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**THE EFFECTS OF VIDEOTAPED PREPARATORY INFORMATION  
ON CLIENTS' EXPECTATIONS, ANXIETY  
AND PSYCHOTHERAPY OUTCOME**

**A thesis presented in partial  
fulfilment of the requirements for the degree  
of Doctor of Philosophy  
in Psychology at  
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## ABSTRACT

The aim of the present study was to determine the effects of videotaped preparatory information on the accuracy of clients' expectations about psychotherapy, state anxiety, and psychotherapy outcome using a Solomon four-group design. The relationships among these variables were also investigated. One hundred and thirty-eight adult clients attending for their first psychotherapy session with a clinical psychologist participated in the research. Clients were randomly assigned to either the experimental condition where the preparatory video was seen prior to the session, or to the control condition where clients followed usual clinic procedure and waited to be seen prior to their first session. Half of the clients completed both pre- and posttest measures while half completed posttest measures only. At the end of the first session, symptom severity and target complaint measures were completed by the psychologist. After two months, or at the completion of treatment if this occurred sooner, follow-up measures were completed by both clients and psychologists. The results confirmed that clients who viewed the video had more accurate expectations about psychotherapy and experienced a significant reduction in state anxiety when compared to control group subjects. These differences were not maintained at two month follow-up. Expectations did not mediate the effects of preparation on state anxiety. In addition, at follow-up there was significantly greater improvement on only one of the ten outcome measures for the group viewing the preparatory video. To conclude, the video preparation had immediate effects on the accuracy of clients' expectations and reduced state anxiety. The relationships between these variables were not as hypothesised and need further clarification. Longer-term effects of the preparation on psychotherapy outcome were almost nonexistent. It is argued that long-term effects may be difficult to detect because they are relatively small and most studies which incorporate alternative treatments in their design have insufficient power. Changes in the accuracy of clients' expectations and state anxiety which occur naturally over the course of psychotherapy may also contribute to the lack of consistent long-term benefits being found as result of pretherapy preparations.

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## CHAPTER 1

### INTRODUCTION

#### *1.1 Overview of the introduction*

This project evolved out of an interest in the early stages of the psychotherapy experience, and a desire to conduct applied research which would also make some theoretical contribution. The present study is divided into two parts. The first part assesses the immediate effects of videotaped preparatory information on clients' initial anxiety and expectations of psychotherapy and explores the relationships among these variables. The second part assesses longer term effects of the video by examining clients' "recovery" as measured by a variety of psychotherapy outcome measures two months after the beginning of psychotherapy. The relationship between anxiety at entry and subsequent outcome is also investigated.

Preparations for psychotherapy have been shown to increase the accuracy of clients' expectations and to lead to improved psychotherapy outcomes, but no consistent effects on anxiety have been established. In contrast, preparatory information for stressful medical procedures has been found to reduce patient anxiety during the procedure, increase the accuracy of patients' expectations, as well as improving subsequent recovery. In the following chapters the findings from both fields are integrated in an attempt to clarify the relationship between clients' expectations, initial state anxiety and subsequent outcomes in psychotherapy.

The first chapter briefly describes anecdotal and research evidence that suggests clients experience considerable anxiety about psychotherapy. It has already been established that clients enter psychotherapy with a set of expectations about what will occur. These expectations are considered accurate or confirmed if they are consistent with what actually occurs in psychotherapy. When the psychotherapy experience differs from what the client anticipated, the client's expectations are considered "disconfirmed". Chapter two briefly introduces a theory which predicts the negative effects of disconfirmed expectations in psychotherapy.

In an effort to reduce the potentially negative effects of disconfirmed expectations a number of researchers have attempted to manipulate clients' expectations through various information provision techniques. The manipulation of expectations in psychotherapy is described, focusing on the types of expectations manipulated and the preparation strategies used to manipulate expectations.

Chapter three describes the effects preparation and expectation manipulation have on psychotherapy process and outcome for child and adult samples. The focus then narrows to critically evaluate the few studies which have attempted to investigate the relationship between preparation, expectations and anxiety.

While there is little research in the psychotherapy area which relates preparation, expectations and anxiety, there is a relative wealth in the area of preparation for stressful medical procedures. Chapter four summarises the theory and research related to information provision as preparation for stressful medical procedures. This body of research provides models for explaining the relationships between expectations, anxiety and therapeutic outcomes.

Chapter five discusses the methodological shortcomings from both preparation for stressful medical procedures and preparation for psychotherapy research and suggests solutions to these problems. In Chapter six, the final chapter of the introduction, the aims and scope of the present study are specified, along with definitions of relevant concepts and the research hypotheses.

Before examining the complexities of theory and research which are important to the present study, the following section attempts to provide some anecdotal and research data to highlight the similarities between the early psychotherapy experience and other stressful procedures.

## *1.2 Is psychotherapy like going to the dentist?*

Imagine the thoughts and feelings experienced while waiting in the reception area of the dentists surgery. There is ample evidence suggesting that people in this situation experience increased levels of anxiety (Ackerman & Endler, 1985; Auerbach, Kendall, Cuttler, & Levitt, 1976; Kent, 1987, 1985; O'Shea, Corah & Thines, 1986; Wardle, 1982). Endler (1980) proposed three situational factors which have consistently been associated with the experience of anxiety; physical danger, ambiguity, and threats to interpersonal status (e.g. self-esteem). Waiting to have a cavity filled or tooth removed by the dentist clearly involves the threat of pain and physical danger, and possibly some elements of ambiguity. Most people have been in this situation at one time or another making it easier to identify and understand the apprehension, worry and tension that is often experienced.

It is probably more difficult to imagine what it is like waiting in the reception area of an outpatient psychiatric clinic. While people may vary in their reactions to meeting a therapist for the first time, it is probable that some degree of apprehension, worry or anxiety would be felt by all. It is a situation which is ambiguous, and where interpersonal status is potentially threatened, two of the three situational factors which have been consistently associated with anxiety (Endler, 1980).

Some evidence that attending a psychiatric clinic for the first time is difficult and may be anxiety provoking is provided in studies which have attempted to determine why clients do not keep their appointments. Noonan (1973) telephoned 64 clients who did not attend their first appointment at a university based psychiatric outpatient clinic and found that 39% were unable to explain why they had not attended, saying they had forgotten or giving no specific reason. The second group (35%) indicated that their problems had improved so that treatment became unnecessary. Twenty-three percent "...stated that they had not arrived because of anxiety regarding what they might encounter or become involved in.", (p.44).

Recently investigators have begun to evaluate fear of psychological treatment more directly. In a study of college students it was found that "treatment avoiders" who said they had needed treatment in the past but had not sought it out, experienced the highest level of treatment fearfulness. Subjects who "never needed treatment" had next highest level of treatment fearfulness, while subjects who "needed treatment and sought it" showed



the least fear. The study also found those subjects about to enter into psychological treatment reported less treatment fearfulness than those who were not considering such services (Kushner & Sher, 1989). These findings were consistent with the authors hypothesis that increased treatment fears led to service avoidance. They viewed treatment fearfulness as "a subjective state of apprehension arising from aversive expectations surrounding the seeking and consuming of mental health services.", (Kushner & Sher, 1989, p.251). If this view is correct then it could be expected that clients who have accurate information about treatment would have less aversive expectations and may also experience less apprehension and fearfulness.

Prior treatment experience is one source of information about treatment and there is evidence indicating people who had prior therapy tended to keep their initial appointment more often than those who had not been in therapy before (Carpenter, Morrow, Del Gaudio, & Ritzler, 1981). One of several possible explanations for this finding is that those people with prior therapy experience have more accurate expectations about what occurs in therapy and are therefore less fearful and less hesitant to return.

These studies suggest that some clients without prior exposure to mental health services may be so anxious about what treatment may hold for them that they avoid attending. It is reasonable to suppose that providing new clients with information about psychotherapy would help decrease the ambiguity of the experience, provide them with more accurate expectations and decrease their anxiety about psychotherapy.

Preparation for psychotherapy has focused on information provision as a way of manipulating clients' expectations, more specifically, improving the accuracy of their expectations. As noted earlier no relationship between preparation, expectations and anxiety has yet been examined in relation to preparation for psychotherapy. The focus has clearly been on the manipulation of clients' expectations. Consequently it is appropriate to begin by clarifying terms related to the study of expectations and then introduce theory backgrounding the research on preparation, expectations and psychotherapy.

## CHAPTER 2

### GREAT EXPECTATIONS

*"What can you expect from counselling?  
Perhaps it might be better to start  
by mentioning what not to expect!"  
(Mourant, 1989, p.104).*

#### 2.1 Clarifying terms

"Expectation refers to the person's understanding of the probability that an event will occur", (Tinsley & Westcot, 1990, p.223). In other words expectations refer to clients anticipation and preconceived ideas about what will occur in psychotherapy.

One of the first reviews of research on expectations (Goldstein, 1962 cited in Duchro, Beal & George, 1979) differentiated two types of expectations relevant to the study of psychotherapy: prognostic expectations and participant role expectations. Prognostic expectations involve therapist and client assessment of the probability of success in psychotherapy. Participant role expectations are related to therapist and client anticipations of behaviour to be displayed in the therapeutic relationship. These include expectations regarding therapist characteristics, therapist behaviour, client behaviour, type of therapy, therapeutic process and procedures.

Prognostic expectations are specific to anticipation of therapeutic gain only and are considered a nonspecific factor or common element of many therapeutic interventions (Strupp & Hadley, 1979). Prognostic expectations have been examined in a variety of contexts (e.g. from systematic desensitization to medication placebo effects). A full review of this research can be found elsewhere (e.g. Kazdin & Wilcoxon, 1976; Wilkins, 1973). It is generally accepted that clients' and therapists' expectations of improvement in psychotherapy are positively related to the degree of subsequent improvement (Barker, Funk, & Houston, 1988; Martin & Sterne, 1975), although the relative degree of importance they have compared to other factors is yet to be fully established (Garfield, 1986).

The present review will focus on participant role expectations since the present study emphasizes and focuses on role expectations in the preparatory video. Prognostic expectations are restricted to the anticipation of therapeutic gain only, while role expectations refer to a wide variety of therapy factors, consequently the review of role expectations covers theoretical and methodological issues common to the research related to prognostic expectations.

Reference to the accuracy of clients' role expectations can be found under a number of subject headings or classifications. Disconfirmed expectations, incongruent expectations, discrepant expectations and inaccurate expectations are all overlapping terms which refer to some difference between what the client anticipated and what actually occurred or was perceived to have occurred in psychotherapy. These terms may reflect a slightly different emphasis between studies, for example, the term incongruence usually relates to differences between client and therapist expectations, while disconfirmation relates to client expectations being different to what they actually experience. Despite these differences the terms all relate to the accuracy of clients' expectations.

Similarly, expectation manipulation, role induction, orientations, pretherapy induction, preparation, preparatory information and information provision are all terms relevant to the study of expectation manipulation. These terms may differ slightly in their specificity, but all involve providing potential clients with information about some aspect of therapy. Different terms may reflect an emphasis on providing particular types of data, focus on a particular goal or specific expectations, but they still reflect a potential to change clients' expectations.

## **2.2 Theoretical background**

Perhaps one of the greatest limitations in the study of participant role expectations in psychotherapy has been the lack of comprehensive and consistent theory.

This has occurred in part because so many theories have been capable of explaining the effects of expectations. Biddle (1958 cited in Duckro et al, 1979) drew from social psychology to predict the effects of disconfirmed expectations on subjects' satisfaction with the initial interview. Festinger's (1957) cognitive dissonance theory was used by Sasseeen (1976) to explain the effects of disconfirmed expectations in psychotherapy. Bandura's (1977) self-efficacy theory was used to explain the effects of expectations in group therapy

(Mayerson, 1984). Tinsley and Westcot (1990), traced counselling psychologists' interest in expectations to social learning theorists such as Rotter (1954) and Tolman (1932) who viewed learning as a function of a person's expectations about an event. Tinsley and Westcot (1990) maintained that this led to the conceptualization of psychotherapy as a one-to-one social learning relationship, in which the congruence of client and therapist expectations could facilitate or impede the overall effectiveness of the counselling process.

Kelly (1955) was perhaps the first to directly address client role expectations specifically related to the psychotherapy experience, although from a general theoretical standpoint. More importantly he also began discussing the consequences of failing to confirm clients' expectations. He postulated that most clients had a highly personal concept of the nature of the psychotherapy relationship even prior to the commencement of treatment. He argued that particularly in the early stages of treatment the psychotherapist must "take the view that he starts with whatever limited conceptualization of psychotherapy the client is initially able to formulate...this does not mean that the clinician must adopt the clients construction of psychotherapy, but it does mean that he must be able to utilize it.", (Kelly, 1955, p.567).

The core of Kelly's (1955) theory is that humans continually attempt to predict and control the events they experience. When there is a lack of consistency between predicted and experienced events, or when expectations are disconfirmed by events, the person experiences anxiety. In Kelly's view the content of the expectations and events is irrelevant to the arousal of anxiety. It is the inconsistency between expectations and events which leads to anxiety.

More elaborate and multidimensional theories regarding the potential effects of clients' expectations in psychotherapy have been proposed and tested (e.g. Block (1964) tested McClelland, Atkinson, Clark and Lowell's (1953) achievement motive theory). However, Kelly's proposition remains of interest and importance for several reasons: he appeared to be both the first to address the role of expectations specifically related to psychotherapy, and the first to mention anxiety as a consequence of disconfirmed expectations. Subsequent research into preparation for stressful medical procedures has provided additional support for a relationship between expectations and anxiety (e.g. Hartfield, Cason & Cason, 1982), but Kelly's hypothesis regarding disconfirmed expectations and anxiety in psychotherapy has not been fully tested.

### 2.3 Disconfirmed role expectations in psychotherapy

Initial research attempted to test the hypothesis that disconfirmation of client role expectations led to negative consequences. A range of negative effects were identified.

Clients with disconfirmed or discrepant expectations:

1. Were found to be less satisfied with therapy, (Gladstein, 1969; Goin, Yamamoto & Silverman, 1965; Isard & Sherwood, 1964; Severinson, 1966);
2. Tended to drop out or terminate therapy earlier (Baekeland & Lundwall, 1975; Borghi, 1968; Garfield & Wolpin, 1963; Heine & Trosman, 1960; Overall & Aronson, 1963; Sandler, 1975);
3. Had poorer psychotherapy outcome (Dougherty, 1973; Gulas, 1974; Webb & Lamb, 1975) and;
4. Had poorer quality psychotherapy process such as being more avoidant in the interview (Pope, Siegman, Blass, & Cheek, 1972; Ziemelis, 1974).

These results initially led to quite widespread acceptance of the hypothesis that disconfirmed role expectations led to negative consequences in psychotherapy. Subsequently the consistency of these findings have been questioned (Duckro et al., 1979). For example, Horenstein and Houston (1976) found no relationship between the disconfirmation of clients' expectations of therapist role and therapy outcome. Their study was notable because they hypothesised that the relationship between expectation discrepancy and psychotherapy outcome was not linear. Most researchers prior to this study had proposed or assumed a linear relationship whereby the greater the expectation discrepancy the poorer the outcome and the greater expectation congruency the better the outcome.

Horenstein and Houston (1976) proposed a parabolic relationship between expectation discrepancy and therapeutic outcome, where high discrepancy led to unsuccessful outcome, moderate discrepancy led to successful outcome, and low discrepancy led to "marginally successful psychotherapy". None of their analyses confirmed a linear trend, and there was only limited support for a curvilinear relationship. Although the authors went on to hypothesize the possibility of moderating factors determining the presence of linear or curvilinear relationships, the majority of the research continued to operate under the assumption that a linear relationship existed between disconfirmed expectations and psychotherapy outcome.

A critical review by Duckro et al. (1979) indicated the research was almost evenly divided with 21 studies supporting and 22 studies not supporting the hypothesis that the greater the disconfirmation of expectations the more negative the effects on psychotherapy. They suggested the source of variation in the findings may have been due to:

1. Imprecise and unreliable operationalization of independent variables;
2. Unclear definitions of expectations and;
3. Incomplete and inappropriate theory.

Subsequent work has addressed the first two of these shortcomings. Unfortunately the development of adequate theory was never fully accomplished. Similarly the effects of disconfirmed expectations on process and outcome was never fully clarified.

Even prior to Duckro et al.'s (1979) review, research interest began to move toward a potentially more fruitful area, the manipulation of client expectations. The underlying logic of this trend seemed to rest on the assumption that if disconfirmation led to negative effects, confirmation should lead to the elimination of these negative effects and possibly positive consequences in psychotherapy.

## **2.4 Manipulation of expectations**

Tinsley, Bowman and Ray (1988) completed an ambitious review of the expectation manipulation literature. They argued that if information provision changed a clients' perceptions of psychotherapy it was logically consistent to assume it would change the clients' expectations of the procedure. In this context perceptions refer to the past or present, and knowledge gained about an event through experience or observation. Only studies including some attempt at manipulation of expectations versus simply measuring them were included in the review. A wide range of subjects were used in the samples: children; counselling, rehabilitation and community mental health centre clients; university students; psychiatric outpatients; and veterans receiving vocational counselling.

Although Tinsley et al. (1988) included articles which used the term "role induction", it is possible this was still not comprehensive enough and neglected terms which implied expectation manipulation (i.e. preparation). A potential shortcoming of the review was the absence of several studies which appeared to meet the reviewers criteria for inclusion (Day

& Reznikoff, 1980a; Dibner, Palmer, Cohen & Gofstein, 1963; Francois, 1978; France & Dugo, 1985; Hagebak, 1968; Hoehn-Saric, Frank, Imber, Nash, Stone & Battle, 1964; Holliday, 1979; Holmes & Urie, 1975; Reeves, 1978; Richardson, 1977; Schonfield, Stone, Hoehn-Saric, Imber, & Pande, 1969; Sloane, Christol, Pepernik & Staple, 1970; Strupp & Bloxom, 1973; Wilson, 1985; Yalom, Houts, Newell, & Rand, 1967; Zweben & Li, 1981; Zwick & Attkisson, 1985).

These omissions seemed to occur in part because the broader concept of "preparation" was not included as a key word for the review search. Despite definitional problems Tinsley et al's (1988) computer and manual searches of Psychological Abstracts and Dissertation Abstracts International generated 190 references with 46 meeting the inclusion criteria.

Although this review may have missed a number of studies which could have contributed to its conclusions, it provides a good representation of the expectation manipulation research. While the Duckro et al. review (1979) cited eight studies related to the manipulation of expectations, the strength of Tinsley et al. (1988) review was that it provided the first systematic review of the literature specifically related to expectaton manipulation. It reviewed the large number of unpublished dissertations which seemed to dominate work in the area, and clearly outlined recurring methodological problems. The expectation manipulation area would also currently benefit form a meta-analytic review and Gelso and Fassinger (1990) suggested the "voluminous literature" in the more general area of expectancies "...seems ripe for a large-scale review.", (p.362-3). Any attempt at reviewing expectation research will always be complicated by the variations in terminology and difficulty in converage of an area which is relevant to so many aspects of psychology.

## **2.5 Types of expectations manipulated**

The types of expectations manipulated have varied considerably. Tinsley et al., (1988) grouped these into five categories:

1. Expectations regarding therapist characteristics such as expertness, helpfulness, attractiveness and/or trustworthiness. The manipulation typically involved presenting subjects with a low or high prestige/credible therapist.
2. Prognostic expectations regarding the anticipation of therapeutic gain. Subjects were typically presented with positive or negative statements regarding the likely success of therapy.

3. Expectations about the therapist behaviour or type of therapy. Clients were usually given information about therapist behaviours such as whether they were directive/nondirective, amount of time they may be silent, or the degree of advice-giving used.
4. Expectations of client behaviours and role. This typically involved information provision in an effort to make client role expectations more realistic. Typical issues addressed were the degree of participation, communication or self-disclosure.
5. Expectations about general counselling process and procedures. Information about duration of therapy, adherence problems, therapeutic process (e.g. resistance), or functions of therapy were provided to subjects.

One of Tinsley et al.'s (1988) criticisms relating to the types of expectancies manipulated was that many of the studies reviewed focused "...on an exceedingly limited range of expectancies.", (p.105). Duckro et al. (1979) in referring to problems of imprecisely defined and globally assessed expectations implied that there were advantages in narrowing the numbers of expectancies studied. The main advantage appeared to be the use of measurement instruments which had sufficient items and were behaviourally precise enough to reliably assess role expectations. Although narrowing the number of expectations may allow more accurate assessment instruments while maintaining their brevity, there are a number of potential disadvantages. Tinsley et al. argued that attempting to relate a person's expectancies to their behaviour in therapy required the study of a broad range of expectancies because complex human behaviour typically had multiple causes. Since researchers are often measuring variables which account for a very limited proportion of the total variance in behaviour it may be important to study as many of the variables as possible to account for the maximum amount of variance.

It is also worth noting that Kelly's (1955) theory indicated that the content of the expectations was relatively unimportant since it was the inconsistency of expectations in relation to what actually occurred which aroused anxiety. With this in mind it would appear important to improve the congruence of as broad a range of expectations as possible in order to decrease the probability of arousing anxiety.

It may be prudent for future research to first establish the effects of expectation manipulation utilizing a wide range of expectation types. Once treatment effects have been consistently established, the most effective ingredients in the intervention can then be sorted out.



## 2.6 Manipulation strategies

Expectancy manipulation strategies range from simple printed instructions through to complicated methods utilizing a variety of media presentations. The Tinsley et al. (1988) review identified at least 13 expectancy manipulation strategies and grouped these into 6 categories:

1. The counselling interview (e.g. Hoehn-Saric, et al., 1964; Mosby, 1972);
2. Verbal instructions (e.g. Childress & Gillis, 1977; Ziemelis, 1974);
3. Printed materials (e.g. Garrison, 1978; Heilbrun, 1972; McGill, 1986; McKee & Smouse, 1983);
4. Audiotaped interventions (e.g. Bonner & Everett, 1982; Friedlander & Kaul, 1983);
5. Videotaped interventions (e.g. Day & Reznikoff, 1980a; Thompson & Mountain, 1987; Zwick & Attkisson, 1985) and;
6. Complex interventions which involve combinations of the other interventions (e.g. Rosenzweig, 1974).

The earliest attempts to manipulate client expectations used interview formats. One influential study was that of Hoehn-Saric, et al., (1964). This group systematically studied client preparation for psychotherapy in relation to psychotherapy process, outcome, and client and therapist variables (Frank, Gliedman, Imber, Stone, & Nash, 1959; Nash, Hoehn-Saric, Battle, Stone, Imber, & Frank, 1965). They used a "Role Induction Interview" based on the "Anticipatory Socialisation Interview" of Orne and Wender (1968). This was designed to give the client appropriate expectations regarding client and therapist roles, the time it would take to expect improvement, and about typical therapy phenomena such as resistance. Those in the prepared group: had significantly better attendance (13.8 versus 11.5 sessions,  $p < .02$ ); were rated better on the Therapy Behaviour Scale (mean scores 40.2 and 34.8,  $p < .01$ ); were rated by therapists more favourably in terms of establishing and maintaining a therapeutic relationship (3.4 versus 2.8,  $p < .05$ ); had more positive outcomes on therapists' ratings of improvement (3.5 versus 2.9,  $p < .05$ ); had higher client ratings of target symptom improvement (4.1 versus 3.4,  $p < .05$ ); and greater improvement on social ineffectiveness ratings (22 versus 16,  $p < .05$ ). These results were replicated in a subsequent study by Schonfield, et al. (1969). However the results of the studies also produced a number of nonsignificant effects on

outcome and even the significant treatment effects appeared to be relatively weak.

The main advantage of verbal interventions such as counselling or role induction interviews, was that clients' questions and expectations could be dealt with on an individual basis with more attention to their specific needs (Heitler, 1976). The disadvantages were their lack of standardization resulting in greater variability in the types of information provided to different clients, and that they required more time and were consequently more expensive.

The use of video and audiotaped interventions decreased the variability in expectation manipulation providing more control for research purposes. Perhaps most importantly video and audiotaped interventions were found to be as or more effective than printed and verbal interventions (Tinsley et al., 1988). This conclusion has been supported by a number of other studies which have directly compared the effectiveness of video versus written or verbal interventions (Barry & Daniels, 1984; Strupp & Bloxom, 1973; Zweben & Li, 1981).

## CHAPTER 3

### THE EFFECTS OF PREPARATION AND EXPECTATION MANIPULATION ON PSYCHOTHERAPY PROCESS AND OUTCOME

#### *3.1 Previous reviews*

A major flaw in the research into the effects of expectation manipulation on therapeutic outcome and process has been the lack of adequate manipulation checks. A manipulation check directly assesses the effects of an expectancy manipulation (or treatment) instead of assuming the manipulation is effective if the outcome data indicates improvement. This can be done by giving clients a measure which helps determine whether they attended to and understood the material, and to present evidence that anticipated expectancy change occurred (e.g. Zwick & Attkisson, 1984).

Of the 46 articles included in the Tinsley et al. (1988) review, 24 attempted to manipulate the subjects' expectations in order to determine the effects of this change on some aspect of the therapeutic process or outcome. A major fault of 18 of these investigations was the failure to perform a manipulation check. Nine of the 18 studies which failed to perform manipulation checks found some change in the therapeutic process and/or outcome. However the lack of manipulation checks made it impossible to ascribe these changes conclusively to the expectation manipulation.

Four of the six studies which included a manipulation check, found the manipulation had an effect on expectations (Tinsley et al., 1988). Only one of these were reported to have found a subsequent effect on the therapeutic process (Marek, cited in Tinsley et al., 1988). Of the two studies which did not find the change on expectations, one reported a change in the therapeutic process while the other did not (Tinsley et al., 1988).

These results raise doubts about the efficacy of expectation manipulation as a means of improving therapeutic process and outcome. However, in many of these studies some improvement in outcome was found but the lack of manipulation checks severely limits the strength with which we can make statements about the cause of the findings. Additional support is available from studies which were not reviewed by Tinsley et al. (1988). These studies may not have been reviewed because they referred to preparation and information provision in general and not specifically to expectations. However where it is demonstrated

that the preparations improved clients' knowledge and understanding of therapy it is highly likely this also increased the accuracy of their expectations. Unfortunately many of those not reviewed by Tinsley's group also neglected to provide manipulation checks (e.g. Birnbaum, 1975; France & Dugo 1985; Francois, 1978; Hoehn-Saric et al., 1964; Yalom et al., 1967; Sloane et al., 1970; Wilson, 1985). Almost all were able to confirm some of the predicted benefits on their multiple process or outcome measures, but for each confirmation there appeared to be another predicted effect which was not confirmed. Orlinsky and Howard (1986) reviewed several of these and other studies not included in the Tinsley et al., review. In all 34 different outcomes were drawn from the 18 studies. Twenty-one of the 34 findings showed significantly better outcomes for patients who received some form of role preparation and no study demonstrated a significant negative effect for preparation (Orlinsky & Howard, 1986). While this limited review confirmed that preparation was able to improve outcomes, it was not as critical or comprehensive as Tinsley et al., (1988) who also clarified the presence of manipulation checks.

Even when a manipulation check is included it may be of questionable value as in the study by Strupp and Bloxom (1973) who attempted to determine the effectiveness of their pretherapy preparations, but used an inadequate manipulation check. They used only three Likert type items. One asked the therapist to rate the client's understanding of therapy and the client's role. The other two asked the client to rate whether they expected to play an active role in therapy and whether they understood the therapist's restraint in offering direct suggestions and solutions. Prepared clients gave ratings which indicated more accurate expectations as a result of the manipulation. They also had more improvement than unprepared clients on: satisfaction; in session therapist ratings of appropriate behaviour; client ratings of post-therapy global improvement; client ratings of specific target symptoms, and self-understanding. No differences between prepared and unprepared groups were found on attendance, therapist ratings of outcome or symptom discomfort.

Studies which have included satisfactory manipulation checks provide the clearest test for the effectiveness of expectation manipulation in improving therapeutic outcome. The following is an updated review of those studies including some form of manipulation check, which were not included in the Tinsley et al. (1988) review. These are divided into two sections, those related to child psychotherapy and those related to adult psychotherapy.

### 3.2 Preparation and expectation manipulation in child psychotherapy

There has been growing research interest related to preparation of parents and children for child psychotherapy. The research stems mainly from concern about the effects incorrect expectations may have on attendance and the treatment process (Day & Reznikoff, 1980b; Bonner & Everett, 1982).

All of the studies reviewed have demonstrated that preparation was able to improve children's and/or parents' knowledge or expectations of psychotherapy (Bonner & Everett, 1986; Coleman & Kaplan, 1990; Day & Reznikoff, 1980a; Holmes & Urie, 1975; Weinstein, 1988). About half were also able to find some improvement in process or outcome variables.

Weinstein's (1988) preparation of 36 children for psychotherapy, while increasing their understanding of therapy, did not find prepared children adapted to the client role any better than those in the control group. Neither was there any significant preparation effect for attendance and dropout measures. Bonner & Everett's (1986) preparation was effective at improving children's and parents' attitudes and expectations of psychotherapy, but no relationship was found between attitudes and expectations. They did not investigate any other process or outcome variables.

Coleman and Kaplan (1990) found preparation improved outcome for children over the course of four therapy sessions. Prepared mothers rated their children as having fewer problematic behaviours than did non-prepared mothers who rated their children. Holmes and Urie (1975) had 88 children participate in either a pretherapy preparation interview or a social history interview "that was irrelevant to therapy." As in Sloane et al's (1970) study they took care to not to include information regarding prognosis or expectations of improvement so that prognostic expectations were not mixed with other information. Prepared clients scored significantly higher than nonprepared clients on the Understanding of Therapy Questionnaire indicating that preparation was effective in providing clients with more information and a better understanding of therapy. They found a significantly lower proportion of prepared (25%) than nonprepared (37.4%) clients dropped out of therapy. None of the process data or data on initial levels of disturbance (a total of six therapy variables) could account for these differences. Preparation did not affect four other therapist assessment measures, nor two parent assessment measures. It was concluded that because therapy information was not confounded with therapy prognostic expectations a

substantial proportion of the variance in therapy continuation was due to the information component of the therapy preparation. Although prepared clients did not appear to benefit more from therapy than nonprepared clients on a number of other process and outcome measures, the fact that preparation reduced premature terminations suggested that preparation enabled more clients to avail themselves of the potential benefits of therapy.

Day and Reznikoff (1980a) completed a similar study at a children's psychiatric unit using videotaped modeling as the preparation procedure. Both parents and children who had seen the videotape had a significantly greater number of correct expectations than did the parents and children in the control group who viewed the control tape. Consistent with Holmes and Urie's (1975) findings the prepared group had fewer broken appointments than did the nonprepared group,  $F(1,27) = 4.90$ ,  $p < .05$ . Although the preparation did not produce a significant effect on dropping out, dropping out was related to incorrect expectations. Preparation was not found to have an effect on children's verbalizations in the sessions or on their satisfaction with therapy.

One of the relatively consistent findings of these studies was that the accuracy of expectations was related to service utilization measures such as dropout or attendance. Similarly, those addressing treatment dropout problems more directly, have commented that much of the dropout problem is related to discrepant client-therapist expectations and that one potential solution to the dropout problem may be to provide pretherapy preparation (Pekarik, 1985a). There is some evidence that interventions which informally increase parents' knowledge and clarify expectations of the treatment setting as part of administrative intake procedures may also improve attendance (Deane, 1991a).

### 3.3 Preparation for adult outpatient psychotherapy

The ability of preparation procedures to modify clients' expectations has been more variable in studies using adult samples. All three role induction procedures utilized in a study of substance abusing patients failed to reduce the discrepancy in treatment expectations between patients and therapists, (Zweben & Li, 1981). Predictably they also failed to find significant differences in clinic attendance between clients in the role induction and control groups. This study may also have been biased by not using strict random assignment to groups.

Holliday (1978) reported limited support for her preparation of community mental health clients in that prepared clients expected the therapist to have a significantly greater psychological focus in therapy than control clients. Unfortunately information regarding other changes in expectations or knowledge was not available to determine the full effectiveness of the preparation. While prepared clients showed improvement on a number of process and outcome variables these differences did not achieve statistical significance.

Hoyt (1980) found clients who were given a pretherapy induction interview had expectations which were significantly more congruent with their therapist's than an attention control interview and no interview group. However, low client/therapist expectancy congruence was not associated with unfavourable psychotherapy outcome. Clients who received preparation did have better outcome ratings by therapists, but these were attributed to more appropriate therapy behaviour and better attendance.

Work conducted by Zwick and Attkisson (1984, 1985; also Larsen, Nguyen, Green, & Attkisson, 1983), provides some of the strongest support for preparation for psychotherapy improving therapeutic outcome particularly for adult psychotherapy clients. They studied the effects of a videotaped orientation on clients first entering outpatient psychotherapy. This study was particularly rigorous in that it utilised: random assignment of subjects from a community mental health setting; a pre-test, post-test design with 1 month follow-up; manipulation checks; a videotaped format to present a wide range of information about psychotherapy; a wide variety of outcome measures using instruments of good reliability and validity; and attention to the effects of prior therapy experience. When suitable instruments were not available the authors developed ones with satisfactory psychometric properties (Zwick & Attkisson, 1984, 1985; Attkisson & Zwick, 1982; Larsen, Attkisson, Hargreaves & Nguyen, 1979).

They found their prepared clients were able to understand the information in the videotape presentation as indicated by significantly higher scores obtained on the Psychotherapy Questionnaire which measured the accuracy of clients' information about psychotherapy. Clients in both the prepared and nonprepared groups showed improvement in self-reported symptoms, therapist ratings of client symptomatology, and therapist ratings of global functioning at the one month follow-up. However, prepared clients showed significantly greater decreases in self-reported symptoms than the control group. Finally there were indications that prepared clients with minor disorders and no past therapy experience obtained the greatest self-reported symptom reductions.

Predictably, not all of the methodological problems of previous research in the area were corrected. Despite randomisation there were differences between the control and experimental group. While 77% of the control group reported prior therapy experience and were diagnosed with "major mental disorder", only 41% of the prepared group reported prior experience and were similarly diagnosed. The design allowed assessment of knowledge about psychotherapy after one month, but did not determine immediate gains in knowledge as a result of the videotape. This may have been particularly important in view of initial differences in group composition.

While Zwick and Attkisson (1985) found differences in their prepared and control groups' knowledge of psychotherapy at one month, it is less clear whether these differences are maintained beyond this point. The next section addresses the issue of the maintenance of these differences and the duration of preparation effects on expectations.

### **3.4 Persistence of preparation effects on expectations**

In summarising the direction for future work related to expectations, Hardin and Subich (1985) considered one of "The most critical questions that remain to be answered concern... how expectations are modified over the course of counseling." (p.134). In general, those clients who do not receive preparation, but still participate in psychotherapy could be expected to have increased information about the experience as a result of their participation and subsequent modification of their expectations. Preparation provides information and modifies expectations prior to the experience with the aim of reducing the negative effects thought to result from disconfirmed or incongruent expectations. Although clients' attendance may be affected as a result of having their expectations disconfirmed (e.g. Day & Reznikoff, 1980a; Holmes & Urie, 1975; Hoyt, 1980), if they remain in therapy their expectations regarding the experience should become more accurate with time.

Some empirical support for this last proposition was found in Duckro et al's (1979) review related to disconfirmed expectations. It was suggested that client and therapist role expectations become more congruent as therapy progresses (Duckro et al., 1979). Although this may involve a mutual coming together of client and therapist expectations, it is more likely the result of the client's increased understanding of how psychotherapy operates. Most studies assessing the longer term effects of preparation for psychotherapy



have not included a measure of expectations beyond the immediate assessment following the intervention (e.g. Coleman & Kaplan, 1990; Holmes & Urie, 1975; Strupp & Bloxom, 1973; Thompson & Mountain, 1987). Thus there is little data regarding the relative change in the accuracy of expectations for prepared and unprepared clients over the course of psychotherapy.

