant difference between treatment and control groups (El & E2) on children's attitude about mental health counseling, as measured by the Mental Health Counseling-Attitude/Disclosure Motivation-Children's Form (MAT).

3. There is no significant difference between treatment and control groups (El & E2) on the children's disclosure motivation regarding personal involvement in mental health counseling as measured by the Mental Health Counseling-Attitude/Disclosure Motivation-Children's Form (MSD).

4. There is no significant difference between treatment and control groups (El & E2) on children's combined global attitude and disclosure motivation about mental health counseling, as measured by the Mental Health Counseling-Attitude/Disclosure Motivation-Children's Form (MGL).
5. There is no significant difference between treatment and control groups (E1 & E2) on children's levels of state anxiety, an inherent factor with involvement in experimental procedures, as measured by the State-Trait Anxiety Inventory for Children-A-State Form (MAX).

In addition to the five primary hypotheses, secondary hypotheses were tested which addressed the five primary variables in terms of differential treatment effects for high-risk and low-risk students:

1. There is no significant interaction between treatment and risk classification with respect to children's knowledge of mental health counseling, as measured by the Mental Health Counseling-Knowledge-Children's Form (MK).

2. There is no significant interaction between treatment and risk classification with respect to children's attitudes about mental health counseling, as measured by the Mental Health Counseling-Attitude/Disclosure Motivation-Children's Form (MAT).

3. There is no significant interaction between treatment and risk classification with respect to children's motivation to self-disclosure about personal involvement with mental health counseling, as measured
by the Mental Health Counseling Attitude/Disclosure Motivation-Children's Form (MSD).

4. There is no significant interaction between treatment and risk classification with respect to children's combined global attitude and disclosure motivation about mental health counseling, as measured by the Mental Health Counseling-Attitude/Disclosure Motivation-Children's Form (MGL).

5. There is no significant interactions between treatment and risk classification with respect to levels of state anxiety, as measured by the State-Trait Anxiety Inventory for Children-A-State Scale (MAX).

Research Procedures

One week before the treatment (E1) began, all pretreatment measures were given. The counselors at each school involved in the study administered all assessment instruments in their respective schools. The counselors were trained by the investigator in the procedures for assisting selected classroom teachers to determine the high-risk and low-risk students. The counselors were also shown how to administer the dependent measures and present the guidance unit orientation to mental health counseling.

During the second week, the experimental treatment was administered. All selected intact classes randomly assigned
to the treatment group (E1) received the developmental guidance unit containing the mental health counseling orientation videotape and group discussion. The control group (E2) did not receive the treatment until all post-treatment assessments were completed and the study was terminated. During the third week both treatment and control groups received the posttest measures.

To insure confidentiality, each participating student was assigned a coded set of forms. Subjects were eliminated from the sample if complete data were not collected for them or if they were not present for either pretest or posttest observations. Of 146 participating subjects, 2 were eliminated due to absences of pre- or posttesting. Children who were absent for the treatment group experimental condition also had their pretest-posttest data eliminated. One subject was eliminated due to absence during the experimental treatment. A total of 143 subjects participated in the study.

All treatment and control group scores were tabulated and recorded on master spread sheets for systematic entry into a computer for analysis. Post hoc analysis included the treatment-by-risk factors which were generated from the individual classroom rosters. The high-risk/low-risk/non-risk student rosters then provided the cross-referenced, name-to-code configurations for added confidentiality of student participation.
Research Participant Training

The three participating Marion County school guidance counselors were trained by the investigator in the experimental procedures during a one-day workshop at each school. Only school counselors who had at least one year of experience in teaching developmental guidance units, who were certified by the State of Florida, and who were available for training by the researcher were eligible for participation. Participating counselors were trained in detail with respect to the administration of the dependent measures, selection of high-risk/low-risk students from class rosters, rationale and mechanics of the videotape presentation, and group facilitation procedures and goals.

School counselors administered the pretest and posttest dependent measures to the classrooms of fifth-grade students and returned them to the researcher. The pretreatment measures were administered one week prior to the developmental guidance unit. The posttreatment measures were administered one week after completion of the guidance unit.

The pretest and posttest measures were administered according to the instructions provided by the researcher. Similarly, mechanics for treatment procedures were adhered to based upon specific instructions by the researcher. After completion of the study, the counselors were interviewed as to the procedures used and their experience with the study.
This information is reported in Chapter V to present a more complete understanding of both content and process of the research.

**Data Analysis**

To examine initial differences between the treatment group and control group, an analysis of variance was performed on the pretreatment scores for each dependent variable. For the five primary hypotheses listed, the significance level was set at the .01 level, holding the overall experimental alpha level to .05. Further analysis of covariance utilizing pretest scores as covariates were then used in examining the main treatment effects.

The pretest and posttest data were then analyzed using a hierarchical design, analysis-of-variance model (Myers, 1979). As indicated earlier, the design involved two treatment levels (experimental condition and control) and three classes nested within each of two treatments, with a minimum of 20 students per class. This analysis was appropriate since each subject belonged to an intact classroom, which may have partly influenced individual subject's scores due to interactions with this particular set of individuals or occurrences. This treatment effect was not accounted for in the standard analysis of variance, thereby potentially inflating the F ratio and contaminating the
treatment effect. In this more appropriate analysis, the effects due to group membership (intact classes) were separated from the within-group residual error term. Although this specific F test was evaluated at a lower number of degrees of freedom, the reduced magnitude of error helped compensate for this loss.

The same hierarchical design was then used to contrast the performance of the five high-risk and five low-risk target students from each class within each school. These students were those identified by their teachers and guidance counselors as having the highest or lowest risk, with school success as an index of academic, behavioral, and developmental problems which might warrant mental health counseling intervention.

Description of Methodological Limitations

Attempts were made to strengthen the internal validity of the study in several ways. A control group was included to neutralize the effects of history, equate for the effects of maturation, control for the effect of statistical regression, and equalize for the effects of pretest measurement on groups. In this study, all groups received the pretest and posttest measures, so all groups may have been sensitized to testing. This may have affected the evaluation of the procedures with groups who were not pretested.
It is also noted that the ratings on the self-report measures may have been affected at the initial observation if full understanding of the task was not achieved by the subjects. Differential response bias could also have occurred at the posttest evaluation, where responses might have been given according to what subjects felt would be the right or appropriate response to give.
CHAPTER IV

ANALYSIS OF THE DATA

This study was designed to investigate the effectiveness of a mental health counseling orientation in videotape format as a developmental guidance unit with children. The data were collected on 143 subjects from 6 intact fifth-grade classes from 3 elementary schools in Marion County, Florida. School counselors implemented a guidance unit to randomly selected intact classes which, in turn, were randomly distributed to treatment and control groups.

The research had two primary objectives with a view toward clinical mental health applications. The first purpose of the investigation was to determine how the videotape orientation to mental health counseling would impact on the children's knowledge and attitudes about counseling, as well as the state-anxiety levels of the subjects during the experimental procedures. A second purpose was to detect differential effects in how high-risk and low-risk students would experience and act upon the videotape orientation.
Results

Each hypothesis was stated in the operational null form. Data relevant to each hypothesis are presented, discussed, and summarized in this chapter. Additionally, each hypothesis was tested at the .01 level using the Bonferonni technique for partitioning the overall alpha level of .05 for the number of separate tests.

Children's Knowledge of Mental Health Counseling

To test the effects of the videotape orientation to mental health counseling on fifth-grade children's knowledge of the roles, process, and goals of counseling, an analysis of covariance was performed. The subjects' pretest results on the Mental Health Counseling-Knowledge-Children's Form (MK) served as the covariate. Results of this analysis are presented in Table 5. Means and standard deviations for the treatment groups with all schools combined are presented in Table 6. Means and standard deviations for treatment groups from the individual schools are presented in Table 7.

**Hypothesis 1:** There is no significant difference between treatment and control groups (E1 & E2) on children's knowledge of mental health counseling, as measured by the Mental Health Counseling-Knowledge-Children's Form (MK).
The analysis of covariance was performed with an obtained F of 154.0, p = 0.0002, df = 1, 4 for the main effect of treatment. There was no significant interaction effect of pretest and treatment as shown in bottom panel of Table 5. Because the F ratio of 154.0 was significant at the .01 level, this null hypothesis was rejected.

A main effect of treatment was noted.

