EFFECTS OF TRAINING CLIENTS TO BE READY FOR INDIVIDUAL PSYCHOTHERAPY UPON OUTCOMES OF PSYCHOTHERAPY

By

Lynne Diane Rich

A DISSERTATION

Submitted to
Michigan State University
in partial fulfillment of the requirements
for the degree of

DOCTOR OF PHILOSOPHY

Department of Counseling, Personnel Services,
and Educational Psychology

1979

ABSTRACT

EFFECTS OF TRAINING CLIENTS TO BE READY FOR INDIVIDUAL PSYCHOTHERAPY UPON OUTCOMES OF PSYCHOTHERAPY

By

Lynne Diane Rich

The purpose of this research was to assess the effects of a specific type of pre-psychotherapy training upon outcomes of psychotherapy. Implications from previous research were that pre-psychotherapy training helps clients to get the most benefit from psychotherapy. This study investigated the usefulness of the written media, in particular, for such training. A booklet, "How Psychotherapy Works," was used to provide subjects' training.

Training in Readiness for Psychotherapy

Reading the booklet "How Psychotherapy Works" comprises pre-psychotherapy training. The booklet was written to provide basic information about the process of psychotherapy, the most helpful behaviors for the client to use in psychotherapy sessions, and the process of resistance, explained in common language. The booklet was also intended to help diminish any embarrassment about seeking professional help and to create realistic yet favorable

expectations about psychotherapy. Within the text of the booklet numerous examples were used to make psychological concepts more readily understood.

Subjects

Subjects were people who called GPC, an outpatient psychiatric clinic, for an appointment for psychotherapy. Forty-five subjects were randomly assigned to one of the three treatment groups; there were 15 subjects in each group. These subjects ranged in age from 18 to 48; there were 8 men and 37 women in the sample. According to therapists' diagnoses,none of the subjects was psychotic. Demographic and medical information was collected for each subject.

Experimental Design and Analysis

The experimental design was a one-factor design (type of treatment) with three levels: read the booklet at the clinic (Group 1); read the booklet at home (Group 2); do not read the booklet (Group 3, control). There were five dependent variables: number of sessions of psychotherapy attended; severity of problems (score on the SCL-90); manifest or State anxiety (score on State-Trait Anxiety Inventory, STAI); extent of typical anxiety or Trait anxiety (score on STAI); degree of self-satisfaction (score on the Phillips Self-Acceptance Scale).

The pre-psychotherapy test scores were used as covariables. To analyze the data, a one-way multivariate analysis of covariance was performed, using the Finn program.

Results

The null hypothesis of no difference between the three groups on the dependent variables was rejected. Subjects who read the booklet at home (Group 2) had significantly more anxiety (higher scores on State and Trait anxiety) than subjects who read the booklet at the clinic (Group 1). Subjects who did not read the booklet (Group 3) had significantly more severe problems (higher SCL-90 scores) and significantly more manifest anxiety (higher State anxiety score on the STAI), and marginally significantly lower self-acceptance (lower score on the Phillips Self-Acceptance Scale) than subjects who read the booklet (Groups 1 and 2).

DEDICATION

To my grandmothers

Razie Zvenetski Bashkurenski

and Golda Grill Neiderbach

in appreciation for their courage and tenacity.

They crossed an ocean to follow, and work

to realize their dreams.

ACKNOWLEDGMENTS

Appreciation is extended to many individuals who assisted me during my doctoral work at Michigan State University.

- Dr. Alex Cade, Committee Chairman. As my major professor, work supervisor, colleague and friend, you have been involved in all aspects of my doctoral program and professional training. Your belief in my abilities and potential was a catalyst to my working toward many professional goals. I appreciate your support throughout my academic endeavors and your work as my committee chairman.

- Dr. Al Rabin, Committee Member. I want to thank you for introducing me to the intriguing intrapsychic world. The knowledge I gained from your classes and the insights you shared about the Rorschach technique have been important to my work as a psychotherapist. I am glad to have had the opportunity of working with you. You were always thorough and fair in your evaluation of my dissertation work.

- Dr. William Schmidt, Committee Member. As my first statistics professor you enabled me to master basic statistical concepts so that those Greek letters came to make sense. Thank you for helping me to plan a research design which guided me toward making meaningful interpretations from the data. I appreciate your continued encouragement throughout my dissertation; you were always there for assistance.

- Mrs. Maryann Stehr, Committee Member. I appreciate your participation on my dissertation committee. Your comments about the experimental booklet were extremely helpful in specifying portions which were too vague in meaning or excessively wordy. As a clinician your questions and comments about the research study raised concerns pertinent to psychotherapy research. This was helpful in my own evaluation of the study. Thank you for your interest and input.

- Al Hammer, research consultant, was a tremendous help in orienting me to using the computer to analyze the research data, and explaining the computer output. Thank you for your patience in deciphering the statistical formulations. Your skill in translating intricate numerical formulas into English phrases was such a help.

- Dr. Beverly Anderson critiqued the booklet "How Psychotherapy Works." Your comments about the first drafts inspired considerable revision. I appreciate your honesty and insights about the booklet's content. Throughout my doctoral program your support and sense of humor have been so encouraging to me. Thank you.

- My friends Karen Hopkins and Mary Ward, doctoral candidates in English at Bowling Green University, carefully edited my booklet for grammatical and literary errors. Thank you both.

- Finally I want to thank my parents, Murray and Sally Rich, for their support throughout my academic endeavors. I will always appreciate your help and love. Your efforts enabled me to begin and complete my college and doctoral education, fulfilling a dream your mothers shared.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

CHAPTER I

THE PROBLEM

Need

Numerous theories have been posited concerning the factors responsible for successful psychotherapy.[1] Proponents of specific theoretical approaches to psychotherapy have argued respectively that it is the therapist's specific theoretical orientation and corresponding application in psychotherapeutic practice which accounts for differential effectiveness in psychotherapy.[2] Others have identified characteristics (e.g., warmth, genuineness, congruence) of the therapist as being the factors crucial to success in psychotherapy.[3] The nature of the dyadic interpersonal relationship itself (between the therapist and the client) has been cited by a number of clinicians and researchers as the most significant element in effecting differences in

---

[1]Rogers, 1942, 1954, 1963; Strupp, 1963, 1969; Lennard, 1960; Volsky, 1965.

[2]Rogers, 1942, 1949; Paul, 1966; Fenichel, 1945; Glover, 1955; Waelder, 1960; Tarachow, 1963; Chessick, 1969; Goodstein, 1963; Gelder, 1967; Paul, 1966.

[3]Jourard, 1959; Rogers, 1951, 1954, 1957; Strupp, 1960; Truax, 1964, 1967.

outcomes of therapy.[4] While there has been some support for each of these theories in research results, thus far, in this writer's opinion, no explanation for psychotherapeutic effectiveness has been isolated or accepted unequivocally by a large majority of clinicians and researchers. One general conclusion does seem apparent from the dearth of theory and research to date: psychotherapy is an extremely complex phenomenon. The fact that some individuals are objectively and subjectively changed as a result of their involvement in psychotherapy and others are not, is a function of numerous factors, it would seem.

This study focuses upon only one component of the dyadic relationship in psychotherapy--the client--and investigates the effects of a certain type of deliberately induced pre-therapy experience (exposure to pre-therapy training) on specifically defined changes made by the client during the course of psychotherapy--the client's contribution--and ways in which this can be manipulated to positively effect the outcomes of psychotherapy.

Purpose

It is the purpose of this study to investigate the effects of client participation (prior to beginning psychotherapy) in training aimed at helping clients get the most

---

[4]Sullivan, 1953; Fiedler, 1950, 1951; Kell & Mueller, 1966; Lennard, 1960; Parloff, 1956; Snyder, 1961.

benefit from individual psychotherapy, upon outcomes of psychotherapy. Pre-therapy training consists of having the client read a booklet, "How Psychotherapy Works." One group of clients read the booklet at the clinic where psychotherapy was conducted and another group of clients read the booklet at home. The third group of clients, the control group, did not read the booklet. The content of the booklet was devised to:

- facilitate motivation for involvement in therapy;
- enhance readiness for change;
- reduce defensiveness about beginning psychotherapy;
- help the client adopt appropriate and realistic expectations about psychotherapy and the client's role in psychotherapy; and
- help the client understand what is appropriate behavior during psychotherapy sessions.

Theoretical Background

The client's contribution to psychotherapy, or more specifically, ways in which the client may affect the outcomes of psychotherapy, has been the topic of much theoretical speculation and many research studies.

Several areas of investigation are relevant to the present study. Investigators have endeavored to identify factors which discriminate between clients who remain in psychotherapy and clients who leave "prematurely."

Premature termination of psychotherapy has been defined as (1) termination without the therapist's advice and/or consent; and/or (2) termination prior to the client attaining an improvement in overall psychological functioning, or an increment in self-satisfaction; or (3) termination of psychotherapy although the client and/or therapist believe it is unfinished.[5] The results of these studies support the theory that clients who remain in psychotherapy do tend to share certain delineable characteristics which differ from clients who quit psychotherapy. Clients who remain in psychotherapy tend to: admit more anxious behavior, be more self-critical, be more passive in interpersonal relationships, be considered by their therapist as better motivated for psychotherapy (McNair, 1963; Freedman, 1958; Frank, 1957). In addition, Freedman (1967) and Wolf (1967) note that clients who remain in psychotherapy are less defensive when they begin psychotherapy than those who quit. Clients who remain in psychotherapy accept instead of denying their mental illness. Further, Frank (1957) comments that clients who remain in psychotherapy are inclined to confide their problems honestly and are less guarded (according to tests taken prior to beginning

---

[5]Brandt, 1965; Fiske, 1964, Frank, 1957; Freedman, 1958; Gliedman, 1957; Lorr, 1958; McNair, 1963; White, 1964a & 1964b; Wolff, 1967.

psychotherapy). Frank also notes that "remainers" are more suggestible than "quitters" and have positive expectations about psychotherapy, and that verbal intelligence was found by previous investigators to correlate with remaining in psychotherapy. White et al. (1964) found resistant silence to be a predictor of dropping out of therapy; clients who remained talked more, with the exception of depressed clients whose silence was related to symptomatology.

Several studies of premature termination of psychotherapy examined an additional variable, improvement in client's overall psychological functioning. The interaction between improvement and duration (number of sessions and/or time span) of psychotherapy was also studied.[6] Findings from these and other studies[7] indicate that the client's improvement is not necessarily a function of the duration of psychotherapy. Some clients can be rated as improved (by subjective self-report and objective rating measures) after very few sessions. Other clients who remain in psychotherapy many months or years, may not show significant improvement. More appears to be required than merely to "stay" in psychotherapy in order for a client to improve. Consequently, in seeking explanations of why some clients

---

[6]Fiske, 1964; Frank, 1957, Gliedman, 1957; Kirtner, 1958.

[7]Frank, 1959; Nichols & Beck, 1960.

experience personal improvement from psychotherapy and others do not, several studies investigated factors which differentiate between successful and unsuccessful psychotherapy.[8] In "successful" psychotherapy client's improvement was rated by their own subjective evaluation and/or therapists' rating and/or results from specific pre- and post-psychotherapy evaluative instruments. Results from these studies pointed to specific variables which seem integral to client improvement via psychotherapy: motivation, severity and duration of complaints, readiness to change, lack of defensiveness regarding need for psychotherapy and minimal manifest defensiveness during psychotherapy sessions, initial level of anxiety, and nature of initial expectations about psychotherapy. From reading additional studies concerning client motivation,[9] readiness to change,[10] and nature of expectations about psychotherapy,[11] this writer maintains that these factors seem

---

[8]Feifel, 1963; Kamin, 1963; Kirtner, 1958; Orlinsky, 1967; Strupp, 1969; Volsky, 1965; Wallach, 1960.

[9]Fink, 1962; Kamin, 1963; Kirtner, 1958; Orlinsky, 1967; Strupp, 1969; Volsky, 1965; Wallach, 1960.

[10]Grant, 1950; Heilbrun, 1962, 1964, 1968; Hoffman, 1969; Minge, 1966.

[11]Aronson, 1966; Begley, 1970; Brady, 1960; Cartwright, 1958; Chance, 1957; Clemes & D'Andrea, 1965; Frank, 1959, 1961, 1968; Frank et al., 1978; Friedman, 1963; Garfield, 1963, Goldstein, 1960, 1961, 1966; Heine, 1960; Irwin, 1944; Drause, 1969; Overall, 1963; Portnoy, 1950; Rosenthal, 1956; Sloane, 1970; Whitehorn, 1958; Wilkins, 1973; Williams, 1967.

to be interrelated, and integral to client improvement. Client defensiveness about involvement in psychotherapy appears to be related to both the client's motivation (reason for entering psychotherapy and intensity of motivation) for psychotherapy, and the client's expectations about psychotherapy.[12]

Another variable has been identified from previous research as significant to client improvement. This variable, awareness of appropriate and facilitative in-psychotherapy client behavior and participation, is a specific expectation of psychotherapy which clients may not have.[13]

It seems plausible that these factors, believed to facilitate a client's improvement, could be manipulated to maximize the likelihood of client improvement. Conversely, other factors which have been demonstrated to be related to client improvement, e.g., severity and duration of complaints, are independent variables, which are inherent in each client's individual situation. Consequently, these cannot be easily manipulated experimentally. Other research findings suggest that the likelihood

---

[12] Frank, 1957; Freedman, 1958; Gliedman, 1957; McNair, 1963; Volsky, 1965; White, 1964; Wolff, 1967.

[13] Kamin & Caughlin, 1963; Heitler, 1971; Kirtner & Cartwright, 1958; Lennard, 1960, 1967; Parrino, 1969; Pierce, 1970; Venema, 1970; Volsky, 1965; White, 1964a & 1964b.

of a client improving as a function of psychotherapy is enhanced if he/she is a "good" client--as judged by the psychotherapist.[14] Goldstein (1959, 1960) found a significant relationship between the therapist's expectations and the client's number of psychotherapy sessions. Studies of therapists' expectations and clients' perceived personality changes have found that these are related (Goldstein, 1959, 1960, 1962). "Good" clients are clients who are judged by their therapists as being more highly motivated for psychotherapy.[15] The mutuality of therapist and client expectancy in affecting client perseverance in psychotherapy as well as outcome, has been stressed by Chance (1957, 1959), Heine & Trosman (1960) and Goldstein (1960, 1966). It is difficult to unravel which happens first: the client demonstrating certain attitudes and expectations about psychotherapy in his/her behavior; the therapist demonstrating certain attitudes and expectations about psychotherapy through his/her behavior, and the ensuing respective evaluations of one another and subsequent behaviors.

Many therapists do not take the time to orient clients to the psychotherapy endeavor, or to developing the conditions which research reports are necessary for

---

[14] Kirtner, 1958; McNair, 1963; Parloff, 1956; Strupp, 1958; Wallach & Strupp, 1960; Frank et al., 1978.

[15] Goldstein, 1969; McNair, 1963; Schofield, 1964; Wallach, 1960.

successful psychotherapeutic intervention. Despite their training and sophistication in psychological matters, too often therapists react negatively if "good" client traits and behavior are not present initially, instead of attempting to assist the "bad" client in developing "good" client behavior. Goldstein (1969), Heine (1960), and Wallach and Strupp (1960) note the negative consequences to the client, when in the early sessions of psychotherapy, the client is prematurely stamped "unsuitable" and this is communicated overtly (via clinical diagnosis, prognosis, or referral elsewhere) or communicated indirectly yet most obviously, to the client by the therapist's in-psychotherapy behavior toward the client who does not exhibit "good" client behavior.

The nature of the "good" client has been discussed by clinicians and explored in research studies.[16] Heine and Trosman (1960) found the following modal expectation of therapists:

> (1) The patient should desire a relationship in which he has an opportunity to talk freely about himself and his discomforts; (2) the patient should see the relationship as instrumental to the relief of discomfort, rather than expecting discomfort to be relieved by an impersonal manipulation on the part of the therapist alone. (3) Hence, the patient should perceive himself as in some degree responsible for the outcome. (p. 278)

---

[16] Clemes & D'Andrea, 1965; Heine & Trossman, 1960; Orlinsky, 1967; Parloff, 1956; Wallach, 1960.

Further, the therapists in this study "did not intend to be led into an active directive role if the patient adopted a passive role" (Heine & Trosman, 1960, p. 278). The investigators also note that therapists follow a "mutual participation model," such as that delineated by Szasz & Hollender (1966). In this model, which is the one most commonly presented in textbooks on psychotherapy as well as being the model most appropriate for helping clients achieve the highest level of maturity (Heine & Trosman, 1960), "the patient shares the responsibility for what goes on in therapy and symptoms are seen as being closely related to the patient's feelings and to interpersonal events" (Clemes & D'Andrea, 1965, p. 398).

It appears then that certain in-psychotherapy behavior is perceived by a number of clinicians and researchers as more facilitative of an effective psychotherapeutic relationship than other behaviors. Orlinsky & Howard (1967) found that patients and therapists thought the most valuable sessions were "actively collaborative, genuinely warm, affectively expressive and humanly involving" (p. 631). Both therapists and patients valued sessions in which the patient was interacting and emotionally involved. Therapists considered sessions "good" when they saw the patients as "(1) seeking insight, (2) not being evasive or withdrawing from person-to-person contact,

(3) not filling time simply to get the session over and (4) desiring attention, approval, sympathy or affection" (p. 626).

The literature suggests that "good" clients, who are aware of appropriate in-psychotherapy behaviors, seem to have an advantage over other clients who are less "ready for psychotherapy." "Good" clients are more likely to improve.

"Readiness," in this study, is not an experimental construct, but is an assumed condition with component variables as follows: (1) extent of motivation, (2) extent of readiness to change, (3) degree of non-defensiveness, (4) extent to which expectations about the process of psychotherapy are realistic, and (5) extent of knowledge about the nature of client participation and appropriate in-therapy behavior. It is these variables which are manipulated in the present study by means of pre-psychotherapy training. They are manipulated in ways which, from a theoretical standpoint seem most conducive to improvement in psychotherapy. The experimental variable in this study, pre-psychotherapy training, is based upon the concept of "readiness for psychotherapy." This concept was derived:

a. from findings of previous research involving pre-therapy training efforts;

b. from data (derived from studies concerning premature termination from psychotherapy and cases of psychotherapeutic success) pertaining to characteristics of clients who persist in psychotherapy as well as clients who achieve "successful" outcomes;

c. from the findings of research encompassing the above topics as well as other studies which suggest how a client may be assisted toward

   1) becoming better motivated for psychotherapy,

   2) becoming more ready to change,

   3) minimizing defensive behavior which impedes progress toward psychotherapeutic improvement,

   4) attaining realistic expectations about the nature of psychotherapy, and

   5) understanding that to gain maximum benefit from psychotherapy he/she should actively participate in the psychotherapy, employing specific appropriate in-therapy behaviors which tend to facilitate client improvement.