An exception is Day and Reznikoff's (1980a) study where children and parents were prepared for treatment. As noted earlier both the children and parents who viewed the preparation videotape began the first session with a significantly greater number of correct expectations than the nonprepared group. However by the end of the sixth treatment session there was no longer a significant difference between prepared and nonprepared parents and children on the number of correct expectations (although this still approached significance,  $F(1,27) = 4.13, p < .06$ ). The implication of these findings are that clients' expectations undergo some change process over the course of psychotherapy, so that the differences between prepared and control subjects become insignificant as therapy progresses.

To summarise, prior research which uses information provision to prepare clients for psychotherapy provides strong support for the ability of these preparations to modify clients' expectations. There is also evidence to suggest that clients' expectations may undergo some correction as a result of experience in psychotherapy, without the benefit of preparation. Accordingly it is hypothesised that any short-term group differences in the accuracy of expectations following preparation disappear over the longer-term course of psychotherapy. The effects of preparation on outcome variables is less consistent, but shows promise for providing clients with some additional benefits on psychotherapy outcome variables. If preparation is associated with greater improvement on psychotherapy outcome, but the effects on expectations are no longer present at follow-up, then the process by which preparations improve the benefits of psychotherapy may involve other intervening variables.

The striking aspect of the research related to preparation and expectation manipulation is the failure to adequately test the effects on anxiety, which had originally been proposed as a product of disconfirmed expectations by Kelly (1955). The section which follows reviews the few studies which have attempted to study preparation, expectations and anxiety in the context of psychotherapy.

### 3.5 Preparation, expectations and anxiety in psychotherapy

Only two studies were found which investigated the effects of disconfirmed client expectations or psychotherapy preparation on anxiety.

The first of these by Clemes and D'Andrea (1965) hypothesised that "patients in an interview which was compatible with their expectations would be less anxious than those patients who received an interview which was incompatible with what they expected" (p.398). Clemes and D'Andrea (1965) derived their hypothesis from the earlier work of Pope and Siegman (1962), who found that a less structured, low-directive therapist style produced more anxiety in clients than did a high-directive style. No prior research on patient expectancies had directly studied the relationship between the degree to which the interview was compatible with patient expectations and the amount of anxiety the patient experienced.

Clemes and D'Andrea (1965) felt it was not so much the low-directive style that created anxiety, but the interaction of that style with the clients' expectations for a high-directive style; in other words the discrepancy in expectations of therapist style. In their study they measured the expectations for high or low therapist directiveness in 85 new psychiatric adult outpatients using a questionnaire developed by Heine and Trosman (1960).

The three questions proposed as being concerned with client expectations were: "1. Please indicate your reasons for coming to the psychiatry clinic? 2. What do you most want from the psychiatry clinic? 3. How do you expect to get what you want from the psychiatry clinic?", (p.399). For each question, the clients were asked to check which out of a number of possible answers best applied to them. Two judges determined whether the responses to each of the three questions were indicative of Participation Expectation (P) or Guidance Expectation (G). The nine participating therapists were instructed to give five structured and five unstructured initial interviews, alternating the order without regard for the particular kind of patient they happened to see. At the end of the initial interview each client was asked to rate the intensity of five emotions (anxiety, irritation, self-blame, sadness, and relief) according to how much they experienced them in the interview. The emotion rating scales were presented as five vertical lines side-by-side each having numbers from 0 to 5 with appropriate cue descriptions. In addition a card-sort measure of anxiety was completed. All interviews were taped and independent raters confirmed that therapists were able to conduct structured and unstructured interviews. To test the

hypothesis that interaction between expectancy and type of interview would affect clients anxiety, the self-ratings of anxiety of those clients receiving interviews consistent with their expectations were compared with self-ratings of clients receiving incompatible interviews.

It was found that, independent of interviewer style, clients whose expectations were not confirmed reported greater anxiety than those who received an interview consistent with their expectations. None of the other emotions on the self-rating scale were able to differentiate between the groups which received interviews compatible or incompatible with their expectations. The card-sort measure of anxiety was not able to confirm this result so that only partial support for the hypothesis was obtained. Additionally it was found that: the kind of interview alone did not effect anxiety; clients with Guidance expectations tended to have fewer visits and their termination was more often nonmutual; and clients with Participation expectations had more prior psychotherapy experience.

The second study to directly investigate the effects of preparation on expectations and anxiety was a doctoral study. Richardson (1977) hypothesised that the 30 minute videotaped preparation which used didactic information and modeling would: improve client knowledge of the counselling process; reduce anxiety about the counselling process; and improve attitudes toward counselling. Subjects consisted of 94 nonemergency clients applying for counselling at a university based counselling centre. During the ten week post-intake waiting period 49 subjects were randomly assigned to the experimental group and asked to view the precounselling orientation video. The 45 control subjects who did not view the video were placed on a waiting list prior to being assigned a counsellor in order to equalize the time the experimental subjects required to view the videotape. Following the experimental manipulation all subjects were assigned to counsellors for their first counselling session. All subjects were asked to complete an anxiety scale, attitude scale and information scale at the completion of the first counselling session. Counsellors completed questionnaires aimed to determine the clients store of information about counselling and behaviors related to anxiety. Prepared clients had significantly more information about counselling than nonprepared clients as indicated by client completed ratings on the information scale and counsellors ratings of clients information about counselling. Although there were no significant differences between the groups in terms of anxiety or attitudes toward counselling, it was noted that consistent differences among the treatment and control groups suggested that client anxiety and attitude variables should continue to be considered in preparation programmes.

There are a number of possible reasons why anxiety was not found to be lower for the prepared group than the unprepared control group. A post-test only design was used so that "reduction" in anxiety was not actually measured since no pretest measures were administered to determine anxiety change. The process involved in the first session may have decreased the control subjects anxiety to a level comparable to the experimental group. This would decrease the likelihood of detecting differences in anxiety which may have been produced by the video intervention. It is also unclear what was involved in the intake procedure for the those "applying for counselling". This is important since clients were randomly selected "during the post-intake waiting period". Consequently they already had some experience with the counselling centre and possibly counselling process, the net effect being an overall reduction in anxiety in all subjects. Unfortunately information about the quality of the anxiety measure itself was not available. However an investigation which did not look specifically at preparation for psychotherapy, but instead assessed the effectiveness of an orientation videotape for new patients undergoing psychiatric hospitalisation, did use instruments of demonstrated reliability and validity (Thompson & Mountain, 1987).

The 30 minute videotape used by Thompson and Mountain (1987) attempted to dispel myths about mental illness, provide information about hospital procedures, the multidisciplinary team approach, psychiatric problems, and treatment process. They predicted that patients viewing the orientation videotape would acquire more accurate information, report less anxiety, fewer hospital relevant fears, and more positive attitudes than their control group counterparts. The sample consisted of 60 patients admitted to a provincial psychiatric hospital. Eligible patients were alternately assigned to the experimental and control groups. All subjects completed the State-Trait Anxiety Inventory-Form X (STAI-X) (Spielberger, Gorsuch, & Lushene, 1970) and the Hospital Fears Rating Scale of Anxiety (HFRS) (Malamed & Siegel, 1975) within 24-36 hours of admission. After completing these questionnaires the experimental subjects viewed the orientation video, all within 24-48 hours after admission. Subjects in the control group did not view the video. Approximately 72 hours after admission all subjects again completed the STAI-X and HFRS. At this time subjects also completed a measure to determine their attitudes toward psychiatric treatment and hospitals, and a 20 item true/false questionnaire to determine the amount of information they had retained from the videotape. Researchers completed a hospital adjustment scale for subjects' first five days of admission, based on casebook notes and nurse consultations. It was found that those subjects viewing the

videotape had more accurate psychiatric information, a variety of more positive attitudes, reported fewer hospital related fears (HFRS), and were perceived as better adjusted than new patients who did not view the videotape. Although there was a reduction in state anxiety (STAI-X) in both groups from the first measure 24 hours after admission and the second 3 days after admission there was not a significantly larger reduction for the experimental group. While the videotape orientation may have facilitated anxiety reduction it did not lead to decreases beyond what already occurred with standard patient care procedures.

As with Richardson's (1977) study Thompson and Mountain (1987) may not have found the hypothesised changes in anxiety, because the STAI-X and HFRS were not administered until 24-36 hours after patients had been in hospital. In their conclusions the authors stated that "Both groups were considerably less anxious 3 days after their admission than during their first 24 hr in the hospital. It seems likely that the hospital environment and staff promote [a] feeling of security and comfort in all patients during the first few days of admission." (p.622). It is conceivable that staff provided the most comfort and reassurance to patients within the first 24-36 hours, so that by the time the pretests were given patients were already "oriented" to the hospital and initial anxiety had already declined to a considerable degree. Since anxiety variance was decreased the likelihood of detecting between group differences was also reduced. The effectiveness of their "orientation" videotape may have been considerably improved if it was shown prior to hospital contact or immediately upon admission.

In summary, the effects of expectation manipulation or preparation on psychotherapy clients' anxiety are far from clear. The available research appears to provide some evidence to suggest preparation may decrease clients' anxiety, but measurement and other methodological problems lead to only cautious conclusions. Unfortunately the vast majority of studies looking at expectation manipulation either ignored or assumed anxiety as an intervening process in effecting outcome. Thompson and Mountain's (1987) study of the effects of videotaped preparation for psychiatric hospitalisation, while not specifically related to psychotherapy, bears close resemblance to studies which have attempted to prepare patients for hospitalisation and stressful medical procedures such as surgery. In the next chapter the research related to preparation for stressful medical procedures is explored in an effort to expand on the potential effects of preparation on expectations, outcome and particularly anxiety.

## CHAPTER 4

### INFORMATION PROVISION AS PREPARATION FOR STRESSFUL MEDICAL PROCEDURES

#### 4.1 The "Work of Worry"

While there has been almost no experimentation in the psychotherapy area on the effects of informational preparation on anxiety there has been a relative wealth of research in the medical psychology area. The use of video and audiotape presentations to psychologically prepare patients for hospitalisation and surgery has been examined in considerable detail. Interestingly, the theory and early studies in this domain began around the same time as those relating to expectations of psychotherapy. Research into preparation for stressful medical procedures helps to generate models and hypotheses regarding the effects of information provision on expectations and anxiety in psychotherapy.

As previously noted, the prospect of entering psychiatric treatment appears to contain the situational components of ambiguity, and threat to interpersonal status or ego (Endler, 1980). The third situational variable of physical danger postulated by Endler (1980), appears to be less of a threat in this context. The threat of physical danger (e.g. pain) is present more for patients undergoing noxious medical procedures, such as going to the dentist for tooth extraction, or hospitalisation for surgery. It was Janis (1958) who first began to study stress reactions in patients about to undergo surgery. He found that presurgical fear was an important determinant of recovery from surgery. Those patients who experienced too much or too little fear prior to an operation experienced more emotional disturbance during postoperative convalescence than did patients who showed moderate anticipatory stress reactions. Janis postulated that those who experienced moderate levels of fear were better prepared for the surgery since they had undergone the "work of worry". The work of worry was viewed as a form of inner preparation that increased the patient's tolerance of subsequent noxious stimuli, but at the expense of experiencing some immediate stress reaction. This view was consistent with Marmors (1958) theoretical paper, first presented in 1955, which formulated anxiety as a emotional signal of impending danger, while worry was seen as a form of mental activity set off by this signal. Anxiety was seen as the alerting mechanism and worry as an effort at problem-solving. Marmor also used the term "work of worry", when referring to the relatively healthy attempts by a person to intellectually deal with a realistic threat. Realistic worry

was viewed as a normal and adaptive response to a distressing or threatening situation. Remaining "unworried" and utilising "denial" as a mechanism for dealing with the anxiety was seen as a less healthy response to that of realistic worry in a stressful situation.

Similarly Janis (1958) found those patients who showed practically no preoperative fear were much more likely to display anger, intense resentment and high emotional tension during the stressful period of postoperative convalescence. Although in some instances the absence of preoperative fear was determined by personality predispositions, there were many cases where the lack of preoperative worry appeared to be attributable to the lack of adequate preparatory communications. Janis felt the failure to experience fear led to a failure to do the "work of worrying" so that the patient remained unprepared for the distressing experiences of surgery and the recovery. In this respect the "work of worry" was similar to cognitive sensitisation, which was stress inducing in the short-run, but which led to long term adaptation. Janis's (1958) propositions have more recently been referred to as emotional-drive theory (Johnston, 1986; Johnson, Lauver, & Nail, 1989).

#### 4.2 Procedural versus sensory information

A large body of research into preparations for stressful medical procedures has attempted to determine the relative utility of different types of information preparation. Procedural information typically provided information about the procedures involved in the operation, such as premedication injection, time and duration of the procedure, transfer to the recovery room. Sensory information informed the patient as to the sensations they would experience during and after the medical procedure such as drowsiness, pain, gagging sensations. Controlling the type of information that patients receive is difficult because usual medical practice involves the provision of at least some procedural information. This is usually necessary in order to make sense of the sensory information.

One of the first carefully controlled experiments set up to test Janis's (1958) proposition regarding the curvilinear relationship between preoperative information and postoperative adjustment was conducted by Egbert, Battit, Welch, and Bartlett (1964). This serves to illustrate the methodology used in this area of research. Ninety-seven patients undergoing abdominal operations were randomly assigned to the experimental or control group. The night before the operation the anesthetist gave both groups routine procedural information about; the time and duration of the operation, anesthesia, and waking in the recovery

room. Those in the experimental group were given additional sensory information about postoperative pain. They were informed about the location, severity and duration of the pain and reassured that it was a normal consequence of the operation. It was found that on the five days following the operation the experimental group required significantly less narcotics than the control group. In addition the experimental patients were released from hospital significantly sooner (2.7 days) and were rated by an anesthetist, blind to patients' group membership, as being in less pain. Although this provided clear evidence that the intervention was effective, it was unclear how much of the effect was due solely to the provision of sensory information, and how much was due to additional training and attention. Since Egbert et al.'s (1964) study there has been an enormous amount of research into the provision of information prior to stressful medical procedures and prior to laboratory procedures designed to induce pain (for reviews see Anderson & Masur, 1983; Gil, 1984; Kendall & Watson, 1981; Ludwick-Rosenthal & Neufeld, 1988; MacDonald & Kuiper, 1983).

A recent review and meta-analysis of studies using information provision to cope with stressful medical procedures and pain (Suls & Wan, 1989) found that information provision produced benefits compared to no instruction. There were some inconsistencies, with variability for certain outcomes. One of the most important conclusions of the review was that dual-process preparation, involving both procedural and sensory information, produced the largest and most consistent benefits. Limited presentations which only mentioned procedures were considered likely to provide few benefits, while those mentioning only sensory information exhibited considerable variability across studies. The sensory-procedural combination was thought to be superior because the procedural information mapped the steps to be taken, while the sensory information helped the patient process and match the ongoing events with expectations in a nonthreatening way (Suls & Wan, 1989).

The review suggested a need for more study of the processes underlying the variability of the effects of preparation. Individual-difference factors such as locus of control were considered plausible moderators which might explain this variability, but the authors recognized there were only limited published studies which examined these interactive effects of personality and preparation (e.g. Auerbach et al., 1976; Wilson, Moore, Randolph, & Hanson, 1982).



### 4.3 *Dispositional factors as moderator variables*

Recognising that patients may respond to information differently, a number of studies have investigated patient variables which might make information provision optimally effective. A rapidly increasing list of personality factors and situational variables have been suggested as possibly interacting with preparations to differentially affect outcomes.

Coping style and locus of control are two of the most frequently studied moderator variables. The research on coping styles has been complicated by the use of different terminology between studies. The most popular categorization has been that of "sensitizers and repressors", with "sensitizers"(or "vigilants") using a coping style characterized by intellectualization and vigilance toward the stressor, while "repressors", ("deniers", "blunters", or "avoiders") use avoidance as their coping style (Schultheis, Peterson & Selby, 1987). Early studies (e.g. Andrew, 1970; DeLong, 1971) found benefits on various recovery measures after the procedure were dependent on the interaction of coping style and information. Patients with avoidant coping styles did not benefit as much from information provision. Subsequent studies using coping style produced inconsistent results which led researchers to begin examining coping as being an ongoing process which varied dependent on the stage of the stress experience (Schultheis et al., 1987). A number of studies provided evidence that patients' stress reactions before, during or after the procedure could be improved when the type or level of preparatory information was consistent with their coping style (e.g. Auerbach, Mercuri & Martelli, 1983; Miller, 1980; Miller & Mangan, 1983; Wilson, et al., 1982). In general the results of these studies provided only tentative conclusions since the wide variety of measures used to categorize patients made integration of the findings difficult.

Similar research has been conducted with locus of control (Rotter, 1966) as the moderating variable. Auerbach et al. (1976) investigated how locus of control interacted with type of information (specific versus general). Just prior to dental surgery, 63 subjects classified as "internals" or "externals" viewed a specific or general information videotape. On the basis of dentists ratings of the subjects adjustment during the procedure, there were no main effects for either type of information or locus of control. However, there was a significant interaction between the locus of control and type of information. Within the locus of control groups, internals who viewed the specific information tape had better adjustment ratings than those who viewed the general information tape. The reverse was true of the externals who had better ratings to the general information tape. Pickett and Clum (1982)

provided additional support for giving internal locus of control patients specific detailed information when it was found they reported less postsurgical pain and anxiety.

A full review of these studies is beyond the scope of the present study. The interested reader can refer to the Schultheis et al. (1987) review for a more comprehensive coverage of the area and associated concerns. Individual-difference factors such as coping style have been identified as plausible moderators which may help explain some of the variability in research on the effectiveness of information provision (Suls & Wan, 1988; Janis, 1986). While a particular locus of control or coping strategy may be more or less beneficial in particular situations, limited and at times contradictory findings in this area suggest a need for more study. What can be stated with more certainty is that information provision appears beneficial in preparing for stressful medical procedures and seems to facilitate recovery. A combination of procedural and sensory information appears to maximise these benefits. These findings appear analogous to those related to preparation for psychotherapy.

A predisposition discussed in the Schultheis et al. (1987) review of person by preparation interactions was trait anxiety. Trait anxiety has been conceptualized as a relatively stable characteristic which reflects a person's anxiety proneness while state anxiety is viewed as being more variable from situation to situation and time to time. The following section introduces the research related to the effects of information provision on anxiety.

#### **4.4 The effects of information provision on anxiety**

Two main hypotheses have been proposed relating preoperative anxiety to postoperative recovery. Janis' (1958) emotional-drive theory suggests a curvilinear relationship between preoperative anxiety and postoperative recovery. Patients with moderate preoperative anxiety would experience the best postoperative recovery, while those with extremely high or low preoperative anxiety would have poorer recoveries characterised by excessive postoperative anxiety, anger or resentment. These relationships are thought to be mediated by the patient's degree of preparation for the impending stressors. The unique aspect of Janis's theory is that there are patients whose anxiety levels are too low and might benefit from increases in preoperative anxiety through preparation.

Secondly, self-regulation theory (Leventhal & Johnson, 1983) proposes a linear relationship between pre-operative anxiety levels and post-operative recovery. This simply suggests that the lower the preoperative anxiety the better the postoperative recovery. The implication of this hypothesis is that minimising preoperative anxiety improves postoperative outcomes. This model predicts a simple positive, linear correlation between preoperative anxiety and postoperative outcomes.

Although Janis (1958) offered some empirical support for his curvilinear model from pre and postoperative interviews with his surgical patients, there has been little subsequent confirmation of these relationships. The bulk of past research has been largely supportive of a linear decline model finding state anxiety is elevated prior to stressful situations such as surgery and declines after surgery and during the postoperative recovery period (Auerbach, 1973; Chapman & Cox, 1977; Spielberger, Auerbach, Wadsworth, Dunn, & Taulbee, 1973; Wolfer & Davis, 1970). The data suggests that elevated levels of presurgical anxiety are related to more distress and slower recovery, and that low-anxiety patients tend to do well postoperatively (Auerbach, 1989; Johnston, 1986; Mathews & Ridgeway, 1981).

In studies which have involved information provision state anxiety scores were highest at the first testing period prior to surgery, declined after information presentation, and remained low after surgery (Anderson, 1987; Auerbach et al, 1983; Johnson, Leventhal, & Dabbs, 1971; Johnston & Carpenter, 1980; Ridgeway & Mathews, 1982; Vernon & Bigelow, 1974; Wolfer & Davis, 1970). In general stressful medical procedures elicited high levels of state anxiety which quickly subsided once the stressor was removed.

It has also been found that trait anxiety is relatively unaffected by the stress of impending surgery with an absence of any pre- and postoperative differences (Auerbach, 1973; Bruegel, 1971; Martinez-Urrutia, 1975; Spielberger et al., 1973). That is, no significant interaction between trait anxiety and situational stress was found. The decline in state anxiety from pre- to postoperative conditions was the same for high and low trait anxiety groups.

Janis's (1958) curvilinear model may not have been confirmed by subsequent studies in part due to methodological differences. For instance Spielberger et al., (1973) used the State Trait Anxiety Inventory (STAI, Spielberger et al., 1970) which differentiated between situational reactive state anxiety and more stable trait anxiety which reflected

anxiety proneness. Janis (1958) on the other hand asked surgery relevant questions such as "During the hour immediately before the operation or treatment started, how intense was the most severe fear or anxiety that you experienced?" (p.278).

Auerbach et al., (1983) provided another explanation for why linear versus curvilinear models are more often confirmed. They attempted to test Janis's (1958) curvilinear relationship between postinformation anxiety and adjustment. Dental patients who reported a high level of postinformation state anxiety prior to surgery had poorer adjustment than did subjects who reported either moderate or low state anxiety levels. Subjects who reported low or moderate anxiety adjusted equally well. The low anxiety group did not do relatively poorly as would be expected with Janis's model. Auerbach et al (1983) speculated that in relatively less severe conditions such as dental extraction under local anesthetic, the situation is not sufficiently threatening for problematic denial to prevent the "work of worry". Dental extraction required a relatively brief and undemanding recovery period compared to Janis's sample, so that even the minimal "work of worry" undertaken by those in the low-anxiety group was sufficient to produce adequate coping.

Anderson and Tewfik (1985) imply similar conclusions about the nature of the situation and the relationship of pretherapy anxiety to "recovery". Their's was one of the few reports offering some support for the curvilinear hypothesis (see also Andersen, Karlsson, Anderson & Tewfik, 1984). In studying the psychological reactions of 45 cancer patients undergoing radiation therapy, Anderson and Tewfick (1985) cited several reasons why a linear decline model might not be found among cancer patients. Cancer patients as a group reported greater anxiety than other groups hospitalised for nonmalignant conditions (Lucente & Fleck, 1972). More, emotional distress, general feelings of experiencing a crisis and of helplessness were reported by cancer patients after surgery than general surgical patients (Gottesman & Lewis, 1982). Many patients undergoing other forms of cancer treatment such as chemotherapy exhibited "extreme" anxiety which at times prevented further treatment (Redd & Andrykowski, 1982). Uncertainty about the effects of radiation therapy after treatment was thought to influence posttreatment anxiety by interfering with the dissipation of anxiety expected with the linear decline model. Anderson and Tewfik (1985) found that patients with low levels of state anxiety prior to radiation therapy reported significant increases in state anxiety at posttreatment such that they equalled state anxiety levels maintained by the group with moderate pretreatment anxiety.

Anderson and Tewfik's (1985) conclusions implied that a curvilinear relationship between pretreatment anxiety and recovery may be dependent on the degree of denial and extreme responses in situations which involved life-threatening illnesses and prolonged recovery. This conclusion is consistent with that of Auerbach et al's (1983) which indicated that in stressful situations which are not threatening enough to prevent realistic cognitive appraisal, a linear model could be expected.

These are tentative conclusions which require more study. One of the difficulties in studying Janis's (1958) emotional-drive theory is classifying patients as having low, medium and high anxiety, since these divisions are likely to vary considerably from study to study (e.g. Andersen & Tewfik, 1985; Johnson et al., 1989). Despite these methodological problems, current research clearly provides the most support for the linear decline model particularly where extreme emotional responses are not present in relation to the situation. The current rationale for approaches using information provision is that information enables an individual to form accurate cognitive expectations about the treatment (Ludwick-Rosenthal & Neufeld, 1988), and that this leads to reduced emotional reactions to the procedure. More specifically preparatory information could be expected to increase the accuracy of expectations regarding the procedure and in turn reduce anxiety.

#### **4.5 Information provision, expectations and anxiety**

Most researchers studying the effects of information provision assumed presurgical anxiety always impeded adjustment and consequently focused on its minimization. This assumption was more consistent with a linear model of anxiety and its relationship to recovery. Jean Johnson and colleagues (Johnson, 1973, 1975; Johnson et al., 1971, Johnson & Leventhal, 1974; Johnson & Rice, 1974; Johnson, Rice, Fuller, & Endress, 1978) conducted a series of studies on the effects of information on emotional responses during threatening situations. These studies assumed that congruency between expected and experienced physical sensations would result in a reduction of emotional responses during a threatening procedure. They proposed that the intensity of an emotional response during a threatening procedure increased in proportion to the incongruency between expected and experienced sensations. Johnson and associates have subsequently elaborated this into self-regulation theory (Leventhal & Johnson, 1983; Johnson et al., 1989).

Self-regulation theory proposes that preparation of patients about to undergo stressful medical procedures allows them to form a clear, accurate, and unambiguous schema (expectations) of their impending experience. This schema operates to: focus patients' attention away from the emotional features of the experience and onto concrete objective features; facilitating the processing of incoming information and enhancing the understanding and interpretation of the experience. These processes in turn improve coping behaviours after the stressful event (Johnson et al., 1989). This theory covers common ground between the research on information provision as preparation for stressful medical procedures and the expectation manipulation literature in the counselling and psychotherapy field.

Johnson's (1973) initial laboratory experiments used ischemic pain in the arm produced by a tourniquet as the threatening experience. Expectations were manipulated by varying the relevance of preparatory information to physical sensations frequently experienced during the painful stimulation. To test the incongruency hypothesis Johnson attempted to vary expectations about the sensations caused by the painful stimulus without suggesting either the magnitude of the sensations or the degree of distress. In order to rule out Janis's theoretical position the preparatory information was designed so as not to differentially arouse fear. The information relevant to forming accurate expectations about the physical sensations was associated with less intense emotional response during painful stimulation.

Johnson (1973) concluded that the effect of the information on distress could not be explained by the intervening process of different fear levels because the only variable which affected the fear level measure was time. Subjects were less fearful after the painful procedure than before and neither the sensory or procedural information affected the level of reported fear. Johnson and Leventhal (1974) then tested their theory in a field setting studying the emotional responses of 48 hospitalised patients about to undergo an gastroendoscopic exam. They found patients who received the sensation information before the procedure gagged less, had more stable heart rates and required less medication than did control patients.

Unfortunately another characteristic this research shared with equivalent studies in the psychotherapy area was the failure to directly assess the individual's expectations. This made it difficult to determine whether obtaining additional information actually modified expectations, or made them more congruent with what actually occurred.

Hartfield and associates (Hartfield & Cason, 1981; Hartfield, Cason and Cason, 1982) attempted to overcome this problem in their study on the effects of procedural and sensation information on 20 patients' expectations of barium enema. They included pre- and postenema measures of state-trait anxiety and sensations expected and experienced as a measure of expectation congruence. Subjects whose sensation expectations were congruent with what they experienced during the barium enema procedure had lower state anxiety levels during the procedure than subjects whose expectations differed from what they actually experienced. They found a significant negative correlation ( $r = -.51$ ) between congruency scores and state anxiety scores. As congruency increased, emotional response decreased consistent with Johnson's original hypothesis. The results supported Johnson's proposition that emotional responses during a threatening procedure were mediated by congruency between expected and experienced physical sensations. Hartfield et al. (1982) also suggested the relationship may be one of mediation. Johnson et al. (1989) have more recently provided additional confirmation of the mediational role of expectations. They found that the positive effects of preparation for radiation therapy on a measure of disruption of recreation and pastime activities were mediated by the similarity between expectations and experience. While both similarity between expectation and experience and sense of understanding one's experience mediated the effect of information on this outcome measure, the mediating effect was primarily attributable to understanding of one's experience.

The theory and subsequent research related to preparation for stressful medical procedures is consistent with Kelly's (1955) proposition related to psychotherapy. Both propose that inconsistency between expectations and events result in elevated anxiety. However, research related to stressful medical procedures has the advantage of increased empirical support and more refined theory.

#### **4.6 *Summary***

Research on information provision as preparation for stressful medical procedures is arguably more advanced and methodologically sound than similar investigations in the psychotherapy area. In particular more headway appears to have been made in identifying moderator variables and conditions under which information provision may be optimal to patients. The main advantage of drawing from the field of preparation for stressful medical procedures for the present study is that it provides models for predicting the effects of information provision on anxiety. Whether these models generalise from patients about to

undergo stressful medical procedures to clients about to enter psychotherapy is in part the subject of the current research project. In this and the following section aspects of the two fields are brought together to clarify some of the hypotheses and methodology used in the present study.

Self-regulation theory suggests information that reduces ambiguity about the impending event influences the person's expectations. The information may confirm some previously formed expectations, add some new properties, or cause others to be rejected, but in general it leads to more realistic or accurate expectations of the impending experience. In turn this is thought to facilitate the reduction of emotional responses such as anxiety which may be related to the experience. Thus the theory predicts that expectations will mediate the effects of information provision on anxiety. Previous research also supports expectations mediating the positive effects of preparation on anxiety and recovery variables (Harfield et al., 1982; Johnson et al., 1989). This combination of theory and empirical support provides the basis for several of the hypotheses in the present study, but in particular the prediction that expectations will mediate the effects of preparation on anxiety.

Self-regulation theory also predicts a linear relationship between pretherapy levels of state anxiety and psychotherapy outcome. This is in contrast to Janis's (1958) theory which predicts a curvilinear relationship between these variables. However, the weight of the research related to preparation for stressful medical procedures supports a linear relationship between pretherapy levels of state anxiety and outcome. Consequently, this forms the basis for the prediction of a linear relationship between pretherapy levels of state anxiety and psychotherapy outcome measures at follow-up.

Earlier it was proposed that clients' expectations undergo correction over the course of psychotherapy (section 3.4) and that differences between prepared and control groups may disappear with time as a function of this process. Since expectations are thought to mediate the effects of preparation on state anxiety it follows that any differences between prepared and control groups on state anxiety may also be lost with increased exposure to psychotherapy. This implies that anxiety changes over the course of psychotherapy and would generally be expected to decrease. Additional support for this proposition is again available from research related to preparation for stressful medical procedures. Patients who were prepared for stressful medical procedures had state anxiety scores which were typically highest prior to the procedure, declined after the preparation, and remained low



after the procedure (e.g. Anderson, 1987; Johnston & Carpenter, 1980). Even without preparation it has been consistently found that state anxiety is elevated prior to the stressful procedure, declines after the procedure and remains low during recovery (e.g. Auerbach, 1973; Spielberger et al., 1973). This provides the basis for the hypothesis which predicts group differences on expectations and state anxiety as a result of preparation, will not be present at follow-up.

It may appear somewhat contradictory to predict long-term effects on psychotherapy outcome measures as a result of preparation and at the same time predict that expectations and anxiety will no longer be effected long-term. However, increasing the accuracy of expectations may be only one of several possible processes whereby information provision reduces anxiety and improves outcome. Expectations and anxiety may in turn influence other therapist-client processes which result in improved outcome. It is possible that information decreases anticipatory anxiety about the unknown so that the client is better able to utilise the initial sessions. Information may allow clients to cognitively prepare for some of the more uncomfortable aspects of psychotherapy and it may be that different processes are responsible for effects on different outcome measures. The present study will not be able to unequivocally state the process by which information provision leads to improved outcomes. It will take the initial step of determining whether anxiety does appear to play a role in the process in conjunction with expectations, and begin to explore the relationships between these variables and subsequent therapeutic outcome.

The present study's aims and methodology are clarified further when methodological problems common to the information provision research in both psychotherapy and medical stress research are critically reviewed.

## CHAPTER 5

### METHODOLOGICAL PROBLEMS IN RESEARCH USING PREPARATORY INFORMATION

In the previous chapters some of the methodological problems encountered in the study of expectation manipulation and information provision were introduced; this chapter will provide a more complete summary of these problems.

#### **5.1 Subject selection**

The frequent practice of using subjects who have had previous experience with the medical procedures may limit the impact of information provision (Ludwick-Rosenthal & Neufeld, 1988). Practically this problem is almost impossible to overcome since it is not usually possible to obtain an information-free control group in an applied medical setting. Prior hospitalisations, and informed consent for medical procedures usually preclude information free subjects, so at best minimal information control groups can be obtained. These constraints are also present for subject selection in research which prepares clients for psychotherapy. This is primarily an issue of external validity in that it relates to the generalizability of any results.

Studies providing information prior to psychotherapy have found the amount of prior therapy experience had an effect on the benefits of the pretherapy information (Zwick & Attkisson, 1985). This suggests prior therapy experience as a potential moderating variable. At a minimum studies should include some measure of prior experience so that the potential effects of this variable can be assessed.

A subject selection issue which relates to internal validity was noted by Tinsley et al., (1988). They found most investigators made the fundamental design error of failing to randomly assign research participants to experimental and control groups. This is particularly problematic when variables such as prior experience are not controlled through randomisation, because it can not be determined whether between group differences were due to the initial make-up of the group or the experimental intervention. While randomisation or matching groups would help minimise potential confounding effects of prior experience, treatment effects may still be diluted by samples with high levels of prior experience.

## 5.2 Design problems

Many studies have used a pretest-posttest design in which subjects' expectations or knowledge were measured prior to information provision. There has been increasing concern that the initial measurement of expectations could have a reactive effect on the efficacy of the experimental manipulation (Tinsley et al., 1988). This is a threat to external validity referred to as a reactive or interaction effect of testing (Campbell & Stanley, 1966) where the pretest changes the respondent's sensitivity to the experimental variable making generalization to the original population of interest suspect.

While Tinsley et al. (1988) noted that reactivity was particularly likely with regard to the measurement of client expectations. Reactivity has also been found when measuring anxiety. Kent (1989) found that asking dental patients about their cognitions while waiting in the reception area of a dental hospital affected the degree of anxiety reported. This was contrary to an earlier study (Kent, 1986) where no differences were found in post-appointment ratings of discomfort between a group asked about their expectations of pain and one which was not. In order to remove the ambiguity of these results Kent (1989) recommended a design similar to the Solomon four-group design (Solomon, 1949) which includes a control condition in which no pretests are taken.

## 5.3 Manipulation checks

A large portion of studies both in the medical stress and psychotherapy domains have failed to make the necessary manipulation checks to determine whether the experimental intervention had been effective (i.e. produced the change in the subjects expectations). Tinsley et al.'s (1988) review found 75% of the 24 published studies attempting to relate expectancy manipulations to aspects of the therapeutic process or outcome failed to perform manipulation checks.

## 5.4 Placebo groups

The issue of placebo groups in information provision research has not been adequately addressed. Horvath (1988) reviewed 20 years of placebo use in general psychotherapy research and recommended cautious use of placebos, suggesting they were most appropriate in investigations which attempted to isolate components in an intervention.

Ideally placebos are therapeutically inert, but Horvath (1988) concluded that placebos in psychotherapy research are most often alternative treatments which may be therapeutically active.