Table 5
Source Table for Analysis of Covariance on Posttest MK

<table>
<thead>
<tr>
<th>SOURCE</th>
<th>DF</th>
<th>SS</th>
<th>F</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>PREMK</td>
<td>1</td>
<td>2292.6</td>
<td>190.3</td>
<td>0.0001</td>
</tr>
<tr>
<td>TRT</td>
<td>1</td>
<td>1745.3</td>
<td>154.0</td>
<td>0.0002</td>
</tr>
<tr>
<td>CLS (TRT)</td>
<td>4</td>
<td>45.3</td>
<td>-----</td>
<td>-----</td>
</tr>
<tr>
<td>PREMK</td>
<td>1</td>
<td>2059.3</td>
<td>175.1</td>
<td>0.0001</td>
</tr>
<tr>
<td>TRT</td>
<td>1</td>
<td>3.9</td>
<td>0.2</td>
<td>0.7</td>
</tr>
<tr>
<td>CLS (TRT)</td>
<td>4</td>
<td>83.5</td>
<td>-----</td>
<td>---</td>
</tr>
<tr>
<td>PRE*TRT</td>
<td>1</td>
<td>14.5</td>
<td>0.6</td>
<td>0.5</td>
</tr>
<tr>
<td>PRE* CLS (TRT)</td>
<td>4</td>
<td>91.1</td>
<td>-----</td>
<td>---</td>
</tr>
</tbody>
</table>

PREMK = Pretest/Mental Health Counseling-Knowledge
TRT = Treatment
CLS = Class
<table>
<thead>
<tr>
<th>Table 6</th>
<th>Means (and Standard Deviations) for Treatment Groups with All Schools Combined on Measure of Mental Health Counseling Knowledge</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>E1 - Treatment</td>
</tr>
<tr>
<td></td>
<td>N = 73</td>
</tr>
<tr>
<td>Pretest</td>
<td>37.7 (5.3)</td>
</tr>
<tr>
<td>Posttest</td>
<td>30.5 (4.8)</td>
</tr>
<tr>
<td></td>
<td>-7.2</td>
</tr>
</tbody>
</table>
Table 7
Means (Standard Deviations) for Treatment Groups from Individual Schools on Measure of Mental Health Counseling Knowledge

<table>
<thead>
<tr>
<th></th>
<th>E1 - Treatment</th>
<th>E2 - Control</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>C1  C2  C3</td>
<td>C4  C5  C6</td>
</tr>
<tr>
<td>Pretest</td>
<td>35.8 39.0 38.1</td>
<td>39.3 38.9 38.6</td>
</tr>
<tr>
<td></td>
<td>(5.5) (5.3) (4.5)</td>
<td>(6.3) (6.6) (6.0)</td>
</tr>
<tr>
<td>Posttest</td>
<td>30.0 31.6 29.8</td>
<td>38.8 38.7 38.1</td>
</tr>
<tr>
<td></td>
<td>(5.5) (4.7) (4.3)</td>
<td>(6.1) (6.0) (5.4)</td>
</tr>
</tbody>
</table>

In summary, the analysis of covariance indicated a significant difference among experimental groups due to the main effect of treatment. The interaction effect of pretest and treatment was not significant. An examination of the means indicated that the treatment groups had a significant decrease in mean scores, therefore reflecting increased knowledge and understanding of mental health counseling on the posttest when compared with control group mean scores. This suggests that the orientation procedure had knowledge-
enhancing properties about counseling for the treatment subjects.

**Children's Attitude About Mental Health Counseling**

To test the effects of the videotape orientation to mental health counseling on fifth-grade children's attitudes about mental health counseling, an analysis of covariance was performed. The subjects' pretest results on the Mental Health Counseling-Attitude-Children's Form (MAT) served as the covariate. Results of this analysis are presented in Table 8. Means and standard deviations for treatment groups with all schools combined are presented in Table 9. Means and standard deviations for individual schools are presented in Table 10.

**Hypothesis 2:** There is no significant difference between treatment and control groups (E1 & E2) on students' attitudes about mental health counseling, as measured by the Mental Health Counseling-Attitude-Children's Form (MAT).

The analysis of covariance was performed with an obtained $F$ of 22.3, $p = 0.009$, $df = 1, 4$ for the main effect of treatment. Again, there was no significant interaction effect of pretest and treatment. Because the $F$ ratio of 22.3 was significant at the .01 level, this null hypothesis was rejected. A main effect of treatment was noted.
### Table 8

**Source Table for Analysis of Covariance on Posttest MAT**

<table>
<thead>
<tr>
<th>SOURCE</th>
<th>DF</th>
<th>SS</th>
<th>F</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>PREMAT</td>
<td>1</td>
<td>924.9</td>
<td>204.2</td>
<td>0.0001</td>
</tr>
<tr>
<td>TRT</td>
<td>1</td>
<td>70.4</td>
<td>22.3</td>
<td>0.009</td>
</tr>
<tr>
<td>CLS (TRT)</td>
<td>4</td>
<td>12.6</td>
<td>-----</td>
<td>-----</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SOURCE</th>
<th>DF</th>
<th>SS</th>
<th>F</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>PREMAT</td>
<td>1</td>
<td>751.7</td>
<td>173.7</td>
<td>0.0001</td>
</tr>
<tr>
<td>TRT</td>
<td>1</td>
<td>6.9</td>
<td>2.2</td>
<td>0.2115</td>
</tr>
<tr>
<td>CLS (TRT)</td>
<td>4</td>
<td>12.5</td>
<td>-----</td>
<td>-----</td>
</tr>
<tr>
<td>PRE*TRT</td>
<td>1</td>
<td>33.5</td>
<td>6.9</td>
<td>0.0582</td>
</tr>
<tr>
<td>PRE*CLS (TRT)</td>
<td>4</td>
<td>19.5</td>
<td>-----</td>
<td>-----</td>
</tr>
</tbody>
</table>

PREMAT = Pretest/ Mental Health Counseling-Attitude
TRT = Treatment
CLS = Class
Table 9
Means (and Standard Deviations) for Treatment Groups with All Schools Combined on Measure of Attitude About Mental Health Counseling

<table>
<thead>
<tr>
<th></th>
<th>E1 - Treatment</th>
<th>E2 - Control</th>
</tr>
</thead>
<tbody>
<tr>
<td>N = 73</td>
<td>N = 70</td>
<td></td>
</tr>
<tr>
<td>Pretest</td>
<td>10.2</td>
<td>11.0</td>
</tr>
<tr>
<td>(3.8)</td>
<td>(4.0)</td>
<td></td>
</tr>
<tr>
<td>Posttest</td>
<td>9.0</td>
<td>10.9</td>
</tr>
<tr>
<td>(3.0)</td>
<td>(3.9)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>-1.2</td>
<td>-.1</td>
</tr>
</tbody>
</table>
Table 10
Means (and Standard Deviations) for Classes in Treatment Groups on Measure of Attitude About Mental Health Counseling

<table>
<thead>
<tr>
<th></th>
<th>C1</th>
<th>C2</th>
<th>C3</th>
<th>C4</th>
<th>C5</th>
<th>C6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pretest</td>
<td>10.3</td>
<td>11.4</td>
<td>8.6</td>
<td>12.3</td>
<td>11.2</td>
<td>9.4</td>
</tr>
<tr>
<td></td>
<td>(4.1)</td>
<td>(3.9)</td>
<td>(2.9)</td>
<td>(4.8)</td>
<td>(3.7)</td>
<td>(3.0)</td>
</tr>
<tr>
<td>Posttest</td>
<td>9.0</td>
<td>10.0</td>
<td>7.7</td>
<td>12.0</td>
<td>11.5</td>
<td>9.3</td>
</tr>
<tr>
<td></td>
<td>(2.7)</td>
<td>(3.7)</td>
<td>(1.8)</td>
<td>(4.5)</td>
<td>(3.8)</td>
<td>(2.9)</td>
</tr>
</tbody>
</table>

In summary, the analysis of covariance indicated a significant difference among experimental groups due to the main effect of treatment and no interaction effect of pretest and treatment. An examination of the means indicated that the treatment groups had a significant decrease in mean scores, therefore supporting that the subjects had more positive attitudes about counseling on the posttest when compared with control groups. This suggests that the orientation procedure had attitude-enhancing properties.
Children's Disclosure Motivation About Mental Health Counseling

To test the effects of the videotape orientation to mental health counseling on fifth-grade children's disclosure motivation about counseling, an analysis of covariance was performed. The subjects' pretest results on the Mental Health Counseling-Attitude/Disclosure Motivation-Children's Form (MSD) served as the covariate. Results of this analysis are presented in Table 11. Means and standard deviations for treatment groups with all schools combined are depicted in Table 12. In a further breakdown, the means and standard deviations for treatment groups from the individual schools are presented in Table 13.

**Hypothesis 3:** There is no significant difference between treatment and control groups (E1 & E2) on fifth-grade students' disclosure motivation about mental health counseling, as measured by the Mental Health Counseling-Attitude/Disclosure Motivation-Children's Form (MSD).

Prior to the analysis of covariance the assumption of homogeneous slopes was tested. The pretest-by-treatment interaction was significant as shown by the F ratio of 28.1 in the lower panel of Table 11. Figure 1 presents the plot of scores depicting the interaction. Regression lines show that the treatment effect was greater for students scoring high on the pretest and had little effect for students scoring low on the pretest. Although the null hypothesis
could not be rejected, an examination of the means indicated
that students who were already more self-disclosing were less
likely to gain from the orientation than students who were
less self-disclosing. Students with high pretest scores
(indicating low self-disclosure) had a greater treatment
effect.