In an effort to manipulate the five variables listed immediately above, the written media (a printed booklet) was used in the present study to conduct pre-therapy training. Two specific conditions were used to define the two experimental treatment groups: asking subjects to read the booklet either (a) at the site where subsequent psychotherapy was to take place, or (b) at home; prior to the first appointment with the subject's therapist. The control group was simply asked to complete the three evaluative psychological instruments prior to beginning psychotherapy, also at a pre-arranged appointment at the site where psychotherapy took place.

Development and inclusion of specific information to comprise the content of the booklet, "How Psychotherapy Works" (the pre-therapy training instrument), was based upon relevant theoretical and clinical writings on psychotherapy and pertinent research findings (relating to the five variables delineated on the preceding page).

Throughout this narrative thus far, the phrases "successful psychotherapy," "client improvement," and "improvement in overall psychological functioning" have been used as commonly defined, to connote the general concept of the client being positively changed as a result of psychotherapy. Needless to say, psychotherapy can be assessed as "successful" and the client rated as "improved" only in terms of attainment of some specified outcome criteria. For the purpose of this study the criteria for client improvement was comprised of three components: diminution in anxiety, lessening of severity of problems, and an increase in self-satisfaction. The actual outcomes of psychotherapy have been assessed by pre- and post-psychotherapy testing using the State-Trait Anxiety Inventory; the SCL-90; an Outpatient Psychiatric Rating Scale; and the Phillips Self-Acceptance Scale. These measure respectively: the extent of anxiety experienced by the subject; the degree of severity of problems experienced; and the extent of satisfaction with oneself.

These three criteria were specifically selected to operationalize "client improvement" inasmuch as each of these is acknowledged as a valid criterion of client improvement by at least one major theoretical orientation to psychotherapy,[17] and most clinicians tend to agree that as a result of "successful" psychotherapy, the client is indeed less anxious, has less severe problems and is more satisfied with him/herself.[18]

Hypotheses

This study was designed to test several hypotheses regarding clients' behavior and attitudes resulting from participation in pre-psychotherapy training or absence of such training, prior to beginning psychotherapy. The hypotheses[19] are:

1. Clients who read the booklet "How Psychotherapy Works" either at the site where they will begin psychotherapy (Group 1), or at home (Group 2), before their first session of psychotherapy will have a lower drop-out rate (premature termination from psychotherapy as previously defined) than clients who do not read the booklet. That is,

---

[17] Dollard & Miller, 1950; Fenichel, 1945; Fromm-Reichman, 1950; Lazarus, 1966; Rickard, 1965; Rogers, 1942, 1951, 1954, 1957; Shoben, 1953; Wolpe, 1958, 1961, 1964; Yates 1958.

[18] Ford, 1963; Fromm-Reichman, 1950; Stein, 1970; Thompson, 1950; Wolberg, 1954; Yates, 1970.

[19] The hypotheses presented here initially are in broad research form. They will be restated in testable research form (null and alternate hypotheses) in Chapter III.

clients who read the booklet (pre-psychotherapy training) will persist in psychotherapy, attending more sessions, while clients who do not read the booklet will terminate psychotherapy much sooner.

2. Clients who read the booklet "How Psychotherapy Works" (pre-psychotherapy training) will experience less anxiety when they stop psychotherapy than clients who do not read the booklet. Anxiety will be measured by results on the Spielberger State-Trait Anxiety Inventory.

3. Clients who read the booklet "How Psychotherapy Works" (pre-psychotherapy training) will have significantly less severe problems (as measured by results on the SCL-90) than clients who do not read the booklet (and so received no pre-psychotherapy training).

4. Clients who read the booklet "How Psychotherapy Works" will have significantly more self-satisfaction than subjects who do not read the booklet (and so received no pre-psychotherapy training). Self-satisfaction is measured by results of the Phillips Self-Acceptance Scale.

Operational Definitions

The following definitions are presented to facilitate attaining consistent, shared definitions of terms widely and commonly used, that are particularly pertinent to this study.

Counseling and psychotherapy. These terms are used interchangeably. "The definitions of counseling would in most cases be acceptable as definitions of psychotherapy and vice versa. There seems to be agreement that both counseling and psychotherapy are processes

involving a special kind of relationship between a person who asks for help with a psychological problem (the client or patient) and a person who is trained to provide that help (the counselor or therapist)" (Patterson, 1973, p. xii).

Termination date. The date that (a) therapist and client mutually agree to discontinue on-going psychotherapy; (b) the client does not keep a scheduled appointment for psychotherapy which is followed by three consecutive weeks in which the client does not contact the therapist to re-schedule an appointment and, upon being asked in a phone conversation, the client confirms that he/she has in fact ended psychotherapy with that particular therapist; or (c) the therapist indicates to the client that he/she will no longer meet with the client for on-going psychotherapy.

Level of psychological functioning. The degree of anxiety (as measured on the Stait-Trait Anxiety Inventory) the client experiences, the severity of problems present (as indicated by the client's responses on the SCL-90), the reported extent of self-satisfaction and self-liking (as measured on the Phillips Self-Acceptance Scale).

Training in readiness for individual psychotherapy. This consists of the subject either (a) being asked to read the booklet "How Psychotherapy Works" at the site where psychotherapy will later begin, and given time to read the booklet there, or (b) being asked to read the booklet "How Psychotherapy Works" at home prior to the subject's first appointment for psychotherapy. The booklet "How Psychotherapy Works" is written to prepare subjects for individual psychotherapy and is based in part upon concepts discussed in:

1. the Anticipatory Socialization Interview delineated by Orne and Wender (1968) and used by Hoehn-Saric et al. (1965) and Sloane et al. (1970) and modified by Sauber (1971).
2. findings from studies pertinent to the variables:
   a. motivation for psychotherapy
   b. readiness to change
   c. defensiveness
   d. expectations about the nature of psychotherapy
   e. expectations about client participation in psychotherapy and corresponding appropriate in-psychotherapy behavior.

   which have been adapted as statements informing subjects about behavior, attitudes and expectations which would be most conducive to enhancing their improvement via psychotherapy.

In-therapy or in-psychotherapy. During the process of psychotherapy or within the duration of a psychotherapy session.

Therapist. Individuals who have had academic training and clinical experience doing psychotherapy. In this study, therapists have at least a master's degree in clinical psychology, counseling psychology, or social work as well as at least four years work-experience doing psychotherapy with outpatients in a psychiatric clinic and/or some other mental health facility.

Client/patient. Both of these terms are used interchangeably, to denote individuals who are involved in "counseling" or "psychotherapy" (see definitions preceding). At the clinic where this study was conducted, individuals involved in psychotherapy are referred to as "patients." Consequently in the booklet used for pre-psychotherapy training ("How Psychotherapy Works") the word "patient" appears throughout.

Overview

Now that the need for and the purpose of this research study have been explored and the relevant theoretical background has been delineated, the content of the subsequent chapters will be outlined.

In Chapter II, literature pertinent to the concept of pre-psychotherapy training for perspective clients will be reviewed.

The design of the study, procedural methodology and statistical analysis to be utilized will be discussed in Chapter III.

Specific results obtained from the research will be presented and interpreted in Chapter IV.

Finally, in the last chapter, Chapter V, the overall research study will be reviewed and summarized. Results of the study will be further discussed in terms of probable explanations of these results, and significant implications of the findings will be explored. Then the need for further research related to aspects of this study will be discussed.

CHAPTER II

REVIEW OF THE LITERATURE

The psychological literature which pertains to pre-psychotherapy training is comprised of three related areas: (a) the "placebo" effect in psychotherapy, or the role of hope, faith, belief; (b) expectations about psychotherapy, and (c) pre-psychotherapy training or orientation of clients for various goals. The literature relevant to these areas will be reviewed.

The Placebo Effect--The Role of Hope, Belief, Faith

The role of hope, faith, and persuasion in effecting psychotherapeutic improvement was the focus of theoretical writing and discussion in clinical literature by psychotherapists. Portnoy (1950) writes that the initial interview may have a very great significance on the patient, due in part to the patient's conscious or unconscious hope of finding help here for his/her problems. In 1956, Rosenthal and Frank discussed implications of the placebo effect for research in psychotherapy:

> . . . It may well be that the efficacy of any particular set of therapeutic operations lies in their analogy to a placebo in that they enhance the therapist's and patient's conviction that something useful is being done. Patients entering psychotherapy have various degrees of belief in its efficacy, and this may be an important factor in the results of therapy but this has not been studied, to our knowledge. (p. 297)

Whitehorn (1958) posits that the placebo effect "leads into a common denominator of all successful psychotherapy--the reinforcement of the patient's faith" (p. 115). Cartwright and Cartwright (1958), responding to Rosenthal's invitation to researchers in psychotherapy to consider the implications of the placebo effect, comment that the patient's faith is a complex construct, encompassing many different beliefs about multiple aspects of psychotherapy. Consequently, they urge therapists to stop worrying about confirming the existence of the placebo effect per se and to start conducting studies which concern actual functional relationships between various kinds of belief and improvement in psychotherapy.

Expectations About Psychotherapy

Research literature concerning expectations about psychotherapy is comprised of two interrelated areas of investigations: (1) the nature of expectations that clients have about psychotherapy and (2) the relationship between client expectations and other variables (as persistence in psychotherapy, and improvement). Beginning in 1957 and

continuing through 1978 studies exploring facets of both of these areas have been conducted and will be reviewed.

The cumulative findings of studies on the nature of expectations which clients have about psychotherapy suggest that even by 1970, clients have had divergent and often unrealistic expectations about psychotherapy, how their therapist will behave, what is expected of them, and so forth.[20] Lower class compared to middle class clients generally expect more directive treatment by therapists, expect direct medical intervention such as medication, and expect the therapist to be the more active of the dyad, asking questions of the client, talking more, and being in charge of the course of the interviews.[21] However, in general, all of the subjects studied had some misperceptions and many of these client-subjects expected and preferred advice, expected to remain in therapy only a short while, expected uniform stereotypic behavior of the therapist (e.g., either enigmatic, detached and objective, or friendly, animated and warm.) Clemes and D'Andrea (1965) and other researchers found that clients with Guidance Expectations (expecting that the therapist

---

[20] Begley & Lieberman, 1970; Chance, 1957; Garfield & Wolpin, 1963; Heine & Trosman, 1960; Strupp, 1963; Volsky, 1965; Williams et al., 1967.

[21] Aronson & Overall, 1966; Frank, 1978; Overall & Aronson, 1963; Williams et al., 1967.

will be very directive, prescribe medicine and/or give advice; further expecting that the patient would merely cooperate without having a say as to what went on in psychotherapy) attended fewer number of psychotherapy sessions and their termination tended to be nonmutual.[22]

The cumulative findings from studies about the relationship between client expectations and other variables (e.g., initial anxiety, improvement of symptoms and other outcome measures) indicate that the expectations of the client and the therapist do influence the psychotherapy process.[23]

Pre-Psychotherapy Training

Conceptually, research investigating pre-psychotherapy training was preceded by theoretical discourse and experimental inquiry concerning the "placebo effect" in psychotherapy, as well as subsequent research investigating effects of clients' expectations about various aspects of psychotherapy. The ensuing research concerning pre-psychotherapy training investigated many factors inherent in this specific topic. The pertinent studies reviewed, in which clients received some type of

---

[22] Clemes & D'Andrea, 1965; Heine & Trosman, 1960; Overall & Aronson, 1963.

[23] Brady, 1960; Clemes & D'Andrea, 1965; Frank, 1959, 1968a, 1968b; Frank et al., 1978; Friedman, 1963; Goldstein, 1959, 1960, 1966, 1969; Krause, 1969.

training prior to beginning psychotherapy may be grouped into three major areas: (a) pre-psychotherapy teaching of helpful in-psychotherapy behaviors, (b) pre-psychotherapy "role induction" interviews and (c) pre-psychotherapy orientation or training using role induction interviews and/or other methods.

Teaching Positive In-Psychotherapy Behavior

A number of studies have been conducted in which clients were instructed about in-psychotherapy behavior. Several studies of "vicarious psychotherapy pre-training" employed the method of having perspective clients listen, prior to beginning psychotherapy, to a tape recording illustrating "good" client behavior in group psychotherapy.[24] This vicarious pre-psychotherapy training was found to positively effect the outcomes of group psychotherapy in hospitalized mental patients and institutionalized juvenile delinquents (Truax et al., 1966, 1968). Related methods of teaching appropriate in-psychotherapy behavior have also been effective. Whalen (1969) found that subjects who were exposed to a film model of interpersonal openness as well as being given direct detailed instructions, tended to demonstrate more interpersonal openness themselves, in a

---

[24] Truax, Wargo & Carkuff, 1968; Truax, Wargo & Voksdorf, 1970.

group setting, than subjects who only saw the film or only received the direct instruction: "be open." Pierce, Schauble and Farkas (1970) taught internalization behavior (seeing problems as stemming from one's own feelings, acts, and contributions) to clients prior to their beginning individual psychotherapy. They found that clients' in-psychotherapy behavior can be changed by pre-psychotherapy instruction. Gendlin et al. (1968) developed a method aimed at teaching the client specifically how to engage in productive psychotherapy process by focusing upon what he is actually doing which is facilitative of getting the most benefit from psychotherapy.

Role-Induction Interviews

A second area of pertinent research concerns the role-induction interview. Psychotherapy may be analyzed as being a special social system with constituent role learning required of participants (Lennard & Bernstein, 1960, 1967). Orne and Wender (1968) developed a structured interview based upon the conceptualization of psychotherapy as a special form of social interaction. They drew upon the psychoanalytic conceptualization of the process of psychotherapy as well, for the content of their structured interview. The "anticipatory socialization interview" was developed as a means of role induction in which the perspective client is "socialized" regarding the role of a

client including developing appropriate role expectations. Orne and Wender state three major purposes for the anticipatory socialization interview:

> (1) to provide some rational basis for the patient to accept psychotherapy as a means of helping him deal with his problems, recognizing that talking is not seen by most patients as a medical modality; (2) to clarify the role of patient and therapist in the course of therapy and (3) to provide a general outline of the course of therapy and its visissitudes with particular emphasis on the clarification of negative transference. (p. 93)

Orne conducted these anticipatory socialization interviews himself with his patients.

Hoehn-Saric et al. (1964) used the concept of a role induction interview in a study with 40 psychoneurotic adult outpatients (ages 18 to 55) in which a role induction interview was conducted prior to the first psychotherapy session by a trained individual other than the therapist. The role induction interview was based upon the anticipatory socialization interview of Orne and Wender and covered four components:

> (1) a general exposition of psychotherapy, (2) a description and explanation of the expected behavior of a patient and of a therapist, (3) a preparation for certain typical phonomena in the course of therapy (e.g. resistance), and (4) the induction of a realistic expectation for improvement within four months of treatment. (p. 220)

After four months of weekly individual psychotherapy, clients who had been exposed to the role induction interview showed a more favorable outcome on five out of eight outcome

measures. Three of these five were at a significant level: therapist's rating of improvement, patient's rating of improvement, and patient's rating of mean target symptom improvement and social ineffectiveness rating.

Nash et al. (1965) utilized the pre-psychotherapy role induction interview with 40 psychoneurotic outpatients who were subsequently seen for four months of individual psychotherapy. Those patients exposed to the role induction interview were found to improve more than patients in the control group.

Battle et al. (1966) utilized a role induction interview in a study of 40 psychoneurotic outpatients ages 18 to 55 in which after the screening interview, and prior to the role induction interview, clients were asked to identify three problems they wanted help with in psychotherapy. Clients exposed to the role induction interview improved significantly more than the control group did, in terms of target complaints as well as therapist ratings of improvement.

Yalom et al. (1967) adapted the idea of a role induction for application to group psychotherapy and developed an appropriate pre-psychotherapy group preparatory lecture which was presented to clients in groups of three to five, prior to the first group psychotherapy session. Sixty clients at a university out-patient clinic were the subjects.

The authors found that such a pre-group psychotherapy preparatory session increased the development of interpersonal interaction, and there was some evidence that patient's faith in group psychotherapy was strengthened.

Heitler (1971) adapted the anticipatory socialization interview for perspective group psychotherapy clients. His subjects were lower class male in-patients at a VA hospital. Following an initial interview, anticipatory socialization interviews were conducted for all subjects in the experimental group. Subjects in the control group participated in a general discussion about types of treatment, following the initial interview. Therapists were asked to rate clients after the first week of daily group psychotherapy sessions (a total of five sessions). "Prepared" patients (those who had anticipatory socialization interviews) were rated by therapists as being more involved, exhibiting a more desirable patient style of participation, having a better "working alliance" in psychotherapy, and were assigned a more hopeful prognosis than control patients. The experimental patients tended to be rated by therapists at the time of discharge as more improved, and as having made more profitable use of group psychotherapy. Patients were observed during the first, third, and tenth group psychotherapy sessions. Patients exposed to the

anticipatory socialization interview tended to initiate communication significantly more readily than control patients in their third group psychotherapy session. Experimental patients participated significantly more in the group psychotherapy sessions and spent more time communicating; they made almost twice as many self-initiated comments as control patients, and their communications were significantly more introspective than that of the control patients.

Sloane et al. (1970) found that psychoneurotic patients exposed to an anticipatory socialization interview, similar to Orne's, did improve slightly but significantly more than those who did not receive this preparation. Subjects were 36 psychoneurotic outpatients ranging in age from eighteen to forty-six years. However, no difference was found between those patients who were told they should feel and function better after four weeks of psychotherapy and those who were not told this.

Imber (1970) also found no difference between clients induced (as part of a pre-psychotherapy role induction interview) to expect improvement after four weeks of psychotherapy and those who were told to expect improvement after four months.

Pre-Psychotherapy Training

In a study of 120 disadvantaged outpatients at an urban psychiatric outpatient walk-in clinic, Jacobs et al. (1972) utilized a pre-psychotherapy fifteen minute orientation for treatment (based upon Orne and Wender's anticipatory socialization interview). In two of four experimental conditions, therapists were also given an orientation concerning the difficulties lower-class patients may have in exploring their feelings, in tolerating delay in receiving immediate help to resolve their problems, and in accepting the idea of psychological motivation. When therapist and patient were both "prepared" or just the therapist was "prepared," 47% of the patients were seen more than five times compared to 17% when neither was "prepared" and 33% when only the patient is "prepared." Therapists wrote out a treatment plan, indicating, according to the authors, desire to help the patient as opposed to merely evaluating him. When both patient and therapist were "prepared" (with pre-psychotherapy training), 78% of therapists expressed desire to help the respective patients; 80% of the therapists indicated desire to help the respective patients when just the therapist has been "prepared" (pre-psychotherapy training). Only 50% of the time did therapists express a desire to help the patient when neither the therapist nor the patient had received pre-psychotherapy

training. More patients in the control group (in which neither the patients nor the therapists received pre-psychotherapy training) were perceived by their therapist as "severe" in early evaluation of their condition. Also, more of these patients were medicated and more of them dropped out of psychotherapy without notification.