While some investigations related to information provision have used placebo presentations (e.g. Day & Reznikoff, 1980a) the vast majority have not. Often treatments described as placebos have merely provided alternative information in order to control for attention effects (e.g. on some unrelated health issue, or historical and financial aspects of the treatment centre). This leaves the "placebos" vulnerable to the criticism that they were actually alternative treatments. Other difficulties arise in attempting to provide a placebo of equal credibility and interest to the client.

The present study will attempt to demonstrate that the intervention produces a significant degree of change on a number of measures. Isolating which treatment components account for the change is not of major concern, so the elimination of confounding variables by means of a placebo control group is unnecessary. Attention provided to participants is held relatively constant by having participants view the video information alone. More importance is placed on maintaining the ecological validity of the design by having participants in the control group wait in the reception area as they would under normal intake procedures.

### **5.5 Measurement problems**

Measurement problems abound in the psychotherapy literature. Duckro et al, (1979) and Tinsley et al, (1988) both voiced concern that investigators often used instruments designed specifically for a particular study, with no information about their reliability or validity. This was especially true for the few studies which assessed anxiety as a variable. The use of different instruments between the studies severely limited the ability to integrate and compare results.

Other reservations concerned the use of single items to measure crucial expectancy variables. There are instruments available which sample the full range of client expectancies (Tinsley, Workman, & Kass, 1980), but these are often too long and time consuming particularly when multiple measures are being made. Coping with some of these measurement issues requires a balance between brevity, specificity, reliability and validity in selecting between measurement instruments.

In Ludwick-Rosenthal & Neufeld's (1988) review of medical stress research it was found that information provision produced the most positive effects on behavioural ratings of discomfort and adjustment. Self-reports of anxiety were much less affected. They felt this may have been due to the information facilitating patients to cope behaviourally, because they often received behavioural instruction along with procedural and sensation information. Observer ratings of discomfort also focused on overt signs of behavioural distress. It was thought that the self-report measures used were not sensitive enough to detect small changes in anxiety. They recommended the use of a wider variety of clinically relevant outcome measures such as patient satisfaction, expectations, or self-report measures related to cognitive coping strategies.

An additional measurement problem not addressed by these reviews relates to the timing of information provision and measurements. Many studies took preinformation measures, presented the information and did not take postinformation measures until after the client had experienced the medical procedure or had their initial interview with the therapist. This made it more difficult to determine how much of the expectancy change was due to the intervention and how much was due to the clients' perception changes as a result of experience with the procedure. As noted previously some studies actually waited until the client had experienced aspects of the procedures before presenting information (Thompson & Mountain, 1987) which may have led to a reduction in the apparent effectiveness of the intervention.

## 5.6 Other deficiencies

Duckro et al. (1979) suggested that "...studies of client expectation cannot be unequivocally understood without the simultaneous investigation of preference." (p.271). They felt it too simplistic to ask whether or not clients' expectations were confirmed and felt it was also necessary to ask whether the person wanted or did not want what he or she expected. The failure of investigators to distinguish clearly between expectation (as anticipation of some event), preference (as a desire that some event will occur), and perception (as knowledge gained from experiencing an event) was a problem noted earlier (Tinsley et al., 1988). The complexity of this conceptual and definitional problem is highlighted by the same criticism being leveled at Tinsley and others (Tinsley et al., 1980; Tinsley & Benton, 1978) in a theoretical paper which attempted to clarify the relationships between preference, perception and expectation (Grantham & Gordon, 1986). The debate

centres around whether asking clients to indicate what they expect elicits expectations or preferences. Tinsley and Westcot (1990) examined this issue with an ingenious analysis of the cognitions stimulated by items on their Expectations About Counseling-Brief Form, (EAC-B). They asked 24 undergraduate university students to complete the EAC-B with the following additional instructions: "Pretend you are about to see a counseling psychologist for your first interview. We would like to know just what you think counseling will be like. On the following pages are statements about counseling. For each statement...read the statement out loud (all responses will be tape recorded). Think about what you expect counseling to be like, and say out loud all of the thoughts going on through your mind" (p.224). Trained judges' analysis of the tape recordings indicated that items on the EAC-B elicited statements about expectations from 73% to 100% of the respondents. It was concluded that the items stimulated cognitions about expectations as distinct from preferences and perceptions. The EAC-B was able to stimulate cognitions about expectations using the item stem "I expect to..." or "I expect the counselor to..." at the top of each page once for approximately 20 items. This provided at least interim support for assuming clients are reporting what they anticipate rather than what they prefer when asked what they expect.

Tinsley et al. (1988) noted several other shortcomings in their review of the expectancy manipulation literature: they were concerned at the focus on a limited range of expectancies; they noted many of the successful expectancy manipulations occurred in laboratory settings with "doubtful external validity" (p.106); they found most investigations failed to evaluate the long-term effects of expectancy manipulations; they observed that most studies did not relate the expectancy manipulation to therapeutic process and outcome, and concluded the problem at the base of all the concerns was the lack of systematic research in the area.

## CHAPTER 6

### THE PRESENT STUDY

#### 6.1 *Recapitulation and aims*

Simply stated, Kelly's (1955) theory implies that inconsistency between expectations and events leads to anxiety. Research suggests that clients who have discrepant expectations are more likely to have negative therapeutic outcomes. Pretherapy preparations involving information provision have been found to increase the congruency of clients' expectations and lead to improved outcomes. There is little research in the psychotherapy area about whether inconsistency between expectations and actual events leads to anxiety. Theory would predict that information provision would lead to more congruent expectations and a reduction in anxiety. While Janis' (1958) theory predicts a curvilinear relationship between pretherapy anxiety and outcomes for stressful medical procedures, subsequent research provides more support for a linear relationship.

The general aim of the present study is to determine the effects of videotaped preparatory information on pretherapy expectations, anxiety, and a variety of psychotherapy outcome measures. The study also aims to examine the relationships between preparation, expectations, anxiety and psychotherapy outcome.

The methodological problems of prior research were outlined in the previous chapter. Obviously not all of these shortcomings will be overcome in a single experiment, but there are already studies such as Zwick and Attkisson's (1985) noted in section 3.3 which have made considerable progress in addressing these problems. By expanding on the strengths of this research through using the Solomon four-group design, it is hoped additional progress can be made in furthering the understanding of pretherapy preparations. One strength of Zwick and Attkisson's (1985) study was the use of a short video presentation which appeared conceptually consistent with the practice of psychotherapy by New Zealand psychologists in outpatient psychology departments. Accordingly, the present study modelled and adapted its videotaped information presentation closely on the script used by Zwick and Attkisson (1984, 1985).

## 6.2 Definitions of expectations and anxiety

When information about a procedure is provided to clients, their perceptions and expectations of the procedure change. This process is explained in Grantham and Gordon's (1986) theoretical paper on "The nature of preference". They proposed the term "expectancy" as a state of readiness where a person is cognitively set to look for something. The person does not necessarily expect anything in particular. They explained that "...the new client is confronted with a series of expectancies generated by perceptual cues. He or she is not sure what is to come. He or she is nonetheless prepared to sift all the cues available to create a mental picture of the anticipated events." (p.397).

Information provision provides some of those perceptual cues. An "expectation" was the end point of the above process considered, "...a configuration of anticipated characteristics unique to that situation and that individual. This scenario is the personalized outcome that this client forecasts." (p.397). Clients with previous experience also go through this process of developing expectations, but their expectations were thought to be more strongly influenced by previous experience (Grantham & Gordon, 1986).

Preference is defined as "a choice one makes", (Grantham & Gordon, 1986, p.396). This choice is based on a complex decision process. For the purposes of the present study expectations are viewed as anticipated events and preferences as choices. As originally proposed by Duckro et al. (1979) it is thought that once preferences are established these influence expectations, and similarly when expectations are created they will influence what one prefers. Whether an individual experiences negative affects, such as anxiety, as a result of disconfirmed expectations is also dependent on what one prefers (e.g. I expect something I do not want, I do not get what I expect resulting in relief; Grantham & Gordon, 1986). While the theoretical interactions and relationships between preferences and expectations are appreciated, confirming these and determining the multiple affective outcomes between the two requires different research. These questions are beyond the scope of the present study which confines itself to the study of expectations related to the effectiveness of the experimental manipulation and anxiety.

Kelly (1955) clearly stated that all discrepancies between anticipations and events no matter how small, precipitated anxiety. However, even Kelly agreed his definition of anxiety was "somewhat unusual" (p.495) and it did not easily lend itself to measurement. When referring to anxiety Kelly indicated it was a state where a person appeared "upset" (p.496). Maddi (1976) when referring to Kelly's conception of anxiety felt it was a tension state.



This is consistent with anxiety states characterized by Spielberger, (1983) as including subjective feelings of tension, apprehension, nervousness, and worry, and by arousal of the autonomic nervous system. The present study makes the distinction between state and trait anxiety as elaborated by Spielberger (1983). State anxiety refers to an anxiety reaction or process taking place at a given time and level of intensity. It is a more sensitive indicator of changes in transitory anxiety as a result of physical danger or psychological stress. Trait anxiety refers to the "...relatively stable individual differences in anxiety-proneness, that is, to differences between people in the tendency to perceive stressful situations as dangerous or threatening and to respond to such situations with elevations in the intensity of their state anxiety reactions." (Spielberger, 1983, p.1). In other words trait anxiety implies differences between people in the disposition to respond to stressful situations with varying amounts of state anxiety.

The general aims, key concepts and the boundaries of the research have been clarified. The next section presents the specific hypotheses under investigation.

### 6.3 *Hypotheses*

1. Videotaped information will increase the accuracy of clients' expectations and reduce state anxiety.
2. Preparation effects on state anxiety will be mediated by expectations.
3. Clients receiving videotaped preparatory information will have more positive therapy outcome at follow-up than the control group.
4. There will be a linear rather than a nonlinear relationship between pretherapy levels of state anxiety and outcome measures at follow-up.
5. There will be no differences between the video and control groups' accuracy of expectations about psychotherapy or their levels of state anxiety at follow-up.

## CHAPTER 7

### METHOD

#### 7.1 Research Settings

The research data was collected from the "Departments of Psychological Medicine" attached to two city public hospitals in New Zealand between April 1989 and October 1990. Both departments provided inpatient and outpatient services and were staffed by psychiatrists, social workers, nurses, occupational therapists, administrative and domestic staff in addition to clinical psychologists.

The first of these departments was located at a public hospital based in a city of 96,200. The psychology department employed four clinical psychologists. The second department was based in a city of 60,700. The psychology department employed five clinical psychologists. The psychologists in both settings were responsible for providing services to inpatients and outpatients, and also consulted with other services in the general hospital and community. There were no charges for services which were paid by the government as part of the state health system.

#### 7.2 Ethical issues

The research was conducted in accordance with the ethical guidelines of the New Zealand Psychological Society (1985). The research project was reviewed and approved by the Massey University Human Ethics Committee, the Palmerston North Hospital Ethics Committee, and the Waikato Hospital Ethics Committee. Those ethical issues particularly pertinent to the research are briefly outlined below.

Confidentiality of client information was maintained for all participants (client and therapist). This was accomplished by use of identification numbers so that participants remained anonymous. No information which could identify clients left the clinic. All client and therapist data was coded and completed questionnaires remained in the clinic records room.

Information about the research was provided at the earliest stages of the protocol in the appointment letter. When clients first received their appointment letter they were invited to participate and briefly informed about the research. Attempts were made to emphasize the voluntary nature of participation in order to eliminate coercion. If clients required additional information about the research they could contact the research psychologist or the clinical psychologist. Clients could indicate their unwillingness to participate by simply not arriving in time to participate in the research. In providing informed consent, care was taken to word the appointment letter and consent form (see Appendix H) in language appropriate to the client sample (Greenwald, 1982; Handelsman, Kemper, Kesson-Craig, McLain & Johnsrud, 1986). The term "randomly allocated" used in the appointment letter was required by the Palmerston North Hospital Ethics Committee. If the client arrived in time to participate then they were given more detailed information about the research on the formal consent form. The research psychologist or trained receptionist was available to provide additional information if required.

Originally it was planned that the clinic receptionists would administer the forms and show the video to clients in both settings in order to increase the generalizability of results and integration of the preparation after the research was completed. However the Palmerston North Hospital Ethics Committee required the research psychologist be present for all potential participants to "go over the purpose of the study" if required. This resulted in the procedure being administered by the research psychologist at this setting.

There were limitations on informed consent for access to client records in order to obtain descriptive data on all potential participants. Demographic and diagnostic information was obtained from clinic records on all those eligible to participate. This data was essential in determining the representativeness of the sample who participated and important to the generalizability of the results. Korchin and Cowan (1982) noted that if archival data from clinical records is treated with appropriate confidentiality and care, the informed consent rule can be waived. Access to this kind of information is common in other fields of science and epidemiologists in particular rely heavily on the ability to search records without client consent (Gordis & Gold, 1980).

The research was considered to pose low risk of harm to participants. There was no prior screening of clients for exclusion based on degree of psychopathology since typical referrals for psychotherapy were not actively psychotic and degree of psychopathology has been found to be unrelated to psychiatric patients capacity to give consent or willingness to

participate (Kane, Robbins, & Stanley, 1982). Those clients who were asked to participate in "screened interviews" as part of clinical students training were not asked to participate in the research. It was considered that asking new clients to participate in both the research and screened interviews was too demanding and sufficiently different from usual intake procedures to warrant their exclusion.

### 7.3 *Subjects*

Clients 18 years and over referred for psychotherapy to the psychology departments were eligible to participate in the study. During the study period there were 346 adult outpatient referrals for psychotherapy to the two psychology departments. Twenty-seven (8%) of these referrals did not follow usual intake procedure because they were screened teaching interviews which required additional consent procedures of clients. An additional 19 (5.5%) clients cancelled their appointment, while 58 (16.8%) did not attend (DNA) for their appointment.

Of the 242 clients who attended their appointment with the psychologist, 138 (57%) agreed to participate and completed the research protocol. Of the 104 nonparticipants, 63 were unable to participate, mostly because they arrived with insufficient time to complete the research protocol, but also due to difficulty understanding what was required or inadequate reading ability. While some of those arriving with insufficient time expressed a desire to participate, it is also likely some of these were "passive refusers". Forty-one of the nonparticipants explicitly declined to participate. Table 1 summarizes the characteristics of the clients who participated in the study.

**Table 1**  
Characteristics of participants (n=138)

Variable	Descriptive information
Age	Mean 33 years; SD= 10.79; Range 18 to 73 years; 95% under 50 years.
Sex	61 % Females; 39 % Males.
Race	93% European; 6 % Maori; 1 % Other.
Marital status	45% Married or in Defacto relationship; 37% Single; 18% Separated, Divorced or Widowed.
Socio-economic status <sup>a</sup>	7% "1 & 2"; 25% "3 & 4"; 20% "5 & 6"; 20% "Houseperson"; 8% "Student"; 13% "Unemployed"; 7% Other.
Education <sup>b</sup>	64% up to 3 years of High School; 23 % 4 or 5 years of High School; 13% some Tertiary.
Referral source	46% Medical Practitioners; 41 % Psychiatrists or Psychiatric Registrars; 13% Other.
Previous therapy	40% None; 12% 1-2 visits; 21% 3-10 visits; 27% more than 10 previous visits.
Source of previous therapy	58% Psychiatrists or Psychiatric Registrars; 23% Psychologists; 19% Other (e.g. social workers).
Diagnostic categories	20% Mood disorder without psychotic features; 20% Anxiety disorder; 14% Adjustment disorder; 11% Eating disorder; 8% Personality disorder; 7% Psychotic disorders <sup>c</sup> ; 9% "Other"; 7% Conditions not attributable to a mental disorder that are the focus of treatment; 4% No diagnosis.

<sup>a</sup>Socioeconomic status (SES) was classified using the Elley-Irving Socioeconomic Index (Elley & Irving, 1976), which bases classification on occupation and ranges from one (high SES) to six (low SES). <sup>b</sup>Educational levels only available from one setting. <sup>c</sup>DSM-III-R category (American Psychiatric Association, 1987) based on classification by psychologist or most recent diagnosis in client records. Psychotic disorders included Schizophrenic disorders (4), Psychotic disorders not elsewhere classified (3), Mood disorder with psychotic features (4), (no participants were classified as Delusional disorders).

Characteristics of participants and nonparticipants were compared using ANOVA for age, and Chi-square for all other variables including diagnostic category. There were no

significant differences between participants and nonparticipants on any of the variables in Table 1, substantially increasing the likelihood that the sample was representative of referrals for psychotherapy.

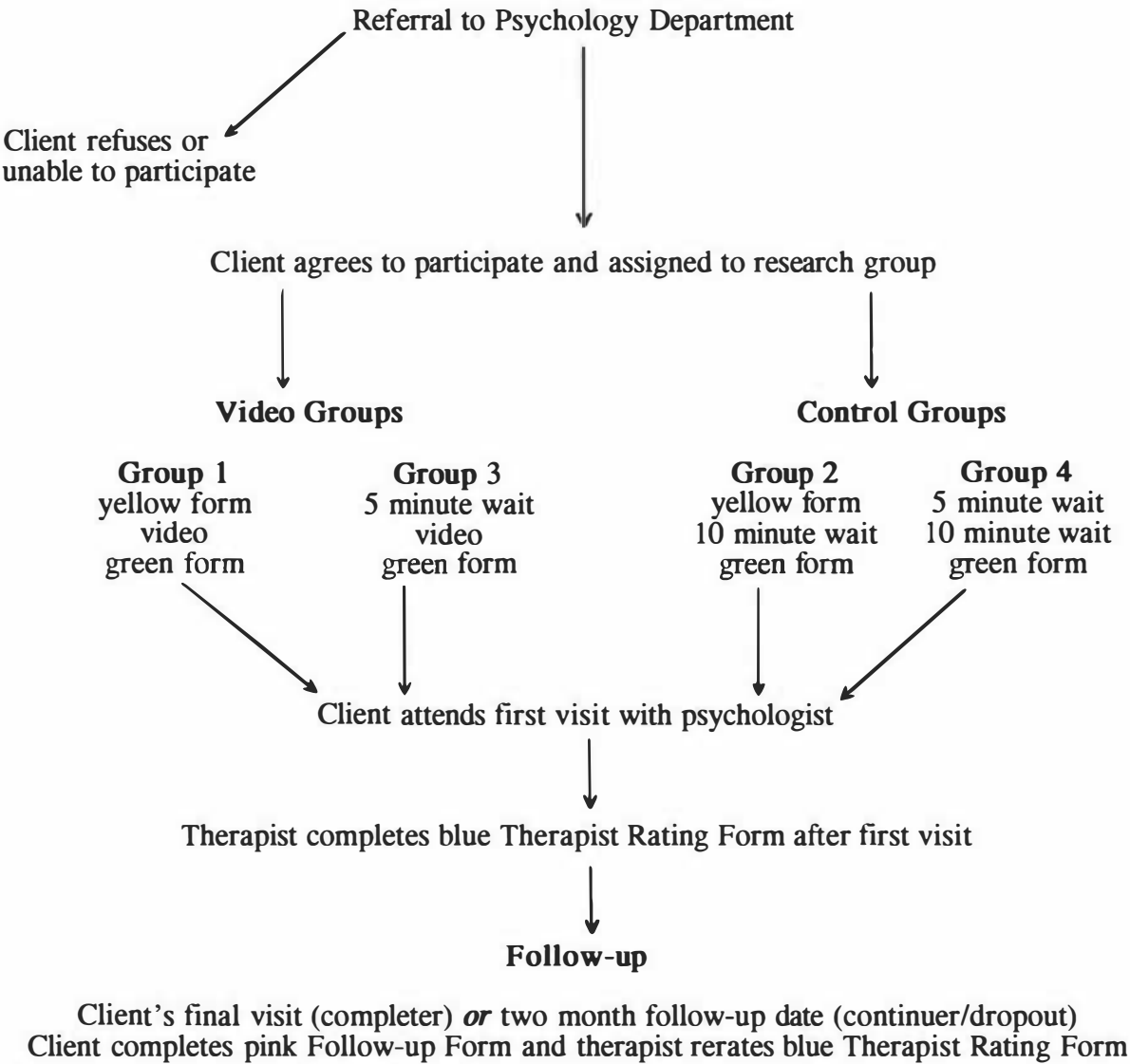
After two months or the completion of psychotherapy, whichever occurred first, participants were asked to complete the follow-up questionnaires. Ninety-two clients completed the follow-up and comprised the follow-up group. Characteristics of those who completed follow-up were compared with those participants who did not complete follow-up, using ANOVA for age and Chi-square for all other variables. There were no significant differences between the follow-up sample and participants who did not complete follow-up, on any of the variables in Table 1. This increases the likelihood that those completing follow-up were representative of all participants. These are important findings since they indicate that nonparticipation and attrition did not significantly bias the sample (Condon, 1986; Howard, Krause & Orlinsky, 1986).

#### 7.4 Therapists

Nine registered clinical psychologists participated in the study. All of them had completed a masters degree in psychology and all but one had a post-masters diploma in clinical psychology. One psychologist was an intern in training for the applied diploma in clinical psychology. On average the group had worked as clinical psychologists for 5 years, and their experience ranged from 1 to 12 years. Six of the psychologists indicated they preferred to practice "short term psychotherapy of 6-10 sessions" while the other three preferred "moderate term psychotherapy of 11-20 sessions". None indicated "crisis oriented psychotherapy of 1-5 sessions" or "longer term psychotherapy of 21 sessions and greater" as their preference. The number of participating clients per psychologist ranged from 5 to 34 with a mean of 15 at intake. The number of clients completing follow-up per psychologist ranged from 2 to 27 with a mean of 10. There were only two cases where the psychologist at intake differed from the psychologist at follow-up. Most therapists were eclectic and adhered to behavioural principles in their practice of psychotherapy. In addition five specifically indicated the use of cognitive behaviour therapy techniques, with two utilizing psychodrama approaches some of the time. All agreed that therapy was problem-oriented and verbal with the client being expected to take an active participatory role.

### 7.5 Research design overview

Before proceeding it is necessary to first understand the general research design which guided some of the decisions regarding the development of the procedure, videotape, and selection of research instruments. The strategy, a Solomon four-group design (Campbell & Stanley, 1966; Solomon, 1949) with two month follow-up is shown in Figure 1. The Solomon four-group design utilizes the traditional pretest-posttest control group design (groups 1 and 2) with additional experimental and control groups which are not pretested (groups 3 and 4). This design not only controls for most threats to internal validity (e.g. history, maturation, testing), but also controls for one of the threats to external validity, the reactive effect of testing or pretest sensitization. Details regarding the analysis of the Solomon four-group design are described in the Statistical Analyses section later in the chapter.



**Figure 1** Diagram of research design and procedure

The questionnaires were colour coded in order to reduce the use of technical and potentially threatening terms (e.g. test) and simplify the receptionists' procedure. Table 2 outlines the data collection schedule indicating which client and therapist measures were taken and at which stage of the data collection. Appendix B provides the measures in full.



Table 2  
Data Collection Schedule

Time of Administration			
<u>Client measures</u>	<u>Pretest (Yellow form)</u>	<u>Posttest (Green form)</u>	<u>Follow-up (Pink form)</u>
STAI-Y1	Groups 1 and 2	all	all
SR7	Groups 1 and 2	all	all
PQ	Groups 1 and 2	all	all
HSCL-21	-	all	all
STAI-Y2	-	all	all
TC	-	all	all
CSQ-8	-	-	all
<u>Therapist measures</u>		<u>After first visit</u>	<u>Follow-up</u>
Demographic sheet <sup>a</sup>		all	-
Prior therapy question		all	-
BHPRS		all	all
TCT		all	all
Dropout items		-	all
all= Groups 1,2,3 and 4		STAI-Y1 = State Trait Anxiety Inventory-Y state scale	
SR-7= 7-item S-R Inventory of Anxiousness		PQ= Psychotherapy Questionnaire	
HSCL-21= Hopkins Symptom Checklist-21		STAI-Y2= State Trait Anxiety Inventory-Y trait scale	
TC= Target Complaints measure (client version)		CSQ-8= Consumer Satisfaction Questionnaire-8	
BHPRS= Brief Hopkins Psychiatric Rating Scale		TCT= Target Complaints-Therapist version	
<sup>a</sup> one setting only, see Appendix H			

7.6 Preparation and pilot work

Developing the procedure

Developing the procedures required careful consideration of the Solomon four-group design. Prior to establishing the procedure, the amount of time it took to complete the

questionnaires and to view the video were calculated. Receptionists estimated that clients typically waited about 10 minutes in the reception area before being seen by their therapists. A sample of waiting times was taken and 10 minutes was considered a typical wait even though the samples ranged from 5 to 20 minutes.

The video was 11 minutes long, that is, as close as possible to clients' typical waiting time in order to balance the research design. The preparation of the videotape is described in detail later in the chapter.

A "waiting" condition served as the control. The use of a waiting condition was ecologically consistent with what occurred when clients arrived for an appointment (i.e. wait approximately 10 minutes to be seen). This waiting condition was seen as preferable to an "attention-placebo control", since providing a theoretically "inert" video would have been difficult, and would more likely have to be considered an alternative treatment (Horvath, 1988). One of the main goals of attention-placebo controls is to control for nonspecific factors such as contact, attention, and clients' expectancy of positive gains (Kendall & Norton-Ford, 1982). Clients who viewed the video, did so alone in order to keep the amount of staff contact and attention constant between the video and waiting condition groups. Waiting and video groups completed the same questionnaires so the amount of contact and attention required for their administration would be the same for each group. Expectancy of positive gains was not considered a variable which had to be controlled because one of the potentially desirable effects of the experimental intervention was to increase expectancy of positive gains.

The posttest ("Green form", see Appendix B, Table 2 and Figure 1.) consisting of the STAI-Y1, SR7, PQ, HSCL-21, STAI-Y2, and TC was pilot tested on four clients at a university based psychology clinic and found to take approximately 15 minutes to complete. Measures included in the pretest ("Yellow Form"), pink "Follow-up Form" and blue "Therapist Rating Form" can be seen in Table 2 and Appendix B. The state anxiety measures were ordered first in each instance to decrease the effects that completion of other scales may have on state anxiety.

#### Standardizing the procedure

Every attempt was made to standardize the procedure at the two settings. Originally it was proposed that the receptionists at both settings would give the client the various forms and present the video. Receptionists had successfully fulfilled similar roles in previous research

(Pekarik, 1983a, 1983b; Deane, 1987). Additionally it was thought that if the preparation proved to be beneficial, receptionist involvement in videotape presentation might become routine clinic procedure. However, the Hospital Ethics Committee at one setting required that the research psychologist explain the research to all subjects, despite this being explained in both the appointment letter and formal consent form. As a result the receptionist completed the procedure for one setting and the research psychologist completed the procedure for the other. Procedural instructions given to the receptionist and therapists are in Appendix G. The receptionist received training and instruction regarding the research procedures before the first client participated. This involved role plays and several "mock runs" through the research procedure. The research psychologist visited this site once every five weeks in order to ensure the procedure was being followed correctly and to collect and code data.

### Assignment to groups

Development of the allocation procedure also required consideration of the constraints of the research design and applied setting. Assignment was achieved by clients being consecutively placed in Group 1 through 4 (i.e. 1234123...). Clients were not aware of which research groups or condition to which they were assigned until after they had agreed to participate. This method of assignment was chosen for a number of reasons: it was simple for the receptionist to follow; it ensured similar numbers of subjects in each of the research groups; and other forms of random assignment were impractical. Minimal referral information coupled with not knowing which clients would turn up to participate made alternatives such as randomized blocks assignment unsuitable. There was no reason to suspect any subtle selection bias as a result of this procedure. Moreover, the subsequent results generally confirmed that the video and control groups were initially equivalent on all measures.

## **7.7 Procedure**

All new client referrals, where a need for outpatient psychotherapy was indicated, were sent a standardized research appointment letter (see Appendix H). This explained the purposes and procedures of the research, advised them of the appointment time for the first interview, the name of the clinical psychologist they were to see and asked them to attend 30 minutes prior to the appointment time. The clinical psychologist who scheduled the client was also responsible for placing the client's name, appointment time, therapist name and referral source on the Research Group Assignment Form (RGAF, see Appendix H).

If the client arrived in time to participate in the research then the receptionist or research psychologist gave them the Consent Form (see Appendix H). If the client agreed to participate they were sequentially assigned to one of the four research groups.

Subjects assigned to Group 1 (see Figure 1) completed the Yellow Form (pretest measure) in the reception area, were taken to the video room and viewed the video alone. They then returned to the reception area and completed the Green Form (posttest measure). Both the Yellow and Green Forms were always completed in the reception area. Group 2 completed the Yellow form, waited for 10 minutes in the reception area, and then completed the Green Form. Group 3 waited in the reception area for 5 minutes, watched the video and then completed the Green form, while Group 4 waited 15 minutes and then completed the Green form. After clients had completed the Green Form they were seen by the clinical psychologist.

The psychologists were aware that some clients were being shown an informational videotape prior to their initial interview, but they were blind to participants' group assignment. The psychologists were aware of the content of the videotape, but not the specific research hypotheses. Psychologists were instructed not to specifically ask clients whether they had viewed the video, but were free to discuss the video and its content if the client initiated discussion or asked questions.

At the completion of the initial session, the psychologist completed the Therapist Rating Form. Clients who were seen for only one visit did not participate any further, (no follow-up was completed). All other clients were followed-up at 2 months. Those clients who completed therapy prior to the 2 month follow-up date (completers), received the follow-up measures at the end of their last visit. Clients were asked to complete the Follow-up Form in the reception area to avoid their responding being influenced by the psychologist's presence. If clients were unable to remain after the visit to complete follow-up they were permitted to complete it at home and return the forms by mail. Similarly the psychologists completed their follow-up ratings on the same Therapist Rating Form upon which they had made their initial ratings.

## 7.8 Videotaped information

The script for the videotape (see Appendix A) was modelled closely on the script used by Zwick and Attkisson (1984, 1985). The practice of psychotherapy as described by Zwick and Attkisson, was consistent with the practice of psychotherapy at the research settings. Some modifications in the script were necessary to incorporate the characteristics of the research settings. These changes were made in the following manner.

First all the psychologists expected to participate in the research and 6 practicing clinical psychologists who were not participating in the research were asked to complete the Psychotherapy Questionnaire (PQ). Designed by Zwick & Attkisson (1984) the 17-item PQ assessed clients' reception, comprehension, and recall of information presented in their video orientation.

The PQ was administered to six of the clinical psychologists in the present study prior to them seeing the video script. The mean score was 13.8 (out of 17,  $SD=2.4$ ) indicating considerable agreement between what the psychologists expected in psychotherapy and the content of the video script.

The first draft was then reviewed by the Senior Clinical Psychologists at the two research settings, the Director of the University Psychology Clinic and four of the other participating psychologists. The script was then further refined to incorporate their suggestions. As a result of this process the videotape used in the present study differed mainly by the inclusion of additional information relevant to the settings rather than any exclusion. The following is an outline of the modifications made to Zwick and Attkisson's script:

1. A number of third person references were changed to first person in an effort to personalize the presentation (e.g. "the therapy appointments" to "your therapy appointments").
2. In many cases the term "therapist" was changed to "psychologist" since these were the professionals clients were to meet.

Additions included:

3. Addressing clients' initial uncertainty about whether they needed to be seen at a psychology department.
4. Since clients often met with a psychiatrist prior to their referral to the psychology department, psychiatrists and other professionals roles were put in context. It was also explained that medication and other forms of treatment such as group therapy may be recommended.
5. Clients were also informed that psychotherapy might involve "learning and practising new skills" in order to prepare them for some of the more behavioural therapy components used by psychologists in the research settings.
6. In order to standardize the video presentation for both settings the research psychologist presented and narrated the videotaped information, whereas Zwick and Attkisson (1985) used the clinic director in this role.
7. While Zwick and Attkisson (1985) used colour slides to illustrate points as they were presented, the present study used the following video sequences with the research psychologist's narration:
  - (a) European (white) female client sitting reading magazine in waiting area. European (white) male therapist greets client and escorts her to office. [Six of the 9 participating psychologists were white males and clinic statistics and prior research (Deane, 1987) indicated over 90% of the clients were of European descent and 67% were female].
  - (b) Client talking to therapist, therapist nodding. Therapist writing a brief note.
  - (c) Brief shot of therapy group.
  - (d) Client talking to therapist, therapist responding.
  - (e) Client and therapist talking. Therapy session concluding with therapist and client standing up and exiting.

Consistent with the conclusion of Zwick and Attkisson's presentation during segment (e) and the summary narration, the following main points were displayed in written form beneath the video sequence:

- (i) "Psychotherapy is an active problem-solving and learning process."
- (ii) "The relationship between you and your therapist is a central part of the therapy process."
- (iii) "It may take some time to get used to being in psychotherapy."

- (iv) "In order to make changes and improve, you must continue to attend even when things are difficult."
- (v) "Progress in psychotherapy does not occur right away, nor is it always steady."
- (vi) "In order to improve you must be willing to discuss things that may be uncomfortable to talk about."
- (vii) "The majority of clients who are willing to actively participate in therapy in this way can expect improvements to occur."

The videotaped presentation was 11 minutes long.

7.9 Instruments

In selecting the research instruments a number of requirements were balanced. The instruments needed to be reliable and valid. They needed to be measures which allowed comparison with similar research into the effects of pretherapy information. The outcome measures in particular had to cover a wide spectrum of psychotherapy outcomes. The measures had to be brief in view of repeated testing and relevant for use with a clinical population in an applied setting. The measures used are generally presented in the order in which they appeared in the study questionnaires, and can be found in Appendix B. Below is a list of the instruments used and their related constructs, with more detailed description of their psychometric properties following.

<u>Construct</u>	<u>Client instruments</u>
1. State anxiety	1. State-Trait Anxiety Inventory-Version Y, State scale (STAI-Y1)
2. State anxiety	2. 7-item S-R Inventory of Anxiousness (SR7)
3. Expectations	3. Psychotherapy Questionnaire (PQ)
4. Psychological distress	4. Hopkins Symptom Checklist-21 (HSCL-21)
5. Trait anxiety	5. State-Trait Anxiety Inventory-Version Y, Trait scale (STAI-Y2)
6. Target complaint/ problem severity	6. Target Complaints, client version (TC)
7. Satisfaction with services	7. Consumer Satisfaction Questionnaire-8 (CSQ-8)
	<u>Therapist instruments</u>
8. Symptom severity	8. Brief Hopkins Psychiatric Rating Scale (BHPRS)
9. Target complaint/ problem severity	9. Target complaints-Therapist version (TCT)

### State-Trait Anxiety Inventory- Version Y (STAI-Y)

The widely used STAI-Y (Spielberger, 1983) is comprised of two separate 20 item self-report scales for measuring state and trait anxiety. The state scale (STAI-Y1) consists of statements which evaluate how respondents feel "right now, at this moment". This scale can also be used to determine how a person felt at a particular time in the recent past. The state scale has been found to be sensitive to changes in transitory anxiety experienced by clients in counselling or psychotherapy (Spielberger, 1983). The trait scale (STAI-Y2) consists of statements which evaluate how respondents "generally feel". The trait scale has been used as a screening device to detect anxiety problems and for evaluating the immediate and long-term outcome of psychotherapy.

The STAI-Y is the revised version of the scale previously known as STAI-Version X (Spielberger, 1973). The STAI-Y is highly correlated with the STAI-X (between .96 and .98 for high school and college students). The revision occurred to improve the ability of the the scale to discriminate between anxiety and depression (e.g. Knight, Waal-Manning & Spears, 1983), to replace items which were "psychometrically weak" for specific groups, and to improve the factor structure of the trait scale by balancing the number of anxiety-present versus anxiety-absent items. The scale is self-rated using a four point Likert-type format from "not at all" to "very much so" for the state version and "almost never" to "almost always" on the trait version. The full scale is presented in Appendix B.