Table 11
Source Table for Analysis of Covariance on Posttest MSD

<table>
<thead>
<tr>
<th>SOURCE</th>
<th>DF</th>
<th>SS</th>
<th>F</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRESD</td>
<td>1</td>
<td>1028.3</td>
<td>163.2</td>
<td>0.0001</td>
</tr>
<tr>
<td>TRT</td>
<td>1</td>
<td>120.3</td>
<td>6.7</td>
<td>0.0611</td>
</tr>
<tr>
<td>CLS (TRT)</td>
<td>4</td>
<td>72.1</td>
<td>-----</td>
<td>-----</td>
</tr>
<tr>
<td>PREMSD</td>
<td>1</td>
<td>922.5</td>
<td>145.6</td>
<td>0.0001</td>
</tr>
<tr>
<td>TRT</td>
<td>1</td>
<td>2.3</td>
<td>0.6</td>
<td>0.5</td>
</tr>
<tr>
<td>CLS (TRT)</td>
<td>4</td>
<td>15.0</td>
<td>-----</td>
<td>-----</td>
</tr>
<tr>
<td>PRE * TRT</td>
<td>1</td>
<td>26.6</td>
<td>28.1</td>
<td>0.0061</td>
</tr>
<tr>
<td>PRE * CLS (TRT)</td>
<td>4</td>
<td>10.5</td>
<td>0.3</td>
<td>0.9</td>
</tr>
</tbody>
</table>

PREMSD = Pretest Mental Health Counseling - Self Disclosure  
TRT = Treatment  
CLS = Class
Table 12
Means (and Standard Deviations) for Treatment Groups with All Schools Combined on Measure of Disclosure Motivation About Mental Health Counseling

<table>
<thead>
<tr>
<th></th>
<th>E1 - Treatment</th>
<th></th>
<th>E2 - Control</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N = 73</td>
<td></td>
<td>N = 70</td>
</tr>
<tr>
<td>Pretest</td>
<td>11.0 (3.8)</td>
<td>12.0 (4.0)</td>
<td></td>
</tr>
<tr>
<td>Posttest</td>
<td>9.7 (3.4)</td>
<td>12.2 (4.3)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>-1.3</td>
<td></td>
<td>+.2</td>
</tr>
</tbody>
</table>
Table 13
Means (and Standard Deviations) for Treatment Groups from Individual Schools on Measure of Disclosure Motivation About Mental Health Counseling

<table>
<thead>
<tr>
<th></th>
<th>E1 - Treatment</th>
<th>E2 - Control</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>C1  C2  C3</td>
<td>C4  C5  C6</td>
</tr>
<tr>
<td>Pretest</td>
<td>12.2 10.7 10.2</td>
<td>13.0 12.1 10.6</td>
</tr>
<tr>
<td></td>
<td>(3.9) (4.0) (3.2)</td>
<td>(5.1) (3.5) (3.2)</td>
</tr>
<tr>
<td>Posttest</td>
<td>10.6  9.6  8.9</td>
<td>14.4 11.6 10.6</td>
</tr>
<tr>
<td></td>
<td>(3.6) (3.6) (2.6)</td>
<td>(4.9) (4.0) (3.1)</td>
</tr>
</tbody>
</table>
Figure 1. Plot of interaction effect of PREMSD and treatment

(Note). + Denotes Treatment Groups
0 Denotes Control Group
Children's Global Attitude and Disclosure Motivation About Mental Health Counseling

To test the effects of the videotape orientation to mental health counseling on fifth-grade children's combined global attitude and disclosure motivation about counseling, an analysis of covariance was performed. The subjects' pretest results on the Mental Health Counseling-Attitude/Disclosure Motivation-Children's Form (MGL) served as the covariate. Results of this analysis are presented in Table 14. Means and standard deviations for treatment groups with all schools combined and from individual school populations are presented in Table 15 and Table 16.

**Hypothesis 4:** There is no significant difference between treatment and control groups (E1 & E2) on fifth-grade students' combined global attitude and disclosure motivation about mental health counseling, as measured by the Mental Health Counseling-Attitude/Disclosure Motivation-Children's Form (MGL).

The analysis of covariance was performed with an obtained $F$ of 21.9, $p = 0.0094$, df = 1, 4 for the main effect of treatment. No interaction effect of pretest and treatment was noted. Because the $F$ ratio of 21.9 was significant at the .01 level, this null hypothesis was rejected. A main effect for treatment was noted.
Table 14

Source Table for Analysis of Covariance on Posttest MGL

<table>
<thead>
<tr>
<th>SOURCE</th>
<th>DF</th>
<th>SS</th>
<th>F</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>PREMGL</td>
<td>1</td>
<td>4123.9</td>
<td>495.5</td>
<td>0.0001</td>
</tr>
<tr>
<td>TRT</td>
<td>1</td>
<td>319.7</td>
<td>21.9</td>
<td>0.0094</td>
</tr>
<tr>
<td>CLS (TRT)</td>
<td>4</td>
<td>58.4</td>
<td>-----</td>
<td>-----</td>
</tr>
<tr>
<td>PREMGL</td>
<td>1</td>
<td>3356.4</td>
<td>402.7</td>
<td>0.0001</td>
</tr>
<tr>
<td>TRT</td>
<td>1</td>
<td>0.02</td>
<td>0.01</td>
<td>0.9</td>
</tr>
<tr>
<td>CLS (TRT)</td>
<td>4</td>
<td>11.9</td>
<td>-----</td>
<td>-----</td>
</tr>
<tr>
<td>PRE*TRT</td>
<td>1</td>
<td>25.1</td>
<td>9.6</td>
<td>0.04</td>
</tr>
<tr>
<td>PRE*CLS (TRT)</td>
<td>4</td>
<td>10.5</td>
<td>-----</td>
<td>-----</td>
</tr>
</tbody>
</table>

PREMGL = Pretest/Mental Health Counseling - Global Attitude/Disclosure
TRT = Treatment
CLS = Class
Table 15
Means (and Standard Deviations) for Treatment Groups with All Schools Combined on Measure of Global Attitude and Disclosure Motivation About Mental Health Counseling Knowledge

<table>
<thead>
<tr>
<th></th>
<th>E1 - Treatment</th>
<th>E2 - Control</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pretest</strong></td>
<td>21.2</td>
<td>22.9</td>
</tr>
<tr>
<td></td>
<td>(6.6)</td>
<td>(7.0)</td>
</tr>
<tr>
<td><strong>Posttest</strong></td>
<td>18.7</td>
<td>23.1</td>
</tr>
<tr>
<td></td>
<td>(5.7)</td>
<td>(7.2)</td>
</tr>
<tr>
<td><strong>Difference</strong></td>
<td>-2.5</td>
<td>+.2</td>
</tr>
</tbody>
</table>
Table 16
Means (and Standard Deviations) for Treatment Groups from Individual Schools on Measure of Global Attitude and Disclosure Motivation About Mental Health Counseling

<table>
<thead>
<tr>
<th></th>
<th>E1 - Treatment</th>
<th>E2 - Control</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>C1  C2  C3</td>
<td>C4  C5  C6</td>
</tr>
<tr>
<td>Pretest</td>
<td>22.5 22.1 18.7</td>
<td>25.3 23.3 20.2</td>
</tr>
<tr>
<td></td>
<td>(7.1) (7.2) (4.5)</td>
<td>(8.9) (5.8) (5.4)</td>
</tr>
<tr>
<td>Posttest</td>
<td>19.6 19.7 16.5</td>
<td>26.4 23.1 19.9</td>
</tr>
<tr>
<td></td>
<td>(5.8) (6.3) (4.1)</td>
<td>(8.7) (6.1) (5.4)</td>
</tr>
</tbody>
</table>

In summary, the analysis of covariance indicated a significant difference among experimental groups due to the main effects of treatment and no effect due to interaction of pretest and treatment. An examination of the means indicated that the treatment groups had decreased mean scores, therefore indicating enhanced attitude and self-disclosure scores on the posttest when compared with the control groups. This suggests the orientation procedure had a predicted positive outcome.
State-Anxiety Level Associated with the Experimental Procedures

To test the effects of the videotape orientation to mental health counseling on students' levels of state-anxiety associated with the experimental procedures, an analysis of covariance was performed. The subjects' pretest results on the State-Trait Anxiety Inventory for Children-A-State Form (Max) served as the covariate. Results of this analysis are presented in Table 17. Means and standard deviations for treatment groups with all schools combined are given in Table 18. A further breakdown of means and standard deviations from individual school populations is presented in Table 19.

Hypothesis 5: There will be no significant difference between treatment and control groups (E1 & E2) on students' levels of state anxiety, as measured by the State-Trait Anxiety Inventory for Children-A State Form (MAX).