A more involved method than the one session pre-psychotherapy role induction interview of preparing clients for psychotherapy was developed by Parrino (1969). The subjects were male and female inpatients and outpatients at the Georgia Mental Health Institute who were afraid of snakes. Three pre-psychotherapy sessions were provided for clients. They met in groups. The first experimental group ("advanced organizer") of clients were instructed to complete one part of a three-part programmed textbook on reinforcement theory. The second group ("expectation group") were told to read a passage which described the desensitization treatment that these subjects were to receive subsequently. The third experimental group combined the "advanced organizer" with the "expectation" group. Finally, there was a control group which used a programmed textbook containing general information about psychotherapy. Both the "advanced organizer" and the "expectation pre-psychotherapy information" conditions had facilitating effects on learning in an operant

situation, significantly above the control group. These two methods were not more effective combined than they were when used separately. This population of interest, snake phobic clients, and the treatment of choice for psychotherapy, operant psychotherapy, are rather circumscribed. Although the findings suggest the usefulness of pre-psychotherapy instruction using three training sessions and using written material for instruction, the limits on generalizing the findings from this study to most other clients must be kept in mind.

Warren and Rice (1972) used 55 clients at the University of Chicago Counseling Center, who were identified as low prognosis-clients, as subjects in a study to investigate the effectiveness of a method developed to increase the likelihood of low-prognosis clients remaining in, and benefiting from psychotherapy. The rating of low prognosis was based upon rating of voice quality in the first interview. Clients who had three or less (out of thirty) focused responses were considered as poor prognosis. The two-part experimental treatment involved four half-hour sessions for each client, with a trained individual other than the therapist. These sessions immediately preceded the second, third, fifth, and eighty psychotherapy hours. "Stabilizing" was at the beginning of these sessions and involved from five to ten minute discussions to encourage

clients to discuss any problems they were having with their therapist or with psychotherapy, and to encourage clients to discuss these concerns with their therapist. Then, in the "structuring" portion of the half hour, a structured teaching approach was used, designed to train clients to productively participate in the process of psychotherapy, spelling out ways to do so and providing practice and feedback. Clients in the experimental and semicontrol (who received only "stabilizing") groups had significantly lower rate of attrition. A significantly greater proportion of clients in the experimental group were rated by therapists as improved, than other clients were. Clients in the experimental group evaluated their therapy experience in a significantly more positive way than did clients in the control group. This method appears to have potential for being useful in working with low prognosis (disadvantaged, lower class or other) clients. However, considerable time and personnel would be required to utilize this on a large scale as a regular part of the psychotherapy process at most outpatient clinics.

Strupp and Bloxom (1973) note this same consideration about the role induction interview (time, expense, and personnel needed are substantial) even though it has been demonstrated to be effective. Strupp and Bloxom therefore developed a role induction film, "Turning Point,"

addressed to lower class patients specifically for preparation for group psychotherapy. In this study of 122 lower class patients selected from twelve community agencies, one group saw the film, one group received a role induction interview patterned after the anticipatory socialization interview developed by Orne and Wender, and one group viewed a neutral film. The following results were obtained:

1. Patients in the film and role induction groups enjoyed their initial role induction or film sessions more than patients in the neutral condition and considered the session as more helpful in preparing them for subsequent group sessions.

2. Both role induction procedures effected a favorable change in the patient's understanding of the process of psychotherapy and his role in it; especially increased was the expectation of playing an active role.

3. Patients in both of the role induction (film and interview) groups were rated as more attractive than those in the neutral group by therapists.

4. Both patients and therapists anticipated a significantly greater improvement for patients who were in a role induction (film or interview) preparation; the film was the most effective in raising patient expectations.

5. Patients in both the experimental groups reported greater, significantly, satisfaction than those in the neutral group.

6. Patients in the film group reported greatest satisfaction with progress in psychotherapy, and patients in the two preparation procedures (film and interview) became more satisfied with their progress as psychotherapy continued.

The results of this study then, confirm the effectiveness of the role induction interview as well as the use of a film ("Turning Point") for role induction, for the purpose of (1) preparing clients for participation in subsequent group psychotherapy, (2) increasing the clients' attractiveness as rated by their therapists, as well as (3) contributing to clients' subsequent satisfaction with their progress in psychotherapy. Thus, utilization of a film appears to be as effective or more effective than individually conducted role induction interviews.

Pre-psychotherapy training utilizing videotape was examined in a study by Venema (1970). Forty-eight lower class outpatients were subjects in the study in which video tape presentation was utilized to provide Expectancy Training (in which subjects were induced to have certain expectations about psychotherapy) based in part upon Orne and Wender's (1968) anticipatory socialization interview. Included in the expectations patients were told to have was the expectation of continuing therapy for at least ten sessions before deciding whether or not therapy is helping. In the Expectancy Control Group patients (who were subjects in this study) watched a video tape presentation containing neutral information about the history of psychotherapeutic treatment. An additional variable, commitment, was studied. In the Commitment Procedure, patients committed themselves

to positive attitudes about psychotherapy by reciting the "commitment script" and their personal identity (name) into a tape recorder after being given the clear impression that others would be listening to this. Subjects who received expectany training had less expectation of their therapists being the more active of the therapeutic dyad, had less medical expectations about their therapist, had less expectation of support from their therapists. Subjects who received expectancy training had fewer disconfirmations of their role expectations during their subsequent intake interview. Subjects in this experimental group or in the commitment group expected more sessions of therapy than other subjects. There were no significant differences between subjects who went through the commitment procedure and others regarding returning for greater number of sessions of therapy or having more positive attitudes about psychotherapy. There were no significant differences between subjects who received expectancy training and others regarding higher expectations of improvement or returning for greater number of therapy sessions.

According to the results of Venema's study, the video tape media can be useful for pre-psychotherapy prior to beginning psychotherapy. The study confines itself, however, to the subject of expectations per se, and does not utilize or investigate a more inclusive orientation as the one created for the present study.

Before examining at length the use of written material for pre-psychotherapy training, the effectiveness of other media as shown in previous research will be summarized.

Summary of Research Utilizing Various Media and/or Methods of Pre-Psychotherapy Training

In studies reviewed earlier in this treatise, several types of media and methods have been found to be effective means of positively influencing aspects of various factors in psychotherapy. The following media and/or methods have each been found to be effective: audiotape,[25] pre-psychotherapy personal instruction,[26] pre-psychotherapy structured interviews (including role induction interviews),[27] instructional and role induction films,[28] and videotape presentations[29] as means of positively influencing certain aspects of (1) subjects' expectations about psychotherapy, (2) subsequent

---

[25] Truax et al., 1968; Truax et al., 1970.

[26] Gendlin et al., 1968; Parrino, 1969; Pierce et al., 1970; Warren & Rice, 1972; Yalom et al., 1967.

[27] Battle et al., 1966; Heitler, 1971; Hoehn-Saric et al., 1964; Imber, 1970; Jacobs et al., 1972; Orne & Wender, 1968; Sloane et al., 1970.

[28] Strupp & Bloxom, 1973; Whalen, 1969.

[29] Sauber, 1971, 1972; Venema, 1970.

in-psychotherapy behavior, (3) subjects' subsequent satisfaction with psychotherapy, (4) progress in psychotherapy, (5) outcomes of psychotherapy, and (6) subsequent rating of subjects (clients) by their respective therapists.

Written Media for Pre-Psychotherapy Training

Concerning the written media, three studies were found which utilized written material for pre-psychotherapy orientation purposes. The use of written instruction in group psychotherapy was investigated by Martin (1962). Martin notes that the perspective client never fully comprehends the therapist's original verbal instructions and that much of the therapist's efforts are directed subsequently to the circumventing of therapeutic procedures by clients. While Martin does not minimize the importance of dealing with such defensiveness in the actual therapist-patient relationship, he posits that, "it does however seem logical that the importance attached to the written word by most people could serve as a useful weapon against such defenses" (p. 24). In his own group work Martin has used a brief paper "Introduction to Group Psychotherapy" (written for non-psychotic persons of above average intelligence) which describes the purpose of group psychotherapy, the setting, and the process of this type of psychotherapy. Martin reports that the use of this paper has been found to be helpful to clients.

The use of written material to prepare clients for psychotherapy was noted in the Parrino (1969) study. However, the written material was not an orientation program but rather was geared to either shaping expectations about the treatment method per se and/or providing information about the theoretical background of the specific treatment method, desensitization. The circumscribed population (snake phobic individuals) and special method of psychotherapy (desensitization) prevent generalizing the findings to most perspective psychotherapy clients.

The use of written material as well as a group role induction interview and a video tape presentation were examined in a study by Sauber (1971, 1972). However, the content of the video tape presentation ("vicarious psychotherapy pre-training") and written material (used in the "therapeutic reading" condition) were adapted specifically for marriage counseling. The subjects in this study were from a circumscribed population: married female students or student wives seeking marriage counseling at a university counseling center. The findings of this study are pertinent but do not essentially overlap with the procedures and hypotheses of the present study, which examines the use of written material for a systematic one-time preparation of clients prior to their beginning psychotherapy. The written material used in the present study is given to

subjects to read at home (Group 2) or subjects are given time and asked to read the booklet at the site where subsequent psychotherapy is to be conducted (Group 1).

From the results of his study, Sauber (1971, 1972) concluded that group role induction was the most effective pre-psychotherapy training method. Vicarious pre-psychotherapy training using a video tape presentation was next most effective and therapeutic reading about the counseling process (the written material in this study) was the least effective of the three methods, yet was still more effective than no pre-psychotherapy training at all.

The results of these three studies imply that written material is an effective media for various types of pre-psychotherapy training. However, because each of these studies is restricted to either a very specific population of interest, snake phobic individuals (Parrino, 1969), married female students or student wives (Sauber, 1971, 1972), and/or restricted to a specific type of psychotherapy, group psychotherapy (Martin, 1962), desensitization (Parrino, 1962), or marriage counseling (Sauber, 1971, 1972), generalization of the findings is also restricted to similar respective populations of clients and/or type of psychotherapy to be utilized.

There are numerous practical advantages of using the written media for conducting an orientation

to psychotherapy: ease of administration, minimal expense and time required, as well as minimal personnel needed. These are among the reasons (along with significant positive results from the related research surveyed) why further investigation of the written media for pre-psychotherapy training seemed to be a pertinent research endeavor.

Summary

The results of the studies reviewed support the hypotheses of the present study, specifically implying that preparing clients for psychotherapy using a written booklet has potential for being more effective than no treatment. Also it has been investigated in this study whether there are significant differences (in outcomes of psychotherapy) when subjects are asked to read the booklet at home or are specifically requested to read the booklet at the site where subsequently, psychotherapy was conducted, and time is deliberately allotted for this activity. The present study was constructed to investigate the extent to which pre-psychotherapy training in readiness for psychotherapy (which is more inclusive in its aim of preparing clients for psychotherapy than the role induction interviews or expectancy training used in the studies reviewed above) effects outcomes of psychotherapy.

CHAPTER III

RESEARCH DESIGN AND METHODOLOGY

This chapter is divided into nine sections: population of interest, sample, setting, procedural methodology, research hypotheses, experimental design, instrumentation, data collection, and analysis of data.

Population

The population of interest is non-psychotic adults over eighteen years of age who seek help with their problems in a mental health facility.

Sample

Actual clients were used as subjects to increase the generalizability of findings. The sample was selected from people who called the Genesee Psychiatric Center to request an appointment for psychotherapy, from November 1977 through July 1978. Forty-five subjects were part of this study. These were a group of eight men and thirty-seven women ranging in age from eighteen to forty-eight. None of these individuals was psychotic. Clients who were subsequently diagnosed as psychotic by their

psychotherapist were not included in the study. Characteristics of subjects are summarized in Table 1 in order to ascertain how this group of clients compares to others. Such specific information about the characteristics of subjects facilitates generalizability (Cornfield & Tukey, 1956).

The total number of subjects is 45 (N = 45), with 15 subjects in each of the three treatment groups (n = 15).

Random Assignment

Clients were randomly assigned (using a table of random numbers) to one of three treatment groups, in the order that these individuals telephoned the clinic to schedule an appointment for psychotherapy.

Setting

Genesee Psychiatric Center (GPC) is a private psychiatric clinic which serves a population of adults, eighteen years or older, who reside somewhere in Genesee County, Michigan or in neighboring counties. Individuals who are seen as outpatients for psychotherapy at GPC tend to be in the middle income range. Socioeconomically, the majority of clients are from the working class, employed in blue collar jobs. About one-fourth of the clients are employed in white collar or professional occupations, and about one-fourth are either homemakers or are unemployed

Table 3.1

Demographic and Medical Information About Subjects

Variable	N	Variable	N
Age . . . . . Range 18-48			
Marital status		Weeks on sick leave	
Single	10	None	37
Married	23	2	1
Separated	3	4	3
Divorced	8	6	1
Widowed	1	8	1
		17	1
Sex		18	1
Male	8		
Female	37	Was subject hospitalized	
		Yes	3
Race		No	42
Caucasian	33		
Negro	10	Type of medication	
Mexican-American . . .	2	None	35
		Mellaril	2
Education completed		Valium	1
Grade school	1	Pamelor	4
Some high school . . .	12	Norpramin	2
High school graduate .	25	Haldol	1
Some college	6		
College graduate . . .	1	Treatment began before Christmas	9
		Treatment began before Easter	5
Employment			
Homemaker	11		
Blue-collar job . . .	26		
White-collar job . . .	6		
Professional job . . .	2		
Diagnosis			
Depressive neurosis	28		
Adjustment reaction of adult life	12		
Hysterical personality disorder	2		
Obsessive compulsive neurosis	1		
Passive aggressive personality disorder	1		
Cardio-vascular psychophysiologic reaction	1		

and receive disability pay, pensions, or welfare, or are in-between jobs.

Methodology

Pre-Psychotherapy Initial Phone Call

When a prospective client telephoned GPC to make an appointment for psychotherapy, after the appointment was scheduled, the person was told that another appointment needed to be scheduled for "an orientation," prior to the appointment for psychotherapy. (The exact script which was read to subjects during this first telephone call is in Appendix A.)

Next, subjects were randomly assigned to one of the three treatment groups.

Treatment

When a subject arrived for the "orientation session," he/she was escorted by the experimenter to an empty room at the clinic. The experimenter (doctoral candidate in counseling psychology) asked the subject to be seated, then explained the purpose of the orientation session and the related research study. The experimenter asked if the subject would participate in the study. The consent form was then given to the subject. (The script for this opening statement by the experimenter is in Appendix B, and the text of the consent forms are in Appendix C.)

If the subject did not sign the consent form he/she was assured that this decision would be kept confidential. Then this individual was given a copy of the booklet "How Psychotherapy Works" and was told that the orientation to psychotherapy was obtainable by reading the booklet. These clients were not used as subjects.

If the person did sign the consent form, then the experimenter administered the three psychological instruments. (A discussion of these instruments follows, under "Instrumentation.")

Next, subjects were treated according to which treatment group they were assigned. All three treatments (which subjects had been told on the telephone were "orientation" sessions) were conducted within three days prior to the subject's first psychotherapy session. Descriptions of the three experimental treatment groups follow.

Pre-psychotherapy treatment I. Following completion of the three psychological instruments, each subject was asked to remain in the room and read the booklet, "How Psychotherapy Works." The experimenter handed this booklet to the subject and said, "It is important that you read the whole booklet carefully." Then the experimenter left the room. A half-hour later, the experimenter returned and thanked the subject. The experimenter said, "The booklet is yours to keep. After you've finished your psychotherapy

you will be contacted about answering the same questions about yourself as you did today."

Pre-psychotherapy treatment II. Following completion of the three psychological instruments, each subject was given a copy of the booklet "How Psychotherapy Works." The experimenter said, "It is important that you read the whole booklet carefully before your appointment with your therapist. The booklet is yours to keep." The experimenter thanked the subject and said, "After you are finished with your psychotherapy, you will be contacted about answering the same questions about yourself as you did today."

Pre-psychotherapy treatment III (Control). Following completion of the three psychological instruments, each subject was thanked by the experimenter for spending the time to complete the questionnaires, and was told, "After you are finished with your therapy, you will be contacted about answering the same questions about yourself as you did today."

Experimental Booklet

The booklet "How Psychotherapy Works" was written by this writer to be used in this study as the primary experimental independent variable. Reading this booklet comprises pre-psychotherapy training. The booklet was intended to provide basic information about (1) the process of psychotherapy, (2) the most helpful behaviors

for the client to use in psychotherapy sessions, and (3) resistance, explained in common language. It was also intended to (1) help diminish any embarrassment about seeking professional help and (2) create realistic yet favorable expectations about psychotherapy.

The booklets were printed on 70-pound, cream-white Beckelfelt paper with black ink, in Theme II Bold type. The Abbey Press in East Lansing, Michigan printed the booklets. The booklet consisted of eight-and-a-half printed pages. Each page was 5 1/2 inches wide and 7 5/8 inches long. The title "How Psychotherapy Works" was printed on the front cover, and on the back cover the name, address and phone number of GPC was printed. Since this writer applied for a copyright, inside on the back of the cover page the words: "copyright 1977 by Lynne Rich" appear, in accordance with regulations by the United States Copyright Office concerning publications pending a copyright. Within the text of the booklet, numerous examples were used to make psychological concepts more readily understood. Writing style and words used were selected so that the ideas presented would be understandable to someone with only an eighth grade education. The full text of the booklet is in Appendix D.

Prior to having the booklets printed, this writer screened the text intended for the booklet with ten actual

clients who were not part of the sample of subjects in this study. These clients were asked to read the text for the purpose of evaluating the clarity of the ideas presented. There were seven women and three men in this group. The average age was thirty-three. The highest grade level was twelfth and the lowest was eighth. The mean grade level of these ten clients was tenth grade.

The text for the booklet was also screened prior to having the booklet printed, by the therapists at GPC, who later conducted psychotherapy with the sample of clients in this study. None of these therapists believed that anything written in the proposed booklet which they read, was at variance with their own approach to conducting psychotherapy.

Post-Psychotherapy Testing

Within a month of each subject's termination from psychotherapy (as "termination" has been defined under "Definitions" previously) subjects were contacted and asked to complete the battery of three tests which were administered to subjects prior to beginning psychotherapy.

Therapists

Eight individuals conducted psychotherapy with the subjects, following the experimental or control treatment. These people are employed as psychotherapists at GPC and have worked as psychotherapists for at least three years.

The mean number of years of experience in conducting psychotherapy of these therapists, prior to the onset of this study is 8.6 years. Five of the psychotherapists are Certified Social Workers, who are licensed by the State of Michigan and were trained as clinical social workers. The other three psychotherapists are psychologists, two of whom are Certified Consulting Psychologists; the other is a Certified Psychologist. All three psychologists are licensed by the State of Michigan. Of these eight psychotherapists, five have a Ph.D. degree, three in psychology and two in social work. The remaining three psychotherapists have a master's degree in their respective fields as well as considerable post-master's training relevant to psychotherapy. Three of the five clinical social workers have attained the ACSW status from the National Association of Social Workers.

Hypotheses

The hypotheses which were tested in the present study are listed below.

H_1o: There will be no significant differences between groups in the number of sessions of psychotherapy that subjects in each group attend.