Test-retest reliability correlation coefficients for the state scale (STAI-Y1) were calculated using 357 high school students and ranged from .34 to .62 (Spielberger, 1983). The test-retest correlation was as low as .16 in a sample of 197 college students using version X. These low reliability coefficients are to be expected for valid measures of state anxiety since these should reflect differing states at various times and situations. Spielberger (1983) reported state scale alpha coefficients greater than .90 for large samples (from 71 to 1,893) of working adults, college students and military recruits. Only for male high school students did the alpha fall to .86, providing strong support for the internal consistency of the scale.

Test-retest reliability correlation coefficients for the trait scale using high school students retested at 30 days and 60 days ranged from .65 to .75, indicating adequate stability of the scale. The alpha coefficients for male and female: working adults, college students, high school students and military recruits ranged from .89 to .91.



Construct validity of the trait scale is evident when comparing the scores of neuropsychiatric patients with "normal" subjects. The scores of the neuropsychiatric patients were substantially higher than for the normal subjects (Spielberger, 1983), suggesting the STAI discriminates between "normals" and psychiatric patients. Similar findings were evident for military recruits undergoing stressful training and who had higher state scores than college and high school students of the same age who were tested in less stressful conditions. The recruits state score was also higher than their trait scores, suggesting increased distress when tested. In contrast, normal subjects tested in nonstressful conditions had similar state and trait scores. State anxiety scores are higher in college students when they are in examination conditions and significantly lower after relaxation training, than when tested in regular class period (Spielberger et al., 1970). It has been found that people who score high in trait anxiety tend to be higher in state anxiety even in relatively neutral situations. In general state scores have been found to increase during stressful situations and decrease after the stressful stimulus has passed, while trait scores remain relatively stable (e.g. Auerbach, 1973; Spielberger et al, 1973). The median correlation between STAI-Y1 and STAI-Y2 for the seven samples reported by Spielberger (1983) was .65.

There is evidence of concurrent validity with Form X of the trait scale, which had moderate to high correlations with a number of other anxiety measures administered to college students and neuropsychiatric patients: IPAT Anxiety Scale (Cattell & Scheier, 1963) range .75 to .77; Manifest Anxiety Scale (MAS, Taylor, 1953) range .79 to .83; and Affect Adjective Checklist (AACL, Zuckerman, 1960) range .52 to .58. The AACL also had low correlations with the IPAT and MAS which lead Spielberger (1983) to suggest the AACL may be a less adequate measure of trait anxiety.

In citing convergent and divergent validity for the STAI, Spielberger (1983) compared correlations of the STAI-X with personality and other tests using a method similar to Campbell and Fiske's (1959) multitrait-multimethod approach. In general there were significant positive correlations with other personality test subscales with related constructs (e.g. MMPI Psychasthenia scale .46 to .75, PRF Aggression scale .28 to .44) and little relationship between the STAI and unrelated constructs such as intelligence or scholastic aptitude (e.g. Beta test). Additional psychometric data for the STAI-Y is available in Appendix C.

### 7 item Situation-Response Inventory of Anxiousness (SR7)

The experimental SR7 was adapted from the S-R Inventory of Anxiousness-Form O (Endler, Hunt & Rosenstein, 1962). There were several reasons for adapting a measure of this kind for the present study.

1. There was a need to tap the emotional autonomic arousal components of state anxiety (Endler, 1980). While the STAI-Y1 adequately assessed the cognitive-worry aspects of state anxiety it appeared to lack items which tapped the autonomic physiological reactions associated with anxiety (e.g. increased heart rate, perspiration).
2. It was considered desirable to have an anxiety measure which explicitly specified the situation to which the client was responding. It clarified for the client that the inventory attempted to tap their reactions to "...coming to psychotherapy...now". This was considered important in view of evidence suggesting that situational factors account for some of the variance associated with anxiety (Endler & Hunt, 1966). For elaboration of these issues see Deane, Spicer & Leathem (1991) in Appendix C.
3. Since anxiety about psychotherapy had been associated with nonattendance at psychotherapy appointments (e.g. Noonan, 1973), it was felt a measure which also tapped the avoidance aspects of anxiety would be useful.

While the SR7 is most similar to the 7-item Behavioral Reactions Questionnaire (BRQ-7, Hoy & Endler, 1969), both the BRQ-7 and the SR7 were derived from the S-R Inventory of Anxiousness (Endler, et al., 1962). The items selected for the SR7 were a result of the Endler et al. (1962) factor-analysis of their original S-R Inventory of Anxiousness-Form O. This S-R Inventory consisted of 11 situations which varied "from the typically innocuous to the quite threatening.", (p.5) and 14 modes of response, totaling 154 items. The seven response modes which had the highest factor loading on Factor 1 were used as items in the SR7. Endler et al. (1962) referred to this factor as "distress-disruption-avoidance". The item content appeared to include the somatic and avoidance aspects of anxiety not apparent in the STAI-Y.

Most variations of the S-R Inventory of Anxiousness (e.g. S-R General Trait Anxiousness, Endler & Okada, 1975) have been trait measures used to determine Person-Situation interactions in anxiety (Endler, 1980). However the BRQ-7 (Hoy & Endler, 1969), 21-item BRQ (Flood & Endler, 1980) and eventually the 26-item Present Affect Reactions

Questionnaire-III (PARQ-III, Endler, 1980) were developed as state anxiety measures. The PARQ-III has 10 items which are classified as "autonomic-emotional" items (Endler, 1980). Several of these are identical to those used in the SR7, (also BRQ-7 and BRQ; e.g. perspire, heart beats faster, mouth gets dry).

The SR7 consists of 7 items rated on a 5 point Likert-type scale ranging from "Not at all" to "Very Much". The situation depicted in the directions of the SR7 was "coming to psychotherapy." This situation was most similar to Endler et al's (1962) situation "You are going to a counseling bureau to seek help in solving a personal problem." While there is little reliability and validity data on the SR7, there is considerable data on the inventories from which it was developed. The total score on the S-R Inventory of Anxiousness had high internal consistency with a Cronbach alpha of .97 (Endler, et al., 1962). The alphas for the seven modes of response also used in the SR7 ranged from .68 to .92. Factor-analysis of the S-R Inventory situations revealed three factors called interpersonal status threatened, inanimate personal danger and ambiguous situation. Factor-analysis for the modes of response found three factors the strongest of which was the "distress-disruption-avoidance" factor (Endler et al., 1962). Positive but modest correlations were found between the S-R Inventory of Anxiousness and other anxiety scales. The BRQ-7, a measure of state anxiety, had a correlation coefficient of .74 with the S-R Inventory. Subjects trait scores on the S-R Inventory to an imagined situation were considered predictive of their state scores when actually in the situation (Hoy & Endler, 1969). Evidence for the predictive and concurrent validity of the S-R Inventory was demonstrated in public speaking situations (Paul, 1966 cited in Endler & Hunt, 1966). Coefficient alpha reliabilities for the shorter and more recent S-R GTA ranged from .62 to .86 for all 4 situations. Neurotic adults reported greater anxiety than normal adults on all situations except physical danger (Endler & Okada, 1975) providing some support for the construct validity of this measure. Again evidence of concurrent validity was found with the S-R GTA having positive correlations with the STAI-trait scale and Taylor Manifest Anxiety Scale. The construct validity of the BRQ-7 and BRQ was supported by studies showing scores were elevated in stressful situations (Hoy & Endler, 1969; Flood & Endler, 1980). Alpha coefficients of the BRQ ranged between .89 on a "nonstressful" trial and .92 for the "stressful" trial (Flood & Endler, 1980). Additional psychometric data regarding the SR-7 is available in Appendix C.

### Psychotherapy Questionnaire (PQ)

The PQ is a 17 item true-false questionnaire developed by Zwick and Attkisson (1984) "to assess clients' reception, comprehension, and recall of the information" (p.447), presented in their pretherapy orientation videotape. They used two versions of the PQ one with female pronouns and one with male pronouns. These pronouns were changed to gender neutral items for the PQ used in the present study. Zwick and Attkisson (1984) reported KR-20 reliability coefficients for the pre-video (entry) administration to 62 outpatient mental health centre clients as .83 and at one month post-video follow-up .78. They found that control group members who did not view the videotape averaged 9.43 and 9.92 correct responses at entry and at follow-up, respectively. Members of the oriented group averaged 13.03 and 13.35 correct responses for the two administrations. The proportion of variance explained by group membership was .22 for the entry PQ and .23 for the follow-up. This provided some support for the validity of the measure.

The directions on the PQ in the present study, included the instruction for participants "...to indicate what you expect occurs in psychotherapy.", with additional reference to what is "expected" in two of the 17 items. Tinsley and Westcot's (1990) findings indicate that this direction stem is likely to stimulate cognitions about expectations as distinct from preferences. Additional psychometric data regarding the PQ can be found in Deane (1991b) in Appendix I.

### Hopkins Symptom Checklist-21 (HSCL-21)

In 1975 a group of experienced psychotherapy researchers met under the auspices of the National Institute of Mental Health (U.S.) to evaluate existing outcome measures and to recommend a core battery of the best instruments for use in psychotherapy outcome (Waskow & Parloff, 1975 cited in Lambert, Christensen, & DeJulio, 1983, p.153). The Hopkins Symptom Checklist (Derogatis, Lipman, Rickels, Uhlenhuth, & Covi, 1974) was recommended as one of the core measures.

The HSCL-21 (Green, Walkey, McCormick, & Taylor 1988) is a 21-item version of the 58 item Hopkins Symptom Checklist (HSCL) (Derogatis, et al., 1974). One of the advantages of HSCL-21 was its brief completion time. There have been many versions of the HSCL (29, 35, 45, & 54 item versions cited in Green et al., 1988), with the most widely used probably being the 90 item Symptom Checklist-90-Revised (SCL-90-R) (Derogatis, 1977). These "symptom checklists" have been widely used as measures of symptom distress in psychotherapy outcome research (e.g. Mintz, Luborsky, & Christoph,

1979), normal populations (e.g. Coyne, Aldwin, & Lazarus, 1981) and psychotherapeutic drug trials (e.g. Rickels, Lipman, Park, Covi, Uhlenhuth, & Mock, 1971). Test-retest reliability, interrater reliability (Rickels et al., 1971); internal consistency (Derogatis et al., 1974); construct validity (Prusoff & Klerman, 1974); and criterion-related validity (Rickels et al., 1971) have all been established. However it was the suspect factor structure of the HSCL and SCL-90-R (Cyr, McKenna-Foley, & Peacock, 1985; Holcomb, Adams, & Ponder, 1983) which led Green et al., (1988) to develop a shorter, more psychometrically sound, version.

The HSCL-21 has a replicable discrete three factor structure producing three subscales of 7 items each: General Feelings of Distress (GFD); Somatic Distress (SD); and Performance Difficulty (PD). These three scales can be summed to obtain a Total Distress Score. The reliability of the HSCL-21 is high with a corrected split-half reliability of .91 and an alpha coefficient of .90 for the total scale. Corrected split-halves for the subscales ranged from .80 to .89 and the alpha coefficients were from .75 to .86 (Green et al., 1988). These coefficients compared favourably with those of longer versions of the HSCL (e.g. Derogatis et al., 1974; Holcomb, et al., 1983). While clinical validation had not been completed there were New Zealand norms available for the HSCL-21 (Green, 1989). This, combined with its strong psychometric qualities, face validity and brevity made it the client self-rating symptom inventory of choice. For additional reliability and validity data, see Deane, Leathem and Spicer (1991) in Appendix D..

### Target Complaints (TC)

Target Complaints measures (client and therapist rated), (Battle, Imber, Hoehn-Saric, Stone, Nash, & Frank, 1966), were also recommended as one of the core measures for measuring psychotherapy outcome (Waskow & Parloff, 1975 cited in Lambert, et al., 1983, p.153). The target complaints measure is an individualized measure of psychotherapy outcome in that its content differs from client to client. It uses "each patient's spontaneously expressed presenting complaints (target complaints) as criteria for evaluating response to psychotherapy", (Battle et al., 1966, p.184). Target complaint measures were first used to assess psychotherapy outcome in research designed to determine the effects of systematic preparation for psychotherapy (Hoehn-Saric et al., 1964). Shortly after this the same group reported the results of three studies on the target complaints measure (Battle et al., 1966). Target complaints continued to be used in studies which examined the effects of preparation for psychotherapy (Strupp & Bloxom, 1973; Holmes & Urie 1975).

Target complaints measures have a number of strengths; they are idiosyncratic, allowing clients to spontaneously describe the problems for which they are seeking treatment; they are brief and easily completed; they are flexible in that they can be used with clients from widely differing settings and with different problems; they can be completed by multiple observers (e.g. client, therapist, family), and; they are appropriate for repeated use and ongoing monitoring of client change.

The methodological difficulties associated with target complaints measures have been elaborated by Mintz and Kiesler (1982). One of the main problems was how to elicit the target complaints. Earlier studies utilised interviewers specifically trained to clarify and specify relevant target complaints (Battle et al., 1966). The present study utilized the more economical method described by Rosen and Zytowski (1977) which asked the client "to write down, in his or her own words the problem(s) for which help is being sought and to rate its problem severity. After the therapeutic contact is completed, the problem statement is transferred to the follow-up questionnaire and the former client is asked to rerate the problem severity." (p.437). For the present study the clients initial rating was also placed on the target complaints measure as a reference point for follow-up ratings.

There have been many versions of TC measures (e.g. Battle et al., 1966; Holmes & Urie, 1975). The version used in the present study asked clients to write down the two most disturbing problems or complaints for which they were seeking help and indicate how much this bothered them on a Likert-type scale ranging from zero ("not at all") to nine ("couldn't be worse"). Therapists were asked to independently write down the clients target complaints and rate how much they thought the client was bothered by them. The target complaints measure was limited to two target complaints based on the average number of complaints elicited in other studies (Battle, et al., 1966; Luborsky, Mintz, Auerbach, Christoph, Bachrach, Todd, Johnson, Cohen, & O'Brien, 1980). This standardization was a compromise, reducing some psychometric and analysis problems, but not allowing some clients to express larger numbers of complaints (Mintz & Kiesler, 1983). A zero to nine response scale was used so that telephone follow-up would be simplified if it proved feasible (Sudman & Bradburn, 1982, p.270-1).

Despite a number of studies having reported on the reliability and validity of the TC measure considerable work is still needed in these areas. Battle et al. (1966) reported a correlation of .68 between rankings of problems before and after the assessment interview.

Severity ratings did not change to a significant degree before and after the psychiatric evaluation interview, despite several patients reporting feeling better after the interview. It was thought the emphasis on severity "in general" lead to this inconsistency. Bierenbaum, Nichols, and Schwartz (1976) reported a correlation coefficient of .79 between clinical psychologist's and patient's own ratings of 21 target complaints. Test-retest stability was demonstrated by Frey, Heckel, Salzberg, and Wackwitz (1976) who reported a highly significant correlation ( $r = .73$ ) between parents' ratings of target complaint improvement at termination and at one-month follow-up. Not all reliability studies have been positive. A study by Bloch, Bond, Quallis, Yalom, and Zimmerman (1977) found low reliability when psychotherapists were asked to independently rate the improvement clients had made on a range of initial target problems. Twenty-seven teams of three judges were formed. Only 10 teams of the 27 agreed on the patient's degree of improvement at a statistically significant level ( $p < .05$ ). Mintz & Kiesler, (1982) commenting on this study felt insufficient information made evaluation of these findings difficult.

Concurrent validity of the TC measures was demonstrated by Hoehn-Saric et al. (1964) who reported a correlation of .61 between patients ratings of improvement on target complaints and therapist global improvement ratings. Battle et al. (1966) claimed "significant" correlations between TC measures and both patient and therapist global ratings of improvement, and Social Ineffectiveness and Discomfort Scales. Unfortunately, no correlation coefficients were reported. Shorer (1970, cited in Mintz & Kiesler, 1982) reported correlations of .71 between target complaints and global improvement ratings for treated patients and .78 for untreated patients. Mintz et al. (1979) found that patient's improvement ratings on target complaints loaded on a general improvement factor derived from a number of patient and therapist ratings of therapy outcome. Evidence of TC construct validity is indicated by studies which have found the TC improvement ratings were greater for psychotherapy versus no-treatment controls (Sloane, Staples, Chritol, Yorkston & Whipple, 1975; Kent & O'Leary, 1976).

Only rarely has the content of target complaints been used (Sloane et al., 1975) and subsequent attempts to categorise TCs using these classification systems have proven difficult (Mintz & Kiesler, 1982). One of the strengths of the TC measures is their face validity allowing heterogeneous client populations to present a variety of initial complaints or problems in a range of psychotherapy situations. For elaboration of methodological issues and additional validity data regarding target complaint measures see Deane and Spicer (1991) in Appendix E.

### Brief Hopkins Psychiatric Rating Scale (BHPRS)

The BHPRS is a therapist completed rating scale comprised of nine primary symptom dimensions and a global pathology index. Each of the dimensions is given a definition and represented on a 7-point Likert-type scale (0-6) ranging from "none" to "extreme". In addition to the usual adjective and numerical descriptors for each of the scale points, three of the 7 points on each dimension are defined by brief clinical descriptors. The descriptors and numerical values of the dimensions were derived by the judgements of 14 psychiatrists (Derogatis, 1978). The global pathology index is a 9-point Likert type scale (0-8) ranging from "absent" to "extreme" with four of the 9 points defined by brief clinical descriptors.

There is little reliability and validity data available on the BHPRS. The scale was used by Tracey (1986) who reported one week test-retest reliability estimates of .89 from an independent sample of 5 therapists who each rated 3 clients. The SCL-90 Analogue (Derogatis & Mellisaratos, 1976) a clinical observer's scale designed for health professionals without detailed training or knowledge of psychopathology, is very similar to the BHPRS. It utilized the same 9 symptom dimensions and global distress scale, but used a graphic versus Likert-type scale ranging from "not at all" to "extremely". Identical definitions of each of the dimensions are on the back of the form. Interrater reliability for these scales ranged from .78 to .96 (Derogatis, 1977). The Global pathology index of the BHPRS is similar to other therapist rated global measures such as the Global Assessment Scale (GAS, Endicott, Spitzer, Fleiss, & Cohen, 1976) which have adequate reliability and validity as measures of overall pathology within specified time periods. Similar global ratings have been made by 27 teams of 3 judges using a 17-point scale, from "worst" to "best" possible outcome (Bloch et al., 1977). Twenty percent of the teams reached perfect agreement, and 60% of the ratings were within a scale point of one another. The authors felt superior agreement could be reached if fewer points on the scales and broader categories were used, (such as with the 9 point global pathology index). Similarly Kuhlman, Sincaban, and Bernstein (1990) reported a reliability coefficient of .95 for two teams of 5 clinicians who separately rated a sample of 39 patients. They cited some evidence for the validity of the GAS scale from the correlations ( $r = -.61$ ) these ratings had with subscales of a standardized nurses' observation inventory.

The BHPRS was used because of its brevity, and because it provided assessment of specific symptom dimensions in addition to the global rating of psychopathology. The BHPRS has also been used previously in research related to the role of expectation in



counselling (Tracey & Dundon, 1988). It is somewhat shorter than similar scales such as the Brief Psychiatric Rating Scale, (Overall & Gorham, 1962) and the Brief Outpatient Psychopathology Scale (Free & Overall, 1977), neither of which have global ratings of psychopathology. The BHPRS Likert-type scale structure was considered superior to the more graphic scale of the SCL-90 Analogue due to its specific descriptions of each of the symptom dimensions along with additional descriptive anchors for each subscale. These further clarified the meaning of each of the dimensions for therapists without requiring them to look elsewhere to find their definitions. Brevity, face validity, and clarity were essential in selecting a therapist completed rating scale, particularly in view of other outcome studies which have been halted due to staff frustration and resentment at having to complete additional monitoring of client outcomes (e.g. Schainblatt, 1980).

Internal reliability of the BHPRS for the sample in the present study was calculated for all 10 items using Cronbach alpha. At entry the alpha coefficient was .71 ( $n=138$ ) and at follow-up .82 ( $n=90$ ).

#### Consumer Satisfaction Questionnaire-8 (CSQ-8)

The CSQ-8 (Attkisson & Zwick, 1982) is an eight item version of the Consumer Satisfaction Questionnaire (Larsen et al., 1979; Levois, Nguyen & Attkisson, 1981). It consists of eight Likert-type items with four response choices, where "1" indicates the lowest degree of satisfaction and "4", the highest. The CSQ-8 has high internal consistency with alpha coefficients ranging from .93 in a sample of community mental health centre clients participating in a pretherapy orientation study (Attkisson & Zwick, 1982) to .874 in a sample of 3,120 clients from a variety of mental health facilities (Nguyen, Attkisson, Stegner, 1983). (An alpha coefficient of .92 was obtained for clients in the present study,  $n=92$ ).

The scale means ranged from 24.16 (Attkisson & Zwick, 1982) to 27.09 (Nguyen et al., 1983) with standard deviations being 4.94 and 4.01 respectively. Factor analysis showed only one factor for the scale (Nguyen et al., 1983). The CSQ-8 has been found to be correlated with whether clients remain or terminate therapy at one month ( $r=.57$ ) and with number of therapy sessions attended in one month ( $r=.56$ ) (Attkisson & Zwick, 1982). Smaller but statistically significant correlations were also found between the CSQ-8 and change in self-reported symptoms, and both client and therapist global improvement ratings (Attkisson & Zwick, 1982). Modest relationships have also been found between other measures of therapy gain and satisfaction (Larsen, 1979 cited in Nguyen et al.,

1983). Partial correlations and the finding that clients' satisfaction ratings were not correlated with their concurrent ratings of symptom levels led Attkisson & Zwick (1982) to conclude the findings were not merely the result of a global satisfaction factor, halo effects or correlations with initial symptom levels. The CSQ-8 was related to three of the five measures of therapy improvement and two of three service utilization measures providing considerable evidence of its construct validity. Therapists were asked to estimate how satisfied they believed their clients to be and their ratings correlated ( $r = .56$ ,  $p < .01$ ) with clients ratings on the CSQ-8 (Larsen, 1979 cited in Nguyen et al., 1983). This provided some evidence of the concurrent validity of the CSQ-8. It has been found that satisfaction as measured by the CSQ-8 (and similarly constructed scales) is negatively skewed reflecting high levels of satisfaction with health and mental health services (Nguyen et al., 1983). This raises concerns about the discriminative validity of this and similar measures, and it appears that while it is able to detect satisfied "customers" it is less sensitive to those who may be dissatisfied.

### **7.10 Service Utilization Measures**

#### **Dropout**

There is considerable controversy concerning appropriate measures of client dropout (Baekland & Lundwall, 1975; Morrow, Del Gaudio, & Carpenter, 1977; Pekarik, 1985a, 1985b 1986). Measures have typically been a function of number of sessions attended, length of time in treatment, or therapist judgments of client dropout. It has become increasingly accepted that length of time in therapy is not a preferred measure since it does not necessarily reflect the number of visits attended. Two clients who have attended for the same length of time may have come to very different numbers of therapy sessions (Baekland & Lundwall, 1975). Pekarik (1985a) argued that the number of visits attended was a problematic measure because different researchers used different numbers of visits as the criterion for categorising a client as a dropout. He also found duration was not necessarily related to dropout status when over half of clients who attended three to five sessions were considered appropriate terminations by their therapists (Pekarik, 1984 cited in Pekarik, 1985a). Pekarik (1986) recommended "Appropriate termination should only be determined by therapist judgement of attendance at the last scheduled therapy session (i.e. a client does not terminate by appointment failure)", (p.26). Consistent with these recommendations the present study asked two questions of therapists at the two month follow-up in order to differentiate dropouts from continuers or appropriate terminators: 1. "Did the client attend the last scheduled appointment?", (Pekarik, 1985a, 1986) and 2.

"Was the client in need of further treatment at last visit?", (Pekarik, 1983a, 1983b). While Pekarik (1985a, 1986) considered the first question had the advantage of reliability, it had the disadvantage of potentially classifying asymptomatic clients who may have been terminated by the therapist in a few more sessions. It also had the problem of not classifying highly symptomatic clients who had stated their intention to "prematurely" terminate (so that no further appointments were scheduled). A compromise is reached by adding question two. This reduces the likelihood of the above disadvantages at the expense of introducing another potential disadvantage; that therapists may use different standards for judging the clients need for further treatment.

#### Attendance measure

As noted above, length of time in treatment and number of sessions attended were not considered adequate measures of client dropout when used alone. However when combined with therapists judgments of termination status these measures have been found potentially useful indicators of clinical improvement (Pekarik, 1986). Pekarik (1983a) made a distinction between "early dropouts" who drop out within one or two visits and "late dropouts" who drop out beyond two visits. He reviewed several studies which provided preliminary evidence that early dropouts had poorer adjustment than late dropouts (Pekarik, 1986, 1983a). Further usefulness of attendance as an outcome measure is suggested by studies which have found a positive relationship between length of therapy and therapeutic outcome (Howard, Kopta, Krause, & Orlinsky, 1986; Luborsky, Chandler, Auerbach, Cohen, & Bachrach, 1971).

The number of subsequent visits to the clinical psychologist within two months of the first visit was used as the attendance measure. This measure was obtained from clinical notes recorded in the clients record. For elaboration of issues related to attendance and dropout see Deane (in press) in Appendix F.

### **7.11 Statistical Analyses**

The statistical analyses were completed using SPSS/PC (Norusis, 1988). The alpha level used in hypothesis-testing was .05 and 2-tailed unless otherwise specified. Alpha levels were not adjusted for multiple comparisons, following Rothman (1986). He demonstrates the arbitrary basis of conventional adjustment strategies, and argues instead for the clear statement of hypotheses and the inclusion of all results (pp.147-150). As it was the subsequent significant results were generally at a level where any adjustment to alpha

would have made little difference. Adjustment of alpha levels for multiple comparisons was also avoided since there were several hypotheses which required non-significance (e.g. Hypothesis 4, 5 and pretest sensitization effects in Hypothesis 1). Any adjustment to alpha may have biased results in favour of these hypotheses.

The Solomon four-group design was used to test the hypotheses regarding the immediate effects of the video preparation on clients' expectations and anxiety. As noted this design is able to assess for the presence of pretest sensitization, a potential threat to external validity. Pretest sensitization means that "...exposure to the pretest increases (or decreases) the Ss' sensitivity to the experimental treatment, thus preventing generalization of results for the pretested sample to an unpretested population.", (Huck & Sandler, 1973, p.54). Statistical analysis of the Solomon four-group design has been elaborated by Braver & Braver (1988). The initial phase of the analysis determines whether evidence of pretest sensitization exists, in this case whether the preparatory video effects expectations or anxiety but only when a pretest is administered. The test for this is a 2 X 2 ANOVA on the posttest scores with the factors being treatment (video vs control) and pretest (yes vs no). Evidence of pretest sensitization is detected by an interaction between the treatment and pretest factors, and a simple effect for treatment for those who were pretested. If there is no interaction it is concluded there is no pretest sensitization and the analysis proceeds by checking for treatment effects.

Multivariate analysis of variance (MANOVA) was used in several analyses. MANOVA is recommended when there are multiple correlated dependent variables, since it provides protection against inflated Type-I error and confounding (Tabachnick & Fidell, 1989). The use of repeated measures MANOVA for the analysis of improvement over the course of psychotherapy also avoided the stringent assumptions of repeated measures ANOVA (O'Brien & Kaiser, 1985; Tabachnick & Fidell, 1989). One-way MANOVA was used to test whether clients in the prepared group had more positive therapy outcomes than those in the control group at outcome. This avoided the problems associated with change or "raw gain" scores (Cronbach & Furby, 1970; Green, Gleser, Stone & Seifert, 1975) and the difficulties with interpreting "residual gain scores" (Mintz & Kiesler, 1982; Mintz et al., 1979). Analysis of covariance has been recommended for analysing change in experimental designs (Cook & Campbell, 1979), using initial level (posttest) as the covariate and posttreatment measures (follow-up) as the dependent variables. This was not appropriate for the present study since covariates must be independent of the experimental manipulation (Cook & Campbell, 1979; Tabachnick & Fidell, 1989). This

generally requires that covariates be gathered prior to the experimental manipulation, but in the present study the potential covariates were not gathered until after. When differences in initial levels of dependent variables are minimal, analysis of final status is an appropriate method for measuring outcome in psychotherapy (Cook & Campbell, 1979; Green et al., 1975). Initial levels of the outcome variables between the video and control groups should be equivalent if randomization was effective, however assessment of posttest scores was completed to provide additional support for this prior to conducting the one-way MANOVA using follow-up scores.

Hierarchical multiple regressions were used to test whether the relationship between state anxiety and outcome measures at follow-up was linear or curvilinear. This procedure was used since it allowed state anxiety squared to be added into the regression equation as an independent variable after state anxiety thereby determining whether a quadratic effect could add significantly to the regression solution.

## CHAPTER 8

### RESULTS

#### ***8.1 Data screening and missing values***

Prior to analysis the PQ, STAI-Y1, SR-7, HSCL-21, STAI-Y2, target complaint measures, CSQ-8, BHPRS and number of visits data were examined for accuracy of data entry, missing values and adequacy of assumptions for multivariate analysis. The variables were examined separately for video and control groups. Originally a second attendance measure was to be used in the analysis (number of visits with psychologist and other mental health professionals, see Appendix F), but this was dropped from the analysis since it was a composite of number of visits with the psychologist and a redundant variable which may have weakened the multivariate analysis. There were small numbers of univariate outliers for a number of variables, but inspection of these cases confirmed they were accurately entered and sampled from the target population. The outliers were not extreme values and in view of a relatively large sample size which was normally distributed on all variables, outliers were not deleted and no transformation of variables was warranted. Results of evaluation of assumptions of normality, homogeneity of variance-covariance matrices, linearity, and multicollinearity were satisfactory (Tabachnick & Fidell, 1989).

Where more than 15% of a scale's items were missing the missing case was replaced by the scale's group mean, otherwise a prorated score was used. Prorated scores were obtained by multiplying the sum of completed items by the number of items in the scale and then dividing the product by the number of items completed. Measures with less than seven items were not prorated since one missing item was greater than the 15% criteria. For follow-up data, this procedure was used only for those who completed and returned the follow-up questionnaire.

For pretest measures the percentage of cases with missing data ranged from zero (SR-7) to 19% (PQ). For all posttest measures except target complaints the percentage of subjects with missing data ranged from 2% (HSCL-21) to 7% (PQ). Ninety-seven (70%) of the 138 participants completed the follow-up questionnaires. For all client follow-up measures except target complaints the percentage of cases with missing data ranged from 1%

(HSCL-21) to 9% (PQ). There was no missing data for therapists initial ratings on the BHPRS and only one case with missing data for follow-up ratings.

Target complaint measures requested the respondent to write the two most disturbing complaints for which treatment was being sought and to rate the severity of each complaint on a 10-point Likert-type scale. Target complaint measures were qualitatively different to other measures since they used an open response format instead of a closed response format. In addition it was expected that not all clients would necessarily provide more than one complaint so incomplete items were not considered "missing" in the usual sense. How missing target complaint values were handled is elaborated further in the results section. A post-hoc analysis confirmed equivalent results were obtained using repeated measures MANOVA with and without estimating missing target complaint values. This repeat analysis with and without missing data increases the confidence in the results using estimates of missing values (Tabachnick & Fidell, 1989).

## 8.2 Hypothesis 1

**Videotaped information will increase the accuracy of clients expectations and reduce state anxiety.**

The recommendations of Braver and Braver (1988) for the statistical treatment of the Solomon four-group design were followed for testing this hypothesis and were outlined in the method chapter.

To test the hypothesised increase in the accuracy of expectations for subjects in the video group the Psychotherapy Questionnaire (PQ) total correct score was used as the dependent variable. A 2x2 between-groups ANOVA was conducted on the four posttest scores. Table 3 provides the means and standard deviations for the treatment and pretest factors. Pretest sensitization would be indicated by a significant interaction, and a significant simple effect for pretested groups, but not for unpretested groups.

**Table 3**  
Means and standard deviations of Psychotherapy Questionnaire  
posttest scores by treatment and pretest factors

Pretest	Treatment					
	Video			Control		
	M	SD	n	M	SD	n
Yes	11.56	2.41	36	10.34	2.36	34
No	12.34	2.43	34	10.22	2.43	34

There was no significant interaction effect for PQ scores on the 2x2 ANOVA, ( $p = .27$ ) indicating no pretest sensitization effects were present. There was a main effect for treatment,  $F(1,134) = 16.41$ ,  $p < .001$ , and mean differences indicated those who viewed the video had more accurate expectations as hypothesised.

Although not necessary for the Braver and Braver (1988) style analysis of Hypothesis 1, pre-posttest means on the PQ for the video and control groups are also provided for descriptive purposes. As can be seen in Table 4 the video group appeared to show an increase in the accuracy of their expectations with an increase in their scores on the PQ, while those in the control group experienced a slight decrease on average.



**Table 4**  
Pre-posttest means and standard deviations on the Psychotherapy Questionnaire

	Treatment			
	Video (n=36)		Control (n=34)	
	M	SD	M	SD
Pretest	10.50	1.76	10.93	2.13
Posttest	11.56	2.41	10.34	2.36

To test the hypothesised decrease in state anxiety both SR-7 and STAI-Y1 total scores were used in separate analyses. A 2x2 between-groups ANOVA using STAI-Y1 scores (Table 5) revealed a significant interaction between treatment and pretest,  $F(1,134)=4.96$ ,  $p=.028$ , suggesting the possibility of pretest effects. A one-way ANOVA using pretested groups only indicated no significant treatment effect,  $F(1,68)=1.19$ ,  $p=.28$ . However, ANOVA indicated the simple main effect for un-pretested groups was significant,  $F(1,66)=4.25$ ,  $p=.043$ , but in the opposite direction to that hypothesised. This suggests pretest sensitization did not occur. To examine treatment effects while ignoring the pretest factor, an ANOVA on posttest scores was conducted and was insignificant,  $F(1,136)=.37$ ,  $p=.542$ .

Table 5

Means and standard deviations of the State-Trait Anxiety Inventory state scale posttest scores by treatment and pretest factors

Treatment						
Pretest	Video			Control		
	M	SD	n	M	SD	n
Yes	43.67	12.27	36	46.91	12.62	34
No	52.27	11.16	34	46.16	13.22	34

When there is no evidence for pretest sensitization and no main effect for treatment Braver and Braver (1988) argued this should not be considered conclusive evidence against a treatment effect because the pretest information has not been used and can increase power substantially. They suggested doing a separate two-group analysis of covariance (ANCOVA) using posttest scores as the dependent variable and covarying pretest scores (see Table 6). The ANCOVA produced a significant main effect for the groups,  $F(1,67)=8.74$ ,  $p=.004$ , indicating a treatment effect in the predicted direction was present for the STAI-Y1 state anxiety measure.

Table 6

Pre-posttest means and standard deviations on the State-Trait Anxiety Inventory state scale

Treatment				
	Video (n=36)		Control (n=34)	
	M	SD	M	SD
Pretest	48.47	12.02	47.44	12.61
Posttest	43.67	12.27	46.91	12.62

To analyse potential treatment effects for the situation-specific state anxiety measure (SR-7), a 2x2 ANOVA (see Table 7) was conducted using posttest SR-7 summed scores. There was no significant interaction between treatment and pretest factors. ANOVA was conducted to examine the main effect of treatment and indicated no significant treatment effect,  $F(1,136) = .91, p = .342$ .