The analysis of covariance was performed with an obtained $F$ of 0.09, $p = 0.8$, df = 1, 4 for the main effect of treatment. There was no significant interaction effect of pretest and treatment. Since the $F$ ratio of 0.09 was not significant at the .01 level, this null hypothesis could not be rejected.
### Table 17
**Source Table for Analysis of Covariance on Posttest STAIC (MAX)**

<table>
<thead>
<tr>
<th>SOURCE</th>
<th>DF</th>
<th>SS</th>
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</thead>
<tbody>
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<td>PREMAX</td>
<td>1</td>
<td>3129.3</td>
<td>207.0</td>
<td>0.0001</td>
</tr>
<tr>
<td>TRT</td>
<td>1</td>
<td>4.7</td>
<td>0.09</td>
<td>0.8</td>
</tr>
<tr>
<td>CLS (TRT)</td>
<td>4</td>
<td>215.6</td>
<td>-----</td>
<td>------</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SOURCE</th>
<th>DF</th>
<th>SS</th>
<th>F</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>PREMAX</td>
<td>1</td>
<td>2555.7</td>
<td>173.4</td>
<td>0.0001</td>
</tr>
<tr>
<td>TRT</td>
<td>1</td>
<td>5.2</td>
<td>0.3</td>
<td>0.6</td>
</tr>
<tr>
<td>CLS (TRT)</td>
<td>4</td>
<td>69.6</td>
<td>-----</td>
<td>------</td>
</tr>
<tr>
<td>PRE * TRT</td>
<td>1</td>
<td>3.6</td>
<td>0.1</td>
<td>0.7</td>
</tr>
<tr>
<td>PRE * CLS (TRT)</td>
<td>4</td>
<td>115.0</td>
<td>-----</td>
<td>------</td>
</tr>
</tbody>
</table>

PREMAX = Pretest/ Anxiety  
TRT = Treatment  
CLS = Class
Table 18
Means (and Standard Deviations) for Treatment Groups with All Schools Combined on Measure of State Anxiety Level

<table>
<thead>
<tr>
<th></th>
<th>E1 - Treatment</th>
<th>E2 - Control</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>73</td>
<td>70</td>
</tr>
<tr>
<td>Pretest</td>
<td>33.8 (7.6)</td>
<td>32.5 (7.9)</td>
</tr>
<tr>
<td>Posttest</td>
<td>31.5 (6.0)</td>
<td>30.6 (6.6)</td>
</tr>
<tr>
<td></td>
<td>-2.3</td>
<td>-1.9</td>
</tr>
</tbody>
</table>
Table 19
Means (and Standard Deviations) for Treatment Groups from Individual Schools on Measure of State Anxiety Level

<table>
<thead>
<tr>
<th></th>
<th>E1 - Treatment</th>
<th>E2 - Control</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>C1</td>
<td>C2</td>
</tr>
<tr>
<td>Pretest</td>
<td>34.2</td>
<td>34.3</td>
</tr>
<tr>
<td></td>
<td>(9.4)</td>
<td>(7.1)</td>
</tr>
<tr>
<td>Posttest</td>
<td>31.2</td>
<td>33.8</td>
</tr>
<tr>
<td></td>
<td>(6.2)</td>
<td>(6.1)</td>
</tr>
</tbody>
</table>

In summary, the analysis of covariance indicated no significant difference among experimental groups due to the main effect of treatment and no effect due to interaction of pretest and treatment. An examination of the means indicated that the experimental and control groups were more anxious during pretest than they were during posttest, which suggests that the experimental procedures had anxiety-reducing properties at best and state-anxiety-stabilizing properties at worst.
Relationship Between Risk and Treatment

In the investigation of the relationship between risk and treatment, data were also analyzed for high-risk and low-risk students. Specifically, the researcher was interested in whether the treatment might have had a differential effect for high-risk and low-risk students. This is equivalent to asking, "Is there an interaction between treatment and student risks classification?" From the means and standard deviations presented in Table 20, the following observations can be made for both risk factor treatment groups in relation to the control groups: knowledge of mental health counseling increased; attitude about counseling shifted to a more positive one; self-disclosure in relation to counseling increased; and state anxiety within the context of the experimental procedure did not increase and, in fact, was either controlled for or reduced.

Although the observed mean differences were in the predicted direction to support inference of treatment effectiveness, the magnitude of these observed differences correlated in direct proportion with the non-risk population. To determine whether the observed differences were statistically significant, further analyses were conducted using analysis of covariance with a two-factor design. The independent variables were treatment and risk. The nested factor design of classrooms was considered random and was thus the appropriate error term with which to test the
significance of treatment effect with risk factor. The
covariates used were pretest scores on the MK, MAT, MSD, MGL,
and MAX, using an alpha level of .05 for the test of
significance. In each analysis, an initial test was made for
covariate-by-treatment interactions. Because none were
found, the assumption of homogeneous slopes for regression
lines on posttest and pretest appear to be met for both high-
and low-risk groups.

The F ratio and probabilities from these analyses are
presented below. In Table 21, PREMK denotes pretest scores
for the MHC-K, POSTMK denotes posttest scores for the MHC-K,
TRT denotes treatment, RSK denotes risk, CLS(TRT) denotes the
nested classroom factor, and RSK*TRT denotes the interaction
between risk category and treatment. Pretest and posttest
scores for all dependent variables are denoted similarly. To
summarize, there were no significant interaction effects of
risk and treatment on the posttest scores.

In summary, an analysis of covariance (risk crossed
within treatment) was conducted for each of the dependent
variables in order to determine whether high-risk or low-risk
students differed with regard to their scores. In all cases,
scores of both the high-risk and low-risk students mirrored
the relative changes of each other. To minimize redundant
information regarding the impact of the mental health
counseling orientation on the differing risk categories noted
in the secondary hypotheses, and, in that risk factor, whether high or low made no significant difference, only the results of the primary hypotheses were presented.

Table 20
Means and Standard Deviations on Pretest and Posttest Scores of the Dependent Variables for the Treatment and Control Groups by Risk

<table>
<thead>
<tr>
<th></th>
<th>Treatment mean (std dev)</th>
<th>Control mean (std dev)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>High Risk</td>
<td>Low Risk</td>
</tr>
<tr>
<td>premk</td>
<td>39.1 (5.2)</td>
<td>38.7 (5.5)</td>
</tr>
<tr>
<td>postmk</td>
<td>31.9 (5.0)</td>
<td>30.1 (4.2)</td>
</tr>
<tr>
<td>premat</td>
<td>11.2 (4.0)</td>
<td>10.5 (3.5)</td>
</tr>
<tr>
<td>postmat</td>
<td>9.0 (2.5)</td>
<td>9.1 (3.0)</td>
</tr>
<tr>
<td>premsd</td>
<td>11.5 (3.0)</td>
<td>9.9 (4.2)</td>
</tr>
<tr>
<td>postmsd</td>
<td>10.0 (3.7)</td>
<td>9.1 (2.9)</td>
</tr>
<tr>
<td>premgl</td>
<td>22.6 (6.2)</td>
<td>20.3 (6.2)</td>
</tr>
<tr>
<td>postmgl</td>
<td>19.0 (4.9)</td>
<td>18.2 (5.7)</td>
</tr>
<tr>
<td>premax</td>
<td>36.6 (9.5)</td>
<td>32.1 (6.3)</td>
</tr>
<tr>
<td>postmax</td>
<td>34.3 (8.0)</td>
<td>31.2 (5.2)</td>
</tr>
</tbody>
</table>
Table 21

Results of Analysis of Covariance for Treatment and Risk Within Treatment Interaction

<table>
<thead>
<tr>
<th>Model</th>
<th>F for Risk by Treatment Interaction</th>
<th>PR &gt; F</th>
</tr>
</thead>
<tbody>
<tr>
<td>POSTMK = PREM + TRT + RSK + RSK*TRT + CLS(TRT)</td>
<td>1.46</td>
<td>0.2351</td>
</tr>
<tr>
<td>POSTMAT = PREMAT + TRT + RSK + RSK*TRT + CLS(TRT)</td>
<td>0.47</td>
<td>0.6281</td>
</tr>
<tr>
<td>POSTSD = PRESD + TRT + RSK + RSK*TRT + CLS(TRT)</td>
<td>0.03</td>
<td>0.9683</td>
</tr>
<tr>
<td>POSTMGL = PREMGL + TRT + RSK + RSK*TRT + CLS(TRT)</td>
<td>0.18</td>
<td>0.8369</td>
</tr>
<tr>
<td>POSTMAX = PREMAX + TRT + RSK + RSK*TRT + CLS(TRT)</td>
<td>0.69</td>
<td>0.9099</td>
</tr>
</tbody>
</table>

Summary

The results of analyses of covariance used to test hypotheses for the dependent variables of fifth-grade students' knowledge, attitudes, disclosure motivation, and state-anxiety levels about mental health counseling were presented in this chapter. Results of analyses of covariance employed to test secondary hypotheses regarding the above-noted dependent variables relative to high-risk and low-risk...
students were also discussed. Each primary hypothesis was described in terms of main effects due to treatment and effects due to interactions of pretest and treatment.

Significant differences in mental health knowledge, attitudes about counseling, and global attitude/disclosure motivation about counseling due to treatment were found in posttreatment scores for the experimental groups. No significant difference in disclosure motivation alone, due to treatment, was found. An interaction effect of pretest and treatment was found to be significant in that examination. Finally, no significant difference in state-anxiety levels, due to treatment, was found in posttreatment scores of the experimental group. Although means moved only slightly in the predicted positive direction of state-anxiety reduction, the results suggest the orientation and experimental procedures had no negative impact on state-anxiety levels.