H_1a: There will be significant differences between groups in the number of sessions of psychotherapy attended by subjects.

H_2o: There will be no significant differences between groups in the severity of problems as indicated by scores on the SCL-90.

H_2a: There will be significant differences between groups in the severity of problems as indicated by scores on the SCL-90.

H_3o: There will be no significant differences between groups in anxiety experienced at the time the subjects complete the Speilberger State-Trait Anxiety Inventory as indicated by scores on the State anxiety part of the Spielberger instrument.

H_3a: There will be significant differences between groups in anxiety experienced at the time subjects complete the Spielberger State-Trait Anxiety Inventory as indicated by scores on State anxiety on the Spielberger instrument.

H_4o: There will be no significant differences between groups in anxiety typically experienced by subjects as indicated by scores on Trait anxiety on the Spielberger instrument.

H_4a: There will be significant differences between groups in anxiety typically experienced by subjects as indicated by scores on the Spielberger instrument.

H_5o: There will be no significant differences between groups in degree of self-satisfaction as indicated by scores on the Phillips Self-Acceptance Scale.

H_5a: There will be significant differences between groups in degree of self satisfaction as indicated by scores on the Phillips Self-Acceptance Scale.

Experimental Design

The design in this study was a one-factor design. This factor was the independent variable of interest, type of treatment, and had three levels: (1) pre-psychotherapy treatment I, training in readiness for therapy, by reading the booklet "How Psychotherapy Works" at the clinic where subsequent psychotherapy was conducted; (2) pre-psychotherapy treatment II, training in readiness for psychotherapy by reading the booklet "How Psychotherapy Works" in the subject's home, prior to the first session of psychotherapy; and (3) pre-psychotherapy treatment III, control, no experimental treatment, just pre- and post-psychotherapy testing.

There are five dependent variables: (1) number of sessions of psychotherapy attended, and the score attained on three instruments completed by subjects after terminating psychotherapy; (2) severity of problems bothering the subject as indicated by the score on the SCL-90; (3) extent of anxiety experienced at that time (State anxiety) and as indicated by the score on the Spielberger State-Trait Anxiety Inventory; (4) extent of anxiety typically

experienced by the subject (Trait anxiety) as indicated by the score on the Spielberger State-Trait Anxiety Inventory; and (5) degree of self-satisfaction as indicated by the score on the Phillips Self-Acceptance Scale.

The experimental design is shown in Figure 1. There are 15 subjects in each of the three treatment cells (n = 15) and a total of 45 subjects (N = 45) in the study.

Independent variable	Dependent variables				
Treatment	Number of sessions	SCL-90 score	State anxiety	Trait anxiety	Phillips Self-Acceptance Scale
I					
II					
III					

Figure 1. Experimental Design.

Dependent Variables and Covariates

The results of the three psychological tests administered to all subjects and the number of sessions of psychotherapy, were used as the dependent variables. The covariates were the results of the pre-psychotherapy tests.

Dependent variables. The dependent variables were:

1. Number of sessions of psychotherapy;
2. Post-therapy State anxiety as measured by the Spielberger State-Trait Anxiety Inventory;
3. Post-therapy Trait anxiety as measured by the Spielberger State-Trait Anxiety Inventory;
4. Post-psychotherapy severity of problems as measured by the SCL-90 (Symptom Checklist); and
5. Post-psychotherapy self satisfaction as measured by the Phillips Self-Acceptance Scale.

Covariates. The covariates were: pre-psychotherapy psychological data from three psychological instruments.

1. State anxiety as measured by the Spielberger State-Trait Anxiety Inventory;
2. Trait anxiety as measured by the Spielberger State-Trait Anxiety Inventory;
3. Severity of problems as measured by the SCL-90; and
4. Self-satisfaction as measured by the Phillips Self-Acceptance Scale.

Instrumentation

Four psychological instruments were used to provide scores concerning four of the dependent variables. These instruments will be discussed in this section.

The State-Trait Anxiety Inventory (STAI)

In 1964 the development of the State-Trait Anxiety Inventory was begun at Vanderbilt University with the objective of constructing a self-report instrument to be used for research which would be objective and capable of measuring anxiety in normal adults.

"State" anxiety (A-state) as described by Spielberger, Gorsuch, and Lushene in the STAI manual (1970) was analogous to "manifest" anxiety as described by Janet Taylor (1953):

> The use of the anxiety scale (Taylor Manifest Anxiety Scale) was based on two assumptions: first, that variation in drive level of the individual is related to the level of internal anxiety or emotionality, and second, that the intensity of this anxiety could be ascertained by a paper and pencil test consisting of items describing what have been called overt or manifest symptoms of this state. (p. 215)

State anxiety is conceptualized as a transitory emotional state or "condition of the human organism that is characterized by subjective, consciously perceived feelings of tension and apprehension and heightened autonomic nervous system activity." This state of anxiety may vary in intensity and fluctuate over time (Spielberger, 1970, p. 3).

Trait anxiety (A-trait) is conceptualized as fairly stable individual differences in proneness to anxiety. That is, individual differences in the tendency to typically respond to situations which are perceived as

threatening with an increase and intensification of anxiety (Spielberger, 1971).

In developing the State-Tait Anxiety Inventory (STAI) three instruments that measure anxiety were used: The Taylor Manifest Anxiety Scale, the IPAT Anxiety Scale and the Welsh Anxiety Scale. A total of 177 individual items correlated .25 or higher with each of the three anxiety scales. Next, those items were rewritten to retain the integral psychological content of the item and to alter the form so each item could be used with different instructions for State and Trait anxiety. From 1964 until the final inventory was published in 1970, many more revisions were made as well as numerous studies of validity and reliability.

The State-Trait Anxiety Inventory consists of 20 statements pertaining to Trait anxiety (asking people to describe how they generally feel) and 20 statements pertaining to the state of anxiety (asking people how they feel at that particular moment in time). The possible score range is 20 to 80 points on each part. The response categories for State anxiety are (a) not at all, (b) somewhat, (c) moderately so, and (d) very much so. For Trait anxiety the response categories are (a) almost never, (b) sometime, (c) often, and (d) almost always.

Test-retest reliability data reveals correlations for the A-trait scale ranging from .73 to .86 while those for A-state scale items have a reliability ranging from .16 to .54. The low test-retest coefficients of the A-state scale is reflective of the influence of particular, unique situational factors which existed at the time of testing, which is important in a valid measure of the state of anxiety. Both the A-state and A-trait scales were found to have a high degree of internal consistency (Spielberger, 1970).

Concurrent validity of the STAI was found and correlations with other anxiety-measuring instruments ranged from .52 to .83. Correlations with the IPAT Anxiety Scale were .75 to .77 and correlations with the Taylor Manifest Anxiety Scale were .79 to .83 according Spielberger (1970).

Parrino (1969) studied the effects of different types of pre-psychotherapy information upon therapeutic outcome. His subjects were snake phobic psychiatric patients. Subjects were involved in three pre-psychotherapy information sessions, three psychotherapy sessions, and three testing sessions in which subjects were confronted with viewing a snake. The STAI scales were administered to patients just before entering the fear-producing situation. The A-state scale was given after the subject left

the situation. The State anxiety scores following psychotherapy were significantly lower than pre-psychotherapy State-anxiety scores. Trait anxiety scores were not significantly changed due to psychotherapy.

In the present study, the STAI was used to measure subjects' pre-psychotherapy (State) anxiety and general (Trait) anxiety. Then after termination from psychotherapy, subjects' State and Trait anxiety were measured again.

SCL-90

The SCL-90 is a self-report clinical rating scale comprised of 90 items. Subjects are told that people sometimes have the problems and complaints which are listed on the test page. Subjects are instructed to indicate how much they were bothered or distressed by each of the problems, in the past seven days including the day of testing. There are five possible answers: (0) not at all, (1) a little bit, (2) moderately, (3) quite a bit, and (4) extremely.

The SCL-90 measures current status of psychological symptoms. The 90 items reflect primary symptom clusters that tend to comprise the majority of symptom behaviors of psychiatric outpatients. The nine symptom clusters are: (1) somatization, (2) obsessive-compulsive, (3) interpersonal sensitivity, (5) anxiety, (6) hostility, (7) phobic

anxiety, (8) paranoid ideation, and (9) psychoticism. The first five of these have been validated in many clinical studies involving over 2,500 patients. This was accomplished using the predecessor of the SCL-90, the Hopkins Symptom Checklist, which is comprised of only the first five scales listed above (Derogatis, 1973).

The following data (Derogatis, 1973) concerning reliability has been found:

Internal Consistency--Reliability	Scale
Somatizatizotion scale	.87
Obsessive compulsive scale	.87
Interpersonal sensitivity scale	.85
Depression	.86
Anxiety	.84

Test-retest coefficients were calculated on a sample of neurotic outpatients and these are as follows (Derogatis, 1974):

Factor	Test-Retest Coefficient
Somatization	.82
Obsessive compulsive	.84
Interpersonal sensitivity	.80
Depression	.81
Anxiety	.75

Concerning validity, construct validity for the first five scales was found to be present in a study by Rickels (Derogatis, 1975) in which distress levels on these scales were found to rank order patient groups in the same

manner suggested by clinical practice and external criteria. The internal consistency (test-retest coefficients) also contributes to the validity of the symptom constructs. In 1970 Derogatis conducted an investigation of the five scales comprising the Hopkins Symptom Checklist and forming the first five scales of the SCL-90. These five symptom clusters as defined by expert clinicians were contrasted with the empirical symptom dimensions which were developed from the factor analysis of 837 patient ratings made by psychiatrists. Agreement between the two sets of symptom structures was quite high which indicated considerable validity for the constructs defined in this way (Derogatis, 1974).

A study of concurrent validity of the SCL-90 was conducted by Bolelovcky (1974). The symptom dimensions of the SCL-90 were correlated with those of the Middlesex Hospital Questionnaire. A .92 positive correlation was found between the Global Severity Index on the SCL-90 and the global score on the Middlesex Hospital Questionnaire.

The scales for the nine symptoms cluster were not used in the present study. The general severity index (GSI), one of the global indices of distress was used for the present study as an indication of severity of the subjects' problems.

According to Derogatis (1977b) the GSI "represents the best single indication of the current level or depth of the disorder and should be utilized in most instances where a single summary measures is required" (p. 27). The possible range of scores on the general severity index is from 0 to .71. The lower the score, the lower the distress the subject indicates experiencing.

The Self-Acceptance Scale

This scale was developed by E. Phillips and was published in 1951. It was constructed to test the clinical hypothesis that self esteem and acceptance of others are positively related. The scale consists of 25 items which are to be answered on a five point scale running from "not at all true" to "true." A negative answer is indicative of high self acceptance. This scale has been administered to adults as well as high school and college students.

Concerning reliability, a five-day test-retest correlation of .84 was obtained. As for convergent validity, Omroake (1954) found a .73 correlation between the Self-Acceptance Scale and the Expressed Acceptance of Self Scale. The Self-Acceptance Scale also received a .55 correlation with the Bills Self-Acceptance Scale. Concerning predictive validity, the prediction on which the scale was constructed (self esteem and acceptance of others

are positively related) has been confirmed. Phillips (1951) found correlations of from .51 to .74 between self acceptance and acceptance of others (Robinson, 1969).

The administration of the scale takes approximately twenty minutes (Robinson, 1969). The language used in constructing the 25 items is rather straightforward and simply understood wording has been used.

In the present study, scores on this scale were utilized as an indication of self satisfaction and the nature of subjects' self concept. The possible score range is 25 to 125. The higher the number, the higher the degree of self-acceptance indicated.

Data Collection

Each subject's diagnosis, demographic data, as well as data concerning medications prescribed, sick leave, hospitalization, and number of sessions attended, were obtained from subjects' charts at GPC. Subjects' scores on tests administered to them were obtained prior to beginning and after terminating from psychotherapy. All data were collected through the date of termination from psychotherapy for all subjects, who became outpatients at GPC between November 1977 and July 1978. The experimental procedures are depicted in chronological order in Figure 2.

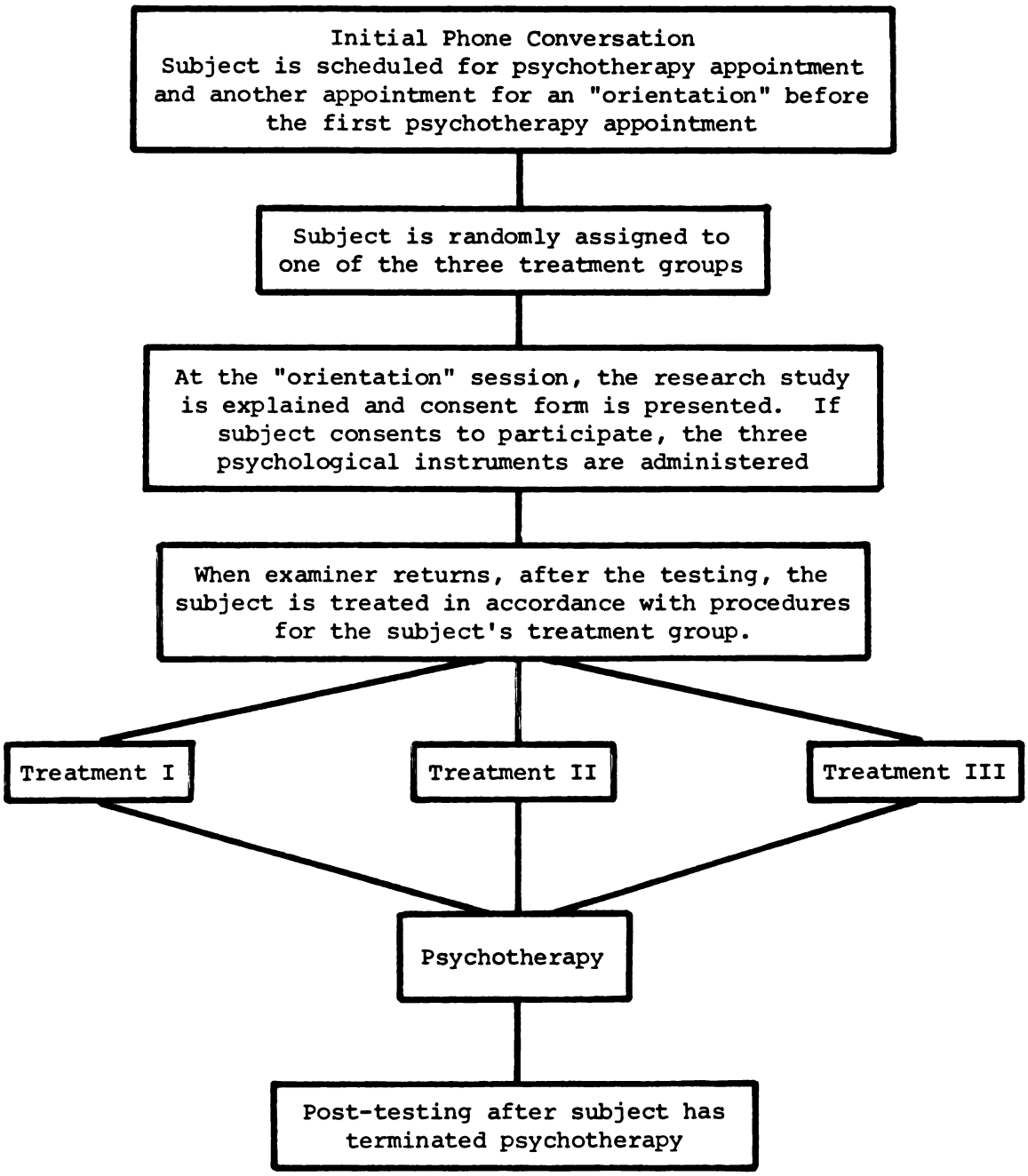

Figure 2. Experimental Procedures.

Analysis

Covariables

In order to ascertain the appropriateness of utilizing as covariates the pre-test scores on the psychological instruments, an overall multivariate test was performed to examine whether or not a significant relationship (between the pre-tests and the dependent variables) existed to justify utilizing those pre-test scores as covariates. Subjects' scores on the pre-tests were used as covariates since they were found to be significantly related (at the .05 alpha level) to the dependent variables.

Multivariate Analysis

A one-way multivariate analysis of covariance (MANCOVA) with planned comparisons was used to test for the effects of treatment on five dependent variables: severity of problems, state anxiety, trait anxiety, self acceptance, and number of sessions of psychotherapy. The Finn Program for multivariate analysis of covariance (Finn, 1968) was used.

Because there was only one independent variable, type of treatment, a one-way analysis was appropriate. Multivariate analysis was used since there were multiple dependent variables. The alpha level was set at .05. By

using a multivariate analysis the alpha level could be retained at the .05 level since all five dependent variables could be simultaneously tested at one alpha level, in this study, .05. This prevented obtaining a high alpha level which would have occurred if the alpha levels were combined as would happen if several individual analyses were performed. The overall multivariate null hypothesis of no difference between groups was therefore tested at the .05 alpha level. Each of the planned comparisons was tested at the .05 level of significance initially. However if the multivariate test proved to be significant, then univariate tests were conducted at lowered alpha levels. The .05 alpha level was divided into lower levels of significance the sum of which was .05.

Planned Comparisons

The following planned comparisons were tested:

$$G_1 - G_2$$

$$\frac{G_1 + G_2}{2} - G_3$$

where G_1 = treatment group 1

G_2 = treatment group 2

G_3 = treatment group 3

These two comparisons are orthogonal and have two degrees of freedom. They were planned comparisons since the results of these comparisons will indicate (1) whether there are significant differences between groups when subjects read the booklet at home instead of reading the booklet at the clinic and (2) whether there are significant differences between groups when subjects read the booklet, regardless of where, or do not read the booklet.

Analysis of Covariance

Analysis of covariance was chosen since pre-test and post-test scores were obtained from subjects. The analysis of covariance with pre-test scores as the covariates is the most preferable analysis when pre- and post-test scores are to be analyzed (Campbell & Stanley, 1963).

Analysis of covariance enables us to determine what would have happened (on the post-test scores for each group) if these groups had been equal initially, in terms of their test scores. Analysis of covariance statistically equalizes all groups.

Assumptions

The assumptions underlying analysis of variance and analysis of covariance are listed and explained below.

1. Independence of observations; that is, all scores are independent of one another. This assumption was met by randomly assigning subjects to groups as well as the fact that subjects in each group were treated independently.

2. Normal distribution of scores on the dependent variables. It is assumed that the subjects' scores are normally distributed.

3. Homogeneity of variance. The within cell covariance matrix between groups is assumed to be the same. Random assignment helped to create homogeneous variance.

Differences Between Groups on Demographic and Medical Variables

Several tests were made to investigate whether, despite random assignment, there were significant differences between groups on demographic and medical variables.

A one-way analysis of variance was performed to test for significant differences between groups in age.

Cross tabulations between treatment groups and ten variables listed below in Figure 3, were done by testing with Chi-square.

Sex	Diagnosis
Marital status	Weeks on sick leave
Race	Whether or not hospitalized
Educational level	Type of medication
Type of employment	Whether psychotherapy began prior to Christmas or Easter

Figure 3. Variables of Interest.