**Table 7**  
Means and standard deviations of the 7-item S-R Inventory of Anxiousness (SR-7) posttest scores by treatment and pretest factors

Pretest	Treatment					
	Video			Control		
	M	SD	n	M	SD	n
Yes	13.58	5.12	36	14.06	6.47	34
No	16.85	6.67	34	14.24	6.52	34

Consistent with Braver and Braver’s recommendation ANCOVA as described above was conducted using SR-7 scores (see Table 8). A significant treatment effect in the predicted direction was present,  $F(1,67) = 10.58, p = .002$ .

**Table 8**  
Pre-posttest means and standard deviations on the  
7-item S-R Inventory of Anxiousness (SR-7)

	Treatment			
	Video (n=36)		Control (n=34)	
	M	SD	M	SD
Pretest	16.61	6.30	14.18	6.15
Posttest	13.58	5.11	14.06	6.47

There was thus strong support for hypothesis 1: the preparatory videotape increased the accuracy of clients’ expectations and reduced state anxiety. In addition the Solomon four-group design enabled the effects of pretest sensitization to be ruled out as an artifact influencing this result. Confirmation that the video increased the accuracy of clients’ expectations and reduced their state anxiety allows the relationship between these variables to be examined further.

8.3 *Hypothesis 2*

**Treatment effects on state anxiety will be mediated by expectations.**

For the mediation hypothesis to be confirmed a number of conditions must be met (Baron & Kenny, 1986):

- (a) The independent variable (video/control) must be significantly related to the presumed mediator (expectations);
- (b) The mediator (expectations) must be significantly related to the dependent variable (state anxiety);

- (c) The independent variable (video/control) must be significantly related to the dependent variable (state anxiety) and;
- (d) When both of the relationships in (a) and (b) above are controlled, the previously significant relationship in (c) is no longer significant.

Thus far two of the conditions have been confirmed: condition (a) that the independent variable significantly accounts for variation in expectations, and the prerequisite significant relationship between the independent variable and state anxiety (condition c). Because the independent variable is assumed to cause the mediator, Baron and Kenny (1986) state these two variables should be correlated. In order to test for the presence of condition (b) simple and within-groups pooled correlations between posttest PQ scores and both STAI-Y1 and SR-7 measures were calculated. Insignificant relationships between expectations and state anxiety on both measures (range  $r = .01$  to  $r = -.14$ ) resulted in no support for the hypothesis that expectations mediated the relationship between the treatment and anxiety. No test for condition (d) was needed since failure to confirm one of the three conditions is sufficient to rule out a mediational relationship.

In view of this result a post-hoc analysis was conducted in an attempt to replicate the findings of Harfield et al. (1982) who found a significant negative correlation ( $r = .51$ ) between expectation congruency scores and state anxiety scores. One possible reason that the predicted relationship between expectations and state anxiety was not confirmed in the present study may have been the expectations measure used. It is possible that accuracy of expectations in the present study was not the same as congruency of expectations used by Harfield et al. (1982). In their analysis they used a direct measure of congruence between expected and experienced sensations, obtained by subtracting postinformation preprocedure (barium enema) expected sensation scores from postprocedure sensation scores. The absolute difference was then subtracted from a large positive constant (75, so that the highest level of congruency was equal to 75 and decreased as congruency decreased).

In an attempt to replicate this result, congruence of expectations with the videotaped information was determined. The absolute arithmetic difference between pretest and posttest PQ scores was subtracted from a positive constant (10) to provide a measure of congruence. The larger the score the higher was congruence between what the client initially expected and then expected after the videotaped information. This congruence

score was then correlated with posttest state anxiety. No significant correlations were found between the expectation congruence measure and either the STAI-Y1 ( $r = .07$ ) or the SR-7 ( $r = .17$ , both  $n = 70$ ).

The congruence of posttest expectations with what was experienced in psychotherapy was correlated with state anxiety. The absolute arithmetic difference between posttest and follow-up PQ scores was subtracted from a positive constant (10) and served as the second congruence measure. This was then correlated with the follow-up state anxiety score. No significant correlations were found between this congruency score and either the STAI-Y1 ( $r = .05$ ) or the SR-7 ( $r = .09$ , both  $n = 92$ ). Thus none of the analyses performed provided support for the hypothesis that the reduction of state anxiety was mediated by expectations.

#### **8.4 Improvement over the course of psychotherapy**

Prior to examining the formal hypotheses related to longer term effects of the informational video on outcome, an analysis of the overall effects of psychotherapy for all clients was conducted in order to clarify the context in which some of the hypotheses were tested. This information is of particular importance for those hypotheses which involve analysis of longer term effects using follow-up data.

In order to determine improvement over the course of psychotherapy, posttest scores prior to the commencement of therapy (entry) and follow-up measures two months later served as within-subjects dependent variables. Repeated measures MANOVA was conducted using posttest and follow-up scores on the HSCL-21, STAI-Y2, and BHPRS as dependent variables. Due to unequal sample sizes a separate repeated measures MANOVA was used to analyse the target complaints measures.

In the first MANOVA of the HSCL-21, STAI-Y2, and BHPRS, the overall multivariate difference between entry and follow-up was significant,  $F(3,89) = 53.36$ ,  $p < .0005$ . Table 9 shows means and subsequent univariate F-tests for all measures. All univariate F-values were significant and all mean differences were in the expected direction.

Similarly the MANOVA of target complaint measures had a significant overall multivariate effect,  $F(4,70) = 49.61$ ,  $p < .0005$ . Again all means and univariate F-tests were significant and in the expected direction as shown in Table 9.

Table 9  
Means, standard deviations and univariate F-tests on  
outcome measures from entry to follow-up

(n=92)	Entry		Follow-up		F(1,91)
	M	SD	M	SD	
HSCL-21	44.76	11.13	38.49	11.24	38.08*
STAI-Y2	53.24	10.98	47.72	13.15	27.27*
BHPRS	15.30	6.24	10.08	6.24	152.24*
(n=74)	M		SD		F(1,73)
	M	SD	M	SD	
TC1	7.31	1.34	4.78	2.51	98.44*
TC2	6.90	1.42	4.31	2.51	72.89*
TCT1	6.31	1.46	4.01	1.91	116.61*
TCT2	5.69	1.46	3.77	1.43	131.95*

\*all p < .0005

HSCL-21= Hopkins Symptom Checklist-21

BHPRS= Brief Hopkins Psychiatric Rating Scale

TC2= second client completed target complaint

TCT2= second therapist completed target complaint

STAI-Y2= State-Trait Anxiety Inventory Form Y trait scale

TC1= first client completed target complaint

TCT1= first therapist completed target complaint

Entry= posttest administration

The results clearly indicated clients showed improvement over the course of psychotherapy. However, this analysis did not establish whether it was psychotherapy which was responsible for this improvement. In order to conclusively show psychotherapy was the change agent, a control group which did not receive psychotherapy would have been required. For our purposes it is sufficient to recognise decreases in symptom distress, trait anxiety, therapist rated symptom severity, and both client and therapist rated target complaint severity occurred from entry to follow-up. The results of the subsequent analyses which tested follow-up effects can be considered in relation to this background of improvement.

### 8.5 Hypothesis 3

**Clients receiving videotaped information will have more positive therapy outcome at follow-up than the control group.**

Clients must have attended at least one visit beyond their initial appointment to be eligible for assessment of therapy outcome. This was considered the minimum criterion for assuming psychotherapy participation and was required for therapists to be able to make a meaningful follow-up rating of clients.

Therapy outcome was measured by 10 variables (HSCL-21, STAI-Y2, TC1, TC2, CSQ-8, BHPRS, TCT1, TCT2, attendance and dropout). Inspection of univariate F-tests of posttest scores (entry level) revealed no significant differences between the video and control groups (see Tables 10 and 11). This suggested initial levels of the outcome variables between the video and control group were equivalent, as would be expected if the randomization process was effective. (It is also noteworthy that Chi-square analyses revealed no significant differences between video and control groups on all variables in Table 1,  $p > .05$ ). Accordingly analysis of follow-up scores without control of initial levels of the dependent variables was appropriate (Cook & Campbell, 1979; Cronbach & Furby, 1970).

Multivariate analysis of variance (MANOVA) was used for the analyses of 9 of the 10 dependent variables. Chi-square was used to test for any differences between the video and control group with regard to dropout status and is reported later.

A one-way MANOVA was conducted using number of visits with the psychologist and follow-up scores on the HSCL-21, STAI-Y2, BHPRS and CSQ-8 as dependent variables ( $n=92$ ). The combined DVs were not significantly affected by treatment,  $F(5,86)=.72$ ,  $p=0.611$ , despite all means being in the predicted direction. Table 10 provides means, standard deviations and univariate F-tests for these dependent variables.



Table 10

Means, standard deviations and univariate F-tests for video and control groups on HSCL-21, STAI-Y2, BHPRS, CSQ-8 and number of visits.

Group	HSCL-21		STAI-Y2		BHPRS		CSQ-8	# visits
	Entry	FU	Entry	FU	Entry	FU	FU	FU
Video (n=43)								
M	45.21	37.43	53.59	47.53	15.54	9.92	27.30	5.61
SD	11.38	11.35	11.47	13.80	5.89	6.29	4.10	2.67
Control (n=49)								
M	44.36	39.43	52.93	47.89	15.10	10.21	26.23	4.97
SD	11.00	11.18	10.64	12.69	6.59	6.60	4.19	2.13
F(1,90)	0.13	0.72	0.08	0.02	0.11	0.05	1.51	1.61
p	0.72	0.40	0.78	0.90	0.74	0.83	0.22	0.21

HSCL-21 = Hopkins Symptom Checklist-21  
BHPRS = Brief Hopkins Psychiatric Rating Scale  
# visits= number of visits with the psychologist  
FU= Follow-up administration

STAI-Y2= State Trait Anxiety Inventory Form Y trait scale  
CSQ-8= Consumer Satisfaction Questionnaire-8  
Entry= posttest administration

Due to a greater proportion of missing data on the Target Complaint measures (TC1, TC2, TCT1, TCT2), a separate one-way MANOVA was conducted using the follow-up target complaint scores (n=74). Clients first and second target complaints were not combined into a single target complaint measure but were analysed as separate problems. This is consistent with Mintz and Kiesler’s (1982) warnings about the difficulties in combining ratings from different problems for target complaints measures. In order to maximize the use of available data and minimize the insertion of group means for missing data, only those cases which included a follow-up rating on the first of the client completed TC’s were included in the analysis. This resulted in 10 group means being inserted, 6 for the second client rated TC and 4 for the second therapist rated TC. There was no missing data for the first of the client or therapist rated target complaints.



Chi-square analysis was used to determine whether clients in the video group were less likely to drop out of therapy than those in the control group. Clients were categorized as dropouts, completers, or continuers based on therapist’s ratings at follow-up. Dropouts did not attend their last scheduled appointment and were in need of further treatment at their last visit. Continuers attended their last appointment and were still in need of treatment at last visit. Completers were those who were not considered by the therapist to be in need of further treatment at their last visit.

Although all of the dropouts for the follow-up sample were in the control group, chi-square analysis revealed no significant differences between video and control groups with regard to dropout status (see Table 12). The number of dropouts in the follow-up group was small in part due to the follow-up attendance eligibility criteria. For comparative purposes dropout status was also provided for all participating clients. Table 12 provides frequencies of dropouts, continuers and completers by treatment for both the follow-up group and all participants.

**Table 12**  
Frequencies and Chi-square values for treatment by dropout status

	All participants (n=134)*			Follow-up group (n=92)		
	Video	Control	%	Video	Control	%
Dropouts	8	9	13	0	3	3
Continuers	42	36	58	29	31	65
Completers	19	20	29	14	15	32

\* missing data on four cases not included in analysis

% = percentage of sample in dropout status category

In summary there was virtually no support for hypothesis 3. Nine of the ten outcome variables were in the predicted direction with clients who viewed the video having more positive outcomes than those who did not. However only the second of the therapist rated target complaints was statistically significant.

## 8.6 Hypothesis 4

**There will be a linear rather than a nonlinear relationship between pretherapy levels of state anxiety and outcome measures at follow-up.**

Hierarchical multiple regressions were used to test the form of the relationship between the two state anxiety measures (STAI-Y1, SR-7) at posttest administration and nine follow-up outcome measures (HSCL-21, STAI-Y2, BHPRS, CSQ-8, TC1, TC2, TCT1, TCT2, and visits). For each of the 18 regressions posttest state anxiety was entered as the first independent variable to determine whether a linear relationship was present. State anxiety squared was then entered as the second independent variable to determine whether a quadratic effect could add significantly to the regression solution.

Since only linear effects were found Table 13 displays only simple correlations between the STAI-Y1, SR-7 and the dependent variables produced from the regressions. Only one of the 18 regressions had a nonlinear relationship which approached statistical significance, (Squared STAI-Y1 with TCT1,  $p = .067$ ), with all other quadratic equations having  $p > 0.4$ .

Table 13  
Correlations between pretherapy state anxiety and therapy outcome measures

Outcome measures (n=92)	State Anxiety measures	
	STAI-Y1	SR-7
HSCL-21	.42***	.54***
STAI-Y2	.48***	.54***
BHPRS	.31*	.43***
CSQ-8	-.04	-.16
# visits	.12	.09
Target Complaints (n=74)		
TC1	.19	.38**
TC2	.23	.37**
TCT1	.13	.13
TCT2	.08	.08

\*\*\*p<.0001    \*\*p<.001    \*p<.005

STAI-Y1 = State Trait Anxiety Inventory Form Y state scale    HSCL-21 = Hopkins Symptom Checklist-21

STAI-Y2 = State Trait Anxiety Inventory Form Y trait scale    # visits = number of visits to psychologist

BHPRS = Brief Hopkins Psychiatric Rating Scale    CSQ-8 = Consumer Satisfaction Questionnaire-8

TC1 = first client completed target complaint    TC2 = second client completed target complaint

TCT1 = first therapist completed target complaint    TCT2 = second therapist completed target complaint

Both measures of state anxiety correlated significantly with follow-up measures of client rated symptom distress (HSCL-21), trait anxiety (STAI-Y2), and therapist rated symptom severity (BHPRS). Only the situation-specific state anxiety measure (SR-7) correlated significantly with both the first and second of the client rated target complaint scores (TC1, TC2). A low to moderate relationship was found between the STAI-Y1 state anxiety measure and the second client rated target complaint (TC2), but this was of marginal significance (p=.053). In general the results support the hypothesis that the relationship between pretherapy levels of state anxiety and follow-up outcome measures is linear.

8.7 Hypothesis 5

**There will be no differences between the video and control groups accuracy of expectations about psychotherapy or in their levels of state anxiety at follow-up.**

Immediate treatment differences in the accuracy of clients expectations were found for all participants when testing hypothesis 1 (n=138, see Table 3). However, before analysing whether this effect was maintained at follow-up it is necessary to confirm that the initial treatment effect found when testing hypothesis 1 is still present for the smaller sample being used to assess the follow-up data. A univariate F-test of the follow-up sample's (n=92) posttest PQ scores replicated the initial significant treatment effect in the predicted direction (see Table 14). A second univariate F-test was conducted to determine whether this effect was maintained using follow-up PQ scores of the same sample. As predicted there was no significant treatment effect at follow-up. Table 14 provides means, standard deviations and results of the univariate F-tests for these analyses.

**Table 14**  
Means, standard deviations and univariate F-test of treatment effects  
for posttest and follow-up Psychotherapy Questionnaire scores

	Treatment					
	Video (n=43)		Control (n=49)		F(1,90)	p
	M	SD	M	SD		
Posttest	11.97	2.10	10.29	2.58	11.61	.001
Follow-up	11.77	2.28	10.86	2.36	3.53	.064

The absolute differences between the video and control groups in the mean number of items correct at posttest is small, but reliable. The change from a significant treatment effect at posttest to no difference at follow-up appears to have occurred predominantly as a result of the small increase in the accuracy of the control groups expectations over the two month exposure to psychotherapy.

Before analysing the treatment effect for state anxiety at follow-up it was again necessary to confirm the initial treatment effect (see Table 6) using the smaller follow-up sample (see Table 15). In this case the initial treatment effect found in hypothesis 1 was established using ANCOVA with the posttest state anxiety measure as the dependent variable and pretest state anxiety as the covariate (n=70, Table 6).

The ANCOVA of posttest STAI-Y1 scores using pretest scores as covariates (as in Hypothesis 1) was replicated using the smaller follow-up sample (n=47, Table 15). This produced a significant main effect for the groups,  $F(2,44)=4.78$ ,  $p=.034$ , confirming the treatment effect on state anxiety with the smaller sample. Table 15 provides means and standard deviations for the pre-post and follow-up state anxiety measures. A second ANCOVA was conducted, this time using follow-up STAI-Y1 scores while again covarying pretest scores on the STAI-Y1. This produced a nonsignificant difference between the video and control group,  $F(2,44)=.94$ ,  $p=.338$ .

**Table 15**  
Means and standard deviations of state anxiety measures  
at pre, post and follow-up administrations

	STAI-Y1				SR-7			
	Video (n=23)		Control (n=24)		Video (n=23)		Control (n=24)	
	M	SD	M	SD	M	SD	M	SD
Pretest	47.47	12.62	50.00	12.95	16.00	6.63	15.00	6.70
Posttest	43.22	13.00	49.04	13.53	12.83	5.37	15.17	7.12
Follow-up	39.92	11.31	44.08	12.71	11.78	5.29	12.63	6.45

STAI-Y1 = State-Trait Anxiety Inventory Form Y state scale

SR-7 = 7-item S-R Inventory of Anxiousness

The same procedure was followed in order to test the hypothesis for SR-7 scores. The ANCOVA used to test initial treatment differences on the SR-7 ( $n=70$ , Table 8) was replicated using the smaller follow-up sample ( $n=47$ , Table 15). Posttest SR-7 scores were used as the dependent variable while the pretest SR-7 scores were used as the covariate (see Table 15). A significant main effect for the groups was confirmed,  $F(2,44)=14.48$ ,  $p<.0005$ . The second ANCOVA using the follow-up ratings on the SR-7 as the dependent variable and the pretest SR-7 scores as covariate, produced no significant main effect for treatment,  $F(2,44)=1.27$ ,  $p=.265$ .

The results provided strong support for hypothesis 5. Although state anxiety was initially reduced for those clients who viewed the video, this effect was not maintained at 2 month follow-up. Similarly, no differences between the video and control groups accuracy of expectations about psychotherapy or levels of state anxiety were found at follow-up.



## CHAPTER 9

### DISCUSSION:

#### IMMEDIATE EFFECTS OF PREPARATION

##### 9.1 *Effects of preparation on accuracy of expectations*

The results provide strong support for hypothesis one. On average those clients who viewed the preparatory video showed an increase in the accuracy of their expectations regarding psychotherapy, while there was no increase in accuracy for those who did not view the video. This finding implies that the accuracy of clients' expectations changed, so that they became more accurate as a result of viewing the preparatory video. This replicates the findings of previous studies using preparatory information to manipulate clients expectations regarding psychotherapy (e.g. see Tinsley et al., 1988).

More detailed discussion of the results in relation to Zwick & Attkisson's (1985) research is appropriate since the videotape used in this study was modelled closely on theirs. Similarly, the use of the Psychotherapy Questionnaire (PQ) also used by Zwick and Attkisson (1984, 1985), allows closer comparison between the two studies.

The absolute difference between the control and video groups in the present study was on average, only about one item (about 10 vs 11, out of 17, see Tables 3 and 4). Zwick and Attkisson (1985) obtained differences of almost four items with their control group scoring approximately 9 and video group 13 out of the possible 17 items. Standard deviations of their sample on the PQ at entry and follow-up ranged from 3.04 to 3.70 while those in the present study ranged from 1.76 to 2.58 (see Tables 4 and 13). This indicates that while the overall differences in their groups were greater so was the variability in scores.

An advantage that the present study had over that of prior research was that pretests on the PQ revealed the control and video groups had equivalent scores prior to the experimental manipulation,  $F(1,68) = .87$ ,  $p = .35$  (see Table 4). Zwick and Attkisson (1985) used a posttest only design to assess the initial effects of their video orientation on the PQ. Randomization should ideally produce equivalent groups, but they noted initial differences between the video and control groups on a number of variables. Of particular note was the finding that 77% of the control group reported prior therapy while only 41% of the

oriented group reported prior therapy. This would theoretically favour higher PQ scores for the control group since more in this group had prior experience and knowledge of therapy. However, it was also reported that for clients who had past therapy experience, those in the oriented group had greater average length of therapy (10 months to 1 year) than those in the control group (4 to 6 months). This makes conclusions regarding the effects of prior therapy on expectations difficult to determine.

In the present study, there were no significant differences between the video and control group with regard to the prior therapy variable ( $X^2=7.41$ ,  $df=3$ ,  $p=.06$ ). Although this was not significant at the usual .05 level it is worth noting that the largest difference occurred for those reporting 1-2 prior visits, with 18.8% of the video group and only 4.4% of the control group in this range. The control and video groups obtained similar percentages of subjects falling in the 3-10 prior visits category and greater than 10 prior visits category. No prior therapy was reported for 45.6% of the control group and 34.8% of those in the video group. These findings suggest the chances of prior therapy being a confounding variable contributing to the preparation effect on expectations is low. This possible confound is an important variable to consider since there is some support for the notion that experience in psychotherapy influences the accuracy of expectations and in particular PQ scores. In a small student sample ( $n=55$ ) who were administered the PQ and also asked to indicate whether they had received any prior psychotherapy or counselling, significantly higher PQ scores were found for those students who reported receiving prior therapy (Deane, 1991b, see Appendix I). It is therefore possible that pre-existing differences between the video and control groups in Zwick and Attkisson's (1985) study contributed to the preparation effect they reported. By using a pretest in the present study it was possible to clarify the equivalence of the video and control groups accuracy of expectations prior to the experimental manipulation, further ruling out initial levels of expectation accuracy as a confounding variable.

The finding that the video increased the accuracy of clients' expectations also served as a manipulation check, suggesting that clients attended to and comprehended the material presented. This is an essential prerequisite for strengthening any conclusions and interpretations regarding effects the video might have on subsequent therapy outcomes (Kendall & Norton-Ford, 1982; Zwick & Attkisson, 1984).

## 9.2 Effects of preparation on state anxiety

The second prediction in hypothesis one was that the videotaped preparation would decrease clients state anxiety. The results provided strong support for this prediction. Both state anxiety measures showed significant pre-posttest reductions for those in the video group but not for those in the control group. It is thought to be the first time that this effect on anxiety has been demonstrated with preparations for psychotherapy.

While others have attempted to test the effects of expectation congruence and preparation on anxiety (Clemes & D'Andrea, 1965; Richardson, 1977) these studies were fraught with measurement and methodological problems making conclusions questionable. The finding that preparation for psychotherapy decreased state anxiety is consistent with the relative wealth of research related to preparation for stressful medical procedures, where preparation resulted in reduction of patients' state anxiety (e.g. Auerbach, 1973; Auerbach et al., 1983; Johnson et al., 1971; Johnson, 1973; Johnston & Carpenter, 1980; Martinez-Urrutia, 1975; Wolfer & Davis, 1971; Vernon & Bigelow, 1974).

While the preparation effect on state anxiety and expectations was statistically significant, and this is important from a theoretical perspective, this provides no evidence of clinical significance. The issue of clinical significance or meaningfulness will be addressed after first clarifying the statistical effects found. The short time interval between pretest and posttest measures suggested the need to use an experimental design which was able to reveal pretest sensitization effects (Bracht & Glass cited in Oliver & Berger, 1980). A need reinforced by studies suggesting that pretest sensitization may be an artifact in research related to expectations (Tinsley, et al., 1988) and anxiety (Kent, 1989).

## 9.3 The anomalous pretest effect

Any concern that pretest sensitization may have contributed to the treatment effects in the present study was testable by the use of the Solomon four-group design. Pretest sensitization would have been present had a significant interaction between the pretest and treatment factors been found along with a simple treatment effect for the pretested group, but not the unpretested group. No interaction was found for either the PQ or SR-7 measure ruling out pretest sensitization as an artifact for these measures.

However, the STAI-Y1 scores produced an anomalous result. A significant interaction between pretest and treatment factors suggested the potential for pretest sensitization effects. However, the simple treatment effect for pretested groups which would usually indicate pretest sensitization was not present, but there was a treatment effect for the unpretested groups. The simple treatment effect for those in the unpretested group was surprising in that those who viewed the video had higher levels of state anxiety than those who did not. Unfortunately, Braver and Braver (1988) did not elaborate on the interpretation of such a result.

There are a number of possible explanations for this finding. Pretest sensitization effects mean that exposure to the pretest increases or decreases the subjects sensitivity to the experimental treatment, thereby producing a positive or negative pretest effect. In Willson & Putmans' (1982) meta-analysis of pretest effects they stated that "For behaviors and personality measures the positive direction reflected the experimental aim of the study; for example, avoidance behavior should decrease in a systematic desensitization to fear of snakes. Thus, fewer avoidance behaviors was a positive outcome in this case.", (p.252). Positive pretest effects are most common. Willson and Puttnams' (1982) meta-analytic review of 32 studies found 64% of all pretest effects were positive. Positive pretest effects usually result in detecting an experimental treatment effect which would not be present if pretests were not given, so that the results can not be generalized to the unpretested population. In the current context this would mean significantly lower state anxiety for the video group compared to the control group but for pretested groups only. The results clearly indicate this was not the case.

Although generally less common, it is possible for pretest sensitization to decrease subjects sensitivity to the experimental treatment resulting in a negative pretest effect. In this situation a suppression or underestimation of treatment effects would be present in the pretested groups so that any treatment difference was lost as a result of pretest sensitization. Assuming the treatment effect is in the direction hypothesised, the results obtained in the present study do not rule out this possibility. If a negative pretest effect was present, no difference between the pretested video and control groups would be expected. Posttest anxiety responses would be suppressed and decreased due to pretest sensitization. Lower levels of anxiety in the unpretested video group compared to the unpretested control group would still be expected, because they were never pretested and therefore no negative pretest effect could be present. However, the results did not support this and indicated that for unpretested groups, those who saw the video reported higher state anxiety than those

who did not. This makes the likelihood of a negative pretest effect slight.

Alternatively, if pretesting did decrease the sensitivity to the experimental treatment *and* the treatment effect was in the opposite direction to that hypothesised then it is theoretically possible to obtain the pattern of results produced by the present study. If the video increased instead of decreased clients' state anxiety *and* pretesting suppressed this effect then there would be no simple treatment effect for the pretested groups, but there would be a simple treatment effect for the unpretested groups. Additionally this simple treatment effect for the unpretested groups could theoretically be in the direction obtained in the present study. While the results are consistent with this conclusion, it requires acceptance of a number of unlikely propositions particularly in view of other findings in the results.

Firstly there would have to be a negative pretest effect, and while this was uncommon across the different studies reviewed by Willson and Puttnam (1982), negative pretest effects were found for personality measures (such as the STAI-Y1). It is less likely that the treatment effect was in the opposite direction to that hypothesised. Theoretically it is possible for information about psychotherapy to increase clients anxiety as a result of inducing the "work of worry" (Janis, 1958; Marmor, 1958). However, as outlined in the introduction (section 4.4) the bulk of prior research indicated anxiety scores would be highest at first testing, decline after information presentation and remain low after the stressful event (Anderson, 1987; Auerbach et al., 1983; Johnson et al., 1971; Johnston & Carpenter, 1980; Vernon & Bigelow, 1974; Wolfer & Davis, 1971). The results for the SR-7 in the present study are supportive of the hypothesis that the preparatory information decreased state anxiety. In addition the analysis of the pre-posttest scores on the STAI-Y1 are also supportive of this hypothesis. So, what is the most plausible explanation for the interaction between pretest and treatment factors?

It seems this result is most likely due to a combination of factors. There were higher levels of overall disturbance found in the unpretested video group than in any of the other three groups (ie. pretested video, control and unpretested control). This group obtained higher scores on all client completed posttest outcome measures (STAI-Y2, HSCL-21, 1st and 2nd target complaints), suggesting one area in which the randomization process may have failed. Univariate F-tests revealed that for the unpretested groups these differences were statistically significant for the first target complaint,  $F(1,65)=4.95$ ,  $p=.03$ , and the HSCL-21,  $F(1,66)=4.19$ ,  $p=.05$ , while the STAI-Y2 and 2nd target complaint did not

reach significance ( $p > .05$ ). The HSCL-21 and first target complaint both have moderate to high positive and statistically significant correlations with the STAI-Y1 ( $r = .63$  and  $r = .37$ , both  $p < .001$ ; see Appendices D & E). This supports the proposition that the pretest and treatment interaction occurred as a result of initial differences in the levels of general disturbance between the unpretested video and control groups. This was more likely an artifact of the randomization process than a combination of both a negative pretest effect and a treatment effect in the opposite direction to that supported by the data and previous research. Consequently, it can be concluded that the preparatory video decreased anxiety and increased the accuracy of clients expectations free from pretest sensitization effects.

#### 9.4 Clinical versus statistical significance

Although the statistical significance of the preparation, free from pretest sensitization has been established, the clinical significance of the results need clarification. Generally, clinical significance refers to the meaningfulness of the magnitude of change and correcting the target problem to the point it is no longer troublesome (Kendall & Norton-Ford, 1982). It refers to the practical value of a particular intervention to improve the client's functioning. These descriptions immediately give rise to questions regarding who defines what is meaningful (provider versus consumer) and how meaningful change is best defined (Hollon & Flick, 1988). Several strategies have been suggested for assessing clinical significance: normative comparisons between treated and normative control groups; social evaluations where the opinions of significant others are sought regarding the importance of a given treatment and; individual improvement where the degree or number of improved subjects in the treatment group are assessed as opposed to looking at group means. All of these methods have notable problems and there is some controversy regarding definitions and assessment of clinical significance, (e.g. Hollon & Fleck, 1988; Hayes & Haas, 1988). Full coverage of these issues is beyond the scope of this study and while some effort is made to use available normative data the assessment of clinical significance is mainly qualitative and in this sense most like the social evaluation method.

The absolute size of the treatment effects on both expectations and state anxiety measures, although consistent, appear small. Posttest only analysis of anxiety scores did not reveal the effects of preparation, and it was not until a more sensitive analysis utilizing pretest information was used that they were detected. The mean pre-post difference on the STAI-Y1 was about 5 scale points. There were only one or two items difference between the

video and control groups with regard to the accuracy of their expectations. These absolute differences appear small and suggest relatively weak treatment effects. However the clinical significance of these effects require consideration of other factors. It is also important to consider possible interaction effects which could be beneficial to clients and may effect judgements regarding clinical significance. In the present study client-therapist process variables were not assessed, but preparation variables have been found to positively effect therapeutic process (e.g. Friedlander & Kaul, 1983; Tracey, Heck, & Lichtenberg, 1981). It is possible that relatively small effects on expectations and anxiety interact with other process variables to produce more substantial effects in the therapeutic relationship.

Only a limited descriptive assessment of clinical significance using normative data was possible because no "local" normative data was available for a representative untreated sample (Kendall & Grove, 1988). Spielberger's (1983) normative data on the STAI-Y1 for "working adults" was the basis for the first assessment of clinical significance. One approach using this method is to determine whether the treatment brings the dysfunctional subjects within one standard deviation of the nondysfunctional groups normative mean (Kendall & Norton-Ford, 1982). The pretest scores of the video group on the STAI-Y1 in the present study ( $m=48.47$ , Table 6) were higher than one standard deviation above the mean in Spielberger's (1983) normative group ( $m=35.20$ ,  $sd=10.61$ ,  $p.5$ ). However, after viewing the video the mean for the group decreased to 43.67 (Table 6) falling within one standard deviation of the normative sample's mean. While this suggests clinical significance, it does not indicate that all individual subjects showed similar improvements. The video group's posttest standard deviation was relatively high at 12.27 suggesting this mean change may not necessarily be representative of the majority of cases (Kendall & Norton-Ford, 1982). These means do not give information about the numbers of clients who had meaningful changes. It is also possible that particular subgroups of clients obtained larger improvements than others. Appropriate norms on other measures were not available so that normative comparison could not be attempted. Despite these deficits in the present normative comparison, the available norms are suggestive of clinical significance.

In the clinical context, it could be argued that any reduction in clients initial anxiety is clinically significant and useful, particularly for clients who are presenting with problems where anxiety is a major component of the disorder. Clinical usefulness should also consider the costs of the intervention. The video preparation was short, required minimal staff time and few resources. It did not require large amounts of client time. One of the

intervention's strengths was that the length of time to view the video was comparable to the typical time clients waited in the reception area to be seen by treatment staff. This provides the potential for the preparation to be easily incorporated into routine clinic procedure. Producing a reduction in clients anxiety about the impending psychotherapy experience with few costs to both the client and staff reflects positively on an intervention's clinical utility.

There are a number of improvements which could also increase the clinical significance and utility of the preparatory video. It is worth noting that the video used in the present study did not focus on the reduction of anxiety. A preparation which targeted anxiety more specifically might be even more effective. Increasing the accuracy of expectations beyond that found in the present study requires consideration of reasons for the small changes found in the present study.

The apparently small absolute changes on expectations may have been due to a number of factors: 60% of all participants had some prior therapy experience with 27% having more than 10 therapy visits. The relatively high scores on the PQ revealed that the clients in this sample already had accurate expectations on average compared to those of Zwick and Attkisson (1984, 1985). As Zwick and Attkisson (1985) suggest pretherapy orientations are most likely to be effective on patients without prior psychotherapy experience. Stronger treatment effects may be obtained if clients received the information before they were seen by anyone at the psychiatric centre. In the present study it was common for clients to have been seen first by a psychiatrist and then referred on to a psychologist after only one or two contacts. The information may have been of more benefit to clients before their first contact with the centre. Although the content of the video would have to be altered slightly there would be some common events and processes between meetings with psychiatrists and psychologists.

The need to receive the information very early in the treatment process was reflected in a note written by a client on the SR-7 (state anxiety measure). She had responded "not at all" for all seven items indicating no anxiety with regard to psychotherapy and wrote: "If I answered this last week (before my initial visit) the outcome may have been slightly different as I did not know what to expect." The client had been seen once by a psychiatrist the previous week and then referred on to a psychologist.



This particular client had made some link between what they expected to happen and, anxiety regarding psychotherapy. Finding the preparatory video increased the accuracy of expectations and decreased state anxiety provided the prerequisite data for testing the second major hypothesis which related to the nature of the relationship between preparation, expectations and anxiety. The following section discusses hypothesis two which predicted that preparation effects on state anxiety would be mediated by expectations.

### 9.5 *Testing the mediating relationship*

The results did not support the hypothesis that the accuracy of clients' expectations mediated the effects of the preparation on state anxiety. There was no significant correlation between the accuracy of expectations and state anxiety so a mediation relationship could not be confirmed.

One possible reason for not confirming the hypothesis was tested posthoc. There may have been differences between accuracy of expectations as used in the present study and congruence as used in previous research. Accuracy of expectations as measured by the PQ should ideally match with the content of the video and with what occurs in psychotherapy and therefore be a reflection of congruence. To rule out differences in the measurement of expectations as a factor contributing to nonconfirmation of the mediating hypothesis, Hartfield et al's (1982) use of congruence scores was replicated. There was still no significant correlation between expectations and state anxiety. This lack of a clear relationship between expectations and anxiety could be explained by a number of factors.