An investigation of the orientation's impact on high-risk and low-risk students was also presented in this chapter. The analyses of covariance did not indicate significant interaction effects for treatment and student risk classification. This suggests that the orientation's impact was uniform and directly proportional across all risk groups. Conclusions, implications, and recommendations from these finding are discussed in Chapter V.
CHAPTER V

FINDINGS, DISCUSSION, IMPLICATIONS, LIMITATIONS AND RECOMMENDATIONS

The effects of a mental health counseling orientation for children, presented as a developmental guidance unit to fifth-grade elementary school students, were examined in the study. More specifically, the children's knowledge and attitudes about mental health counseling and their state-anxiety levels during the experimental procedures were investigated. Additionally, the above-noted variables were evaluated in terms of students from high-risk and low-risk populations.

Three randomly selected elementary schools in Marion County, Florida, participated in the study, with each school providing two fifth-grade classes randomly distributed to experimental and control groups. School guidance counselors presented a 19-minute videotape orientation to mental health counseling in a single-session format to intact classes as part of each school's developmental guidance program. These classes were then compared with control groups of classes not seeing the videotape orientation. A total of 146 students
participated in the study. Complete data were collected and analyzed on 143 of the students.

A pretest-posttest control group design was used to investigate the treatment effects. Because the study utilized intact classes, the design was expanded into a nested format to accommodate for the impact of group influence, thereby statistically treating the data with the appropriate error term. Two classes in each of the three schools were randomly assigned to experimental (E1) and control (E2) groups respectively. All students completed pretest and posttest instruments measuring knowledge (MHC-K) and attitudes (MHC-A/ MHC-SD) about mental health counseling and state anxiety (STAIC) during the experimental procedures. Students in the control group did not receive the treatment orientation videotape until the study was completed.

An analysis of covariance was used for data analysis on the independent variables. Pretest scores were used as the covariates. An analysis of covariance was also used to evaluate the possible interaction effect of treatment for students classified as high-risk or low-risk.

**Findings**

All five primary hypotheses were tested at the .01 level of significance and resulted in rejecting the null hypotheses on three variables and failing to reject the null on two
variables. The data regarding the hypotheses revealed the following:

**Hypothesis 1:** There is no significant difference between treatment and control groups (E1 & E2) on fifth-grade students' knowledge of mental health counseling, as measured by the Mental Health Counseling-Knowledge-Children's Form (MK).

This null hypothesis was rejected at the .01 level of confidence. The adjusted mean difference on posttest scores favored the experimental group.

**Hypothesis 2:** There is no significant difference between treatment and control groups (E1 & E2) on students' attitude about mental health counseling, as measured by the Mental Health Counseling-Attitude-Children's Form (MAT).

This null hypothesis was rejected at the .01 level of confidence. The adjusted mean difference on posttest scores favored the experimental group.

**Hypothesis 3:** There is no significant difference between treatment and control groups (E1 & E2) on students' disclosure motivation about mental health counseling, as measured by the Mental Health Counseling-Attitude Disclosure Motivation-Children's Form (MSD).

This null hypothesis was not rejected at the .01 level of confidence.
Hypothesis 4: There is no significant difference between treatment and control groups (E1 & E2) on fifth-grade students' combined global attitude and disclosure motivation about mental health counseling, as measured by the Mental Health Counseling-Attitude/Disclosure Motivation-Children's Form (MGL).

This null hypothesis was rejected at the .01 level of confidence. The adjusted mean difference on posttest scores favored the experimental group.

Hypothesis 5: There is no significant difference between treatment and control groups (E1 & E2) on students' level of state anxiety, as measured by the State-Trait Anxiety Inventory for Children-A State Form (MAX).

This null hypothesis was not rejected at the .01 level of confidence.

The above five primary hypotheses were also addressed in terms of high-risk and low-risk students' scores compared with the non-risk student's scores. These secondary hypotheses were tested at the .05 level and resulted in a failure to reject the null hypothesis in each case. There were no significant differences between high-risk or low-risk students' scores in terms of treatment effectiveness.
Discussion

Children's Knowledge of Mental Health Counseling

There was a significant difference at the .01 level between E1 and E2 on the variable of knowledge of mental health counseling due to main effects of the orientation treatment. In addition, no interaction of pretest and treatment was found.

A comparison of the differences between pre- and posttest means indicated a positive enhancement of counseling knowledge by the subjects; experimental groups from each of the three schools had more realistic and accurate information about counseling when rated on the posttest MHC-K (MK). Subjects in E1 had a decrease of 7.2 points, compared to the control group decrease of .4 points. These scores were based on a 60-point range. This decrease of mean scores indicates a positive direction toward enhanced counseling knowledge, and therefore greater client/counselor congruence of counseling role, process and goals. The scores are in the same direction as a number of studies which investigated similar client variables for adults.

Several of the studies discussed in Chapter II concluded that a client's knowledge and expectations concerning the roles, functions, and goals of counseling influenced the extent to which the client progressed in treatment, and even whether or not counseling was seen by nonclients as a
resource for dealing with life issues. Further, it appeared that discrepancies between a therapist's and client's expectations not only interfered with treatment process, but actually increased the likelihood of the client's premature dropout from treatment. To this effect, these studies (Sloane et al. 1970; Strupp & Bloxom, 1973; Warren & Rice, 1972) suggest that increasing congruence between clients' and therapists' expectations should facilitate therapeutic process and therefore a more positive outcome in treatment. It is possible to increase congruence in a variety of ways, one of which is by enhancing clients' knowledge of roles, functions, and goals of mental health counseling.

Results of this research endeavor demonstrated that a brief videotape orientation to mental health counseling was able to enhance in a positive direction fifth-grade students' knowledge of counseling roles, functions, and goals. Key elements such as whether or not counselors judge good or bad in people (no); who talks and who listens during a counseling session (client talks/counselor listens); what a person who sees a counselor is called (client); and who solves client's problems (combined counselor and client) were typical of areas addressed by the orientation.

Subjects in the experimental group were able to integrate counseling knowledge information from the orientation videotape into a more positively congruent direction. This
suggests that by providing more accurate information to children about counseling, issues such as apprehension, defensiveness, and resistance to treatment may be reduced before entry into treatment.

Children's Attitude About Mental Health Counseling

The variable of children's attitude about mental health counseling was investigated by examining subjects' general attitude about counseling and disclosure motivation, willingness to engage in counseling process, and self-disclose about the experience. Elements such as counseling negativity, apprehension about counseling, and resistance were viewed under the general attitude dimension. Client participation, disclosure willingness, and viability of counseling as a resource were examined under the disclosure motivation dimension. These two overall attitude dimensions were viewed independent of one another (MAT)/(MSD) and in conjunction with each other as a global attitude view (MAT) + (MSD) = (MGL).

General attitude dimension

There was a significant difference at the .01 level between E1 and E2 on the variable of attitude (MAT) due to the main effect of treatment. In addition, no interaction of pretest and treatment was found.

A comparison of the differences between pre- and posttest means indicated a shift in a positive direction; subjects in
the experimental groups from all schools presented more favorable attitudes about counseling when rated on the posttest MHC-A (MAT). Subjects in E1 had a decrease of 1.2 points compared to the control group's difference of .1 point. These scores are based on a 20-point range. The significant decrease of mean scores point toward more favorable attitudes about counseling. These included decreased hostility and negativity about counseling and diminished apprehension about counseling, as well as increased viability of counseling as a resource.

Enhancement toward more favorable attitudes about counseling is in the same direction of previous studies which have investigated the impact of inductions and orientations to counseling with adult populations. Gomes-Schwartz (1978) and Jakes (1982) suggested that client hostility and negativity as attitude dimensions were more predictive of positive treatment outcome than initial motivation of client or counselor variables. Zwick and Attkisson (1985) demonstrated that subjects viewing an 11-minute videotape orientation to counseling had enhanced response to treatment, increased satisfaction and attitude about counseling, and increased therapist-rated client attractiveness based on appropriate behaviors and attitudes about treatment.

Results of this study suggest that a brief videotape orientation was able to enhance the general attitudes of
children about counseling. Key elements such as whether people who see counselors are "weird or crazy" (no), whether it is a sign of weakness to talk to a counselor (no), and whether talking with a counselor might be a good way to solve problems (yes) were addressed by the orientation.

Subjects in the experimental group presented more favorable attitudes about mental health counseling. It would appear possible then to impact favorably on the attitudes of fifth-grade children about mental health counseling by presenting information which presents counseling as a favorable, healthful and helpful, growth-oriented treatment option available to "normal" people.

Disclosure motivation dimension

There was no significant difference between experimental groups E1 and E2 on the variable of posttest disclosure motivation. Additionally, an interaction of pretest and treatment was found.

A comparison of the differences between pre- and posttest means indicated a decrease of mean scores for the treatment groups suggesting a positive, yet nonsignificant, shift in disclosure motivation as an attitude dimension about mental health counseling when rated on the posttest MHC-A (MSD). Subjects in E1 had a decrease of 1.3 points compared to the control groups increase of .2 points. These scores are based on a 20-point range.
Additionally, an interaction effect was noted between pretest and treatment. In this case, the treatment effect was greater for students scoring high on the pretest and had little effect on students scoring low on the pretest. This may suggest that those students who were already more self-disclosing were less likely to gain from the orientation than were students who were less self-disclosing.