CHAPTER IV

RESULTS

Overview

In this chapter results of the analysis of the data are presented. The results of this study are based upon (1) subjects' test scores on four variables and (2) the total number of sessions of psychotherapy subjects attended. There were 45 subjects, 15 in each of the three groups. Subjects in Group 1 were instructed to read the booklet "How Psychotherapy Works" (which comprises training in readiness for psychotherapy) at the clinic where subsequent psychotherapy was conducted. Time was specifically allotted for reading and a place to read undisturbed was provided. Subjects in Group 2 were given the booklet and were asked to take it home and read it prior to their first appointment for psychotherapy. Subjects in Group 3, the control group, were not given a booklet; they left following completion of the pre-tests.

The data collected concerning the five dependent variables were as follows:

Variable of Interest	Obtained From
1. Severity of problems	Test score on post-test of the SCL-90.
2. Level of manifest anxiety	Test score on post-test of Spielberger State-Trait Anxiety Inventory on State anxiety.
3. Level of general anxiety	Test score on post-test of Spielberger State-Trait Anxiety Inventory on Trait Anxiety.
4. Nature of self-concept and self-acceptance	Test score on post-test of the Phillips Self-Acceptance Scale.
5. Number of sessions of psychotherapy	Actual number of sessions of psychotherapy attended as indicated in subject's clinic chart.

Subjects were administered the test battery before they began psychotherapy and these test scores were used as covariates. After subjects terminated psychotherapy they were administered the four psychological instruments again.

Covariables

An overall multivariate test of the relationship between each of the four covariates: (a) pre-test score on the Symptom Checklist, (b) the pre-test score on State anxiety, (c) the pre-test score on Trait anxiety, and (d) the pre-test score on the Phillips Self-Acceptance Scale, and the five dependent variables was performed. The null hypothesis of no relationship between the five dependent variables and the four covariates was rejected ($F = 21.1013$,

degrees of freedom 28 and 113.72 and $p < .001$). The probability of the relationship occurring simply due to chance was less than .001. Therefore since the overall multivariate test indicated that a significant relationship exists between the four pre-test scores and the five dependent variables, the pre-test scores were used as covariates to analyze the data.

A multivariate analysis of covariance, the Finn program (Finn, 1968) with planned comparisons between groups, was used to test for significance between groups over the set of five dependent variables.

The pre-tests (covariates) were found to be the best predictors of their respective post-tests. This can be seen in Table 4.1 which depicts the standardized regression coefficients.

Table 4.1

Standardized Regression Coefficients[a]

Pre-tests	SCL	SA	TA	SC	NS
PSCL	.909	-.176	.163	-.228	.014
PSA	-.036	.591	.055	.043	.214
PTA	-.060	.136	.777	.160	-.041
PSC	-.010	-.330	.005	.709	-.066

[a]SCL = Symptoms Checklist; SA = State Anxiety; TA = Trait Anxiety; SC = Phillips Self-Acceptance Scale; NS = Number of Sessions.

Number of sessions, however, is not predicted by the covariates. There is a very low positive correlation between pre-test scores on State anxiety and number of sessions. Also a very low negative correlation exists between the pre-test score on the Phillips Self-Acceptance Scale and number of sessions. This can be seen in Table 4.2 which shows the sample correlation matrix. These results then, show that subjects with high State anxiety prior to beginning psychotherapy had a greater number of sessions of psychotherapy than subjects with lower State anxiety on the pre-test. Also subjects with a poor self concept as indicated by a low score on the Phillips Self-Acceptance Scale before beginning psychotherapy (the pre-test), had a greater number of sessions of psychotherapy than subjects who had more self-acceptance initially (as depicted by a higher pre-test score on the Phillips Scale).

Hypothesis Testing

A multivariate analysis of covariance was used to test the hypotheses with an alpha level of .05. The Finn Program for Multivariate Analysis of Covariance (Finn, 1968) was used.

There are differences between the three groups on the five dependent variables. The null hypothesis H_o: $\mu_1 = \mu_2 = \mu_3$ is rejected and the alternate hypothesis, stated below, is accepted.

Table 4.2

Sample Correlation Matrix[a]

	NS	PSCL	PSA	PTA	PSC	SCL	SA	TA	SC
NS	1.000								
PSCL	0.127	1.000							
PSA	0.228	0.469	1.000						
STA	0.077	0.428	0.440	1.000					
PSC	-0.142	-0.444	-0.375	-0.271	1.000				
SCL	-0.041	0.871	0.367	0.316	-0.384	1.000			
SA	-0.007	0.305	0.692	0.410	-0.511	0.380	1.000		
TA	-0.081	0.519	0.471	0.869	-0.299	0.503	0.472	1.000	
SC	0.236	-0.454	-0.259	-0.111	0.750	-0.484	-0.394	-0.336	1.000

[a]SCL = Symptoms Checklist; SA = State Anxiety; TA = Trait Anxiety; SC = Phillips Self-Acceptance Scale; NS = Number of Sessions.

H_1: There are differences between the three groups on the five dependent variables.

In order to determine the specific nature of the differences between groups, two planned comparisons were made. These are stated below in null hypothesis form:

$$H_o: \quad \frac{\mu_1 + \mu_2}{2} = \mu_3$$

$$H_o: \quad \mu_1 = \mu_2.$$

The results of these comparisons will be presented separately in the following sections. Each contrast was tested using the Finn Program (Finn, 1968) for multivariate analysis of covariance with $p = .05$.

$H_o: \quad (\mu_1 + \mu_2) \div 2 = \mu_3$

The null hypothesis that the mean of Group 1 and Group 2 combined is equal to Group 3 on the five dependent variables is rejected. At the $p = .05$ level ($F = 3.3925$ with 5 and 34 degrees of freedom and $p < .0137$), there are significant differences between the two experimental treatment groups (G_1 and G_2) and Group 3 on two of the dependent variables: Symptom Checklist and State Anxiety. This was determined by dividing the .05 alpha level into five smaller levels of probability which combined to add up to .05. This is shown in Table 4.4.

The differences between Groups 1 and 2 combined and Group 3, in terms of the least squares estimates adjusted for covariates, are shown in Table 4.3.

Table 4.3

Least Squares Estimates Adjusted for Covariates[a]

	SCL	SA	TA	SC	NS
$G_1G_2 - G_3$	-0.040	-4.289	-1.600	7.769	-0.639

[a]SCL = Symptom Checklist; SA = State Anxiety; TA = Trait Anxiety; SC = Phillips Self-Acceptance Scale; NS = Number of Sessions.

There is a significant difference between Groups 1 and 2 combined and Group 3 on the post-test score on the Symptom Checklist (SCL) and on State anxiety. On the average Group 3 is 0.040 points higher on the Symptom Checklist, which indicates severity of problems bothering the subject. On the average Group 3 is 4.289 points higher on State anxiety on the post-test than Groups 1 and 2 combined; this difference is significant.

In order to elaborate on the difference between the two experimental groups (in which subjects read the booklet) and the control group, Group 3 (in which the subjects did not read the booklet), the standard errors on the adjusted estimates were used with the least square estimates to construct confidence intervals. The formula used is shown below:

Table 4.4

Multivariate Test of the Contrast $(G_1 + G_2) \div 2 - G_3$

Variable[a]	Hypothesis mean square	Univariate F	p less than	Divided alpha level	Significance
SCL	0.0211	8.0265	.0074	.0100	Significant
SA	245.9332	4.7782	.0351	.0397	Significant
TA	34.2327	1.2173	.2769	.0001	Nonsignificant
SC	806.8742	4.3720	.0433	.0001	Nonsignificant
NS	5.4515	0.1845	.6733	.0001	Nonsignificant

[a]SCL = Symptom Checklist; SA = State Anxiety; TA = Trait Anxiety; SC = Phillips Self-Acceptance Scale; NS = Number of Sessions.

$$LSE \pm 2(SE)$$

where: LSE = least squares estimates adjusted for covariates; and

SE = standard errors.

This resulted in confidence intervals at the .05 level of significance. For the contrast $(G_1 + G_2) \div 2 - G_3$ the range of differences is shown in Table 4.5.

Table 4.5

Confidence Intervals for the Contrast $(G_1 + G_2) \div 2 - G_3$

Variable[a]	95% Confidence interval	Significance
SCL	-0.07 to -0.01	Significant
SA	-8.21 to -0.36	Significant
TA	-4.20 to 1.30	Nonsignificant
SC	0.34 to 15.20	Significant
NS	-3.61 to 2.33	Nonsignificant

[a]SCL = Symptom Checklist; SA = State Anxiety; TA = Trait Anxiety; SC = Phillips Self-Acceptance Scale; NS = Number of Sessions.

According to this post hoc analysis, there is a significant difference between Group 3 and Groups 1 and 2 combined on the Phillips Self-Acceptance Scale, in addition to a significant difference on the SCL-90 and State anxiety.

The scores on the SCL-90 attained by subjects in Group 3 were from .01 to .07 points higher than scores attained by subjects in Groups 1 and 2.

Subjects in Group 3 attained test scores on State anxiety which were from 0.36 to 8.21 points higher than test scores of subjects in Groups 1 and 2.

Subjects in Groups 1 and 2 attained test scores on the Phillips Self-Acceptance Scale that were from 0.34 to 15.20 points higher than test scores of subjects in Group 3. This must be considered as being marginally significant since the confidence interval is significant at the .05 level of significance. At the .05 level of significance, the multivariate test (for the contrast $[G_1 + G_2] \div 2 - G_3$) yielded p less than .0433 for differences on the Phillips Scale. If just this one variable were considered, it would be significant at the .05 alpha level. However, when the alpha level was divided into smaller portions, only two variables were significant, SCL-90 and State anxiety. Technically, differences between the combined experimental groups and the control group on the Phillips Self-Acceptance Scale at the .05 alpha level are significant. Yet, since the probability level (p less than .0433) is so close to .05, were a lower alpha level used, significance would not be attained. Therefore differences between the combined experimental groups and the control group on the Phillips Self-Acceptance Scale are marginally significant.

H_o: $\mu_1 = \mu_2$

The null hypothesis that there is no difference between Group 1 and Group 2 on the five dependent variables is rejected. At the $p = .05$ level ($F = 4.3723$ with 5 and 34 degrees of freedom, and $p < .0036$), there are significant differences between Group 1 and Group 2. The differences are picked up on two of the dependent variables, State anxiety and Trait anxiety. Table 4.6 shows how Group 1 compares to Group 2 when the contrast was set as $G_1 - G_2$.

Table 4.6

Multivariate Test of the Contrast $G_1 - G_2$

Variable[a]	Univariate F	p less than	Significance
SCL	1.638	.208	Nonsignificant
SA	13.318	.001	Significant
TA	9.324	.004	Significant
SC	3.139	.084	Nonsignificant
NS	0.016	.899	Nonsignificant

$F = 4.3723$; d.f. 5, 34; $p < .0036$.

[a]SCL = Symptom Checklist; SA = State Anxiety; TA = Trait Anxiety; SC = Phillips Self-Acceptance Scale; NS = Number of Sessions.

There is a significant difference between Group 1 and Group 2 on State anxiety and Trait anxiety. On the average Group 2 is 7.28 points higher than Group 1 on the post-test State anxiety score (after termination from psychotherapy). On Trait anxiety, Group 2 is, on the average, 4.50 points higher than Group 1. This is shown in Table 4.7.

Table 4.7

Least Squares Estimates Adjusted for Covariates[a]

	SCL	SA	TA	SC	NS
$G_1 - G_2$	-0.018	-7.282	-4.504	6.695	0.193

[a]SCL = Symptom Checklist; SA = State Anxiety; TA = Trait Anxiety; SC = Phillips Self-Acceptance Scale; NS = Number of Sessions.

The least squares estimates provide a point estimate of the differences between groups on the five dependent variables. In order to determine (at the .05 level of significance) the range of differences between groups, the standard errors of adjusted estimates were used with the least square estimates in the formula below.

$$LSE \pm 2(SE)$$

where: LSE = least squares estimates adjusted for covariables; and

SE = standard errors of adjusted estimates.

For the contrast $G_1 - G_2$ the range of differences are shown in Table 4.8

Table 4.8

Confidence Intervals for the Contrast $G_1 - G_2$

Variable	95% Confidence interval	Significance
SCL	-0.05 to 0.01	Nonsignificant
SA	-11.27 to -0.33	Significant
TA	-7.45 to -1.55	Significant
SC	-0.86 to 14.25	Nonsignificant
NS	-2.83 to 3.22	Nonsignificant

[a]SCL = Symptom Checklist; SA = State Anxiety; TA = Trait Anxiety; SC = Phillips Self-Acceptance Scale; NS = Number of Sessions.

The scores on State anxiety attained by subjects in Group 2 were from 0.33 to 11.27 points higher than test scores of subjects in Group 1. Subjects in Group 2 attained test scores on Trait anxiety which were from 1.55 to 7.45 points higher than test scores of subjects in Group 1. In terms of both manifest anxiety (State anxiety) and typical anxiety (Trait anxiety) subjects in Group 2 were significantly more anxious than subjects in Group 1.

Characteristics of Subjects

The cell means and standard deviations are shown in Tables 4.9 and 4.10, respectively.

Although forty-five subjects had been randomly assigned to one of the three treatment groups, it still seemed plausible that there might be significant differences between groups on certain demographic and medical variables. To test this probability, cross tabulations between treatment groups and ten variables were done by testing with a Chi-square. The variables of interest were subjects' sex, marital status, race, educational level, type of employment, diagnosis assigned by respective psychotherapist, weeks on sick leave, whether or not subject was hospitalized, type of medication prescribed, if any, and whether or not subjects began psychotherapy prior to the Christmas or Easter holiday season.

A significant difference between groups in age of subjects was found when a one-way analysis of variance was performed. The mean age of the entire population of 45 subjects was 29.4 years. The mean age of subjects in Group 1 was 33.7 years while the mean age for subjects in Group 2 was 27.2 years and 27.3 years for subjects in Group 3.

Table 4.9

Observed Cell Means[a]

Treatment Group	NS	PSCL	PSA	PTA	PSC	SCL	SA	TA	SC
1	6.867	0.235	54.467	47.467	73.067	0.129	37.067	38.400	93.133
2	6.800	0.318	57.333	55.400	72.600	0.213	48.933	52.533	82.800
3	6.800	0.246	50.067	52.267	81.067	0.197	43.933	47.333	85.600

[a]Rows are cells--columns are variables. SCL = Symptom Checklist; SA = State Anxiety; TA = Trait Anxiety; SC = Phillips Self-Acceptance Scale; NS = Number of Sessions. The prefix P indicates the pre-tests on these instruments.

Table 4.10

Observed Cell Standard Deviations[a]

Treatment Group	NS	PSCL	PSA	PTA	PSC	SCL	SA	TA	SC
1	5.579	0.108	9.180	8.357	20.044	0.092	9.114	7.926	19.201
2	5.102	0.104	11.178	11.885	17.295	0.092	9.779	12.053	21.079
3	5.201	0.142	11.209	10.957	20.910	0.115	12.413	12.099	21.440

[a]Rows are cells--columns are variables. SCL = Symptom Checklist; SA = State Anxiety; TA = Trait Anxiety; SC = Phillips Self-Acceptance Scale; NS = Number of Sessions. The prefix P indicates the pre-tests on these instruments.

No significant difference was found between groups in the medications taken.

A significant difference was found between groups concerning whether or not psychotherapy began prior to a holiday season (Christmas or Easter; raw Chi square = 9.974, with 4 degrees of freedom and significance = $p < .0409$). In Group 1 two subjects began psychotherapy before Christmas and one subject began psychotherapy before Easter. In Group 2, two subjects began psychotherapy before Easter. In Group 3 five subjects began psychotherapy before Christmas and four subjects began psychotherapy before Easter.

While the difference in diagnosis between groups was not statistically significant, there are noteworthy differences in how subjects were diagnosed. In Group 1 ten subjects were diagnosed as "depressive neurosis" and the other five subjects in this group were diagnosed as "adjustment reaction of adult life." The diagnosis of eleven subjects in Group 2 was "depressive neurosis," one subject was diagnosed as "adjustment reaction of adult life," one diagnosis of "passive-aggressive personality disorder," one diagnosis of "hysterical personality disorder," and one diagnosis of "obsessive compulsive neuroses." In Group 3 the diagnosis of "depressive neurosis" was for seven subjects, six

subjects were given the diagnosis "adjustment reaction of adult life," and one diagnosis of "hysterical personality disorder," and one diagnosis of "cardiovascular psychophysiologic disorder." The diagnoses per group are shown in Table 4.11 and discussed in Chapter V.

Table 4.11

Diagnoses of Subjects

	Treatment group		
Diagnoses	1	2	3
Depressive neurosis	10	11	7
Adjustment reaction of adult life	5	1	6
Hysterical personality	0	1	1
Passive-aggressive personality	0	1	0
Obsessive compuslive neurosis	0	1	0
Cardiovascular psychophysiologic disorder	0	0	1

Summary of Results

The test results suggest that subjects who read the booklet "How Psychotherapy Works" (which provides training in readiness for psychotherapy) do differ significantly from subjects who do not read the booklet. Subjects who did not read the booklet in this study scored significantly

higher (from .01 to .07 points higher) on the SCL-90 than subjects who read the booklet. This signifies that non-reading subjects were bothered by more severe problems after terminating psychotherapy than subjects who read the booklet. Subjects who did not read the booklet had significantly higher State anxiety (from 0.36 to 8.21 points higher) than subjects who read the booklet. Subjects who read the booklet had higher self-acceptance (from 0.33 to 15.20 points higher on the Phillips Self-Acceptance Scale) than subjects who did not read the booklet; this difference was marginally significant.

Group 1 was compared to Group 2 to assess whether there were any significant differences on the five dependent variables between the two groups, since Group 1 was asked specifically to read the booklet at the clinic and Group 2 was given the booklet to read at home. There were no significant differences between the two groups in terms of number of sessions of psychotherapy attended, scores on the SCL-90, or scores on the Phillips Self-Accepance Scale. However, Group 1 differed significantly from Group 2 on scores of State and Trait anxiety. Subjects in Group 2 scored from 0.33 to 11.27 points higher than subjects in Group 1 on State anxiety. Subjects in Group 2 scored from 1.55 to 7.45 points higher than subjects in Group 1 on Trait anxiety. This indicates that subjects

who did not read the booklet at the clinic, but were asked to take it home and read it prior to the first psychotherapy session, were significantly more anxious after they terminated psychotherapy than subjects who read the booklet at the clinic.