Differences between medical procedures and the psychotherapy experience may be one of those factors. Psychotherapy may arouse less situational emotional distress than stressful medical procedures such as barium enema, surgery, or gastroendoscopic examination. (State anxiety scores of the psychotherapy clients in the present study were generally lower than those of the patients who underwent barium enema, despite the trait anxiety scores of the psychotherapy clients being higher, Hartfield & Cason, 1981; Harfield et al., 1982). Less variability in the levels of state anxiety may make detection of relationships between anxiety and expectations more difficult.

The type of threat may be of equal importance to the amount of distress it produces. Where medical procedures usually present some physical threat, psychotherapy probably produces more of a threat to self-esteem or threat as a consequence of the ambiguity of the situation. While physical sensations in a specific medical procedure can be relatively reliably predicted, it is much more difficult to predict particular types of psychotherapy experience since there is greater variability involved in this "procedure". High therapist scores on the PQ before and after the study period supported some general consensus regarding the conceptual approach used in psychotherapy (e.g. a learning process). However, there is likely to be considerable variation in how psychotherapy is conducted as a consequence of client problem, therapist style or therapist-client interaction. Consequently it is more difficult to provide information which is as specific as that which might be provided for stressful medical procedures. This potentially increases the relative ambiguity associated with psychotherapy such that there may be more threat as a result of ambiguity than in medical contexts. Similarly, the process which allows congruence between expected and experienced sensations to reduce anxiety during a physically threatening procedure may be different to that which occurs during emotionally threatening procedures.

Another related explanation concerns differences in the type of information provided. The video used in the present study provided a variety of information including what could be considered both "sensation information" regarding feelings the client may experience, and "procedural information". However, the relationship between expectation congruence and anxiety found by Hartfield et al., (1982) was only found for sensation information. Consequently this mixture of information although considered superior for most preparatory procedures, may operate to effect anxiety in different ways.

Anxiety about psychotherapy may be less related to the accuracy or congruency of expectations than the type of expectations held. It may, for example, be possible that those who have more positive expectations such as expecting the therapist to be genuine, experience less anxiety about therapy than those with more negative expectations such as anticipating the therapist to be confrontational.

In addition to these contextual and content issues, failure to find a significant relationship between anxiety and expectations may be a consequence of alternative models being more appropriate. It could be speculated that preparation has quite separate effects on anxiety and expectations involving some parallel process. However, Baron & Kenny (1986)

provide arguments which suggest less radical change to existing models. They note that mediation is best done in the case of a strong relation between the predictor (expectations) and the criterion variable (state anxiety). The relationship between expectations and anxiety was very weak. Baron & Kenny (1986) go on to note that "Moderator variables are typically introduced when there is an unexpectedly weak or inconsistent relation between a predictor and a criterion variable...", (p.1178). Initially the search to clarify the relationship between expectations and anxiety may involve moderators. Dispositional factors have been suggested as moderator variables in the effectiveness of preparations for stressful medical procedures (Schultheis, et al., 1987). It may be that in preparation for psychotherapy moderating variables such as coping style or desire for information can better account for the relationship between preparation, expectations and state anxiety.

## CHAPTER 10

### FOLLOW-UP EFFECTS OF PREPARATION

#### **10.1 Improvement over the course of psychotherapy: The "psychotherapy effect"**

*"Psychotherapy is a slippery  
subject to study."*

*(Sloane, et al., 1975, p.1)*

Prior to examining the effects of the video preparation on psychotherapy outcome, an analysis of the change on psychotherapy outcome measures for all participating clients from entry to follow-up was conducted (see section 8.4). Subjects in the video and control groups were combined for this analysis. Determining improvement over the course of psychotherapy was necessary in order to clarify the context in which the effects of preparation occurred. As the results showed, all clients combined had significant reductions on trait anxiety and both client and therapist completed symptom distress and target complaints over the 2 month psychotherapy period. The results clearly showed consistent improvement on all outcome measures. This is an encouraging finding from a clinical perspective, in that it suggests significant improvement was shown in clients in as little as 2 months with an average of approximately 4 sessions. In addition almost 60% of those who completed therapy within the 2 month period, finished within 3 visits (see Deane, in press, Appendix F). While improvement occurred over the course of therapy the results do not show that improvement occurred as a consequence of psychotherapy. A control group who did not receive psychotherapy would have been necessary to make more conclusive statements regarding the effectiveness of psychotherapy. While aware of this caution, the improvement over the course of psychotherapy will be referred to as the "psychotherapy effect". When assessing the effects of preparation it must be recognised that any effects must stand out from this strong and consistent psychotherapy effect.

#### **10.2 The effects of video preparation on psychotherapy outcome**

Hypothesis 3 proposed that those clients who received video preparation would have more positive psychotherapy outcomes at follow-up than those who did not. This is the end point of the expected sequence of effects predicted by preparations for psychotherapy. The initial prerequisite effects on expectations and state anxiety have already been confirmed so that

change on outcome can be anticipated.

There was only weak support for hypothesis 3. While 9 of the 10 outcome measures were in the predicted direction, reflecting more positive outcomes for those in the video group, only one of these measures was statistically significant. Only the second of the therapist-completed target complaints was significantly lower for those in the video group than those in the control group.

As with prior studies, inconsistent results make it difficult to make definitive statements regarding the long-term efficacy of pretherapy preparations of this sort. No studies could be found where preparation produced significant improvement on all outcome measures used. Typically the effects of preparations were evident on only a few of the measures and there was considerable variability in the kinds of measures which detected differences (e.g. Childress & Gillis, 1977; Coleman & Kaplan, 1990; Day & Reznikoff, 1980; Hoehn-Saric et al., 1964; Holmes & Urie, 1975; Strupp & Bloxom, 1973; Zwick & Attkisson, 1985).

In the present study, the prepared group experienced greater reduction in severity ratings on the second of the target complaints. Several previous studies have also found target complaints measures were affected significantly by preparation (Hoehn-Saric et al., 1964; Nash et al., 1965; Strupp & Bloxom, 1973). However as with other outcome measures there have also been investigations which found no significant treatment effect on target complaints measures (Holmes & Urie, 1975; Sloane et al., 1970). Only one study used severity ratings (Sloane et al., 1970) while the others used improvement ratings (For explanation of the differences between severity and improvement ratings see Deane & Spicer, 1991 in Appendix E). Strupp and Bloxom (1973) found greater improvement on target complaints measures for prepared clients than those who were not prepared. However, the improvement seen in patients' ratings of specific target symptoms was not present in therapist ratings. It was suggested this may have been due to patients and therapists using different baselines or criteria for improvement, and therapists using different comparison groups as a standard (Strupp & Bloxom, 1973). These explanations remain just as valid for treatment effects in therapists ratings being found, but no similar effects for client ratings. Perhaps of more relevance to the present study was the speculation that the overall behaviour change accomplished in their limited study period (12 weeks) was insufficient to "register dramatic differential effects.", (p.382). If this explanation is valid then it may be particularly true for the present study which used only an 8 week study period.

### ***10.3 Preparation plus psychotherapy as an alternative treatment***

The present study involved two stages of analysis, firstly the assessment of the immediate effects of preparation, and secondly the assessment of longer term effects at the two month follow-up. The first stage involved the use of a treatment/no-treatment experimental design, with those in the experimental group receiving the pretherapy preparation and those in the control group receiving no preparation. While this description is accurate for assessing the immediate effects of the preparation, it is less so when regarding the second stage which assessed the effects of preparation on outcome measures after two months of psychotherapy. When assessing psychotherapy outcomes at two months all clients received psychotherapy, both those in the video and control group, consequently the design was most like that of an alternative treatment design.

Generally there has been an absence of clear outcome differences between alternative treatments in comparative psychotherapy outcome research (e.g. Stiles, Shapiro, & Elliot, 1986). To some degree this is not surprising in that many "alternative treatments" have more features in common than differences (e.g. empathy and support, Waterhouse & Strupp, 1984).

The alternative treatments in the present study presumably had more common ingredients, particularly when compared to other alternative treatment research. The only difference between the video and control groups was the presence of the short preparatory video. Within the limits of randomization, on average both groups received equivalent psychotherapy experiences. This factor could be expected to have a greater impact on psychotherapy outcome than the effects of the video.

It is possible that the video and control groups were even "less different" than one would expect as a result of the preparatory video. Therapists often routinely provide information about psychotherapy to clients in the early stages of treatment, albeit less systematically than in a preparation. The therapists in the present study were instructed to avoid asking clients directly about the video in an effort to prevent them routinely knowing client's group assignment. They were not discouraged from discussing the video if the client initiated the topic, nor were they discouraged from providing information to clients about psychotherapy as they would usually do during the course of treatment. Consequently the assessment of psychotherapy outcome was more a comparison between video information

plus therapist provided information and therapist information only. So that these alternative treatments had therapist provided information in addition to the psychotherapy factor in common.

Concern has been raised regarding the lack of power most psychotherapy outcome studies have to detect differences between alternative treatments (Kazdin, 1986; Kazdin & Bass, 1989). When two active interventions, (i.e. psychotherapy/video and psychotherapy/control) are expected to produce change, "...the investigation must be sufficiently sensitive to detect what could prove to be relatively small differences.", (Kazdin & Bass, 1989, p. 138). The power of alternative treatment outcome studies to detect differences between treatments was assessed by examining the effect and sample sizes of 75 studies comparing two or more treatments (Kazdin & Bass, 1989). It was found that for those studies which assessed outcome at posttreatment the mean sample size for each group was approximately 16 with 75% of the studies having fewer than 20 subjects per group. The mean effect size for the alternative treatment studies at posttreatment was .50 (Kazdin & Bass, 1989). Using Cohen's (1977) classification of small (.20), medium (.50), and large (.80) effect sizes as a guideline, the data clearly indicated that the comparisons of alternative treatments span the small-to-medium range (Kazdin & Bass, 1989). Using tables provided by Cohen (1977) and based on sample sizes and estimated effect sizes the power of the studies to detect significant differences between alternative types of comparisons yielded a median of .74. This meant that the median chance of a study to detect a difference was about 7 in 10. Kazdin and Bass (1989) found that the majority of studies (54.7% or 41 of 75) did not meet the recommended level of power ( $> .80$ ).

The lack of power of alternative treatment studies to detect treatment differences led to concerns regarding the power of the present study. It was estimated that the effect size for the present study would be in the small range. This was based on Kazdin and Bass' (1989) findings and, the belief that an 11 minute video preparation in addition to equivalent psychotherapy would constitute a minimum alternative treatment and thus produce a small effect size. Given an effect size of approximately .20, a significance level of .05, and a one-tailed test, the power tables of Kraemer and Thiemann (1987) suggested a sample size of 152 or 76 per group would be necessary to detect differences between groups of equal size at the recommended level of power (.80). While the initial number of clients participating was close to this sample size ( $n=138$ ), attrition and nonresponding led to a much lower number at follow-up ( $n=92$  and  $n=74$ ). This loss of subjects over time was

particularly problematic for an outcome measure such as dropout which was of very low frequency in the follow-up group (3%). This made detecting statistically significant differences between the treatment groups even more difficult.

As Kraemer and Thiemann (1987) note, the power of a study should ideally be considered during the planning stage, not after the study is done. During the planning stage of the present study the effect sizes were considered (although formal power calculations were not conducted) and attempts were made to obtain a sample size large enough to be able to detect differences between the treatment groups. The sample size used in the present study was substantially larger than those of other studies for this reason (e.g. Zwick & Attkisson, 1985,  $n=62$  at entry and  $n=36$  at follow-up). However, a post-hoc power analysis suggesting insufficient power does not change the finding that most of the outcome measures were not significantly affected by the video preparation.

It is important to consider the effect sizes of present study in order to plan a better study in the future. Preliminary calculations of effect sizes in the present study suggested that the average effect size for pretherapy preparations may be even lower than the .20 estimate based on the research of Kazdin and Bass (1989). If this is accurate for all pretherapy preparations then the obvious suggestion for future research is to increase sample sizes. Power can also be optimized by reducing error variance (Kazdin & Bass, 1989). This could be accomplished by selecting a more homogeneous sample of clients than was used in the present study. Zwick and Attkisson (1985) have already suggested that pretherapy preparations may be most beneficial for clients with minor disorders and no past therapy experience. This suggests that clients who are less knowledgeable about what occurs in psychotherapy may benefit more from preparation. The results of the present study suggest a sample which had relatively accurate expectations so that the immediate effects of the manipulation would be minimal in absolute terms. Future research selecting a sample which is less sophisticated, with less accurate expectations of psychotherapy may increase the effect size substantially and also help clarify the relationships between preparation, expectations and anxiety.

Error variance can also be reduced by using reliable and sensitive outcome measures. While the measures used in the present study met these conditions, in retrospect some were more appropriate than others. Those sensitive to specific therapy related problems or symptoms such as the HSCL-21 and target complaints measures appear more likely to detect differences between prepared and unprepared groups than those which assess more



stable personality traits such as the STAI-Y2.

To summarize, the results do not provide strong support for the efficacy of using psychotherapy preparations of this sort in order to improve clients psychotherapy outcomes. Any effects on psychotherapy outcome measures appear to be small at best. While the video preparation appeared to have a negligible effect on psychotherapy outcome measures, it did produce immediate reductions in state anxiety. The relationship between pretherapy levels of state anxiety with outcome measures at follow-up is the subject of the next section.

#### ***10.4 Pretherapy state anxiety and psychotherapy outcome***

Hypothesis 4 proposed a linear rather than nonlinear relationship between pretherapy levels of state anxiety and outcome measures at follow-up. This was based on previous research providing the most support for a linear relationship and theoretical concerns suggesting this was most appropriate to the psychotherapy experience.

The results provided strong support for a linear relationship between pretherapy (posttest) levels of state anxiety and psychotherapy outcome measures. Initial anxiety about psychotherapy (STAI-Y1 & SR-7) was significantly related to client completed measures of symptom distress (HSCL-21), trait anxiety (STAI-Y2) and therapist ratings of symptom severity (BHPRS). While the relationship with the CSQ-8 and attendance measures did not reach significance they were generally in the predicted direction. None of the target complaints measures correlated significantly with the STAI-Y1, but they too were generally in the expected direction with higher pretherapy anxiety being related to poorer outcomes. The situation-specific state anxiety measure (SR-7) had significant moderate positive correlations with the first and second of the client completed target complaints. The finding that a quadratic effect could not significantly contribute to the regression solution provided the most support for hypothesis 4. Even where there were no strong linear effects, nonlinear relationships were not significant.

This finding of linearity provides preliminary support, to suggest that the relationship between initial anxiety about therapy and psychotherapy outcomes is more consistent with Johnson's self-regulation theory (Johnson et al., 1989; Leventhal & Johnson, 1983) than Janis's (1958) emotional-drive theory. Self-regulation theory predicts a linear relationship between initial levels of state anxiety and outcome. It proposes that provision of objective

information about a stressful event allows patients to form accurate expectations (schema) of their impending experience. This in turn diverts attention away from emotional features and facilitates information processing to enhance understanding and interpretation of the experience. This process is thought to foster problem-solving approaches to coping and reduce negative emotion during and after the experience.

One of the effects of informational preparations is to reduce levels of anxiety prior to the experience in order to improve recovery through the mechanisms noted above. This has implications for the utilization of preparations for psychotherapy. If lower levels of anxiety about therapy are associated with improved outcomes this would imply the lower initial state anxiety the better subsequent outcomes. The ability of the present preparatory video to decrease anxiety about therapy has already been established, but consistent benefits on outcome were not found.

While the results support a linear relationship between pretherapy anxiety and outcome, some caution is needed in the interpretation of the values in Table 13 if these are used as an estimate of the strength of this relationship. As noted earlier there are a number of qualitative differences in medical procedures and psychotherapy as stressful events. Recovery variables for a stressful medical procedure could be expected to be less related to a psychological construct such as state anxiety than would outcome variables in the psychotherapy experience. Spielberger (1983) has already established a strong relationship between state and trait anxiety with correlations typically around .65. Individuals who are high in trait anxiety tend to respond to stressful situations with higher levels of state anxiety than those who are low in trait anxiety. Consequently, it is possible that the strength of the relationships between pretherapy state anxiety and the outcome measures are somewhat inflated and may be partially a function of clients initial problem or symptom severity.

### **10.5 Maintenance of preparation effects on expectations at follow-up**

Hypothesis 5 predicted that there would be no difference between the video preparation and control groups accuracy of expectations about psychotherapy at follow-up. The prerequisite to testing this hypothesis was established, in that initial differences on the PQ between the groups were found immediately following the preparation. These differences were initially found using the larger entry sample ( $n=138$ ) and were again confirmed using the smaller follow-up sample ( $n=92$ ). Although the absolute differences from entry to

follow-up were small, as hypothesised the difference in accuracy of expectations between the prepared and unprepared groups at follow-up became statistically insignificant. It can not be concluded that this nonsignificant result was totally a consequence of clients in the control group experiencing an increase in the accuracy of their expectations over the course of psychotherapy. However the result is consistent with the proposition that expectations are modified or change over the course of psychotherapy.

The mean PQ scores (Table 14) suggest that the initial significant preparation effect on expectations became nonsignificant primarily as a function of control clients' improved scores on the PQ. This was accompanied by a smaller reduction in the scores of the video group. While the control group scores were consistent with an increase in the accuracy of expectations as a result of experience in psychotherapy, it is also possible that those in the video group found psychotherapy less like the ideal portrayed in the video preparation, leading to a slight decrease in their PQ scores.

This finding is consistent with earlier research which suggested that client and therapist role expectations become significantly more congruent as therapy progresses (Duckro et al., 1979). Day and Reznikoff (1980a) also found that the differences in the accuracy of prepared and unprepared clients' expectations was not maintained as therapy progressed.

The study by Zwick and Attkisson (1985) is worthy of more detailed analysis since they used an equivalent measure of expectations (PQ) to that of the present study. Zwick and Attkisson (1985) found that the PQ scores of both the oriented group and control group were almost identical from entry to follow-up. In other words the superiority of the oriented group was maintained at one month follow-up, but there was no change in these scores from entry. Similarly the control group who scored relatively low at entry, remained low, with follow-up scores almost the same as entry scores. This result is somewhat surprising since previous studies have suggested that exposure to psychotherapy would have the effect of changing these clients' perceptions and increasing the accuracy of information and expectations they had about psychotherapy. This change should have been reflected in higher scores on the PQ, if it in turn reflected the content of the orientation video and psychotherapy as practiced at the clinic. It is possible no change occurred due to a lack of match between psychotherapy practice and the video preparation; or because clients had insufficient exposure to psychotherapy over the one month follow-up period.

It is difficult to address the issue of sufficient experience or exposure over the course of psychotherapy. While long-term service utilization data was reported (1-year), the number of visits over the one month follow-up period was not reported. An estimate of the number of sessions attended by clients can be made from the method section which indicated "In general, sessions were held once a week.", (p.515) and from the results which indicated the median proportion of missed appointments was "close to zero" for both groups (Zwick & Attkisson, 1985). This suggests clients were seen for approximately four sessions over the one month study period, frequently enough to expect some change in the accuracy of the information and/or expectations about psychotherapy to have occurred.

The match between the preparation and how psychotherapy was conducted in Zwick and Attkisson's (1985) investigation is also unclear because the orientation script was developed by the researchers independently of the therapists involved in the study. Although the script was reviewed by graduate students in educational psychology, the directors of the clinic and mental health centre, and 10 clinicians not from the data collection site, no check was made to determine whether the script was consistent with psychotherapy as practised by the participating therapists. While the script was general enough to be applicable to a wide range of therapeutic approaches it is unclear whether it was consistent with the practice of the participating therapists who had a variety of professional backgrounds (psychiatry, psychology, social work, and nursing). Differences in the findings of the present study and those of Zwick and Attkisson's (1985) may thus be due to the magnitude of differences between the prepared and unprepared group's PQ scores, or the match between the video preparation and psychotherapy experience.

It might be concluded from the results, that since clients may undergo some correction of expectations in as few as four sessions of psychotherapy, preparation is unnecessary. Before precluding preparations there are additional issues to consider. Many clients do not remain long enough in therapy for this correction process to occur and it has been found that inaccurate expectations may contribute to dropping out (e.g. Borghi, 1968; Garfield & Wolpin, 1963; Heine & Trosman, 1960; Overall & Aronson, 1963). Day and Reznikoff (1980a) warned that although correction of expectations apparently took place in their unprepared parents and children, the finding that dropping out was related to incorrect expectations, suggested it was still important to address the issue of client expectations before therapy begins.

### 10.6 Maintenance of preparation effects on anxiety at follow-up

The second part of hypothesis 5 predicted that there would be no differences between the video and control groups levels of state anxiety at follow-up.

There were several reasons for assuming state anxiety would no longer be different as a function of group membership at the two month follow-up. State anxiety tends to be elevated prior to stressful medical procedures, declines after the procedure, and remains low during recovery (e.g. Auerbach, 1973; Spielberger et al., 1973). It was also hypothesised that expectations would mediate the effects of preparation on state anxiety. Although this was not confirmed in the present study, based on this theoretical relationship it would be expected that as correction in expectations occurred over the course of psychotherapy then there would be a concomitant change in state anxiety.

The prerequisite group differences in state anxiety as a result of the preparatory video were found at entry. In order to test that these effects were no longer present at follow-up, this initial effect using the smaller follow-up sample was replicated. When these same effects were tested using follow-up scores the preparation effect for both the STAI-Y1 and SR-7 was no longer significant.

Strong support was found for hypothesis 5, with the preparation effect on expectations and state anxiety becoming insignificant at follow-up. This finding is consistent with, but not indicative of expectations and anxiety about psychotherapy changing over the course of psychotherapy.

Also of note was the finding that state anxiety measures showed the same pattern of change as has been found in studies of preparation for stressful medical procedures (see Table 14). For the prepared group state anxiety was highest prior to therapy, declined after preparation and was lowest at follow-up. Control subjects had the highest state anxiety levels prior to psychotherapy, these remained high after a 10 minute wait prior to seeing their therapist, and then decreased by follow-up. This supports the notion that clients have specific anxiety related to their impending psychiatric treatment (Kushner & Sher, 1989).

## CHAPTER 11

### CONCLUSION

#### *11.1 Summary of the present study*

The present study investigated the effects of an 11 minute preparatory video about psychotherapy. Attempts were made to correct many of the methodological weaknesses in previous studies. Theorists as early as Kelly (1955) stressed the importance of understanding the clients' expectations regarding psychotherapy. He proposed that when expectations were disconfirmed by events, people experienced anxiety. While the relationship between expectations and anxiety was possibly assumed, it was never fully tested. Collateral support for the relationship appeared in research related to preparation for stressful medical procedures, but was not confirmed in the context of preparation for psychotherapy.

The preparatory video was able to increase the accuracy of clients' expectations of psychotherapy and decrease clients' anxiety about the impending psychotherapy experience. While preparations such as this have been shown to increase the accuracy of clients expectations regarding psychotherapy, it is thought to be the first time that the effects on state anxiety have been demonstrated. The present study was able to confirm that New Zealand psychotherapy outpatients do appear to have some expectations which are inaccurate or discrepant with the way psychotherapy is typically conducted. It was also found that clients experience specific anxiety about psychotherapy and that this anxiety can be reduced through the use of a short preparatory video.

Attempts were made to determine whether the effects of preparation on state anxiety were mediated by expectations. No significant correlations between expectations and state anxiety were found and the mediating relationship was not confirmed.

There was significant improvement on all outcome measures over the course of psychotherapy. However when the follow-up effects of preparation were assessed it was found that greater improvement for the prepared group was present on only one of the 10 outcome measures. Those in the prepared group showed greater improvement on the second therapist completed target complaint, providing minimal support for the efficacy of the video preparation for improving psychotherapy outcome over two months. It was

suggested this result could be explained due to the difficulty in finding differential effects in alternative treatment designs (Kazdin & Bass, 1989). This has traditionally been difficult in large part due to high attrition resulting in inadequate power (Kazdin & Bass, 1989). It is possible the present study may have suffered from lack of power, and future research should plan for increased sample sizes to detect relatively small effects and/or the use of samples with specific characteristics (e.g. minor disorders with no prior therapy).

The results suggested that the effects of preparation were relatively short-term. Supplementary support for this proposition was provided by immediate effects of the preparation on expectations and state anxiety disappearing by the 2 month follow-up period. Replication and extension of this finding is needed in order to clarify the temporal effects of preparation.

Finally, a linear relationship was found between pretherapy levels of state anxiety and psychotherapy outcome measures at follow-up. This relationship was investigated in an effort to clarify the theory most appropriate for explaining the effects of preparation. Since the present study endeavoured to make some theoretical contribution in addition to the applied goals, the theoretical implications will be discussed in more detail.

## ***11.2 Theoretical implications***

Attempts were made to have existing research and theory guide the hypotheses in the present study. From a theoretical perspective it was encouraging to find that expectations were affected by preparation. One of the more consistent effects of preparations has been their ability to increase the accuracy of clients' expectations. Similarly, there were suggestions that expectations about psychotherapy may be modified over the course of psychotherapy, even without preparation. This is consistent with expectations being influenced and changed as a function of additional information. These findings are consistent with background theory related to how preparations manipulate expectations (Tinsley et al., 1988).

There was no support for Kelly's (1955) proposition that disconfirmed expectations result in anxiety. While anxiety was reduced by preparation, no relationship between expectations and anxiety was found. If the primary active component in informational preparation is the manipulation of expectations, then finding an effect on anxiety provides at best a only tentative link between expectations and anxiety.

In attempting to generalize the theory pertinent to preparation for stressful medical procedures, it was proposed that the effects of preparation on anxiety would be mediated by expectations. Again this was not supported since no significant relationship between the accuracy of expectations or expectation congruency and anxiety was found. This is problematic in terms of existing theory, since this finding is not easily explained. A number of factors were suggested (section 9.5), including alternative models. However, prior to extending theory it is suggested that existing models be tested further using variations of the existing constructs with alternative measures. The PQ used for measuring the accuracy of expectations in the present study was a short 17-item questionnaire. Brevity was needed due to multiple administrations of several measures. A more comprehensive expectation measure such as the Expectations About Counseling-Brief Form (66-items) (Tinsley & Westcot, 1990), may help differentiate particular expectation domains and provide clearer discrimination between clients with accurate and inaccurate expectations. It has also been suggested that this measure may be useful in differentiating overall positive or negative expectations (Prospero, 1987 cited in Hardin, Subich & Holvey, 1988). It may be this construct, as opposed to expectation accuracy or congruency, which establishes the relationship with anxiety. It is suggested that future research efforts first focus on clarifying the relationship between expectations and anxiety, before testing larger models which include preparation. While there was no support for expectations mediating the effects of preparation on anxiety, there was support for anxiety being involved as a potential process variable, which in turn could potentially have effects on subsequent outcome.

Both linear and nonlinear relationships between pretherapy levels of state anxiety and psychotherapy outcomes were tested. The results suggested that this relationship was best explained by a linear model more consistent with self-regulation theory (Leventhal & Johnson, 1983) than Janis's (1958) emotional-drive theory.

To summarise, the implications of the results for theory were mixed. There is almost no support for Kelly's (1955) theory. There was partial support for generalizing self-regulation theory from preparations for stressful medical procedures to preparation for psychotherapy. Finding that anxiety was reduced by preparation and there was a linear relationship between pretherapy state anxiety and outcomes provided primarily functional support for this theory. As much as anything this served to demote Janis's (1958) emotional-drive theory as a suitable model for understanding the effects of preparation for



psychotherapy. There still remain a number of substantive issues regarding the differences between the types of stressor which may substantially decrease the generalizability of even self-regulation theory to preparation for psychotherapy.

For the development of theory in the immediate future, it is suggested that researchers focus on the relationship between expectations and anxiety, or on the short-term relationships between preparation, expectations and anxiety. This may require the introduction of moderating variables such as has occurred in research related to preparations for stressful medical procedures (Schultheis et al., 1987). Once these relationships are better understood this may guide research into how longer-term outcome is affected and shed more light on the appropriateness of self-regulation theory in understanding preparations for psychotherapy.

### ***11.3 Preparation in clinical practice***

One of the strengths of the present study was the high external and ecological validity of the design which remained as close as possible to the clinics' usual intake procedures. Additionally the samples obtained appeared to be highly representative of typical adult outpatient referrals for psychotherapy (see section 7.2). Consequently the findings of the study are likely to generalize to similar samples and settings. The use of receptionist staff and the application of the preparatory video as part of usual intake procedure also increase the ease with which an intervention such as this may be used in routine clinic practice.

It appears that pretherapy video presentations have a number of benefits which might recommend their use in clinical practice. Finding no negative effects as a result of preparation is important in view of some research suggesting that patients about to undergo stressful medical procedures with particular coping styles may do worse if provided with preparatory information (Miller, 1980,; Miller & Mangan, 1983). Before considering any intervention in clinical practice it is important to consider the addage "do no harm". The preparation did not have any apparent detrimental effects and outcome measures consistently pointed in the direction of more positive outcomes for those in the prepared group even though most did not reach statistical significance.

With a trend toward more consumer oriented mental health services (e.g. Manthei, 1988; Morrison, 1979), preparations such as this have even more to recommend them. Ethical and practice guidelines stress that all clients have the right to be fully informed of the treatment they receive (American Psychological Association, 1981a, 1981b; Levine, Stolz & Lacks, 1983; New Zealand Psychological Society, 1985). Informational preparations such as the one used in the present study go a long way toward meeting these recommendations. While most therapists attempt to adhere to these professional guidelines, often information may be incomplete or forgotten as it takes a back seat to the business of understanding the clients' problems and getting rather than giving information. This was confirmed by several of the psychologists involved in the research who commented that they typically attempted to provide information to clients about psychotherapy, but that this was not usually systematic or comprehensive. The development of rapport and the therapeutic relationship usually took precedence. A video presentation has the advantage of providing comprehensive information in a familiar, nonthreatening, efficient and economical manner.

While the present study has demonstrated that preparation provides clients with more accurate expectations and less anxiety regarding psychotherapy in the short-term, minimal support was found for longer-term benefits. However, even short-lived effects may be beneficial when the structure of psychotherapy is considered. There is ample evidence to suggest that most clients remain in therapy for relatively few sessions (approximately 4) and that most attend only one or two visits (Deane, in press; Fiester, Mahrer, Giambra, Ormiston, 1974; Phillips, 1985; Sue, McKinney & Allen, 1976). With so little time to work with, clinicians may be even less inclined to spend the limited time providing comprehensive information about psychotherapy, and instead move quickly to assessment and treatment. Information provided through a preparatory video gives immediate assistance, providing clients with a welcome head start in therapy.

It is possible that if the preparation were to be used at an even earlier stage of clients entry into therapy, that these short-term benefits may be even more potent. It has been suggested that anxiety regarding psychotherapy may contribute to clients avoiding treatment altogether (Kushner & Sher, 1989; Noonan, 1973). The effects of anxiety regarding psychological treatments on the nonattendance problem has not been fully explored. Certainly, nonattendance at first appointments has been identified as a substantial problem for outpatient services, with rates as high as 55% being reported (Hochstadt & Trybula, 1980) and the rate in the present study around 20% (Deane, in press, see Appendix F).

There are encouraging signs that the nonattendance rate for first appointments can be decreased with certain administrative changes to referral and appointment scheduling procedures (e.g. Deane, 1991a; Hochstadt & Trybula, 1980), and preparations have been suggested as having potential to decrease other attendance problems (Pekarik, 1985a).

Combining preparation with administrative changes may serve to decrease the number of clients who do not attend for their first appointment. A flexible appointment scheduling system which encouraged clients to come to the clinic to obtain more information about services before scheduling a formal appointment, would allow an immediate response to clients requests for help, allow them to view the preparatory video and to complete the administrative requirements of the clinic. This task could be completed by receptionist staff requiring little or no therapist time.

An intervention such as this would increase the accuracy of the clients expectations of therapy, decrease their anxiety regarding treatment, and has the potential to increase attendance to initial appointments. If the effects of the preparatory videos are shortlived then its usefulness may be maximized early in the treatment process. It is for future research to determine whether preparations can be used to assist with the problem of nonattendance at initial appointments or whether the effectiveness of preparations can be improved long-term.

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## APPENDIX A

### VIDEO SCRIPT

Title: "About Psychotherapy"

Hello I'm Frank Deane. I'm a psychologist from Massey University conducting a study at this centre. I'd like to welcome you to the centre, and thank-you for being a part of the study.

Through this presentation I will be providing you with some information about what you can expect from the centre and from your participation in psychotherapy, sometimes referred to as "talking therapy". If you have taken part in psychotherapy before, some of this information may already be familiar to you. Previous experience shows us that clients who receive an orientation like this one are better prepared to benefit from services.

In this orientation, I'll be covering several main points. First I will talk briefly about the hesitancy which many people feel when considering psychiatric treatment or psychotherapy. Another issue to be discussed is the special quality of the relationship between the client and the therapist. Next, I'll talk about what can be expected to occur during your therapy appointments. Finally, I will discuss the kinds of changes you can achieve through psychotherapy.

Now I'd like to go into further detail about the points I've just mentioned. What about the hesitancy that many people feel about deciding to meet with a psychiatrist or psychologist? We know that people are often unsure about whether they really need to see a psychologist, and whether they really have the kind of problem that is helped at a psychiatric clinic. This is a natural concern and a large part of your time with the psychologist will involve the two of you clarifying the problem and then working together to help you deal with your difficulties. Another thing that people often worry about is becoming too dependent on someone else. Its important to realise that there are times when people do need other people. Most clients do not become overly dependent on their therapists. In fact one of the goals of therapy is to help you develop ways of solving problems on their own in the future.

Another concern that new clients often have is that that they will not have enough to talk about or that they will be too embarassed or shy to talk about their problems. Its true that some clients find it takes a while before they can express themselves freely. However its not necessary for you to spend the entire therapy appointment talking. You may want to use part of the time just to think things over.

At any rate, its not uncommon for clients to have these kinds of doubts about psychotherapy. Deciding to try therapy despite these concerns is often an indication of strength.

When you first come to the centre you may meet with a psychiatrist. The psychiatrist works as part of a team which includes psychologists, social workers, nurses, and occupational therapists. Should you need specialised services then you may also work with a therapist from the rest of the team. Initially, you and your therapist will meet to discuss your individual concerns and problems in order to arrange services most suitable to you. The type of service varies depending on a clients problems and needs. Several forms of treatment are available, including: group psychotherapy, individual psychotherapy, family therapy and medication. In most cases the client sees the therapist in individual psychotherapy as an outpatient once a week for 50 minutes. For some clients it is helpful to have more contact with the centre and it may be recommended that they attend as a daypatient or receive inpatient treatment.

If you have participated in psychotherapy before or if you have heard or read much about the process, you are aware that the relationship between a client and a therapist is quite different from the relationship between a patient and a medical doctor. It also differs from an ordinary social relationship. Psychotherapy is essentially a learning process, the process of which is to help you understand yourself and deal more effectively with your problems. This may involve learning to use the skills you already have more effectively, or learning and practicing new skills in order to make the changes you want in your life. This process of change can sometimes be assisted through the use of medications recommended by your psychiatrist.

While a medical doctor often provides specific advice to patients, your therapist will serve largely as a skilled listener who tries to help you learn why you're experiencing difficulties. The communication that takes place during therapy is frequently unlike an ordinary social conversation. For instance a therapist may often be silent for considerable periods of time. Also, you can feel free to talk about anything without the usual social restrictions. In an ordinary social conversation, most people avoid saying things that they think are impolite, insignificant, or perhaps too personal. However, in therapy you can feel free to say what ever comes to mind even if it seems offensive or unimportant. Everything that is discussed in psychotherapy is confidential. You are an active participant in the psychotherapy process and you will have an opportunity to discuss problems and work with your therapist to arrive at possible solutions.