Results of this research demonstrated that the videotape orientation had little effect on the disclosure motivation of fifth-grade students about mental health counseling. Key elements, such as whether or not I would be afraid to talk to a counselor (no), whether I might worry less and feel better after talking with a counselor (yes), or whether I would tell someone in my family about counseling if they had a problem (yes), were addressed by the orientation on this variable.

One explanation of the resistance to change on the attitude dimension of disclosure motivation might be that considering personal involvement in counseling may be more resistant to change than considering counseling in general as a possibility for others. The items on the MSD focused on a more personal domain by addressing issues about the subjects' world specifically.

Global Attitude and Disclosure Motivation

There was a significant difference at the .01 level between E1 and E2 on the variable of combined general
attitude and disclosure motivation about mental health counseling due to main effects of the orientation treatment. In addition, no interaction of pretest and treatment was found.

A comparison of the differences between pre- and posttest means indicated an enhancement of overall attitude in combination with disclosure motivation by the subjects. Experimental groups in all schools had significantly more favorable attitudes about mental health counseling even when disclosure motivation was included in the statistical treatment of the data. When rated on the posttest MHC-A/SD, (MAT + MSD) = (MGL), subjects in E1 had an decrease of 2.5 points, compared to the control group difference of an increase of .2 points. These scores are based on a 20-point range whereby a lower score is indicative of more positive attitudes about counseling and greater willingness to self-disclose about counseling.

This positive direction toward enhancement of global attitude and global disclosure about counseling suggests that the orientation videotape was especially effective on attitudinal elements of the subject's general domain vis-a-vis the subject's personal domain. In essence, counseling may be much more acceptable as an experience for others, yet not necessarily more acceptable as an experience for the subject. Further, attitudes about others engaged in counseling may be less negative; however, this enhancement of
attitude may not necessarily generalize to a less negative feeling toward engaging in counseling.

Previous research aimed at addressing the operationally illusive term of attitude has focused on a wide variety of attitudinal dimensions. Though the general concept of attitude is an ingredient which most researchers would agree is essential to successful treatment outcome, valid means of measuring it have been difficult to standardize. The two most essential questions which arise are "Is it possible to directly and positively affect those client attitudinal variables which have been shown to be predictive of positive outcome?" and "Is it possible to facilitate a client's involvement in treatment prior to treatment?" (Gomes-Schwartz, 1977; Jakes, 1982; Sloane et al. 1975).

In this research, it is suggested that subjects in the experimental group were able to integrate information from the videotape orientation which had the effect of enhancing their overall attitude about counseling. Though the subjects did not necessarily see counseling as an experience that they individually felt better about, a more favorable view of counseling in general and a less negative view about counseling being for other people was indicated. The impact of a more favorable climate about counseling in general may have further effects in an overall less-stigmatized view of mental health counseling and counseling participation.
State-Anxiety

There was no significant difference at the .01 level between E1 and E2 on the variable of state-anxiety during the experimental procedures due to main effects of the orientation treatment. In addition, no interaction of pretest and treatment was found.

A comparison of the differences between pre- and posttest means indicated no significant enhancement of state-anxiety reduction when rated on the posttest STAIC. Subjects in E1 had a decrease of 2.3 points compared to the control group difference of a decrease of 1.9 points. These scores are based on a 40-point range. Although a decrease of mean scores is indicated for the experimental group, suggesting decreased state anxiety, the decrease was not significant enough to support a main treatment effect.

The absence of state-anxiety reduction may be the product of that variable's tendency toward stability in standardized situations. Closer examination of the means indicated that the experimental and control groups were more state-anxious during pretest than they were during posttest. This suggests that although the experimental procedures did not reduce state-anxiety to a significant degree, the procedures had no deleterious effects. Both the orientation and the testing procedures were apparently acceptable and therefore more available to the subjects.
Previous efforts to reduce state-anxiety in children by employing systematic induction and orientation procedures have far and away been proven effective with medical, dental (Siegel, 1975; Henry, 1983), and educational (Smead, 1981) applications. Videotape orientations to surgical procedures, stays of hospitalization, testing situations, social learning situations, and expectation enhancement in general have been shown to be as effective as individual orientations, audio orientations, and group discussion procedures.

The ability to measure emotional reactions such as state-anxiety may be limited in this study because of the influence of "social desirability." As with other applications of the STAIC, subjects may have wanted to appear less anxious or to be without problems, in essence, to appear good (Snyder, 1986). Previous research on the STAI and STAIC with adult, adolescent, and child populations has consistently demonstrated that on trait-anxiety scores are relatively impervious to the experimental conditions (Johnson & Spielberger, 1968; Spielberger et al., 1970), but state-anxiety scores are (by design) influenced by the immediate environment.

Results of this research endeavor demonstrated that the experimental procedures had little positive impact on reducing state-anxiety levels of the subjects. This does suggest, however, that the experimental procedures were not perceived by the subjects as being threatening or anxiety
provoking. The medium of presentation through the developmental guidance format appears an acceptable vehicle for both the orientation videotape and the testing procedures.

Students at Risk and Treatment

One objective of the study was to investigate the guidance unit's impact on specific risk groups of students. Of particular interest was the orientation's impact on high-risk students, those students identified by counselors and teachers as meeting criteria of academic, behavioral, and/or developmental precariousness. Would students from high-risk, low-risk, and non-risk groups interpret and act upon the orientation to counseling in significantly different ways?

An analysis of covariance with a two-factor design was utilized to evaluate risk factor nested within treatment effect. There was no significant difference at the .05 level between scores of low-risk, high-risk, and non-risk students due to main effects of the orientation treatment on all dependent variables. The orientation's impact appeared fairly consistent for all groups, albeit that no specific risk group was targeted for orientation content focus or identification.

A comparison of pre- and posttest means indicated a corresponding score relationship between all risk groups. Mean differences in high and low-risk groups corresponded
with treatment effect scores from the non-risk groups. Main treatment effects on the variables of knowledge, attitude, and global attitude/disclosure motivation were identified. As with the non-risk subject population, there were no significant differences on the variable of disclosure motivation alone and no significant differences on state-anxiety levels.

Subjects from high-risk and low-risk experimental groups were impacted upon similarly by the videotape orientation to mental health counseling. No interaction effect between treatment and risk classification was noted. Further research may focus on identifying whether the assessment instruments or the orientation itself may have been over-generalized as to not be sufficiently sensitive to the factor of risk. Refinement of the experimental procedures will be discussed further under Implications.

Implications

Students' knowledge of the processes, functions, and goals of mental health counseling increased for all experimental groups. Similarly, attitudes about counseling in general improved in terms of reduced negativity and hostility, although the subtle positive improvement in self-participation (disclosure motivation) was not significant for the experimental group. Finally, state-anxiety levels of
treatment-group subjects were not significantly different when compared with control-group state-anxiety levels.

On the basis of this study and other research, it appears that knowledge and general attitudes about counseling may be independent from motivation to self-disclose or self-engage in counseling. It may be feasible to alter children's cognitive beliefs and expectations about counseling, but not necessarily their willingness to engage in counseling.

High-risk and low-risk students showed no significantly different scores on treatment effects. This could mean that the orientation's presentation, content, and medium were conceptually "available" to all students regardless of risk category. It could also suggest that the orientation's content may have been over-generalized in an attempt to reach a wide range of children at differing risk levels. In either case, it is noteworthy that those children identified as meeting criteria for high-and low-risk groups had parallel treatment effect scores when compared with the treatment effect scores of non-risk students.

This result suggests possible areas for future research investigation. Specific target populations of race, risk factor, sex, age, or presenting problem may benefit from an orientation content or style which focuses more specifically on target population needs. Data from this research area could then be used to develop the content and presentation of
orientations tuned specifically to children of these specific target group needs.

In postexperimental interviews with the counselors participating in the orientation videotape presentation, there was unanimous support for the use of the videotape medium. It was also seen as being economical in terms of time utilization and stimulation of the subjects. Counselors overseeing the orientation presentation also reported that subjects in the experimental groups initiated discussion about counseling after viewing the orientation videotape. They willingly talked about counseling in general, friends or family who had been to counseling, and identification with characters in the videotape. Students' responses to the videotape orientation to mental health counseling, as reported by their counselors, were most favorable, characterized by spontaneous discussions and disclosures about counseling involvement.

Major advances in technology, and clear acceptance of the videotape medium in both public and commercial domains create interesting opportunities for the counselor. Traditional exposure to the medium of videotape for counselors in the workplace usually comes in the form of taped sessions utilized in supervision and treatment skill enhancement. The last decade has made for critical application advancements with videotape technology especially with respect to counseling applications. Due in large part to an economic
imperative, quality videotape technology, once the near-exclusive realm of large clinics and teaching universities, is now readily available. First-generation production equipment, which was cumbersome and expensive, has given way to the economically available and highly portable, personal camcorder. The necessity of a production company for early film and videotape applications has given way to the individual as producer, director, camera operator, and editor. For those projects requiring more highly refined production, competition in the marketplace has made professional production economically available for counselors developing materials for pretreatment or treatment services.