CHAPTER V

SUMMARY, DISCUSSION AND IMPLICATIONS

Summary

The purpose of this research was to assess the effects of a specific type of pre-psychotherapy training upon certain outcomes of psychotherapy. Subjects were actual clients who called Genesee Psychiatric Center (GPC) for an appointment for psychotherapy between November 1977 and July 1978. In the initial phone conversation subjects were told that an appointment for an "orientation session" needed to be scheduled prior to the first psychotherapy session. At this "orientation session" the research study was explained and if the subject agreed to participate in the study, three psychological instruments were administered: The SCL-90, the Spielberger State-Trait Anxiety Inventory and the Phillips Self-Acceptance Scale. Following completion of these instruments, subjects who had been randomly assigned to Group 1 were given a copy of the booklet "How Psychotherapy Works," and were asked to read the whole booklet carefully in a quiet, private room at the clinic. Subjects in Group 2 were given a copy of the booklet and were asked to take it home and read it carefully

before their first appointment for psychotherapy. Subjects in Group 3 were not given a booklet, but left the clinic following the testing.

The study was intended to examine experimentally the implications from previous research that pre-psychotherapy training helps clients to get the most benefit from psychotherapy. The usefulness of the written media, specifically, was to be investigated.

The booklet, "How Psychotherapy Works," was written to be used in this study to provide pre-psychotherapy training. The booklet was intended to make psychological concepts readily understandable to someone with only an eighth grade education. Numerous examples were used throughout. The basic information presented in the booklet concerned: the process of psychotherapy, the most helpful behaviors for the client to use in psychotherapy sessions, resistance, explained in common language. The booklet was also intended to help diminish any embarrassment about seeking professional help and to create realistic yet favorable expectations about psychotherapy.

The experimental design was a one-factor design. This factor was the independent variable of interest, type of treatment, and had three levels: read the booklet at the clinic (Group 1), read the booklet at home (Group 2), and no booklet (Group 3). There were five dependent variables:

(1) number of sessions of psychotherapy attended; (2) severity of problems bothering the subject, as indicated by score on the SCL-90; (3) extent of anxiety experienced at that time (State anxiety), as indicated by score on the Spielberger State-Trait Anxiety Inventory; (4) extent of anxiety typically experienced (Trait anxiety), as indicated by score on the Spielberger State-Trait Anxiety Inventory; and (5) degree of self-satisfaction, as indicated by score on the Phillips Self-Acceptance Scale.

There were 45 subjects, 15 in each treatment group. There were 37 women and 8 men whose ages ranged from eighteen to forty-eight. According to therapists' diagnoses of these subjects, none was psychotic. Demographic and medical information was collected for each subject and is summarized in Table 3.1 of Chapter III.

The pre-psychotherapy test scores were used as covariables and the one-way multivariate analysis of covariance was performed, using the Finn program (Finn, 1968).

The results of this study do not support the null hypothesis that there would be no differences between the three groups on the five dependent variables. Therefore, that null hypothesis was rejected. No significant differences between Groups 1 and 2 were found on the Symptom Checklist (SCL-90), on the Phillips Self-Acceptance Scale,

or in the number of sessions of psychotherapy attended. However there were significant differences between Group 1 and Group 2 on State anxiety scores and Trait anxiety scores. Subjects in Group 2 scored from 0.33 to 11.27 points higher on State anxiety and from 1.55 to 7.45 points higher on Trait anxiety than subjects in Group 2.

Significant differences were also found when Groups 1 and 2 together were compared with Group 3. After terminating psychotherapy, subjects in Group 3 had more severe problems (from .01 to .07 points higher on the SCL-90) than subjects in Groups 1 and 2. Subjects in Group 3 had higher State anxiety (from 0.36 to 8.21 points higher) than subjects in Groups 1 and 2. Subjects in Groups 1 and 2 had higher self-acceptance (from 0.33 to 15.20 points higher) than subjects in Group 3; this difference is marginally significant.

Discussion

There were several differences on outcome measures, after psychotherapy, between the groups, which were significant. One important question is whether these differences between groups were exclusively due to the particular type of treatment subjects received or due to other variables.

Demographic and medical information was collected for all subjects. There were 11 variables for which data was obtained for each subject. These variables were subject's age, marital status, race, educational level, type of employment, diagnosis, number of weeks on sick leave, hospitalization, if any, medication prescribed, if any, and, whether or not subjects began psychotherapy prior to the Christmas or Easter holiday season.

There were statistically significant differences between groups on the variables of age and whether psychotherapy began prior to a holiday season. Group 1 had the highest mean age (33.7) and this group also had significantly lower State and Trait anxiety than Group 2. Subjects in Group 2 were, on the average, younger (mean age = 27.2) than subjects in Group 1. Group 1 was the only group in which there were subjects over age forty. There were three such subjects in Group 1 whose ages were 42, 47, and 48. In order to discuss whether the test scores of these three older subjects might have greatly influenced the mean scores of Group 1, the scores of these three subjects were compared with the mean of Group 1 on the five dependent variables. These comparisons are shown in Table 5.1. The scores of these three oldest subjects on the post-tests of State and Trait anxiety were not the highest nor the lowest scores of subjects in their group,

Table 5.1

Oldest Subjects' Scores Compared to Group Means

Subject's age	NS	SCL	SA	TA	SC
48	10	.31	36	47	79
42	01	.20	50	48	87
47	10	.25	31	49	63
Group 1 Mean					
33	6.9	.13	37	38	93

Group 1. We cannot conclude from these scores that because three subjects in Group 1 were the oldest of the sample in this study that this accounts for the reason Group 1 was significantly lower than Group 2 in terms of post-psychotherapy State and Trait anxiety.

There were no significant differences between groups on the following variables: sex, marital status, race, educational level, type of employment, whether or not subject was hospitalized, diagnosis and type of medication prescribed.

The only other significant difference between groups was whether subjects began psychotherapy prior to the Christmas or Easter holiday season. Table 5.2 shows the number of subjects per group who began treatment prior to a holiday. According to these figures there is a considerable difference in group means, as follows: $\mu_1 = .20$,

Table 5.2

Subjects Who Began Psychotherapy Prior to a Holiday

Group	Before Christmas	Before Easter
1	2 subjects	1 subject
2	2 subjects	0 subject
3	5 subjects	4 subjects

$\mu_2 = .13$, $\mu_3 = .53$. Differences between groups regarding starting treatment prior to a holiday season would be expected to appear in the pre-test scores. Pre-holiday depression has been acknowledged by the National Institute of Mental Health (Rogers, 1977) as a prevalent phenomenon. In reviewing the scores of subjects who began treatment prior to a holiday, a few very high scores on the Phillips Self-Acceptance Scale were found. Three subjects scored 97, 115, and 120 on the pre-test and on the post-test the same subjects scored 99, 117, and 117, respectively; these three subjects were all in Group 3. The mean for Group 3 on the Phillips Self-Acceptance Scale for the pre-test was $\mu_3 = 73.07$ and for the post-test the mean was $\mu_3 = 93.13$. (On this instrument a higher score signifies more self-acceptance.) Since the pre-test scores were used as covariates for the purpose of statistically equalizing pre-psychotherapy differences among subjects, we cannot

conclude that the poorer performance of Group 3 compared to Groups 1 and 3 was due to the time in which subjects in Group 3 began psychotherapy. Still, since psychotherapy prior to a holiday was a statistically significant difference between groups, it would be worthwhile to conduct a study like the present one, in which either all subjects began psychotherapy prior to a holiday season or none of the subjects did. This way the effect of beginning psychotherapy prior to a holiday could be evaluated in terms of effects on outcome measures following termination of psychotherapy.

As results of the multivariate analysis of covariance indicate, subjects in Group 2 were significantly more anxious after terminating psychotherapy than subjects in Group 1 (as indicated by significantly higher scores on State and Trait anxiety attained by subjects in Group 2.) Even though Groups 1 and 2 combined were significantly different in positive ways than Group 3, it seems worthwhile to explore and discuss probable hypotheses which would account for subjects in Group 2 being more anxious than subjects in Group 1 (on the average). Statistically, it has been shown that these differences between Groups 1 and 2 are not due to chance. Subjects in Group 2 received the same experimental booklet as subjects in Group 1. Two explanations seem likely to account for the differences

between Groups 1 and 2. First, the difference in how the importance of reading the booklet was conveyed to subjects, might have led to different personal reactions in subjects in Group 2. By requesting subjects (in Group 1) to read the booklet at the clinic (after administration of the tests) it is likely that a subliminal message could have been conveyed. It might have underscored and intensified subjects' belief that reading the booklet was indeed very important.

Secondly, because subjects in Group 2 were requested to take the booklet home and to read the whole booklet carefully, it seems likely that if the subject did not read the booklet he/she might have worried later about "getting in trouble" somehow for disregarding the directions. Subjects who did not read the booklet could have become very concerned and anxious, worrying if the therapist might mention something from the booklet and "quiz" the client during the first session of psychotherapy. This might have been a factor contributing to Group 2 having higher anxiety than Group 1. Other possible manifestations of reactive worry about not reading the booklet could have been a combination of anxiety, guilt, or even paranoid ideation (e.g., "Will that testing person tell my therapist I was given a booklet to read?") Feelings such as these seem possible and could account for the higher scores on anxiety of Group 2 compared to Group 1.

Unfortunately, it was not possible to contact subjects in Group 2 to inquire, "Did you really read that booklet?" In fact, such questioning of the client might be antithetical to lessening the amount of his/her anxiety. It is also possible that if asked, clients might say, "Yes, I read the booklet," even if that was not true, due to embarrassment or guilt about not reading the booklet after being told to.

According to the results of the statistical analysis of the data, subjects in Group 2 were significantly more anxious (both in State and Trait anxiety) than subjects in Group 1. What is not known is whether this difference is due to the place where the client read the booklet or if the client read the booklet at all.

Another factor which might have affected Group 2 having higher anxiety (State and Trait) after psychotherapy ended than Group 1, is the diagnosis of subjects. While differences between groups on diagnoses were not found to be statistically significant according to the Chi-square test, nonetheless the differences between diagnoses in Groups 1 and 2 seem meaningful. (These diagnoses have been shown in Table 4.11). In Group 1 the diagnosis of 10 subjects was "depressive neurosis"; the remaining five subjects were diagnosed as having transitional situation reactions, "adjustment reaction of adult life." This latter

diagnosis is not considered to be as severe as the neuroses or personality disorders. Rather, "adjustment reaction of adult life" can be either a developmental problem or a situational reaction catalyzed by one or more very stressful events.

In Group 2, only one subject was diagnosed as "adjustment reaction of adult life." Eleven subjects in Group 2 had "depressive neurosis" for their diagnosis. The remaining three subjects were diagnosed as "hysterical personality disorder," "passive aggressive personality disorder," and "obsessive compulsive neurosis." According to the diagnoses of subjects in Groups 1 and 2, subjects in Group 2 as a whole had more severe pathology than subjects in Group 1. It seems plausible then, once they terminated psychotherapy, subjects in Group 2 might not have fully resolved their problems if they were only in psychotherapy for a few sessions. The mean number of sessions of psychotherapy for Group 1 was 6.87. The mean number of sessions of psychotherapy for Group 2 was 6.80, just very slightly smaller. Yet, if indeed Group 2 had more severe symptoms than Group 1, subjects in Group 2 might have needed more psychotherapy than they received in order to improve. In Table 4.9 the observed cell means show that Group 2 had, according to their pre-test scores, more severe problems (SCL-90 score), greater State and Trait anxiety than that

of subjects in Group 1. This is summarized in Table 5.3. If the premise that subjects in Group 2 had more pathology (based on diagnoses and pre-test scores) than subjects in Group 2, is accurate, then it is also plausible that more psychotherapy sessions than they received would be required for subjects in Group 2 to improve more than they did.

Table 5.3

Pre-Test Scores of Groups 1 and 2 on Three Variables

Treatment Group	Variabels[a]		
	PSCL	PSA	PTA
1	.235	54.467	47.467
2	.318	57.333	55.400

[a]The prefix P indicates the pre-tests on these instruments; SCL = Symptom Checklist; SA = State Anxiety; TA = Trait Anxiety.

When subjects in Groups 1 and 2 combined were compared with subjects in Group 3, subjects in Group 3 had more severe problems after psychotherapy as well as a higher level of manifest anxiety (State anxiety). Subjects in Groups 1 and 2 who were given the booklet to read, had higher self-acceptance than subjects in Group 3 who were not given the booklet; this difference, however, was a marginally significant difference. These results do imply that clients who read (prior to beginning psychotherapy) a

booklet, "How Psychotherapy Works," which provides training in readiness for psychotherapy, tend to differ significantly from clients who do not receive such a booklet before beginning psychotherapy. The most striking differences between subjects who read the booklet (Groups 1 and 2) and the subjects who did not read the booklet were: (1) significantly less severity of problems (as indicated by SCL-90 scores), and (2) less intense manifest (State) anxiety (as indicated by scores on the STAI) in subjects who read the booklet (Groups 1 and 2). Further, a marginally significant difference between Groups 1 and 2 combined (booklet readers) and Group 3 (no booklet) was found regarding self-acceptance after psychotherapy ended. The subjects who read the booklet (Groups 1 and 2) had higher self-acceptance after psychotherapy ended than subjects who did not read the booklet (Group 3).

There are several possible reasons for these favorable results in Groups 1 and 2. It is possible that the particular attention shown to these clients made a strong positive impact upon them initially, and this favorable beginning perception of the psychotherapy enterprise may have carried over into their psychotherapy sessions. While no "big fuss" was intended to be made over clients in Group 1, the experimental procedure of bringing them to a large spacious room in the clinic in which they were tested and

then asked to remain to read the booklet, might have made some of these clients feel they were receiving special treatment.

Subjects in Group 2 might have also felt special due to experimental procedures. They were given a booklet which they were told was very important to be read at home. In that the first encounter with a mental health or medical clinic often arouses anxiety and questions, the very structured format of the "orientation" session could have allayed anxiety considerably. Further, being given the booklet to take home (Groups 1 and 2 were told the booklet "is yours to keep"), might have been experienced by subjects as demonstrating extra warmth and concern. Also feelings from childhood might have been stirred up, regarding being given a lollypop after a visit to the doctor's office. This time the "lollypop" was the booklet.

Subjects in Group 3 spent the least time at GPC for their "orientation" session. The questions asked on the three inventories could have evoked considerable anxiety and yet these subjects did not receive subsequent warmth from the experimenter in the form of being given an "important booklet." Instead these subjects (Group 3) were merely thanked for the time they spent. This difference in treatment procedure might have been a factor in the poorer performance of subjects in Group 3 compared to subjects

in Groups 1 and 2. Because they were given something (the booklet) which they were told was "very important," subjects in Groups 1 and 2 had more reason to feel important than subjects in Group 3 did, based upon the specifics of how they were treated and the amount of time they were accorded during the "orientation" session.

Conclusions

According to the results of this study, using the booklet "How Psychotherapy Works" (which was written to prepare clients to get the most benefit from psychotherapy) is useful for clients to read before beginning psychotherapy. Reading such a booklet on the premises where subsequent psychotherapy will be conducted has been found to reduce anxiety more than taking the booklet home to read. However, all subjects who read the booklet before beginning psychotherapy had significantly less severe problems, significantly less State anxiety (manifest anxiety) and marginally significantly higher self-acceptance than subjects who did not read the booklet, when subjects were tested after their termination of psychotherapy.

Implications for Future Research

Much previous research and the present study as well show that some type of pre-psychotherapy training or orientation enables clients to get the most benefit from their involvement in psychotherapy. This being so, one aim of future research would be to study methods of training used so far and refine these. Because of the minimal amount of personnel required as well as minimal expense, and no need for equipment, the written media is an excellent vehicle for conducting pre-psychotherapy training. It is my hope that the present study can be replicated with some minor changes in order to ascertain how much effect on outcome measures was caused by pre-holiday season beginning of psychotherapy, age of subjects, and subjects' diagnoses. These are the three variables the effects of which have been questioned in the present study.

Other types of written media would be worth testing for effectiveness. A programmed book in which as the client read about various facets of mental health and emotional problems, the client would respond to brief questions about his/her own feelings, goals, lifestyle, strengths, and inadequacies. Another potentially effective use of the written media would be a booklet specifically written for relatives of clients who are in psychotherapy or are

hospitalized for psychological problems. Such a booklet could provide realistic information and thus help to dissipate fears based upon myths and superstitions pertaining to mental illness and "nervous breakdowns."

It would be interesting and worthwhile to replicate the present study but use different outcome measures to determine whether subjects who read the booklet actually are more active participants in their therapy sessions. Another use for the booklet used in the present study would be for the therapist to discuss the concepts in depth with the client, answering questions after the client read the booklet. Perhaps such a procedure of making the first two sessions of psychotherapy preparatory in nature, might insure a lower drop-out rate and less easily discouraged clients who receive more benefit from psychotherapy. Despite numerous studies (cited earlier in this dissertation) identifying and discussing "good" and "bad" clients, in this writer's opinion there are no "bad" clients, merely clients who have little or no conception of what psychotherapy is all about. Much more can and should be done to help the so-called "bad" clients become "good" clients so that they may receive the help they seek for problems distressing them.

APPENDICES

APPENDIX A

SCRIPT FOR INITIAL PHONE CONTACT WITH SUBJECTS

APPENDIX A

SCRIPT FOR INITIAL PHONE CONTACT WITH SUBJECTS

We're asking all new patients to come to the Center for an orientation. This would be before your appointment with your therapist. You will be asked to complete some short paper and pencil questionnaires which will be helpful for your therapy. We feel that this is important for new patients to do before they begin psychotherapy. You may come here sometime before your appointment with (name of therapist). I'd like to arrange a time now, when you can come here before (time and date of psychotherapy appointment).

APPENDIX B

EXPERIMENTER'S STATEMENT TO SUBJECTS DURING "ORIENTATION" SESSION

APPENDIX B

EXPERIMENTER'S STATEMENT TO SUBJECTS DURING "ORIENTATION" SESSION

As you were told on the phone, we're asking all new patients to take part in a brief orientation before beginning psychotherapy. That's what you'll be doing here today. There will be three short questionnaires for you to complete. We've found that by answering questions about yourself and how you have been feeling, you will get a clearer idea about what specifically has been bothering you. This will help you to tell your therapist about what's been on your mind. I'll go over the directions for these questionnaires with you in a few minutes.

Right now I'd like to tell you about an important project at this Center that we're asking patients to help us with. We're evaluating our services so that we can improve these in whatever ways are necessary. The way that patients like yourself can help with this is explained on this paper (experimenter hands appropriate consent form to subject). Please read this now. (When subject has stopped reading, the experimenter asks:) Will you take part in this evaluation of this Center? (If subject agrees

then he/she is asked to sign the consent form. If subject does not agree, he/she is told: This will not in any way interfere with your therapy here. This will be kept confidential. Here is a copy of the booklet being used for the orientation. Please take it with you. It explains information about psychotherapy that people often ask about. Thank you for coming here today/night.) (If subject did sign the consent form the experimenter goes on to explain the directions for completing the three psychological instruments.) I'll leave these questionnaires here with you to work on and I'll come back to see if you're finished in about half an hour. There's no rush though; just work at your own rate. (Experimenter leaves and returns in a half-hour. If the subject is not finished, he/she is told to continue working. When the subject is finished with the tests the experimenter says:) I'll take these now. Again, let me say that this information will be kept completely confidential. In fact it will not be given to your therapist, but will be used only for the Center's evaluation. (Subjects in Group 2 are told:) Please take this booklet home with you. It is important that you read the whole booklet carefully before your appointment with your therapist. (Subjects in Group 1 are told:) Please remain in this room and read this booklet. It is important that your read the whole booklet carefully.