Learning to express feelings and thoughts to your therapist is a central part of the psychotherapy process. Ordinarily this happens gradually rather than immediately. For this reason, clients often find that the changes and improvements they would like to make do not occur right away. In fact, clients who are in psychotherapy for the first time sometimes find the experience a little strange at first. They may wonder whether the therapist they're seeing is right for them. They may even question whether therapy is really "for them" at all. Sometimes clients find that they don't feel like returning after the first appointment. However, it's best not to try to decide these things too fast. New clients usually need a few weeks to get used to psychotherapy, and those who have been in therapy before may need time to adjust to a new therapist. So, if you're having some doubts about therapy it's a good idea to stick with it for at least a few visits and to talk things over with your therapist before making a decision.

Although you may feel some initial relief when you have the opportunity to discuss your problems with someone, perhaps for the first time, progress is not usually immediate or steady and there may be some ups and downs.

During the course of therapy there may be some times when you do not feel like going to your appointment. It's very important to keep coming to appointments during these difficult times and to discuss these feelings with your therapist. Expressing these kinds of strong feelings can often be a significant step toward improvement.

Progress in therapy often involves discussing feelings or events which may be uncomfortable to talk about. In addition, it is essential to continue attending therapy appointments even when it seems tempting to skip them.

The amount of time needed before you see improvement varies depending on the type and severity of your problem. Improvement also depends on your needs and the effort you make in working toward your goals. If you have questions about this issue you should discuss it with your therapist. During the change process your therapist will serve as a guide and a source of support. In general, if you want to change, are willing to attend regularly, and work actively with your therapist toward solutions to problems, you'll find that therapy can help you feel better.... experience less anxiety and depression and feel more motivated to pursue your personal goals in life. The key points to keep in mind are the following:

-Psychotherapy is an active problem-solving and learning process. Although medicines may assist in your treatment mostly you will learn to use the skills you already have and learn new skills to help you to deal more effectively with your problems or concerns.

-The relationship between you and your therapist is a central part of the therapy process. This relationship differs in important ways from both patient-doctor relationships and social friendships. While a medical doctor often provides the patient with specific advice, the therapist serves instead as a skilled listener. Unlike a social acquaintance, the therapist will not expect you to stick to any particular rules of conversation. On the contrary you can feel free to say what ever comes to mind.

-It may take some time to get used to being in psychotherapy. Therefore, if you have doubts or hesitations at first about whether or not to stay in therapy, you should attend at least a few appointments and should discuss these concerns with your therapist before making a decision.

-In order to make changes and improve, you must continue to attend even when things are difficult.

-Progress in psychotherapy does not occur right away, nor is it always steady. There may be difficult periods during which you feel tempted to skip appointments.

-In order to improve you must be willing to discuss things that may be uncomfortable to talk about.

-The majority of clients who are willing to actively participate in therapy in this way can expect improvements to occur. Therapy can help clients feel less troubled by anxiety and depression and to be more able to live their lives according to their own plans.

I hope you have found this introduction helpful. Thank you for your attention and for your help in the study. Please return to the receptionist who will let you know how to proceed.

Text: "Acknowledgements and thanks to Rebecca Zwick and Clifford Attkisson of the University of California for providing the initial script."

## RESEARCH INSTRUMENTS

**1. *Pretest (Yellow form)***

- (a) State-Trait Anxiety Inventory-Form Y1, State (STAI-Y1).
- (b) 7-item S-R Inventory of Anxiousness (SR-7).
- (c) Psychotherapy Questionnaire (PQ).

**2. *Posttest (Green form)***

- (a) State-Trait Anxiety Inventory-Form Y1, (STAI-Y1, as in pretest).
- (b) 7-item S-R Inventory of Anxiousness (SR-7, as in pretest).
- (c) Psychotherapy Questionnaire (PQ, as in pretest).
- (d) Hopkins Symptom Checklist-21 (HSCL-21).
- (e) State-Trait Anxiety Inventory-Form Y2, Trait (STAI-Y2).
- (f) Target Complaints measure clients (TC).

**3. *Follow-up (Pink form)***

- (a) State-Trait Anxiety Inventory-Form Y1, (STAI-Y1, directions altered, items as in pretest and posttest).
- (b) 7-item S-R Inventory of Anxiousness (SR-7, directions altered, items as in pretest and posttest).
- (c) Psychotherapy Questionnaire (PQ, as in pretest and posttest).
- (d) Hopkins Symptom Checklist-21 (HSCL-21, as in posttest).
- (e) State-Trait Anxiety Inventory-Form Y2, Trait (STAI-Y2, as in posttest).
- (f) Target Complaints measure clients (TC, directions altered, initial complaints written verbatim with original ratings crossed).
- (g) Reasons for no longer attending therapy (also see Appendix F).
- (h) Consumer Satisfaction Questionnaire-8, (CSQ-8).

**4. *Therapist Rating Form (Blue form)***

- (a) Prior treatment question
- (b) Target Complaints-Therapist version (TCT).
- (c) Brief Hopkins Psychiatric Rating Scale (BHPRS).
- (d) Dropout items.

PRETEST

STAI-YI

Name: \_\_\_\_\_ Date: \_\_\_\_\_

DIRECTIONS: A number of statements which people have used to describe themselves are given below. Read each statement and then circle the appropriate number to the right of the statement to indicate how you feel right now, that is, at this moment. There are no right or wrong answers. Do not spend too much time on any one statement but give the answer which seems to describe your feelings best.

	NOT AT ALL	SOMEWHAT	MODERATELY SO	VERY MUCH SO
I feel calm.....	1	2	3	4
I feel secure.....	1	2	3	4
I am tense.....	1	2	3	4
I feel strained.....	1	2	3	4
I feel at ease.....	1	2	3	4
I feel upset.....	1	2	3	4
I am presently worrying over possible misfortunes	1	2	3	4
I feel satisfied.....	1	2	3	4
I feel frightened.....	1	2	3	4
I feel comfortable.....	1	2	3	4
I feel self-confident....	1	2	3	4
I feel nervous.....	1	2	3	4
I am jittery.....	1	2	3	4
I feel indecisive.....	1	2	3	4
I am relaxed.....	1	2	3	4
I feel content.....	1	2	3	4
I am worried.....	1	2	3	4
I feel confused.....	1	2	3	4
I feel steady.....	1	2	3	4
I feel pleasant.....	1	2	3	4



**SR-7**

DIRECTIONS: This inventory is a way of studying people's reactions to coming to psychotherapy. Below are some common types of reactions and feelings listed. By circling one of the numbers on each of the 5-point scales below please indicate how much you are experiencing these reactions and feelings now.

Heart beats faster	1	2	3	4	5
Not at all					Very much
Get an "uneasy feeling"	1	2	3	4	5
Not at all					Very much
Emotions disrupt action	1	2	3	4	5
Not at all					Very much
Become immobilised	1	2	3	4	5
Not at all					Very much
Want to avoid situation	1	2	3	4	5
Not at all					Very much
Perspire	1	2	3	4	5
Not at all					Very much
Mouth gets dry	1	2	3	4	5
Not at all					Very much

DIRECTIONS: Below are some statements which describe different aspects of psychotherapy. Please circle true or false to indicate what you expect occurs in psychotherapy.

The client usually finds that talking with the therapist is much like chatting with a friend .....	True	False
The therapist can be expected to offer many suggestions about ways in which the client's problems can be solved .....	True	False
Most clients find that they can express thoughts and feelings to the therapist almost immediately .....	True	False
If a client finds psychotherapy upsetting they should discuss their feelings with their therapist .....	True	False
In order to make progress in psychotherapy, a client must discuss uncomfortable topics .....	True	False
A client is expected to be prepared to talk for the entire session .....	True	False
The most important task of the client in psychotherapy is to follow the instructions given by the therapist .....	True	False
If a client feels uncomfortable with their new therapist, they should switch to another therapist as soon as possible .....	True	False
One of the most important tasks of the therapist is to serve as a skilled listener .....	True	False
Most clients tend to become very dependent on their therapists .....	True	False
If a client feels uncomfortable during therapy appointments, it probably means that psychotherapy is not for them .....	True	False
In therapy, the client can say whatever comes to mind, even if they think it will shock or offend the therapist .....	True	False
One of the most important tasks of the therapist is to give advice to clients, much as a medical doctor does .....	True	False
During the therapy session, the therapist may often be silent for long periods of time .....	True	False
A new client should wait several weeks after their first visit before deciding if psychotherapy is right for them .....	True	False
For most psychotherapy clients, progress occurs almost immediately .....	True	False
A client should go to their psychotherapy appointments even when they strongly feel they are not in the mood .....	True	False

STAI-YI (as in pretest).

SR-7 (as in pretest).

PQ (as in pretest).

DIRECTIONS: How have you felt during the past seven days including today? Circle the appropriate number to describe how distressing you have found these things over this time.

	NOT AT ALL	A LITTLE	QUITE A BIT	EXTREMELY
Difficulty in speaking when you are excited.....	1	2	3	4
Trouble remembering things.....	1	2	3	4
Worried about sloppiness or carelessness.....	1	2	3	4
Blaming yourself for things.....	1	2	3	4
Pains in the lower part of your back.....	1	2	3	4
Feeling lonely.....	1	2	3	4
Feeling blue.....	1	2	3	4
Your feelings being easily hurt.....	1	2	3	4
Feeling others do not understand you or are unsympathetic.....	1	2	3	4
Feeling that people are unfriendly or dislike you.....	1	2	3	4
Having to do things very slowly in order to be sure you are doing them right.....	1	2	3	4
Feeling inferior to others.....	1	2	3	4
Soreness of your muscles.....	1	2	3	4
Having to check and double check what you do.....	1	2	3	4
Hot or cold spells.....	1	2	3	4
Your mind going blank.....	1	2	3	4
Numbness or tingling in parts of your body.....	1	2	3	4
A lump in your throat.....	1	2	3	4
Trouble concentrating.....	1	2	3	4
Weakness in parts of your body..	1	2	3	4
Heavy feelings in your arms and legs.....	1	2	3	4

DIRECTIONS: A number of statements which people have used to describe themselves are given below. Read each statement and then circle the appropriate number to the right of the statement to indicate how you *generally* feel. There are no right or wrong answers. Do not spend too much time on any one statement but give the answer which seems to describe how you generally feel.

	ALMOST NEVER	SOMETIMES	OFTEN	ALMOST ALWAYS
I feel pleasant.....	1	2	3	4
I feel nervous and restless.....	1	2	3	4
I feel satisfied with myself....	1	2	3	4
I wish I could be as happy as others seem to be.....	1	2	3	4
I feel like a failure.....	1	2	3	4
I feel rested.....	1	2	3	4
I am "calm, cool, and collected"	1	2	3	4
I feel that difficulties are piling up so that I cannot overcome them.....	1	2	3	4
I worry too much over something that really doesn't matter.....	1	2	3	4
I am happy.....	1	2	3	4
I have disturbing thoughts.....	1	2	3	4
I lack self-confidence.....	1	2	3	4
I feel secure.....	1	2	3	4
I make decisions easily.....	1	2	3	4
I feel inadequate.....	1	2	3	4
I am content.....	1	2	3	4
Some unimportant thought runs through my mind and bothers me..	1	2	3	4
I take disappointments so keenly that I can't put them out of my mind.....	1	2	3	4
I am a steady person.....	1	2	3	4
I get into a state of tension or turmoil as I think over my recent concerns and interests...	1	2	3	4

TC

DIRECTIONS: Please write down the two most disturbing problems or complaints for which you are seeking help through treatment. Circle the number which best describes the amount of disturbance felt for each problem.

Problem: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

In general how much does this  
problem or complaint bother you?

not at all										couldn't be worse
0	1	2	3	4	5	6	7	8	9	

Problem: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

In general how much does this  
problem or complaint bother you?

not at all										couldn't be worse
0	1	2	3	4	5	6	7	8	9	

**STAI-Y1** (Directions altered, items as in pretest and posttest).

DIRECTIONS: A number of statements which people have used to describe themselves are given below. Read each statement and then circle the appropriate number to the right of the statement to indicate how you felt at your last psychotherapy session. There are no right or wrong answers. Do not spend too much time on any one statement but give the answer which seems to describe your feelings at your last psychotherapy session best.

**SR-7** (directions altered, items as in pretest and posttest).

DIRECTIONS: This inventory is a way of studying people's reactions to coming to psychotherapy. Below are some common types of reactions and feelings listed. By circling one of the numbers on each of the 5-point scales below please indicate how much you experienced these reactions and feelings at your last psychotherapy session.

**PQ** (as in pretest and posttest).

**HSCL-21** (as in posttest).

**STAI-Y2** (as in posttest).

**TC** (Directions altered, items the same as in posttest, initial complaints written verbatim with original ratings crossed).

DIRECTIONS: Below are the two most disturbing problems or complaints for which you sought help at the beginning of treatment. The number crossed was the amount of disturbance you felt for each problem at that time. Please CIRCLE the number that currently describes the amount of disturbance felt for each problem now.

**REASON FOR NO LONGER ATTENDING THERAPY** (Since this question was not related to the formal research hypotheses it was not discussed in the body of the report. It is included here because it was a part of the Follow-up Form. For additional information regarding this question see Appendix F).

Why did you stop coming to the centre? Please circle the number for the reason that applies most. Circle only one number.

1. Lack of time.
2. Problem has been solved or improved to an acceptable level.
3. Pressure from other people to stop coming.
4. Centre too far away.
5. Dislike of type of therapy.
6. Transportation problems.
7. Fears and anxiety about psychiatric treatment.
8. Sought help elsewhere.
9. Conflict with work hours.
10. Dislike of therapist.
11. Other: (please specify). \_\_\_\_\_

**CSQ-8**

**DIRECTIONS:** We would like you to answer some questions about the services you have received. We are interested in your honest opinion, whether positive or negative. Please answer all of the questions. Thank you very much, we really appreciate your help.  
**CIRCLE YOUR ANSWER**

1. How would you rate the quality of the service you have received?

4	3	2	1
_____ Excellent	_____ Good	_____ Fair	_____ Poor

2. Did you get the kind of service you wanted?

1	2	3	4
_____ No, definitely not	_____ No, not really	_____ Yes, generally	_____ Yes, definitely

3. To what extent has our programme met your needs?

4	3	2	1
_____ Almost all of my needs have been met	_____ Most of my needs have been met	_____ Only a few of my needs have been met	_____ None of my needs have been met

4. If a friend were in need of similar help, would you recommend our programme to him or her?

1	2	3	4
_____ No, definitely not	_____ No, I don't think so	_____ Yes, I think so	_____ Yes, definitely

5. How satisfied are you with the amount of help you have received?

1	2	3	4
_____ Quite dissatisfied	_____ Indifferent or mildly dissatisfied	_____ Mostly satisfied	_____ Very satisfied

6. Have the services you received helped you deal more effectively with your problems?

4	3	2	1
_____ Yes, they helped a great deal	_____ Yes, they helped somewhat	_____ No, they really didn't help	_____ No, they seemed to make things worse

7. In an overall, general sense, how satisfied are you with the service you have received?

4	3	2	1
_____ Very satisfied	_____ Mostly satisfied	_____ Indifferent or mildly dissatisfied	_____ Quite dissatisfied

8. If you were to seek help again, would you come back to our programme?

1	2	3	4
_____ No, definitely not	_____ No, I don't think so	_____ Yes, I think so	_____ Yes, definitely



THERAPIST RATING FORM

Ratings of clients should be made as soon as possible after the initial intake interview, and again at two month followup or at the clients final session which ever occurs first. For the INTAKE RATINGS CROSS (X) the appropriate number, and for FOLLOWUP RATINGS CIRCLE (O) the appropriate number.

Client's Name \_\_\_\_\_ I.D. \_\_\_\_\_

Intake Therapist (X) \_\_\_\_\_ Intake Date \_\_\_\_\_

Followup Therapist (O) \_\_\_\_\_ Followup Date \_\_\_\_\_

DIRECTIONS: Please cross one of the following responses to indicate whether this client has had any previous counselling or psychotherapy by a professional therapist or counsellor and the approximate number of visits.

none            1-2            3-5            6-10            10+

The client was seen by previously by a: \_\_\_\_\_

DIRECTIONS: Please write down the two most disturbing problems or complaints for which the client is seeking help in treatment. CROSS (at followup circle) the number which best describes the amount of disturbance felt for each problem.

Problem: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

In general how much does this  
problem or complaint bother this client?

not at all										couldn't be worse
0	1	2	3	4	5	6	7	8	9	

Problem: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

In general how much does this  
problem or complaint bother this client?

not at all										couldn't be worse
0	1	2	3	4	5	6	7	8	9	

**DIRECTIONS:** The Brief Hopkins Psychiatric Rating Scale (BHPRS) is comprised of 9 primary symptom dimensions and a global pathology scale. In making your ratings first familiarise yourself with the definition of the dimension and at intake cross and at followup circle the appropriate number that most accurately reflects the degree of that syndrome manifested by the client.

<p>1. <b>SOMATIZATION:</b> IS DEFINED AS THE TENDENCY TO REACT TO STRESS OR TENSION OF PSYCHOLOGICAL ORIGINS THROUGH PHYSICAL BODILY SYMPTOMS. COMPLAINTS TEND TO BE FOCUSED ON CARDIOVASCULAR, GASTROINTESTINAL, RESPIRATORY, SKIN, AND OTHER SYSTEMS WITH STRONG AUTONOMIC MEDIATION AND LACK A CLEAR ORGANIC BASIS.</p>	<p>0 1 2 3 4 5 6</p> <p>NONE SLIGHT MILD MODERATE MARKED SEVERE EXTREME</p> <p>↓</p> <p>↓</p> <p>↓</p> <p>Patient reveals occasional somatic symptoms which have psychic origins.</p> <p>Patient consistently complains of somatic symptoms which may have psychic origins.</p> <p>Patient is highly distressed and incapacitated by a psychosomatic condition.</p>
<p>2. <b>OBSSIVE-COMPULSIVE:</b> REFERS TO PERSISTENT THOUGHTS, RUMINATIONS, IMPULSES, AND IMPELLING URGES TO ACT, THAT ARE UNREMITTING AND IRRESISTABLE BUT ARE OF AN EGO-ALLEN OR UNWANTED NATURE.</p>	<p>0 1 2 3 4 5 6</p> <p>NONE SLIGHT MILD MODERATE MARKED SEVERE EXTREME</p> <p>↓</p> <p>↓</p> <p>↓</p> <p>Patient has occasional periods when unpleasant thoughts will not leave his mind.</p> <p>Patient experiences persistent thoughts, urges, or acts which are impelling, but cause minimal interference in life activities.</p> <p>Patient's daily functioning is significantly impaired by obsessive compulsive ruminations or rituals.</p>
<p>3. <b>INTERPERSONAL SENSITIVITY:</b> FOCUSES ON FEELINGS OF PERSONAL INADEQUACY AND INFERIORITY. SELF-DEPRECIATION, FEELINGS OF UNEASINESS, AND MARKED DISCOMFORT DURING INTERPERSONAL INTERACTIONS ARE CHARACTERISTIC OF PERSONS WITH HIGH LEVELS OF INTERPERSONAL SENSITIVITY. FEELINGS OF ACUTE SELF CONSCIOUSNESS, AND POOR EXPECTANCIES ABOUT SOCIAL COMMUNICATION ARE ALSO TYPICAL CHARACTERISTICS.</p>	<p>0 1 2 3 4 5 6</p> <p>NONE SLIGHT MILD MODERATE MARKED SEVERE EXTREME</p> <p>↓</p> <p>↓</p> <p>↓</p> <p>Patient sometimes wonders if some personal deficiency is preventing a more complete life fulfillment.</p> <p>Patient is often absorbed by convictions of ineptness, and lack of mastery.</p> <p>Patient is deeply distressed by pervasive convictions of personal inadequacy.</p>
<p>4. <b>DEPRESSION:</b> REFLECTS A BROAD RANGE OF SIGNS AND SYMPTOMS OF THE CLINICAL DEPRESSIVE SYNDROME. SYMPTOMS OF DYSPHORIC AFFECT AND MOOD, WITHDRAWAL OF INTEREST IN LIFE ACTIVITIES, LACK OF MOTIVATION, AND LOSS OF VITAL ENERGY ARE ALL DEPRESSIVE SYMPTOMS. IN ADDITION, FEELINGS OF HOPELESSNESS, HELPLESSNESS, AND FUTILITY ARE KEY SYMPTOMS. AS ARE SUICIDAL RUMINATIONS.</p>	<p>0 1 2 3 4 5 6</p> <p>NONE SLIGHT MILD MODERATE MARKED SEVERE EXTREME</p> <p>↓</p> <p>↓</p> <p>↓</p> <p>Patient has occasional periods of feeling flat and uninvolved in life.</p> <p>Patient is sad and pessimistic, with concern over increased difficulty in handling responsibilities.</p> <p>Patient is deeply depressed with feelings of guilt, hopelessness, and self-depreciation.</p>
<p>5. <b>ANXIETY:</b> IS DEFINED IN TERMS OF ITS CLINICAL FEATURES AS A NEGATIVE EMOTIONAL STATE SIMILAR TO FEAR BUT ARISING FROM A MORE DIFFUSE SOURCE. TYPICAL SIGNS AND SYMPTOMS ARE NERVOUSNESS, APPREHENSION AND DREAD, RESTLESSNESS, FEELINGS OF IMPENDING DOOM, TREMBLING, AND PANIC.</p>	<p>0 1 2 3 4 5 6</p> <p>NONE SLIGHT MILD MODERATE MARKED SEVERE EXTREME</p> <p>↓</p> <p>↓</p> <p>↓</p> <p>Patient sometimes feels nervous and jittery.</p> <p>Patient experiences periods of persistent tension or unexplained dread and feels under constant pressure.</p> <p>Patient is frightened and tremulous with somatic symptoms, feelings of impending disaster, and fears of death.</p>

<p>6. <b>HOSTILITY:</b> IS DEFINED AS A NEGATIVE EMOTIONAL STATE CHARACTERIZED BY IRRITABILITY, ANGER, AGGRESSION AND HOSTILE FEELINGS. MANIFESTATIONS MAY BE IN TERMS OF THOUGHTS, FEELINGS, OR ACTIONS, OVERT OR COVERT, VERBALLY OR BEHAVIORALLY EXPRESSED.</p>	<div><div>0123456</div><div>NONE SLIGHT MILD MODERATE MARKED SEVERE EXTREME</div><div>↓</div><div>Patient has occasional bursts of irritability, anger and hostile thoughts.</div><div>Patient is hostile and aggressive, and clearly reveals anger and aggression in his thoughts and behavior.</div><div>Patient is enraged, is verbally abusive, and physically combative.</div></div>
<p>7. <b>PHOBIC ANXIETY:</b> IS DEFINED AS A PERSISTENT FEAR RESPONSE WHICH IS INVOLUNTARY, IRRATIONAL, AND DISPROPORTIONATE TO THE STIMULUS, AND WHICH LEADS TO AVOIDANCE OR ESCAPE BEHAVIOR. PHOBIC FEARS ORIENTED TOWARD TRAVEL, OPEN SPACES, CROWDS, PUBLIC PLACES OR CONVEYANCES AND SOCIAL INTERACTIONS COMPRISE THIS SYNDROME.</p>	<div><div>0123456</div><div>NONE SLIGHT MILD MODERATE MARKED SEVERE EXTREME</div><div>↓</div><div>Patient indicates minor transient episodes of phobic behavior which involve minimal distress.</div><div>Patient remains clear phobic response to one or more objects or situations which involves avoidance or escape.</div><div>Patient reveals multiple phobias with generalization, panic attacks, and substantial life interference.</div></div>
<p>8. <b>PARANOID IDEATION:</b> IS DEFINED AS A MODE OF THOUGHT CHARACTERIZED BY HOSTILITY, SUSPICIOUSNESS, RIGIDITY, AND PROJECTIVE THINKING, WITH PERSECUTORY THEMES AND CONCERNS OVER LOSS OF INDEPENDENCE AND AUTONOMY FREQUENTLY BEING PRESENT. AT MORE SEVERE LEVELS, GRANDIOSITY AND DELUSIONS MAY ALSO BE REVEALED.</p>	<div><div>0123456</div><div>NONE SLIGHT MILD MODERATE MARKED SEVERE EXTREME</div><div>↓</div><div>Patient is easily slighted and complains of injustices but complaints and hostility are minimal.</div><div>Patient is suspicious and angry and tends to blame others for his predicaments through denial and rationalization.</div><div>Patient manifests fixed ideas of reference with a definite delusional system in operation.</div></div>
<p>9. <b>PSYCHOTICISM:</b> THE PRESENT DEFINITION REPRESENTS A CONTINUUM GOING FROM A MILDLY ALIEN LIFE STYLE AT ONE EXTREME TO FLORIDLY PSYCHOTIC STATUS AT THE OTHER. INDICATIONS OF SCHIZOID, UNUSUAL, ALIENATED STYLE OF LIFE WILL SCORE A PERSON AT ONE END OF THE CONTINUUM, WHILE DRAMATIC SYMPTOMS OF PSYCHOSIS- HALLUCINATIONS, DELUSIONS, ETC. WILL PLACE HIM AT THE OTHER.</p>	<div><div>0123456</div><div>NONE SLIGHT MILD MODERATE MARKED SEVERE EXTREME</div><div>↓</div><div>Patient complains of being alienated and different from other people.</div><div>Patient presents a schizoid picture with the possibility of active psychotic process being present.</div><div>Patient manifests clear evidence of a psychotic disorder with multiple symptoms and signs.</div></div>

GLOBAL PATHOLOGY INDEX ( G P I )

PLEASE RATE THE PATIENT'S GLOBAL LEVEL OF PATHOLOGY BY CIRCULING THE VALUE THAT MOST ACCURATELY DESCRIBES HIS CURRENT LEVEL OF FUNCTIONING. USE A TIME FRAME OF THE PAST 7 DAYS INCLUDING TODAY. AND ALLOW YOUR RATING TO REFLECT HIS POOREST LEVEL OF FUNCTIONING DURING THIS PERIOD.

8	EXTREME	PATIENT SHOWS MAJOR IMPAIRMENTS IN MULTIPLE AREAS OF FUNCTIONING. MOOD IS INAPPROPRIATE, AND HALLUCINATIONS AND DELUSIONS MAY BE PRESENT. JUDGEMENT IS IMPAIRED, CONCEPTUAL PROCESSES MAY BE CLEARLY DISORGANIZED AND PATIENT MAY SHOW DISABILITIES IN VOLITIONAL AND MOTOR AREAS. PATIENT MAY NOT BE CAPABLE OF CARING FOR SELF, AND MAY BE A RISK TO SELF, OR OTHERS.
7	SEVERE	
6	MARKED	
5	SUBSTANTIAL	ADJUSTMENT IS MARGINAL. MANIFEST SYMPTOMS ARE PRESENT WHICH CAUSE THE PATIENT CONSIDERABLE DISTRESS. INTRAPSYCHIC PROCESSES SHOW SIGNS OF DISRUPTION, AND INTERPERSONAL FUNCTIONING IS IMPAIRED. MOOD TENDS TO BE DYSPHORIC, AND NEED FOR TREATMENT IS OBVIOUS.
4	MODERATE	
3	MILD	GENERAL FUNCTIONING IS SOMEWHAT DISTURBED. PATIENT COMPLAINS OF CERTAIN DISTRESSING SYMPTOMS AND MOOD IS SLIGHTLY IRREGULAR; HOWEVER, SOCIAL AND INTRAPSYCHIC PROCESSES APPEAR NORMAL.
2	SLIGHT	
1	MINIMAL	LITTLE PATHOLOGY PRESENT. FEW SYMPTOMS ARE MANIFEST, AND LITTLE DISTRESS IS REPORTED BY THE PATIENT. INTERPERSONAL FUNCTIONING IS UNIMPAIRED, AND AFFECT IS USUALLY WITHIN NORMAL LIMITS.
0	ABSENT	

FOLLOW-UP ONLY (circle "Yes" or "No")

Did the client attend the last scheduled appointment?..... Yes No

Was the client in need of further treatment at last visit?..... Yes No

## APPENDIX C

Deane, F. P., Spicer, J., & Leathem, J. (1991).  
A situation-specific state anxiety scale.  
Manuscript submitted for publication.

### A SITUATION-SPECIFIC STATE ANXIETY SCALE

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#### Abstract

It is proposed that standard state anxiety self-report measures may frequently need augmenting, particularly by defining the situation of interest. The 7-item S-R Inventory of Anxiousness (SR-7) was designed as a situation-specific state anxiety measure, and was compared to the State-Trait Anxiety Inventory (STAI-Y, Spielberger, 1983). One hundred and forty-one clients referred for outpatient psychotherapy with psychologists completed the SR-7 and the STAI-Y at their first visit. The SR-7 had high internal consistency, and while it correlated strongly with the STAI-Y, it also showed evidence of tapping unique aspects of state anxiety.

#### Introduction

Self-report measures of state anxiety have been used widely in a variety of clinical research settings, with one of the most widely used being the State-Trait Anxiety Inventory (Spielberger, 1983). While tests such as this are typically reliable and valid, they may be inadequate for specific purposes and require, augmenting to improve their relevance. One such context is the assessment of patients' stress responses to noxious medical procedures (Hartfield, Cason & Cason, 1982; Kent, 1987). A recent review of information provision approaches to stress management during stressful procedures found a lack of expected anxiety reduction effects (Ludwick-Rosenthal & Neufeld, 1988). It was suggested that the use of anxiety measures of questionable validity and inadequate sensitivity were to blame.

The State-Trait Anxiety Inventory (STAI; Spielberger, Gorsuch, & Lushene, 1970), has been used frequently as a self-report measure of anxiety in studies investigating the responses to noxious medical procedures (e.g. Hartfield et al., 1982; Kendall, Williams, Pechacek, Graham, Shisslak & Herzoff, 1979). This measure has satisfactory reliability and validity, but while it adequately assesses the cognitive-worry aspects of state anxiety it lacks items which tap self-reported emotional autonomic arousal components of state anxiety, such as heart rate and perspiration (Endler, 1980). These somatic symptoms may be particularly salient to state anxiety and to specific reactions to situations in medical settings.

In addition, the STAI does not fully handle the issue of situation specificity. In the investigation of patients' responses to noxious medical procedures they may be asked to

make ratings before, during and/or after the procedure. When retrospective ratings are sought the situation is usually specified, but this is not usually the case for ratings before or during the procedure (e.g. Kendall et al., 1979). The A-State scale of the State-Trait Anxiety Inventory-Y (Spielberger, 1983) is typically administered with the instruction "to indicate how you feel right now, that is, at this moment". The assumption is that the subject will respond in relation to the immediate situation they are in. However, it remains unclear whether the patient is responding to the situation of interest (e.g. visit to dentist) and/or to other cues or psychological processes (e.g. worry over marital problems). Although there will always be some "seepage" of other psychological conflicts from one situation to another, by explicitly stating the situation to which you wish the subject to respond, it should be possible to reduce this confounding effect and potentially increase sensitivity.

We suggest that adjuncts to existing anxiety measures may be needed in situations such as these, and that they would benefit from having a number of characteristics in addition to the usual reliability and validity requirements: they should be brief to enable repeated administration; they should sample a variety of anxiety dimensions of relevance to the research context and; most importantly they should be situation-specific.

In the present study clinical data on a number of measures was collected on clients referred to two Psychology Departments for psychotherapy. This data was collected as part of a larger study investigating whether self-regulation theory (Leventhal & Johnson, 1983) could be generalized from explaining the effects of preparations for stressful medical procedures to explaining the effects of preparations for psychotherapy. Consequently we wanted to determine clients initial anxiety levels immediately prior to attending their first psychotherapy visit with a psychologist. Subjects in the current research context were considered particularly susceptible to the problem of reporting state anxiety not related to the situation of interest, because they were arriving with a number of other situational concerns (e.g. family conflict) which would arouse state anxiety. It was felt that by making the situation explicit we could obtain a clearer measure of state anxiety more specifically related to the situation than their general level of distress. We also wanted a measure which tapped avoidance aspects of anxiety and it was hoped the measure might in the future prove to have some predictive value with regard to attendance at clients first psychotherapy visit. This was considered important since anxiety about psychotherapy had been associated with avoidance of mental health services (e.g. Kushner & Sher, 1989; Noonan, 1973). Finally, the supporting measure needed to sample autonomic aspects of anxiety which were not present in the STAI-Y.

We were initially attracted to the work of Endler, Hunt & Rosenstein, (1962), who had already addressed the issue of situation specificity with regard to measures of trait anxiety, and had developed the S-R Inventory of Anxiousness, a measure of situation-specific trait anxiety (Endler et al., 1962; Endler, 1980). A factor-analysis performed by Endler et al. (1962) on the original inventory revealed a factor containing response modes which appeared to sample the additional anxiety components sought in the present study. Consequently these response modes were used in the development of the SR-7.

The aims of the present study were to provide some preliminary reliability and validity data on the SR-7, with evidence for the concurrent validity of the SR-7 being provided through comparison with the State-Trait Anxiety Inventory Form Y. It was anticipated that the SR-7 would have moderate correlations with the A-State scale of the STAI-Y since both measured state anxiety, but that this correlation would not be too high since the SR-7 should measure different symptoms associated with state anxiety. In addition we expected the SR-7 to have a relatively low correlation with the A-Trait scale of the STAI-Y, and that this relationship would almost disappear once other aspects of state anxiety not associated with the situation were controlled.

## Method

### Subjects

One hundred and forty-one clients 18 years and over referred for psychotherapy to the outpatient Psychology Departments of two New Zealand General Hospitals participated in the study.

### Measures

#### SR-7

As noted, the items of the SR-7 were selected as a result of the factor-analysis of the original S-R Inventory of Anxiousness-Form O, a situation-specific measure of trait anxiety (Endler, et al., 1962). The seven response modes of the S-R Inventory of Anxiousness-Form O which had the highest factor loading on Factor 1 were used. Endler et al. (1962) referred to this factor as "distress-disruption-avoidance".

The SR-7 is intended as a situation-specific measure of state anxiety and consists of 7 items rated on a 1 to 5 point Likert-type scale ranging from "Not at all" to "Very Much". The respondents received the following instructions: "This inventory is a way of studying peoples' reactions to coming to psychotherapy. Below are some common types of reactions and feelings listed. By circling one of the numbers on each of the 5-point scales below please indicate how much you are experiencing these reactions and feelings now."

Subjects responded to the following items: 1. Heart beats faster; 2. Get an "uneasy feeling"; 3. Emotions disrupt action; 4. Become immobilised; 5. Want to avoid situation; 6. Perspire; 7. Mouth gets dry.

#### STAI-Y

The STAI-Y (Spielberger, 1983) comprises two separate 20 item self-report scales for measuring state and trait anxiety. The state scale (A-State) consists of statements which evaluate how respondents feel "right now, at this moment", and can also be used to determine how a person felt at a particular time in the recent past. The trait scale (A-Trait) consists of statements which evaluate how respondents "generally feel", and has been used as a screening device to detect anxiety problems and for evaluating the immediate and long-term outcome of psychotherapy. The scales are self-rated using a four point Likert-type format from "not at all" to "very much so" for the state version and "almost never" to "almost always" on the trait version. In general the reliability and validity of the STAI-Y are well supported (Spielberger, 1983). While normative data on the STAI-Y are available for working adults, college students, high school students and military recruits (Spielberger, 1983), there are limited norms available for psychiatric populations, with the Manual only reporting norms for male neuropsychiatric patients using the earlier version of the STAI, Form X (Spielberger, 1970).