Not withstanding the creative dimension necessary to create a script from a concept, establish and direct the acting and videotaping parameters, and edit the raw material into a useable product, equipment and production services are readily available. The cost of a state-of-the-art VHS camcorder when this study was implemented was between $900.00 and $1800.00. An industrial VHS camcorder will vary in cost from $1500.00 to $3000.00. Computerized home editing units designed to work in conjunction with home VHS videotape VCRs cost from $800.00 to $1000.00. Ancillary lighting and microphone/mixer systems cost approximately $200.00 to $300.00. The portability and productivity factors are very high for this type of equipment, which makes studio or indoor/outdoor applications readily available to the
counselor. If professional production is necessary or desired, mixing and editing services cost from $30.00 to $60.00 per hour. Rental equipment for videotape production is also available through a variety of video industries, although any extended production time may negate the cost benefits of equipment rental.

The mission of this particular research sought to positively orient nonclient children to mental health counseling via the medium of a videotape orientation. Other possible applications available to the counselor in a variety of settings could include

1. modeling appropriate counseling behaviors to enhance treatment;
2. information to nonclients prior to treatment to reduce resistance;
3. videotape feedback for clients; and
4. information to parents of children in treatment about adjunctive behaviors to support the counselors' treatment strategies.

Limitations

The goal of this study was to alter in nonclient children the variables of knowledge, attitudes, and state-anxiety levels about counseling. These same variables have been shown to correlate significantly with positive treatment
outcome with actual clients. The use of nonclient subjects in the experimental procedures limits the generalizibility of the results to the general population of children. Variables such as previous counseling experience and motivation to seek treatment may have influenced scores; however, the effect would be presumed equal for both treatment and control groups. Further research is needed to replicate the design with actual children in pretreatment/treatment conditions to determine whether treatment effects are valid with actual clients and what orientation content relationship exists for predicted positive treatment outcome.

The three-week experimental period for this study was relatively brief. Posttest measures may have been more or less significant with added time span of the experimental procedures. Group format, within the context of a classroom developmental guidance condition, was the intended audience of the videotape. The single-session format was also a specific condition of this research. In this case, less is viewed as more. The implication of this research is that any enhancement to this style of orientation to mental health counseling, whether in terms of postorientation facilitation procedures, enhanced subject/content focus, or refinement of the videotape medium, may further impact on the treatment effect potential which was recognized in this study.

It is noteworthy, however, that given the positive direction of the data, brevity of treatment time may be a
limitation in this study. In an effort to address the
treatment sensitization variables, future research might
focus on extending treatment periods and/or experimental
periods to assess durability of realized treatment effect
over time.

A similar limitation exists with respect to taking a
pretest. This experimental experience may have heightened
subjects' awareness of their feelings and attitudes about
mental health counseling. It may have been that experimental
subjects wanted to appear more positive in their knowledge
and attitudes about counseling.

There are also some limitations with respect to the
instruments developed to assess the variables of knowledge,
attitudes, and feelings of children about mental health
counseling. Additional research on the validity and
reliability assessment in terms of item analysis, content
focus, and standardization would be appropriate.

Further research attention also needs to be drawn to the
use of intact classes and the relationship of contamination
and treatment effect. The basic assumption of influence of
each subject's score by the class to which they belong has
been addressed in this research. The use of a hierarchical
design is a statistical mechanism to control for this factor.
Implementing counseling orientations for children in an
individual context, such as one-to-one counseling situations
and focused small-group activities, may yield further information regarding such orientations' effectiveness.

**Recommendations**

The following specific recommendations are made for the purpose of assisting other researchers who are interested in designing future studies in this area:

1. Increase the opportunity for postorientation class discussion/facilitation with the counselor. Added discussion time for students receiving the orientation videotape may have had greater impact on attitudes about counseling, especially with respect to the dimension of disclosure motivation or self-participation and counseling attitudes.

2. Refine assessment instruments for knowledge, attitudes, and feelings about mental health counseling, especially with respect to target population focus and item content.

3. Replicate the study with differing age groups, matching age- and cognition-appropriate content.

4. Future research should also to address the risk factor with respect to children's mental health needs. By focusing on the risk factor sensitivity of the assessment instruments and orientation materials, researchers may refine those elements necessary to increase counseling effectiveness with at-risk children.
5. The orientation to mental health counseling for children may also be implemented in a mental health setting, thereby allowing the researcher to address orientation applications with clinical populations of children rather than a general population of children.

6. Replicate the study presenting the videotape alone to assess the impact of the medium as a separate component of the developmental guidance unit.

7. The orientation to mental health counseling for children may also be implemented with children of differing general or target populations.

Regardless of the orientation approach taken, it is evident that future research in this area of counseling dynamics with children will be able to focus profitably upon the investigation of those variables shown to facilitate productive counseling outcome and presentation mediums which are shown to be effective in presenting such variables.

The objective of the treatment variable in this study was to alter in children their knowledge, attitudes, and feelings about counseling that have been shown to correlate favorably with variables such as increased congruence of expectations about counseling roles and processes, decreased resistance and negative bias about participating in counseling, decreased anxiety about counseling, and a greater likelihood to consider counseling as a viable means to help cope with
the problems of life. These same factors that influence knowledge and attitudes in non-clients about counseling have been shown to correlate significantly with positive counseling outcome with actual clients.

The research endeavor demonstrated that a brief videotape orientation was capable of impacting in a positive direction the knowledge and attitudes of children about mental health counseling.
APPENDIX A

HIGH-RISK/LOW-RISK STUDENT INVENTORY
High-Risk/Low-Risk
Student Inventory

DIRECTIONS: Using the five criteria of student risk printed below, assign each student with a global-risk index number from 1 to 5. Little or no student risk would warrant a score of 1. High or significant student risk would warrant a 5.
*(see example below)*

1. **Acting-Out** (disruptive behavior, aggressive, defiant, discouraged).

2. **Withdrawal** (restricted functioning, depression, avoidant).

3. **Distractibility** (short attention span, anxious, inadequate study skills, truancy).

4. **Disturbed Peer Relations** (poor social skills, negative self-image, aggressive).

5. **Immaturity** (dependency-style relationships, inadequate).

**EXAMPLE:**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CLASS ROSTER:</strong></td>
<td><strong>STUDENT ROSTER:</strong></td>
</tr>
<tr>
<td>1 - No Risk</td>
<td>Student A . . . 3</td>
</tr>
<tr>
<td>2 - Little Risk</td>
<td>Student B . . . 4</td>
</tr>
<tr>
<td>3 - Neutral Risk</td>
<td>Student X . . . 1</td>
</tr>
<tr>
<td>4 - Some Risk</td>
<td>Student Y . . . 2</td>
</tr>
<tr>
<td>5 - Significant Risk</td>
<td>Student Z . . . 5</td>
</tr>
</tbody>
</table>
APPENDIX B

MENTAL HEALTH COUNSELING-KNOWLEDGE-
CHILDREN'S FORM
<table>
<thead>
<tr>
<th>CHECK ONE</th>
<th>strongly agree</th>
<th>undecided</th>
<th>strongly disagree</th>
</tr>
</thead>
</table>

1. A person who goes to a **Counselor** is called a **Client**.  

2. The **Client** talks about feelings and problems.  

3. The **Client** lies on a couch and talks about dreams.  

4. The **Counselor** talks while the **Client** listens.  

5. The **Client** should talk about problems, but not feelings about the **Counselor**.  

6. The **Counselor's** job is to tell **Clients** what they should do.  

7. The **Counselor** is a person who helps **Clients** understand feelings and solve problems.  

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8. The Counselor's job is to judge good and bad in people.

9. The Counselor's job is to solve all the Clients' problems.

10. The Counselor tries to change a Client's feelings.

11. The Counselor sets goals for the Client.

12. Puppets, art, and games are sometimes used in Counseling.

13. Trust between the Client and Counselor happens right away.

14. The important feelings that a Client tells a Counselor are confidential and private.

15. Talking about feelings and problems really does help a Client feel better.
APPENDIX C

MENTAL HEALTH COUNSELING-ATTITUDE/DISCLOSURE MOTIVATION-
CHILDREN'S FORM
Mental Health Counseling

ATTITUDE & DISCLOSURE MOTIVATION - (Children's Form)

<table>
<thead>
<tr>
<th>CHECK ONE</th>
<th>strongly</th>
<th>undecided</th>
<th>strongly</th>
</tr>
</thead>
<tbody>
<tr>
<td>agree</td>
<td>agree</td>
<td>disagree</td>
<td>disagree</td>
</tr>
</tbody>
</table>

1. All people who go to Counseling are crazy or weird. ______ ______ ______ ______ ______ ______

2. I could always figure out my own feelings and better than a Counselor. ______ ______ ______ ______ ______ ______

3. It is a sign of weakness for a person to see a Counselor about problems and feelings. ______ ______ ______ ______ ______ ______

4. Talking with a Counselor about feelings is sometimes a good way to solve problems. ______ ______ ______ ______ ______ ______

5. It would be embarrassing for me to go and see a Counselor. ______ ______ ______ ______ ______ ______

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6. If I were unhappy or had a problem I would think about seeing a Counselor. 