Subjects in Groups 1 and 2 are told "the booklet is yours to keep." Subjects in all three groups are thanked and told: "Thank you for taking part in this evaluation. You will be contacted when you are done with your therapy here, so that you can complete these same questionnaires at that time."

APPENDIX C

CONSENT FORMS

CONSENT FORM FOR GROUPS 1 AND 2

You are being asked to take part in this pre-therapy orientation for two reasons. First, we hope that by completing the three brief questionnaires (psychological surveys) you will have a clearer idea about things that are bothering you. This may help to make it easier for you to tell your therapist about what's been on your mind, what brought you to the Center for therapy. And we expect that reading the pamphlet "How Psychotherapy Works" will give you a better idea of what psychotherapy is like, what you can expect, how therapy can help you. (This booklet will be given to you after the inventories.)

Second, we are evaluating our services here and working to continually deliver the most beneficial service to our patients. With your permission then, we would like to use the information you provide about yourself as part of our study to evaluate the Center. Of course all information you provide will be kept confidential and you yourself will remain anonymous in our evaluation. (This information will not be given to your therapist but will be used anonymously in the Center's evaluation of services.) If you agree to participate in our study it would simply mean that you would complete the three inventories to be given to you now. After that you will read the booklet "How Psychotherapy Works" which will be given to you. Then once you have stopped seeing your therapist for therapy here, you will be telephoned and asked to return once again to the Center to complete the same brief inventories. We will appreciate your participation. If you agree to take part in this program, please sign your name below. Thank you.

(Signature)_____

APPENDIX D

TEXT OF BOOKLET: "HOW PSYCHOTHERAPY WORKS"

APPENDIX D

TEXT OF BOOKLET: "HOW PSYCHOTHERAPY WORKS"

The purpose of this booklet is to give you information which will assist you in getting the most help from your psychotherapy here. Psychotherapy is a particular type of treatment for psychological problems. Most people have some psychological problems at one time or another in their lives. People who have come here for therapy previously were either referred here by their family doctor, were asked to come here by someone in their family, or coming here was suggested by a friend, neighbor, someone at work, or they decided themselves to come here to talk to a therapist.

People who became patients (after their first meeting with their therapist they continued having therapy, generally for several more appointments) came here for many different reasons, usually because of problems which were bothering them. Some of the reasons why people have come here for therapy are: marriage or family problems, feeling very nervous, upset, or having other feelings of emotional discomfort, having trouble getting along with other people, getting angry and "exploding" too quickly, not liking himself or herself, feeling confused, sad, panicky, hopeless or scared and not knowing why. Psychotherapy is an effective method of treating such problems.

You may be interested to know that last year in Michigan alone over 300,000 people talked with psychotherapists because of personal problems.

Psychotherapy is not the same kind of treatment as getting a shot (for a sore throat, perhaps) that <u>by itself</u> can help you start feeling better. Instead, psychotherapy is a type of treatment which requires <u>your</u> cooperation, <u>your</u> effort as well as that of your therapist. You cannot come to your therapist and just sit there and say nothing, and then suddenly feel better. It simply does not happen that way. Basically what happens in psychotherapy is that you will talk about yourself with a psychotherapist. More about psychotherapy will be explained shortly--how it works, what you are expected to do, some things your therapist will talk about, things that usually happen in psychotherapy, and so on. Your psychotherapist, who you will meet at your next

appointment, will be either a social worker or a psychologist who is qualified and licensed to do psychotherapy. Each of the therapists who works at this clinic has been doing psychotherapy for a number of years.

Psychotherapy has been called the "talking cure." This is because the way that patients are helped to feel better is by talking to their therapist about themselves, their feelings, thoughts, talking about whatever is on their minds. Your psychotherapist will talk also, but he or she will not do all the talking. A very important part of your treatment, of psychotherapy, is you talking about yourself.

Therapy is different than being in a classroom. When you were a student in school, usually you were expected to sit still and be quiet most of the time. Generally, it was the teacher who talked a lot, who explained things to you, told you what you were expected to learn, what to remember. The teacher even (it might have seemed sometimes) told you what or how to think. Your therapist is not a schoolteacher and his or her office is not a classroom. You and your therapist are both adults. It is your therapist's job to listen and to talk with you. Your therapist is an expert about the ways that people develop psychological problems. There are many, many possible ways--how and why--people become, for example, nervous, worried, scared, panicky, angry, sad. And, how and why people sometimes start to feel hopeless, confused, unhappy. In short, your therapist has learned a lot about the general ingredients of human behavior, mental health and psychological problems. It is you, not your therapist, however, who knows the most about the details of your life--your feelings, behavior, and reactions in different situations. Let's say, for example, you have been really feeling nervous and that's why you are coming here for therapy.

Your therapist knows a lot about the general ways that people become nervous and how they can become calmer, start feeling better. You are the one, not your therapist, who knows (or can, with effort, remember) what has been going on in your life during these past several weeks (months or however long you've been bothered by these feelings). An important step toward feeling better is finding out all the things that caused you to feel upset. Your therapist is the one who knows a lot about mental health, emotional and psychological problems. But you are the one who knows the most about how you spend your time, with whom, and what happens. That's why the two of you working together (listening and talking) will figure out

how you can do things a little differently so that you will feel better, along with being able to do the things which are important to you (for example, living more happily in your home, having fewer problems at work). Therapy then, is team work. You and your therapist are a team. You both work together and start doing "detective work." That is, you talk and remember things which were happening at times when you felt badly and times when you felt well. It is your job to talk freely about your feelings, thoughts, reactions to situations and people. Your job includes being aware of, remembering and talking about why and when you have felt (or still feel) upset, and why and when you feel (or have felt) happy and satisfied.

Nothing is too bad to talk about in therapy. Each of the therapists who works here has talked with many, many people over many years. There is probably no kind of problem we haven't heard about before. Other people might tell you, when you talk about feeling very troubled or being very worried, "oh that's silly," or "oh that's just a small thing, you shouldn't let it bother you." If something bothers you, worries or upsets you, then it does bother you. For you, it is a problem no matter whether or not it would be a problem for someone else. If it bothers you, it is a problem for you. No matter what anyone else thinks, whatever is bothering you does bother you. We have found that there is always a reason for feeling troubled. Perhaps these reasons aren't really clear to you. That's one of the tasks that will be worked on in your psychotherapy here--you and your therapist will be working together to find out just how you came to have these problems. And after that, you will find out how you can live your life without these problems continuing to crop up. That is, you will find ways you can be with people, ways you can act so that you are not, for example, "so nervous," or so hot tempered, so that you are not as upset as you may have felt recently.

Trying to think of, to figure out how and why your problems developed may seem like trying to solve a big mystery. Why do you have the problems that bother you? Somewhere in your mind is the answer.

Lots of information about yourself is stored in your mind: everything you've seen, heard, said, all the things you have done, thought, wished. Sometimes you (like the rest of us) cannot remember exactly what happened, what went on that made you start, for example, to feel so sad or so nervous.

Talking about yourself to your therapist jiggles your memory. Imagine your mind as being like a large pile of bricks. Engraved on every brick is a memory. All your thoughts, your memories about what you've done, felt, said, wished, etc., are in your mind somewhere. When you say one thing about yourself, it is like pulling a brick out of the huge pile in your mind. This jiggles all the other "bricks" so that these "bricks" (your thoughts and memories) aren't wedged in so tightly. Don't worry, it's not quite like an avalanche. It might feel unsettling until you are finally able to re-arrange that "pile of bricks" (your thoughts, memories, feelings) so that they are not as unbalanced; so that no single thought, feeling or memory can cause a "landslide"--many feelings falling out all at once. An example of that kind of "landslide" for some people would be: suddenly, lots of feelings rush out--anger, fear--right after you hear someone laugh who is behind you in the check-out line at your grocery store.

Your thoughts can be re-arranged in your mind so they are more balanced. This happens as you gain more and more understanding about yourself and the reasons why you think and feel the way you do. Such understanding is called "insight." Insight is like a blueprint, sort of like a floor plan of your mind that explains how your past experiences, and your thoughts, affect and influence your feelings and behavior.

Such understanding will lead to you feeling more in control of your life so that you are the one who controls your emotional reactions. You can think of it as you yourself regulating your "emotional thermostat," so that you don't suddenly feel "too hot" (too angry, raging mad , violent; yelling and screaming too easily and too often) or become "too cold" (too frightened, sad, lonely, afraid to make a decision, too scared to speak or leave your house). Instead of suddenly feeling "out of control," you yourself will be able to regulate your emotional reactions.

Usually before their first meeting with their therapist, people have many questions. Possibly you already have some idea of what your first appointment with your therapist might be like. This might be because of things you have read, or seen on television, or from having talked to friends or neighbors who have also been in therapy. However, it is very possible that your first appointment with your therapist may be a little different

from the way you expect it to be. It is very possible that you will still have some questions which your therapist may not answer fully enough to explain what you were wondering about, and so you will still want to know more. If after your first appointment with your therapist you still wonder about some things, do be sure to ask your therapist about these concerns or questions the next time you meet for therapy. In between appointments, often things come up in a patient's mind which perhaps were not thought about during the therapy appointment. If you have questions, comments, or additional things that you want to talk with your therapist about, be sure to talk about these things the next time the two of you meet for therapy.

If your first appointment with your therapist is very different or is different in some ways from what you expected, talk to your therapist about this the next time the two of you get together. This is very important. It has been found that often when a person's first therapy appointment is very different from what he or she expected, if these differences bother the patient and he or she doesn't talk about this, the person may become discouraged. He or she might just quit before giving therapy a really good try. Therefore it is very important for you to talk with your therapist about concerns or questions you have in the beginning as well as throughout your psychotherapy. It is important to talk with your therapist about whatever is on your mind.

It is your therapist's job to listen and to tell you what things seem to be affecting you or causing you to feel certain ways as soon as he or she has ideas about this. It is your job to talk with your therapist about whatever is going on in your life that concerns you. If unpleasant things keep happening to you, or you keep having upsetting feelings and you continue to tell your therapist about these during your appointments together, then after a while either you or your therapist or both of you will realize which situations, circumstances, people, thoughts, or behavior seem to be the "ingredients" or the things which are partly responsible for you feeling upset, the causes of the problems that bother you. In time your therapist will probably be talking with you in more detail about ways or things you yourself can do to assist him or her in finding out what is causing you to be having these problems, as well as ways you yourself can help, or things that you can do, so that you will start feeling better.

Again, psychotherapy is a kind of "team work." Your therapist will not do his or her job alone. You will be expected to work along with your therapist. You can do this. Your therapist can help you to understand in what ways you can assist so that you will start feeling better.

Something else that you should know about is something that usually happens sometime during psychotherapy. At some point, perhaps just when you begin to feel better, just when things are starting to go better in your life, you may start to do things to get in the way of feeling better. This is called "resistance." Resistance is the process of the patient doing or saying things that prevent him or her from feeling better (or not doing or saying things which would help him or her feel better). Maybe that sounds a little crazy itself.

Let me explain it a little bit more. The problems that bother you right now are also problems that probably have bothered you for some time. There is a certain safety, a safe feeling, in things staying the same, just as you feel safer when you know what to expect, when you aren't uncertain about things. Let's say, for example, that you are planning to go on a trip. Most people usually feel a little safer or feel a little bit more secure if they have gone there before or if they have really good directions about how to get there and feel certain they'll be able to find the place. Generally people feel a little bit less safe when it's the very first time that they've attempted this trip or if they don't know how to get there, or are really not sure about the road or weather conditions. There is a certain safety in having some idea of what to expect and being fairly certain that what you expect to find will be something that you <u>will like</u>.

Now very likely there are certain things in your life which have been causing, or are responsible, for the problems that are bothering you. Therefore it is also very likely that in order for you to feel better, it may be necessary for you to make some changes in your life. Some of these changes may not be great big ones. Perhaps something as simple as writing down the things you must remember if you have trouble remembering things. Nonetheless, it will mean making a change. Any change, even a small change or a change that is pleasant, does cause most people to feel a little uneasy. Studies have shown that any change, even positive changes (for example, a special vacation you have planned) does cause a person some stress, tension. Enough change, even good changes, can bring about serious stress or

tension, so much so that a person can become emotionally or physically ill if too many changes happen at the same time.

Therefore when it seems necessary for a person to make some changes in his or her life in order to start feeling a lot better, even though the person wants to feel better, he or she usually resists making these changes. In therapy people do resist doing or saying things that will lead to changes in their lives. Some examples of resistance (or ways that patients may stand in the way of helping themselves to start feeling better) are: forgetting the time of their appointment and therefore missing it, or suddenly feeling that it is very important for them to do something else the day of their appointment and cancelling the therapy appointment. Another example of resistance is a patient just not bothering to talk with a friend about something this person said which upset the patient, even though in therapy both the patient and therapist concluded that it was important for the patient to tell the friend that his or her comment was upsetting.

In talking about their therapy, patients have said that after they started to feel a little better, they went through a period of time when everything seemed worse, when they once again did things that especially (they had discovered in therapy) caused them to feel badly. This is a sign of "resistance." But here is something optimistic: when rather suddenly a patient starts feeling a lot worse for no apparent reason (soon after he or she had started feeling a little better) it is usually a sign that very shortly he or she will be feeling a whole lot better. Generally patients do go through a short period in which they feel worse just before they feel a whole lot better. During this time there is usually some resistance going on and this can be worked through in therapy.

It is very important for you to remember that the problems which are bothering you took time to develop and will also take time to understand and to solve. You certainly might like it best if right away you could learn why you have these problems and then start feeling better immediately, or at least within the next week. However, so you won't be disappointed or discouraged, you should know that usually it takes some time both to find out why you are having the problems that are bothering you, and also to find out how you can feel better. While probably the reason that you came here is to find out how to feel better, one way to look at today's appointment is that this is a

starting point, a beginning. It is the first step in you starting to feel better. If, at the end of your first appointment with your therapist, you don't feel completely better or if you still don't fully understand why and how you got upset or if you still don't fully understand why and how you got to feel so badly in the first place, please do not go away feeling disappointed, upset, or discouraged. It generally takes some time for people to start feeling better. The problems that are bothering you probably took some time to develop. It will also take some time for you to find out with your therapist, why and how these problems developed and what can be done so that you will feel better. The answers are in your mind somewhere. Please know for certain that this is information that you can discover. Many, many other people like you have had problems that were very upsetting to them. They got better; so can you.

There was a commercial on television a few years ago. In it, a woman was showing and talking about a dress she had sewn herself on her new sewing machine even though she had never sewn before. She had only recently learned to sew. After explaining how she made the dress and how the machine worked she said, "If I can sew, you can sew." Or, in other words, if someone like me who really never sewed before has been able to learn how to make this dress which is so pretty and turned out so well, if I can do it, so can you.

What we're telling you now is that if so many, many people with problems which bothered them as badly or worse than your problems are bothering you, have been able to feel better, to get well, you can be certain that you will also be able to feel better. Know that if it does take a little longer than you were hoping or you expected, to feel better, it doesn't mean that you won't get to feel better, nor does it mean that something is wrong. It simply means that it does take time for emotional problems to improve.

Maybe it sounds a little like being asked to take something "on faith" to be told now that you should believe that you will feel better. The reason that this can be said to you truthfully (and it is not a "come on" or a "snow job") is that the therapy staff here has worked with so many, many people with all kinds of problems, that we do feel certain that whatever the problems are which are bothering you, you can be helped to feel better. But remember, psychotherapy is a treatment which requires your effort and your participation, too. You are as much a part of the activity of

psychotherapy as your therapist. Your therapist can help you discover for yourself how you can solve your problems. During your appointments with your therapist the two of you will be working together. As you talk you will learn to be more honest with yourself and learn to understand yourself better.

We hope reading this booklet helps you to have a better idea of what psychotherapy is like, and that you will find this information useful.

BIBLIOGRAPHY

BIBLIOGRAPHY

Apfelbaum, B. Dimensions of transference in psychotherapy. Berkeley: University of California Press, 1958.

Aronson, H., & Overall, B. Treatment expectations of patients in two social classes. Social Work, 1966, 11, 35-41.

Battle, Carol C., Imber, Stanley D., Hoehn-Saric, R., Stone, Anthony C., Nash, Earl R., & Frank, Jerome D. Target complaints as criteria of improvement. American Journal of Psychotherapy, 1966, 20, 184-192.

Begley, C. E., & Lieberman, L. R. Patient expectations of therapist's techniques. Journal of Clinical Psychology, 1970, 26(1), 112-116.

Blain, G. B., & McArthur, C. C. What happened in therapy as seen by the patient and his psychiatrist. Journal of Nervous and Mental Diseases, 1958, 127, 344-350.

Boleloucky, Z., & Horvath, M. The SCL-90 rating scale: First experience with the Czech version in healthy male scientific workers. Act. Nerv. Super., 1974, 16, 115-116.

Butler, John M. Measuring the effectiveness of counseling and psychotherapy. Personnel and Guidance Journal, 1953, 32, 88-92.

Brady, J. D., Reznikoff, M., & Zeller, W. W. The relationship of expectation of improvement to actual improvement of hospitalized psychiatric patients. Journal of Nervous and Mental Diseases, 1960, 130, 41-44.

Brandt, Lewis W. Studies of 'dropout' patients in psychotherapy: A review of findings. Psychotherapy: Theory, Research & Practice, 1965, 2, 6-13.

Campbell, D. T., & Stanley, J. C. Experimental and quasi-experimental designs for research. Chicago: Rand McNally & Company, 1963.

Cartwright, D. S., & Cartwright, R. D. Faith and improvement in psychotherapy. Journal of Counseling Psychology, 1958, 5, 174-177.

Chance, Erika. Families in treatment. New York: Basic Books, 1959.

Chance, Erika. Mutual expectations of patients and therapists in individual treatment. Human Relations, 1957, 10, 167-178.

Chessick, Richard D. How psychotherapy heals: The process of intensive psychotherapy. New York: Science House, 1969.

Clemes, S., & D'Andrea, V. Patient's anxiety as a function of expectation and degree of initial interview ambiguity. Journal of Consulting Psychology, 1965, 29, 397-404.

Cornfield, J., & Tukey, J. W. Average values of mean squares in factorials. Annals of Mathematical Statistics, 1956, 27, 907-949.

Derogatis, L. R., & Cleary, P. A. Confirmation of the dimensional structure of the SCL-90: A study in construct validity. Journal of Clinical Psychology, 1977a, 151, 1424-1428.

Derogatis, L. R., Lipman, R. S., Rickels, K., Uhlenhuth, E. H., & Covi, L. The Hopkins Symptom Checklist (HSCL): A self-report symptom inventory. Behavioral Science, 1974, 19, 1-15.

Derogatis, L. R., Lipman, R. S., & Covi, L. The SCL-90: An outpatient psychiatric rating scale--preliminary report. Psychopharma, 1973, 9, 13-27.

Derogatis, L. R., SCL-90 R (revised) version manual-I. Baltimore: Johns Hopkins University Press, 1977b.

Fiedler, F. E. Factor analysis of psychoanalytic, non-directive and Adlerian therapeutic relationships. Journal of Consulting Psychology, 1951, 15, 32-38.

Fiedler, F. E. A comparison of therapeutic relationships in psychoanalytic, non-directive and Adlerian therapy. Journal of Consulting Psychology, 1950, 14, 436-443.

Feifel, Herman, & Eells, Janet. Patients and therapists assess the same psychotherapy. Journal of Consulting Psychology, 1963, 27(4), 310-318.

Fine, Reuben. The age of awareness. The Psychoanalytic Review, 1972, 56(1).

Finn, J. Univariate and multivariate analysis of variance, covariance and regression. Version 4, June 1968.

Frank, J. D. Influences of patients' and therapists' expectations on the outcome of psychotherapy. British Journal of Medical Psychology, 1968, 41, 349-356.

Frank, Jerome D. Persuasion and healing: A comparative study of psychotherapy. Baltimore: Johns Hopkins Press, 1961.

Frank, Jerome D. The role of hope in psychotherapy. International Journal of Psychiatry. 1968, 5, 383-395.

Frank, J. D., Gliedman, L. H., Imber, J. D., Stone, A. R., & Nash, E. H. Patient's expectancies and relearning as a factor determining improvement in psychotherapy. American Journal of Psychiatry, 1959, 115, 961.

Frank, J. D., Gliedman, I. H., Imber, S. D., Nash, E. H., & Stone, E. R. Why patients leave psychotherapy. Archives of Neurological Psychiatry, 1957, 97, 283-299.

Frank, J. D., Nash, E. H., Stone, A. E., & Imber, S. D. Immediate and long-term symptomatic course of psychiatric outpatients, American Journal of Psychiatry, 1970, 171, 203-215.

Frank, J. D., Hoehn-Saric, R., Imber, S. D., Liberman, B. C., & Stone, A. P. Effective ingredients of successful psychotherapy. New York: Brunner/Mazel, 1978.

Freedman, N., Engelhardt, D. M., Hankoff, L. D., Glick, B. S., Kay, H., Buchwald, J., & Stark, J. Drop-out from outpatient psychiatric treatment: Personality and situational determinants. AMA Archives of Neurological Psychiatry, 1958, 80, 657-666.

Friedman, H. J. Patient expectancy and symptom reduction. Archives of General Psychiatry, 1963, 8, 61-67.

Fromm-Reichman, Frieda. Principles of intensive psychotherapy. Chicago: The University of Chicago Press, 1950.

Garfiels, S. L., & Wolpin, M. Expectations regarding psychotherapy. Journal of Nervous and Mental Disease, 1963, 127, 353-362.

Gelder, M. G., Marks, I. M., & Wolff, H. W. Desensitization and psychotherapy in the treatment of phobic states: A controlled inquiry. British Journal of Psychiatry, 1967, 113, 52-73.

Gendlin, E. T., Beebe, J., Cassino, J., Klein, M., & Oberlander, M. Focusing ability in psychotherapy, personality and creativity in Shlien (Ed.). Research in Psychotherapy, Vol. 3, Washington, D.C.: APA, 1960.

Glass, G. V., & Stanley, J. C. Statistical methods in education and psychology. Englewood Cliffs, N.J.: Prentice-Hall, Inc., 1970.

Gliedman, L. H., Stone, A. R., Frank, J. D., Nash, E. H., & Imber, S. D. Incentives for treatment related to remaining or improving in psychotherapy. American Journal of Psychotherapy, 1957, 1, 489-598.

Glover, E. The techniques of psychoanalysis. New York: International Universities Press, 1955.

Goldstein, A. P. Maximizing expectancy effects in psychotherapeutic practice. International Journal of Psychiatry, 1968, 5, 397-399.

Goldstein, A. P. Therapist and client expectancies of personality change in psychotherapy. Journal of Counseling Psychotherapy, 1968, 7, 180-184.

Goldstein, A. P. Maximizing the initial psychotherapeutic relationship. American Journal of Psychotherapy, 1969, 23, 430-431.

Goldstein, A. P. Prognostic and role expectancies in psychotherapy. American Journal of Psychotherapy, 1966, 29, 35-44.

Goldstein, A. P., Heller, K., and Sechrest, L. B. Psychotherapy and the psychology of behavior change. New York: Wiley, 1966.

Goldstein, A. P., & Shipman, W. G. Patient expectancies, symptom reduction and aspects of the initial psychotherapeutic interview. Journal of Clinical Psychology, 1961, 17, 129-133.

Grant, J. D., & Grant M. Q. Therapy readiness as a research variable. Journal of Consulting Psychology, 1950, 14, 156-157.

Heilbrun, A. B. Counseling readiness and the problem solving behavior of clients. Journal of Consulting and Clinical Psychology, 1968, 32, 396-399.

Heilbrun, A. B. Further validation of a counseling readiness scale. Journal of Counseling Psychology, 1964, 11, 290-292.

Heilbrun, A. B., & Sullivan, D. J. The prediction of counseling readiness. Personnel & Guidance Journal, 1962, 41, 112-117.

Heine, R. W., & Trosman, H. Initial expectations of the doctor-patient interaction as a factor in continuance in psychotherapy. Psychiatry, 1960, 23, 275-278.

Heitler, J. B. Preparation of lower class patients for group psychotherapy, Doctoral dissertation, The University of Michigan, 1971.

Heller, K. Effects of modeling procedures in helping relationships. Journal of Consulting and Clinical Psychology, 1969, 33(5), 522-526.

Hoehn-Saric, R., Frank, J. D., & Gurland, B. J. Focused attitude change in neurotic patients. Journal of Nervous and Mental Diseases, 1968, 147, 124-133.

Hoehn-Saric, R., Frank, J. D., Imber, S. D., Nash, E. H., Stone, A. R., & Battle, C. C. Systematic preparation of patients for psychotherapy. I: Effects on therapy behavior and outcome. Journal of Psychiatric Research, 1964, 2, 267-281.

Hoffman, H. E. Scanning and the counseling readiness scale, Perceptual & Motor Skills, 1969, 29(2), 645-646.

Howland, M., & Hogan, R. A. Some guidelines for beginning psychotherapy. Downey, Calif.: Howland and Hogan, 1969.

Imber, S. D., Pande, S. K., Frank, J. D., Hoehn-Saric, R., Stone, A. R., & Wargo, D. G. Time focused role induction. Journal of Nervous and Mental Diseases, 1970, 1, 27-30.

Irvin, F. W. The realism of expectations. Psychological Review, 1944, 51, 120-126.

Jacobs, D., Charles E., Jacobs, T., Weinstein, H., & Mann, D. Preparation for treatment of the disadvantaged patient: Effects on disposition and outcome. American Journal of Orthopsychiatry, 1972, 42, 666-674.

Kamin, I., & Coughlin, J. Subjective experiences of outpatient psychotherapy: A follow-up study. American Journal of Psychotherapy, 1963, 17, 660.

Kell, B. L., & Mueller, W. J. Impact and change. New York: Appleton-Century-Crofts, 1966.

Kelman, H. C., & Parloff, M. B. Interrelations among three criteria of improvement in group therapy: Comfort, effectiveness and self-awareness. Journal of Abnormal & Social Psychology, 1957, 54, 281-288.

Kirtner, W. L., & Cartwright, D. C. Success and failure in client centered therapy as a function of initial in-therapy behavior. Journal of Counseling Psychology, 1958, 22, 329-333.

Kline, N. S. Criteria for psychiatric improvement. Psychiatric Quarterly, 1957, 31, 31-40.

Krause, M. S., Fitzsimmons, M., & Wolf, N. Focusing on the client's expectations of treatment, Brief Reports, Psychological Reports, 1969, 24(3), 973-974.

Lazarus, A. A. Behavior rehearsal vs. nondirective therapy vs. advice in effecting behavior change. Behavior Research and Therapy, 1966, 4, 209-212.

Lennard, H. L., & Bernstein, A. The anatomy of psychotherapy. New York: Columbia University Press, 1960.

Lennard, H. L., & Bernstein, A. Role learning in psychotherapy. Psychotherapy: Theory, Research & Practice, 1967, 4(1), 1-6.

Lorr, M., Katz, M. M., & Rubenstein, E. A. The prediction of length of stay in psychotherapy. Journal of Consulting Psychology, 1958, 22, 321-327.

Malamud, D. I., & Machover, S. Toward self understanding: Group techniques in self confrontation. Sprinfield, Ill.: Charles C. Thoman, 1965.

Martin, H., & Shewmaker, K. Written instructions in group psychotherapy. Group Psychotherapy, 1962, 15, 24.

McNair, D., Lorr, M., & Callahan, D. Patient and therapist influence on quitting psychotherapy. Journal of Consulting Psychology, 1963, 27, 10-17.

Minge, M. R. Counseling readiness as readiness for change. In Litwack, Getson & Saltzman (Eds.), Research in Counseling, 1966.

Mowrer, O. H. (Ed.). Psychotherapy: Theory and research. New York: Ronald Press, 1953.

Nash, E. H., Hoehn-Saric, R., Battle, C. C., Stone, A. R., Imber, S. D., & Frank, J. D. Systematic preparation of patients for short-term psychotherapy. II. Relation to characteristics of patient therapist and the psychotherapeutic process. Journal of Nervous & Mental Diseases, 1965, 140(5), 374-383.

Nichols, R. C., & Beck, K. W. Factors in psychotherapy change. Journal of Consulting Psychology, 1960, 24, 383-399.

Omroake, K. The relation between acceptance of self and acceptance of others shown by three personality inventories. Journal of Consulting Psychology, 1954, 18, 443-446.

Orlinsky, D., & Howard, K. I. The good therapy hour. Archives of General Psychiatry, 1967, 16, 621-632.

Orne, M. T. Implications for psychotherapy derived from current research on the nature of hypnosis. American Journal of Psychiatry, 1962, 118, 1097-1103.

Orne, M. T., & Wender, P. H. Anticipatory socialization for psychotherapy: Method and rationale. American Journal of Psychiatry, 1968, 124(9), 1202-1212.

Ourth, L., & Landfield, A. W. Interpersonal meaningful and nature of termination in psychotherapy. Journal of Counseling Psychology, 1965, 12, 366-371.

Overall, B., & Aronson, H. Expectations of psychotherapy in patients of lower socioeconomic class. American Journal of Orthopsychiatry, 1963, 33(3), 421-430.

Parloff, M. B. Some factors affecting the quality of therapeutic relationships. Journal of Abnormal and Social Psychology, 1956, 52, 5.

Parloff, M. B. Therapist-patient relationships and outcomes of psychotherapy. Journal of Consulting Psychology, 1961, 25, 29-38.

Parloff, M. B., Kelman, H. C., & Frank, J. D. Comfort, effectiveness and self-awareness as criteria of improvement in psychotherapy. American Journal of Psychiatry, 1954, 111, 343-352.

Parrino, J. J. The effects of pre-therapy information on learning in psychotherapy. Doctoral dissertation, Louisiana State University, 1969.

Paul, G. I. Insight vs. desensitization in psychotherapy. Stanford: Stanford University Press, 1966.

Patterson, C. H. Theories of counseling and psychotherapy. New York: Harper & Row, 1973.

Phillips, E. Attitudes toward self and others: A brief questionnaire report. Journal of Consulting Psychology, 1951, 15, 79-81.

Pierce, R. M., Schauble, P. G., & Farkes, A. Teaching internalization behavior to clients. Psychotherapy: Theory, Research & Practice, 1970, 7, 217-220.

Portnoy, I. An initial interview. American Journal of Psychoanalysis, 1950, 10, 48-52.

Raskin, A. Some factors therapists associate with motivation to enter therapy. Journal of Clinical Psychology, 1961, 17(1), 62-65.

Rickard, H. C. Tailored criteria of change in psychotherapy. Journal of General Psychology, 1965, 72(1), 63-68.

Robinson, J. P., & Shaver, P. R. Measures of social psychological attitudes. Ann Arbor: Institute for Social Research, The University of Michigan, 1969.

Rogers, C. R. Counseling and psychotherapy. Boston: Houghton-Mifflin, 1942.

Rogers, C. R., and Dymond, R. F. (Eds.). Psychotherapy and personality change. Chicago: The University of Chicago Press, 1954.

Rogers, C. R. The necessary and sufficient conditions of therapeutic change. Journal of Consulting Psychology, 1957, 21, 95-103.

Rogers, C. R. Client centered therapy. Boston: Houghton-Mifflin, 1951.

Rosenthal, D., & Frank, J. D. Psychotherapy and the placebo effect. Psychological Bulletin, 1956, 53, 294-302.

Rosenzweig, S. A dynamic interpretation of psychotherapy oriented toward research. Psychiatry, 1938, 1, 521-526.

Sauber, S. R. Approaches to precounseling and therapy training: An investigation of its potential influence on process and outcome. Doctoral dissertation, Florida State University, 1971.

Sauber, S. R. Patient training prior to entering psychotherapy. Social Psychiatry, 1972, 7(3), 139-143.

Schofield, W. Psychotherapy: The purchase of friendship. Englewood Cliffs, N.J.: Prentice-Hall, 1964.

Shlien, J. M. Time-limited psychotherapy: An experimental investigation of practical values and theoretical implications. Journal of Counseling Psychology, 1957, 4, 318-322.

Siegel, N., & Frink, M. Motivation for psychotherapy. Comprehensive Psychiatry, 1962, 3, 1970-1973.

Sloane, R. B., Cristel, H. H., Pepernick, M. C., & Staples, F. R. Role preparation and expectations of improvement in psychotherapy. Journal of Nervous and Mental Disease, 1970, 150, 18-30.

Snyder, W. W. The psychotherapy relationship. New York: Macmillan, 1961.

Stein, J. Neurosis in contemporary society. Belmont, Cal.: Brooks/Cole Publishing Company, 1970.

Stoler, N. Client likeability: A variable in the study of psychotherapy. Journal of Consulting Psychology, 1960, 27(2), 175-178.

Stone, A. R., Frank, J. D., Nash, E. H., & Imber, S. D. An intensive five year follow-up study of treated psychiatric outpatients. Journal of Nervous and Mental Disease, 1961, 133, 410-422.

Strupp, Hans H., & Bloxom, A. L. Preparing lower-class patients for group psychotherapy: Development and evaluation of a role-induction film. Journal of Counseling and Clinical Psychology, 1973, 41(3), 373-384.

Strupp, H. H. Psychotherapy revisited: The problem of outcome. Psychotherapy, 1963, 1, 1-13.

Szasz, T. S., & Hollander, M. H. The basic models of the doctor-patient relationship. AMA Archives of Internal Medicine, 1956, 97, 585-592.

Tarachow, S. Introduction to psychotherapy. New York: International University Press, 1963.

Taylor, J. A. A personality scale of manifest anxiety. Journal of Abnormal and Social Psychology, 1953, 48, 285-290.

Thompson, C. Psychoanalysis: Evolution and development. New York: Hermitage Press, 1950, 241-243.

Truax, C. B. Effective ingredients in psychotherapy: An approach to unraveling the patient-therapist interaction. Journal of Counseling Psychology, 1968, 10, 256-263.

Truax, C. B., & Carkhuff, B. R. Toward effective counseling and psychotherapy: Training and practice. Chicago: Aldine Publishing Co., 1967.

Truax, C. B., Wargo, D. G., Carkhuff, R. R., Kodman, F., & Moles, E. A. Changes in self concepts during group psychotherapy as a function of alternate sessions and vicarious therapy pre-training in institutionalized juvenile delinquents. Journal of Consulting Psychology, 1966, 30, 309-314.

Truax, C. B., Shapiro, J. G., & Wargo, D. G. The effects of alternate sessions and vicarious therapy pre-training on group psychotherapy. International Journal of Group Psychotherapy, 1968, 18(2), 186-198.

Truax, C. B., Wargo, D. G., & Volksdorf, N. R. Antecedents to outcome in group counseling with institutionalized juvenile delinquents. Journal of Abnormal Psychology, 1970, 76, 235-242.

Venema, J. R. The effects of expectancy training commitment and therapeutic roading conditions upon attrition from outpatient psychotherapy. Doctoral dissertation, Fuller Theological Seminary, 1970.

Waelder, R. Basic theory of psychoanalysis. New York: International Universities Press, 1960.

Wallach, M. S., & Strupp, H. H. Psychotherapists' clinical judgements and attitudes towards patients. Journal of Consulting Psychology, 1960, 24, 316.

Wallerstein, R. S. The problems of assessment of a change in psychotherapy. International Journal of Psycho-analysis, 1963, 44(1), 31-41.

Warren, N. C., & Rice, L. N. Structuring and stabilizing of psychotherapy for low prognosis clients. Journal of Consulting and Clinical Psychology, 1972, 39, 173-181.

Whallen, C. Effects of a model and instructions on group verbal behaviors. Journal of Consulting and Clinical Psychology, 1963, 33(5), 509-521.

White, A. M., et al. Measure for predicting dropping out of psychotherapy. Journal of Consulting Psychology, 1964, 28, 326-332(a).

White, A. M., Fichtenbaum, L., & Dollard, J. Evaluation of silence in initial interviews with psychiatric clinic patients. The Journal of Nervous and Mental Diseases, 1964, 139, 550-557(b).

Whitehorn, J. C. Psychiatric implications of the "placebo effect." American Journal of Psychiatry, 1958, 114, 662-664.

Widroe, Harvey, & Davidson, Joan. The use of directed writing in psychotherapy. Bulletin Menninger Clinic, 1961, 25, 110-119.

Williams, H. V., Lipman, R. S., Uhlenhuth, E. H., Rickels, K., Covi, L., & Mock, J. Some factors influencing the treatment expectations of anxious neurotic outpatients. Journal of Nervous and Mental Diseases, 1967, 145, 208-220.

Wilkin, Wallace. Expectancy of therapeutic gain: An empirical and conceptual critique. Journal of Consulting and Clinical Psychology, 1973, 40, 69-77.

Wolberg, Lewis R. The technique of psychotherapy. New York: Grune & Stratton, 1954.

Wolff, W. M. Psychotherapeutic persistence. Journal of Consulting Psychology, 1967, 31, 429.

Wolman, B. B. (Ed.). Success and failure in psychoanalysis and psychotherapy. New York: McGraw-Hill Book Co., 1975.

Wolpe, J. Psychotherapy by reciprocal inhibition. Stanford: Stanford University Press, 1958.

Wolpe, J. The systematic desensitization treatment of neuroses. Journal of Nervous and Mental Diseases, 1961, 132, 189-203.

Wolpe, J. Behavior therapy in complex neurotic states. British Journal of Psychiatry, 1964, 118, 28-34.

Yalom, Irwin D., Houts, Peter S., Newell, G., & Rand, K. H. Preparation of patients for group therapy. Archives of General Psychiatry, 1967, 17, 416-427.