7. I would be afraid to talk to a Counselor about my feelings. 

8. If I talked to a Counselor I would probably worry less and feel better. 

9. If someone in my family had a problem, I would tell them about Counseling. 

10. A Counselor could help me with my problems.
APPENDIX D

STATE-TRAIT ANXIETY INVENTORY

FOR CHILDREN-A-STATE SCALE
HOW-I-FEEL QUESTIONNAIRE
(STAIC A-STATE Scale)

DIRECTIONS: Read each statement carefully and decide how you feel right now. Put an X in the box in front of the word which best describes how you feel at this moment.

1. I feel[ ] very calm [ ] calm [ ] not calm
2. I feel[ ] very upset [ ] upset [ ] not upset
3. I feel[ ] very pleasant [ ] pleasant [ ] not pleasant
4. I feel[ ] very nervous [ ] nervous [ ] not nervous
5. I feel[ ] very jittery [ ] jittery [ ] not jittery
6. I feel[ ] very rested [ ] rested [ ] not rested
7. I feel[ ] very scared [ ] scared [ ] not scared
8. I feel[ ] very relaxed [ ] relaxed [ ] not relaxed
9. I feel[ ] very worried [ ] worried [ ] not worried
10. I feel[ ] very satisfied [ ] satisfied [ ] not satisfied
11. I feel[ ] very frightened [ ] frightened [ ] not frightened
12. I feel[ ] very happy [ ] happy [ ] not happy
13. I feel[ ] very sure [ ] sure [ ] not sure
14. I feel[ ] very good [ ] good [ ] not good
15. I feel[ ] very troubled [ ] troubled [ ] not troubled
16. I feel[ ] very bothered [ ] bothered [ ] not bothered
17. I feel[ ] very nice [ ] nice [ ] not nice
18. I feel[ ] very terrified [ ] terrified [ ] not terrified
19. I feel[ ] very mixed-up [ ] mixed-up [ ] not mixed-up
20. I feel[ ] very cheerful [ ] cheerful [ ] not cheerful
APPENDIX E

THE GUIDANCE UNIT
THE GUIDANCE UNIT

The guidance unit will consist of a single 30-minute session. The session will be divided into three parts: Introduction (5 minutes); Activity I- Videotape Orientation (19 minutes); Activity II - Discussion and Closure/Summary (6 minutes).

In general, the Introduction will be used to: (1) gain the class' attention, (2) prepare the students for the videotape orientation, (3) provide transition from general school experience to thinking about orientation information, and (4) introduce the focus of the orientation. Activity I will be counselor presented to the entire class and will feature the videotape orientation material. Activity II will be a focused summary of the videotape, and will include general open-ended discussion and closure/summary.

Time management is important. As counselors implement the guidance session, they present general information, introduce the topic, use facilitative responses to lead discussion, structure the session, elicit student ideas and feelings, and make summary statements about the topic material. They model behaviors and help make the sessions a positive experience. Instructions and guidelines for the Introduction, orientation videotape, group discussion and summary will be provided to the Counselor as a means of standardizing the presentation of the guidance unit.

PURPOSE: To help the class get organized for this developmental guidance class in which they will see a videotape orientation to mental health counseling. The orientation will focus on roles, functions, and counseling content/process for counselors and clients.

MATERIALS: 
1. VHS Video Recorder (NOT BETAMAX).
2. Television Monitor.

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INTRODUCTION

GENERAL INSTRUCTIONS: Include the following basic statements in your own facilitative style.

1. "Hi everyone. My name is __________, and in case some of you don't remember me, I'm our school's guidance counselor. Today we're going to spend some special time as part of our developmental guidance program."

2. After everyone has taken their seats the Counselor asks the students to focus in, and take a deep breath or two to relax, and as well, shift their focus from academics to self and peer awareness.

3. "Today we're going to see a videotape about counseling. What's special about this videotape is that it's been made from a kid's point of view...not by actors, or adults, but by regular fifth graders."

4. "Some of you may already know about counseling, either from having gone to counseling yourself, or maybe you know a friend or family member who has gotten some help from going to counseling. The point is this, more and more people look to counseling as a means of helping them with all sorts of feelings and problems and ways to help grow up in a really positive and healthy way."

5. "The kids in this video are pretty regular, everyday persons. The story goes something like this...One Saturday morning two friends are watching television. After they share with each other that each of them is going to counseling with his family, they decide to call up their best friend to find out about counseling from a kids' point of view. Since their best friend has already been to counseling, the two boys find out about what counselors do...and what the kids do...and what really happens in counseling...and what it looks like...and who goes to counseling."
SUMMARY/CLOSURE

GENERAL INSTRUCTIONS: Include the following basic statements in your own facilitative style.

1. "Today we've talked about counseling, and we've seen a videotape about counseling from the point of view of fifth graders who go to counseling."

2. "We've found out that Counselors help kids understand their feelings and solve problems. A person who goes to a Counselor is called?" (A Client).

3. "We've seen the kind of things that happen in a counseling session. Who can tell me some of the things that happened in this videotape counseling session?" (talking; puppets; board games; drawing; etc.).

4. "We've also learned about how trust happens between a counselor and a client, and how things are confidential and private."

5. "And we've learned that counseling can be for anyone who wants to discover more about his/her feelings; and ways to solve problems with school, or home, or between friends. And counseling can even be a way to help grow up in a really positive, healthy, and confident way."
PRETEST/POSTTEST ADMINISTRATION INSTRUCTIONS

GENERAL INSTRUCTIONS: Include the following statements in your own facilitative style.

1. Welcome of students to the developmental guidance session and introduction of the guidance counselor to students.

2. "Today as part of our school's developmental guidance program we're going to do something very special. Today, instead of the counselor teaching the students, ... you students will teach your counselor."

3. "I'm going to distribute some checksheets to you. Please take out a pencil or pen, and with me, let's go through these checksheets as I read the questions to you. After we're done, you will have taught me about your knowledge and feelings about counseling."

4. "This is not a test and there are no grades for these checksheets. I want to better understand your feelings and knowledge about counseling. If you know a lot about counseling or if you know very little about counseling, you will all help me to understand your needs better."

5. "First, place your name on the top right-hand corner of the top facing page (draw example page on blackboard and mark appropriate spot). Next, (draw the five Likert-style responses on the blackboard) take a look at these five different categories which read...Strongly Agree....... Agree....... Undecided....... Disagree....... Strongly Disagree. As I read the checksheet statements, I'd like you to check which of these statements best fits how you want to answer the question."

6. "Answer all the questions as best you can. Take your best shot at answering even those questions you are not quite sure of."
REFERENCES


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BIOGRAPHICAL SKETCH

Theodore Richard (T.R.) DeRoche was born on June 25, 1947. He was the only child of a wartime romance between a nurse lieutenant and a steel-guitar-playing sergeant. She was from Newark, New Jersey, and he was a hunting and fishing guide from the Rangley Lakes region of Maine.

T.R. obtained primary and secondary education in the hometowns of his parents. He graduated from Newton High School in 1965, ranked 141th out of 282. He was an accomplished outdoorsperson and second-string quarterback, and he had a fascination with the sea. The day after his high school graduation, he joined the U.S. Navy and served three years as a radar communications specialist with an airborne, antisubmarine warfare unit patrolling the Mediterranean. He graduated from Southampton College with a Bachelor of Arts in 1971. He received a Master of Arts from the College of William and Mary in 1974, and a Specialist in Education from the University of Florida in 1985.

For the past seven years T.R. has been in private practice as a licensed mental health counselor and clinical member of the American Association for Marriage and Family Therapy. He specializes in the counseling needs of children and families. Before entering private practice, T.R. served
as therapist and Director of Childrens Services with West Central Florida Human Resources Center.

Traditional education aside, T.R. has lived in remote villages on the islands of Barbados and Tobago conducting figure-drawing projective tests to native children, and has studied art and sculpting in New York and film making in Hawaii. He has played guitar and piano in some very strange places with some equally strange and brilliant musicians. He has written adventure stories for Mosquito Magazine over the past six years under the pseudonym of Dr. Incogniteau. Inspired by a group of devoted watermen and intrepid travelers, T.R. learned to surf in 1968. He acknowledges the role of generous and powerful oceans, international travel to earth's remote places, and a parade of "Pump House Gang" characters with helping to shape a global community consciousness and an "Endless Summer" mindset.
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.

Robert D. Myrick
Chairman
Professor of Counselor Education

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.

Woodroe H. Parker
Professor of Counselor Education

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James G. Joiner
Associate Professor
of Rehabilitation Counseling

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.

Robert C. Ziller
Professor of Psychology
This dissertation was submitted to the Graduate Faculty of the College of Education and to the Graduate School and was accepted as the partial fulfillment of the requirements for the degree of Doctor of Philosophy.

August 1990

Dean, College of Education

Dean, Graduate School