### Procedure

Clients were sent an appointment letter which explained the purposes and procedures of the research and requested they attend 30 minutes prior to their appointment time with the psychologist if they were willing to participate. If they arrived in time to participate a formal consent form was also completed. The STAI-Y and SR-7 were two of five psychological questionnaires administered and completed in the reception area of the clinic under the supervision of the research psychologist or trained receptionist immediately prior to the clients first visit with the psychologist. The other instruments administered involved a total of 40 items and included measures of client expectations, symptom distress and target complaints. The A-State scale was the first to be given in

all cases, followed by the SR-7 and then the A-Trait scale. The instructions and scoring for the STAI-Y were the same as used in the Manual (Spielberger, 1983).

### Results & Discussion

Of the 269 consecutive clients who attended their appointment with the psychologist, 141 (52%) agreed to participate. Of the 128 nonparticipants, 87 were unable to participate due to being unable to read or having insufficient time and 41 declined. Of the 141 clients who agreed to complete the STAI-Y, five clients missed items on the A-State scale and the SR-7, while four missed items on the A-Trait scale. These clients scores were not included in the statistical analyses or preparation of STAI-Y and SR-7 norms.

The participants had the following characteristics: The mean age was 33 years, and ranged from 18 to 73 years with 95% under 50 years. Sixty-one percent were female. Ninety-three percent were of European descent, 6% Maori and 1% Other. Forty-five percent were married, 37% single and 18% separated, divorced or widowed. Socioeconomic status was determined using occupation (Elley & Irving, 1976) with 7%, class "1 & 2"; 25%, class "3 & 4"; 20% class "5 & 6"; 20%, Housepersons; 8%, Students; 13%, Unemployed; and 7%, Other. Sixty-four percent had up to 3 years high school; 23%, 4 or 5 years high school; and 13% some tertiary education. Forty-six percent were referred by medical practitioners, 41% by psychiatrists or psychiatric registrars and the remaining 13% from other sources. Forty percent had received no prior psychiatric treatment, with 33% receiving between 1 and 10 prior sessions and 27% over 10 prior sessions. Of those who received prior treatment, 58% received this from psychiatrists or psychiatric registrars; 23% from psychologists; and 19% from other mental health professionals. Clients were placed in DSM-III-R (American Psychiatric Association, 1987) diagnostic categories by treatment staff with 20% Mood disorders with out psychotic features; 20% Anxiety disorders; 14% Adjustment disorders; 11% Eating disorders; 8% Personality disorders; 7% "Psychotic disorders"; 9% "Other"; 7% Conditions not attributable to a mental disorder that are the focus of treatment; and 4% No diagnosis.

Characteristics of participants and nonparticipants were compared using ANOVA for age, and Chi-square for all other variables including diagnostic category. There were no significant differences between participants and nonparticipants on any of the characteristics noted above (all  $p > .05$ ). This substantially increases the likelihood that the sample was representative of all psychotherapy referrals at these hospitals.

Three 2x3 ANOVAs of A-State, A-Trait, SR-7 total scores revealed no significant main effects or interaction effects for sex or age (age was divided into three subgroups of 18-29, 30-39, 40-73). Correlational analysis revealed no significant linear relationships between scale scores and age. The finding that there were no differences in mean scores for age and sex groups is different from that reported for "normal" samples (Spielberger, 1983). As there were no differences in scores on the scales for different levels of age and sex a single mean and standard deviation was used to reflect sample scores on each scale (A-State,  $m=47.18$ ,  $sd=12.71$ ; A-Trait,  $m=52.69$ ,  $sd=11.01$ ; SR-7,  $m=14.70$ ,  $sd=6.32$ ). Cronbach alpha coefficients indicated high internal consistency for all scales (A-State and A-Trait both, .93; SR-7, .87). Corrected item-total correlations ranged between .54 and .74, and deletion of items did not improve the alpha coefficient for any of the scales.

In order to clarify the relationships between the three anxiety measures simple and partial correlations were calculated. As expected the A-State scale had a moderate to high positive simple correlation with the A-Trait scale ( $r=.75$ ,  $p<.001$ ). The SR-7 also had moderate and positive statistically significant correlations with the A-State scale ( $r=.70$ ,  $p<.001$ ) and A-Trait scale ( $r=.56$ ,  $p<.001$ ). Some support for the construct validity of the SR-7 as a state anxiety measure was provided by a larger simple correlation with the A-State scale than the A-Trait scale. However people with



high A-Trait levels also tend to be higher in A-State (Spielberger, 1983). Partial correlations clarify these relationships further. These revealed that a moderate to strong positive relationship between A-State and the SR-7 remains even when the effects of A-Trait are eliminated (partial  $r = .51$ ,  $p < .001$ ). This provides additional support for assuming they are both tapping aspects of state anxiety. The relationship between the SR-7 and A-Trait almost disappears when the effects of A-State are controlled (partial  $r = .07$ ,  $p > .05$ ), whereas the relationship between A-Trait and A-State remains strong when the effects of SR-7 are controlled (partial  $r = .61$ ,  $p < .001$ ). An implication of this finding may be that the SR-7 isolated situation-specific state anxiety while the A-State scale suffered from the influence of trait anxiety because it did not specify the situation for the respondent.

There is initial support for the validity and reliability of the SR-7 as a measure of state anxiety. Simple and partial correlations suggest the SR-7 is tapping aspects of state anxiety beyond that of the A-State scale of the STAI-Y. These additional facets most probably relate to increased situational specificity and the autonomic and avoidance content of the SR-7 items. This suggests that researchers should consider making the situations of interest explicit, rather than assuming clients will respond to the situation if asked to indicate how they feel "now". In addition the SR-7 appears to be a useful adjunct to other state anxiety measures such as the STAI-Y. Further validity and reliability data beyond the psychotherapy situation is yet to be established and would require replication utilizing a variety of situation descriptions as has been done with situation-specific trait measures (Endler et al., 1962). Of particular value would be future work on predictive validity with regard to treatment avoidance. The present study also provides needed supplementary normative data for the STAI-Y using a clinical sample of clients referred for psychotherapy and generally found reliability and validity data consistent with that reported in the STAI-Y manual (Spielberger, 1983).

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## APPENDIX E

Deane, F. P., & Spicer, J. (1991).  
Validation of a target complaints measure.  
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### VALIDATION OF A TARGET COMPLAINTS MEASURE

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#### Abstract

Target complaints measures have been used frequently as measures of psychotherapy outcome, but lack adequate validity data and suffer a number of methodological problems. Client and therapist rated target complaints measures were completed concurrently with a variety of other commonly used outcome measures on 138 clients at the beginning of psychotherapy and then at two months follow-up. Strong support was found for the validity of the target complaints measures. Both client and therapist ratings of target complaints had high positive correlations with measures of anxiety, symptom distress and symptom severity, and were negatively correlated with client satisfaction. A number of methodological issues related to administration and analysis of target complaints measures are addressed.

#### Introduction

The target complaints measure is an individualized measure of psychotherapy outcome which uses ratings of "each patient's spontaneously expressed presenting complaints (target complaints) as criteria for evaluating response to psychotherapy", (Battle, Imber, Hoehn-Saric, Stone, Nash, & Frank, 1966, p.184). Target complaints measures were first used to assess psychotherapy outcome in research designed to determine the effects of preparation for psychotherapy (Hoehn-Saric, Frank, Imber, Nash, Stone, & Battle, 1964). Shortly after this the same group reported the results of three studies on the target complaints measure (Battle et al., 1966). In 1975 a group of experienced psychotherapy researchers met under the auspices of the National Institute of Mental Health (U.S.) to evaluate existing outcome measures and to recommend a core battery of the best instruments for evaluation of psychotherapy outcome (Waskow & Parloff, 1975 cited in Lambert, Christensen, & DeJulio, 1983, p.153). One of the recommended core measures was target complaints to be completed by both client and therapist.

Target complaints measures have a number of strengths: they are idiosyncratic, allowing clients to spontaneously describe the problems for which they are seeking treatment; they are brief and easily completed; they are flexible in that they can be used with clients from widely differing settings and with different problems; they can be completed by multiple observers (e.g. client, therapist, family), and; they are appropriate for repeated use and

ongoing monitoring of client change. Despite their frequent use and apparent advantages the target complaints measures pose a variety of methodological problems, not least of which is a relative shortage of validity information. In this article we first discuss some of these problems including: mode of eliciting target complaints; number of complaints elicited; the use of improvement or severity ratings and; scoring and analysis issues. We then present a validity assessment of a particular form of target complaints measurement.

The way in which target complaints have been elicited varies, with earlier studies utilizing interviewers specifically trained to clarify and specify relevant target complaints with the client (Battle et al., 1966). This approach was relatively time consuming and required considerable therapist time. More recently computer interviews (Farrell, Camplair, & McCullough, 1987) have been used to standardize the collection of target complaints, but this technology remains relatively unavailable in most clinic settings. Rosen and Zytowski (1977) used a more economical approach which asked the client "to write down, in his or her own words the problem(s) for which help is being sought and to rate its problem severity. After the therapeutic contact is completed, the problem statement is transferred to the follow-up questionnaire and the former client is asked to rerate the problem severity." (p.437). This approach used a written format only, which did not require interaction between client and therapist. This also had the potential advantage of not diluting the clients spontaneously expressed complaints through the therapists therapeutic orientation or interpretation. While Rosen and Zytowski's (1977) method is threatened somewhat by the risk that clients might specify complaints not appropriate to therapy, this is offset by using multiple sources in obtaining target complaints ratings.

Target complaints can be completed by clients and/or therapists. The use of multiple respondents allows a number of perspectives in the change which occurs on the clients complaints over therapy. In the present study we allowed both therapist and client to independently write each target complaint in their own words. This strategy does not constrain the therapist to stating the client's problems in the form used by the client, when they may wish to use more behaviourally precise terminology. Similarly clients are able to express their complaints in language with which they feel comfortable. Client completed complaints are still available to the therapist to assist them in understanding the client's perspective, but the content of therapist and client completed target complaints may differ. These differences in content may in themselves be informative and reflect variations in therapeutic goals.

A further difficulty concerns the analysis of different numbers of target complaints per client. Averages of between 2.2 and 4.6 target complaints given by clients and up to 7.3 per client given by therapists have been reported (Mintz & Kiesler, 1982). To decrease this variability some studies have limited the number of complaints per client (e.g. Sloane, Staples, Christol, Yorkston, & Whipple, 1975). In the present study the number of complaints for each client was limited to two a figure based on the average number of target complaints elicited in other studies and also a number to which it was anticipated most clients could respond (Battle, et al., 1966; Luborsky, Mintz, Auerbach, Christoph, Bachrach, Todd, Johnson, Cohen, & O'Brien, 1980).

Most studies which have used target complaints to assess treatment outcome have required clients to rate the degree of improvement on the target complaint at the end of treatment (e.g. 1 = "worse" to 5 = "A lot better", Battle et al., 1966). Other investigators have asked clients to rate the severity of their target complaints before and after treatment. As Mintz and Kiesler (1982) noted the decision to use improvement or severity ratings is not a trivial one.

It has been suggested that improvement ratings may be more reliable and sensitive to change than pre-post differences in severity ratings, but the paucity of research in this area

makes any conclusions premature (Bloch, Bond, Quallis, Yalom, and Zimmerman, 1977; Mintz & Kiesler, 1982). Improvement and severity ratings require different cognitive tasks of respondents, involving different ways of appraising the impact of therapy. Although it is unclear exactly what process or reference points are involved when clients make their assessment of improvement, it seems these ratings would require a greater evaluative component. Typically clients must consider improvement over the course of treatment, a task which requires incorporating greater amounts of information than when making severity ratings. Severity ratings call for the client to determine how much they are bothered by the problem at the time they complete the rating, but does not necessarily ask them to reflect and evaluate change over the course of therapy. Severity ratings appear less susceptible to demand characteristics than improvement ratings. Severity ratings require clients rate how much they are bothered by a particular problem or complaint while improvement ratings ask clients to rate whether they are "better" or "worse". It may be more difficult for a client to indicate they had got worse (and suggest that they and the therapist failed) than to give a higher numerical severity rating after therapy. Clients may be hesitant to make strong evaluative ratings which reflect on their treatment, but more willing to make ratings which reflect on problem severity.

In psychotherapy outcome studies initial ratings are useful in checking the equivalence between control and experimental groups at entry. If there is nonequivalence some form of matching based on initial severity levels or statistical control is possible.

The reliability of severity ratings may be enhanced by making pretreatment ratings available at the time posttreatment ratings are elicited (Guyatt, Berman, Townsend & Taylor, 1985). Typically the severity of each target complaint has been rated at posttreatment without allowing raters to refresh their memories (e.g. Sloane et al., 1975). It is unclear what process respondents use to make their posttreatment ratings if they do not have access to their initial ratings. Some may attempt to remember their initial ratings (with some being accurate and others inaccurate), while others may determine their posttreatment severity rating based on their present state only. Allowing access to initial severity ratings when posttreatment ratings are made, should improve reliability by reducing the variability as a result of raters differential memories of their initial ratings (guessing) and by providing some standardization of the process involved (i.e. in relation to initial levels and current state). Consequently the present study used severity ratings allowing clients access to their pretreatment ratings when posttreatment ratings were elicited.

Even when the number of complaints per patient is limited to two, the researcher must still decide whether to score and analyse each target complaint separately or to sum or average the ratings for all complaints. Mintz and Kiesler (1982) have elaborated on the pitfalls involved in summing and averaging target complaints. The main problem with summing is that the resulting score is highly correlated with the number of complaints. Averaging does not take into account the differences in the relative severity of different complaints, when typically the initial complaint is relatively severe while subsequent complaints usually receive lower severity ratings.

When severity ratings are used the simplicity of a raw gain score (pre-post difference) is attractive but is generally not recommended due to a number of serious statistical problems (Cronbach & Furby, 1970; Mintz, Luborsky, & Christoph, 1979). It has also been suggested that the reliability problems of target complaints measures are likely to be compounded by the use of difference scores and to make it more difficult to obtain significant results in outcome studies (Mintz & Kiesler, 1982). Although more complex residual gain scores have been advocated by some (Mintz et al., 1979) they are often difficult to interpret. Generally recommended is either analysis of covariance which uses initial levels as the covariate and posttreatment scores as the dependent variables (Cook &

Campbell, 1979; Cronbach & Furby, 1970), or multivariate repeated measures analysis of variance (O'Brien & Kaiser, 1985) using initial and posttreatment scores as within-subjects dependent variables.

Reliability and validity data on target complaints measures has been lacking and more detailed work in this area is needed (Mintz & Kiesler, 1982). Since most of the research using target complaints have utilised improvement ratings the preponderance of reliability and validity data relate to this form of rating. Battle et al. (1966) reported a correlation of .68 between rankings of problems before and after the assessment interview. Severity ratings taken before and after the psychiatric evaluation interview did not change to a significant degree despite several patients reporting feeling better after the interview. Bierenbaum, Nichols, and Schwartz (1976) reported a correlation coefficient of .79 between a trained clinical psychologist's improvement rating and patient's own improvement ratings of 21 target complaints. Although there was substantial agreement on the relative amount of improvement of each of the problems, the use of only one independent judge raises questions regarding the generalizability of this result. Test-retest stability was demonstrated by Frey, Heckel, Salzberg, and Wackwitz (1976) who reported a large highly significant correlation ( $r = .73$ ) between parents' improvement ratings of their child's target complaint at termination and parents' ratings again one-month later. However, the correlation between therapists and parents improvement ratings at termination was  $r = .31$  and insignificant despite rating the same complaints. The correlation between therapists and parents ratings taken again one month later was even lower ( $r = .04$ ,  $p > .05$ ). In another study twenty-seven teams of three psychotherapists were asked to independently rate the improvement clients had made on a range of initial target problems. Only 10 teams of the 27 agreed on the patient's degree of improvement at a statistically significant level (Bloch et al., 1977). The scant research assessing the reliability of target complaints has thus produced mixed results, but provides some support for interrater reliability, particularly in relation to the degree of improvement patients make on target complaints.

Those few studies which have reported concurrent validity data suggest improvement ratings on target complaints tap a broad improvement factor rather than discrete independent ratings of change on particular aspects of therapy outcome. Hoehn-Saric et al. (1964) reported a correlation of .61 between patients ratings of improvement on target complaints and therapist global improvement ratings. Battle et al. (1966) claimed "significant" correlations between target complaints ratings and both patient and therapist global ratings of improvement, and Social Ineffectiveness and Discomfort Scales. Unfortunately, no correlation coefficients were reported. Shorer (1970, cited in Mintz & Kiesler, 1982) reported correlations of .71 between target complaints and global improvement ratings for treated patients and .78 for untreated patients. Mintz et al. (1979) found that patient's improvement ratings on target complaints loaded on a general improvement factor derived from a number of patient and therapist ratings of therapy outcome. This information aside there has been a notable absence of attempts to correlate target complaints measures with more specific and commonly used outcome measures, a deficiency echoed by Mintz & Kiesler (1982) who stated "Detailed concurrent validity data are lacking.", (p.507).

Support for the construct validity of target complaints has been provided by studies which have found target complaints improvement ratings were greater for psychotherapy than for no-treatment controls (e.g. Sloane et al., 1975). Only rarely have the content of target complaints been used (Sloane et al., 1975), and subsequent attempts to categorise target complaints using these classification systems have proven difficult (Mintz & Kiesler, 1982).

The aim of the present study was to construct a version of the target complaints measure

which combatted the problems discussed above, and to test its validity by assessing its change over therapy and correlating it with several commonly used psychotherapy outcome measures.

## Method

### Subjects

Two hundred and forty-two clients 18 years or older, referred for psychotherapy to the outpatient Psychology Departments of two New Zealand General Hospitals were asked to participate in the study. One hundred and thirty-eight (57%) agreed to participate and completed the research protocol. Of the 104 nonparticipants, 63 were unable to participate due to difficulty understanding what was required, inadequate reading ability or having insufficient time. Most of those classified as unable to participate, arrived with insufficient time to complete the research protocol. While some expressed a desire to participate, it is also likely some of these were "passive refusers". Forty-one (39%) of the nonparticipants explicitly declined to participate.

The participants had the following characteristics: The mean age was 33 years, and ranged from 18 to 73 years with 95% under 50 years. Sixty-one percent were female. Ninety-three percent were of European descent, 6% Maori and 1% Other. Forty-five percent were married, 37% single and 18% separated, divorced or widowed. Socioeconomic status was determined using occupation (Elley & Irving, 1976) with 7%, class "1 & 2"; 25%, class "3 & 4"; 20% class "5 & 6"; 20%, Housepersons; 8%, Students; 13%, Unemployed; and 7%, Other. Data regarding educational levels was only available from one setting with, 64% having up to 3 years high school; 23%, 4 or 5 years high school; and 13% some tertiary education. Forty-six percent were referred by medical practitioners, 41% by psychiatrists or psychiatric registrars and the remaining 13% from other sources. Forty percent had received no prior psychiatric treatment, with 33% receiving between 1 and 10 prior sessions and 27% over 10 prior sessions. Of those who received prior treatment, 58% received this from psychiatrists or psychiatric registrars; 23% from psychologists; and 19% from other mental health professionals. Clients were placed in DSM-III-R (American Psychiatric Association, 1987) diagnostic categories by treatment staff with 20% Mood disorders with out psychotic features; 20% Anxiety disorders; 14% Adjustment disorders; 11% Eating disorders; 8% Personality disorders; 7% "Psychotic disorders"; 9% "Other"; 7% Conditions not attributable to a mental disorder that are the focus of treatment; and 4% No diagnosis.

Characteristics of participants and nonparticipants were compared using ANOVA for age, and Chi-square for all other variables including diagnostic category. There were no significant differences between participants and nonparticipants on any of the variables noted above, substantially increasing the likelihood that the sample was representative of all psychotherapy referrals at these hospitals. Ninety-two clients attended at least one visit beyond their initial appointment and these subjects formed the follow-up group.

### Instruments

Target complaints. The target complaints measure used in the present study asked clients to write down the two most disturbing problems or complaints for which they were seeking help and to indicate how much this bothered them on a Likert-type scale ranging from zero ("not at all") to nine ("couldn't be worse"). Therapists were asked to independently write down what they considered the clients two main target complaints to be and to rate the severity of each complaint ("In general how much does this problem or complaint bother this client?"). A zero to nine response scale was used so that telephone follow-up would be simplified if it proved feasible (Sudman & Bradburn, 1982). Target complaints and initial



severity ratings were transferred verbatim to the follow-up forms by the researcher.

**State-Trait Anxiety Inventory Form Y (STAI-Y)**. The STAI-Y comprises two separate 20 item self-report scales for measuring state and trait anxiety. The state scale (STAI-Y1) consists of statements which evaluate how respondents feel "right now, at his moment", and can also be used to determine how a person felt at a particular time in the recent past. The trait scale (STAI-Y2) consists of statements which evaluate how respondents "generally feel", and has been used as a screening device to detect anxiety problems and for evaluating the immediate and long-term outcome of psychotherapy. The scales are self-rated using a four point Likert-type format from "not at all" to "very much so" for the state version and "almost never" to "almost always" on the trait version. The STAI-Y (Spielberger, 1983) is the revised version of the scale previously known as STAI-X. The STAI-Y is highly correlated with the STAI-X (between .96 and .98 for high school and college students). In general the reliability and validity of the STAI-Y are well supported and documented (Spielberger, 1983).

**Hopkins Symptom Checklist-21 (HSCL-21)**. The Hopkins Symptom Checklist (HSCL) was originally developed as a self-report inventory to measure clinical change in psychotherapy patients. There have been many versions of the HSCL and the 58-item HSCL (Derogatis, Lipman, Rickels, Uhlenhuth, & Covi, 1974) along with the target complaints measures, was also recommended as a core outcome measure for use in psychotherapy outcome research (Waskow & Parloff, cited in Lambert, Christensen, & DeJulio, 1983, p.153). The HSCL-21 is a 21 item version of the Hopkins Symptom Checklist (Green, Walkey, McCormick, & Taylor, 1988). These items were chosen following repeated confirmation of a three factor structure using a number of different samples and HSCL scales of varying lengths (Green et al., 1988). The HSCL-21 has a replicable, discrete three factor structure producing three subscales of 7 items each: General Feelings of Distress (GFD); Somatic Distress (SD); and Performance Difficulty (PD). These three scales can be summed to obtain a Total Distress Score. Only total distress scores were used in the present study. The reported alpha reliability coefficients of .75 to .86 for the subscales, and .90 for the total scale (Green et al., 1988), are of comparable magnitude to those achieved by the longer versions (Derogatis et al., 1974). Concurrent and construct validity of the HSCL-21 is well supported (Green et al., 1988; Deane, Leathem & Spicer, 1990).

**Brief Hopkins Psychiatric Rating Scale (BHPRS)**. The BHPRS (Derogatis, 1978) is a therapist completed rating scale comprised of nine primary symptom dimensions and a global pathology index. Each of the dimensions are given a definition and represented on a 7-point Likert-type scale (0-6) ranging from "none" to "extreme". In addition to the usual adjective and numerical descriptors for each of the scale points, three of the 7 points on each dimension are defined by brief clinical descriptors. The descriptors and numerical values of the dimensions were derived by the judgements of 14 psychiatrists. The global pathology index is a 9-point Likert type scale (0-8) ranging from "absent" to "extreme" with four of the 9 points defined by brief clinical descriptors. This index is similar to other therapist rated global measures such as the Global Assessment Scale (GAS), (Endicott, Spitzer, Fleiss, & Cohen, 1976) which have adequate reliability and validity as measures of overall pathology within specified time periods.

Tracey (1986) used the sum of all ten items and reported one week test-retest reliability estimates of .89 from an independent sample of 5 therapists who each rated 3 clients. Interrater reliability of the SCL-90 Analogue (Derogatis, 1977) which uses the same 9 symptom dimensions and global distress scale as the BHPRS, ranged between .78 and .96.

**Consumer Satisfaction Questionnaire-8 (CSQ-8)**. The CSQ-8 (Attkisson & Zwick, 1982) is an eight item version of the Consumer Satisfaction Questionnaire (Larsen, Attkisson,

Hargreaves, Nguyen, 1979). It consists of eight Likert-type items with four response choices, where "1" indicates the lowest degree of satisfaction and "4", the highest. The CSQ-8 has high internal consistency with alpha coefficients ranging from .93 in a sample of community mental health centre clients (Attkisson & Zwick, 1982) to .87 in a sample of 3,120 clients from a variety of mental health facilities (Nguyen, Attkisson, Stegner, 1984). Factor analysis showed only one factor for the scale (Nguyen et al., 1984). Small but statistically significant correlations were also found between the CSQ-8 and change in self-reported symptoms, and both client and therapist global improvement ratings (Attkisson & Zwick, 1982). Partial correlations and the finding that clients' satisfaction ratings were not correlated with their concurrent ratings of symptom levels led Attkisson & Zwick (1982) to conclude the findings were not merely the result of a global satisfaction factor, halo effects or correlations with initial symptom levels.

### Procedure

Clients were sent an appointment letter which explained the purposes and procedures of the research and requested they attend 30 minutes prior to their appointment with the psychologist if they were willing to participate. If they arrived in time to participate a formal consent form was also completed. The questionnaires were administered and completed in the reception area of the clinic. The STAI-Y1 was completed first, followed by the HSCL-21, STAI-Y2, and target complaints measure. Clients then attended their initial interview with the psychologist. The psychologist completed the target complaints measure and then the BHPRS in that order as soon as possible after the initial interview. The researcher transferred clients target complaints verbatim to the follow-up questionnaire along with the severity rating. At two month follow-up or at the completion of therapy if this occurred before, all questionnaires were completed by the client and therapist. For target complaints measures clients had access to their pretreatment ratings. If clients did not have time to complete the questionnaire at the centre they were permitted to complete them at home and returned them in a postage paid envelope.

### Results

#### Frequency of target complaints

Even though the number of target complaints was limited to two, 14% of the clients did not give a second complaint, while 25% of therapists did not give a second target complaint for the client. The written prompt was able to elicit a least one target complaint from 97% of the 138 clients and two complaints from 83% of the clients. Therapists rated at least one target complaint for all clients but two complaints were produced for only 75% of clients. Approximately 80-90% of the 92 clients in the follow-up group completed the follow-up ratings on the target complaints measures. All but one follow-up rating was completed for the therapist completed target complaints measures.

#### Reliability of target complaints measures

The traditional analysis of internal reliability of the target complaints measures using Cronbach alpha coefficients is not possible since we argue below that these should be treated as single item measures. Test-retest reliability was also difficult to assess with the current data set, since psychotherapy occurred during the test-retest interval and 60% of the participants were rated as having completed therapy by their therapist at follow-up. This would have the effect of substantially reducing the test-retest correlation coefficients because the relative order of clients ratings would change dependent on the nature of their problems and how effective psychotherapy was for them. Unfortunately the target complaints measures were not administered to clients who did not undergo psychotherapy. The test-retest correlations for client and therapist target complaints over 2 months of



psychotherapy are reported with the aforementioned limitations. The first client completed target complaint had a moderate test-retest correlation coefficient,  $r(72) = .49$ ,  $p < .001$ , while the second client completed target complaint had a smaller coefficient,  $r(66) = .22$ ,  $p = .036$ . Both the first,  $r(89) = .47$ ,  $p < .001$  and second,  $r(67) = .62$ ,  $p < .001$ , of the therapist completed target complaints had moderate and statistically significant coefficients. These results suggested that clients tended to maintain their relative order with regard to target complaint severity, with the possible exception of the second client completed target complaint.

### Correlations between target complaints

At entry the first and second client completed target complaints had a significant correlation of  $r(113) = .34$ ,  $p < .001$ . At follow-up the correlation coefficient between the first and second client completed target complaints increased to  $r(72) = .75$ ,  $p < .001$ . Similarly the correlation between the first and second therapist completed target complaints at entry was moderate  $r(102) = .51$ ,  $p < .001$ , but increased at follow-up,  $r(99) = .66$ ,  $p < .001$ . While the correlations between first and second complaints appear larger at follow-up, at entry the moderate relationships suggest the first and second target complaints may be tapping discrete target problems of differing severity. Consequently the first and second target complaints were treated separately and not pooled for subsequent analyses.

Correlations were calculated between client and therapist target complaint ratings at entry (1st TC,  $r(132) = .33$ ,  $p < .001$ ; 2nd TC,  $r(84) = .25$ ,  $p = .011$ ) and at follow-up (1st TC,  $r(71) = .49$ ,  $p < .001$ ; 2nd TC,  $r(50) = .44$ ,  $p < .001$ ). These coefficients suggested that although measuring different aspects of target complaints, client completed target complaints were related to therapist measures and therefore more likely to be relevant to the goals of psychotherapy as defined by the therapist.

### Target complaints ratings before and after therapy

Table 1 shows the mean target complaints ratings at entry and follow-up. Repeated measures MANOVA (O'Brien & Kaiser, 1985) was conducted on the four target complaints measures using entry and follow-up scores on the target complaints as within-subjects dependent variables. Ten group means were inserted to balance cells, six for the second client rated target complaint and four for the second therapist rated target complaint. When this adjustment was made only 2% of available data was not included in the MANOVA. For this particular data set the results of MANOVA with and without the use of group means to replace missing values was the same. The MANOVA produced a significant overall effect,  $F(4,70) = 49.61$ ,  $p < .0005$ . Table 1 lists mean target complaints ratings for clients and therapists and provides t-tests of two dependent means at entry and follow-up. All follow-up target complaints measures were lower than at entry and this difference was statistically significant for all complaints. The results indicate that all target complaints ratings changed with therapy whether they were first, second, client or therapist completed complaints.

Table 1:  
Mean target complaint ratings at entry and follow-up

	Client		Therapist	
	TC1	TC2	TCT1	TCT2
<u>Entry</u>				
mean	7.25	6.90	6.30	5.75
s.d.	1.43	1.47	1.70	1.80
n	134	115	138	104
<u>Follow-up</u>				
mean	4.78	4.29	4.08	3.77
s.d.	2.51	2.62	1.92	1.78
n	74	68	91	69
t*	9.92	7.92	12.61	10.07
df	73	67	90	68

\* all  $p < .0005$

TC1 = First client completed target complaint                      TC2 = Second client completed target complaint  
TCT1 = First therapist completed target complaint                      TCT2 = Second therapist completed target complaint

Relationships between target complaints ratings and outcome measures

Table 2 provides the correlations between the target complaints measures and outcome measures. The correlations between the first and second target complaints, whether completed by clients or therapists, and whether at entry or follow-up, were very similar in both magnitude and direction. As may be expected correlations between client completed measures tended to be consistently higher, if only slightly, than those between client and therapist completed measures. Similarly correlations between therapist completed measures were slightly higher than those between client and therapist measures.

Correlations between target complaints measures and outcome measures at entry were generally moderate and positive. The only low and insignificant relationships were between: client rated target complaints and the therapist rated BHPRS; and therapist rated target complaints and client completed state anxiety (STAI-Y1). At follow-up correlations between target complaints measures and anxiety, symptom distress and symptom severity measures were all moderate to high and statistically significant. Only the client completed satisfaction questionnaire (CSQ-8) produced substantial negative correlations, indicating that lower follow-up ratings on the target complaints measures were associated with higher levels of satisfaction as would be expected. The correlation between the second therapist target complaint and the satisfaction measure did not reach statistical significance. Generally the relationship between the target complaints ratings and outcome measures were stronger at follow-up than at entry.

Table 2:

Correlations between target complaint ratings and outcome measures at entry & follow-up

	Entry				Follow-up			
	Client		Therapist		Client		Therapist	
	TC1	TC2	TCT1	TCT2	TC1	TC2	TCT1	TCT2
STAI-Y1	.37**	.29**	.18	.11	.69**	.68**	.53**	.51**
STAI-Y2	.34**	.38**	.33**	.35**	.71**	.74**	.40**	.49**
HSCL-21	.36**	.33**	.29**	.30*	.68**	.69**	.46**	.46**
BHPRS	.14	-.02	.36**	.24*	.50**	.40**	.54**	.51**
CSQ-8					-.58**	-.37*	-.28*	-.11
n	126	110	128	96	80	60	80	60

\*p &lt; .01 \*\*p &lt; .001

TC2 = Second client completed target complaint

TCT2 = Second therapist completed target complaint

STAI-Y2 = Trait scale of State-Trait Anxiety Inventory Form Y

BHPRS = Brief Hopkins Psychiatric Rating Scale

TC1 = First client completed target complaint

TCT1 = First therapist completed target complaint

STAI-Y1 = State scale of State-Trait Anxiety Inventory Form Y

HSCL-21 = Hopkins Symptom Checklist-21

CSQ-8 = Consumer Satisfaction Questionnaire-8

## Discussion

In general this target complaints measure was an effective measure of psychotherapy outcome. Written prompts were effective in eliciting target complaints, suggesting that an interview format is not necessary. Restricting the number of complaints to two should not have appreciably reduced the face validity of the measure since clients were asked for their "two most disturbing problems or complaints".

There was a significant reduction in severity ratings from entry to follow-up. This is particularly notable in view of Mintz and Kieslers' (1982) comments that finding significant differences in severity scores appeared more difficult than when using improvement ratings. It is possible that the sensitivity of the target complaints measure was improved as a function of increased reliability. Allowing respondents access to their initial severity ratings may well have increased the reliability of the target complaints measure, which also improved its sensitivity. In future studies the sensitivity of the measure could be further tested by comparing change in a no-treatment control group. Finding target complaints measures were sensitive to changes occurring over the course of psychotherapy strengthens the suggestion that the content of client completed target complaints were appropriate for psychotherapy. In addition low to moderate positive correlations between client and therapist target complaints ratings at entry and at follow-up provided further reassurance that client completed target complaints were relevant to psychotherapy.

There was strong support for the validity of the target complaints measures. With few exceptions all target complaints had moderate to high correlations with a variety of other psychotherapy outcome measures. They were related to client rated state and trait anxiety, psychological distress, satisfaction and therapist rated symptom severity. At entry the client

completed target complaints had low correlations with the therapist completed symptom severity measure (BHPRS). Similarly low correlations were obtained between therapist target complaints and the client completed state anxiety scale (STAI-Y1). The lack of relationship between these measures is not too surprising since in the first instance, target complaints defined by clients may have differed substantially from the content and form of items on the symptom dimensions on the BHPRS. Therapist target complaints ratings may have been unrelated to clients state anxiety because they were asked to rate target complaints in "general" while the state anxiety measure related to how they clients felt "now". The relationships between all target complaints measures and outcome measures may have become more substantial at follow-up as there was clarification and consensus regarding the client's problems and progress. At follow-up the only low and nonsignificant correlation was between the second therapist target complaint (TCT2) and client satisfaction (CSQ-8). This might be a reflection of clients placing lower importance on improvement of the second target complaint than the first. This proposition is in part supported by a lower correlation between TC2 and satisfaction than that between TC1 and satisfaction. In all cases the first of the target complaints received a higher severity rating on average than the second complaint and the results clearly suggest that satisfaction with therapy is most related to levels on the first target complaint at follow-up.

In summary the target complaints measures following the procedure in the present study were found to be economical in that written prompts effectively elicited the complaints. They were sensitive to change over the course of psychotherapy, and had moderate to high correlations with a number of client and therapist completed outcome measures. Although therapist and client target complaints were completed independently (so that complaint content may have differed), the presence of moderate correlations between the client and therapist severity ratings suggests some concurrence regarding the relative severity of these complaints. The relationships between therapist and client ratings as well as target complaints with other measures might suggest target complaints may be redundant as outcome measures. However, the correlations although substantial are still only moderate in most cases, suggesting that the different target complaints ratings do provide discrete and unique information not shared with other outcome measures. The flexible format, brevity, economy, and face validity of target complaints measures makes them both a useful and attractive adjunct to psychotherapy outcome measures for researcher and clinician.

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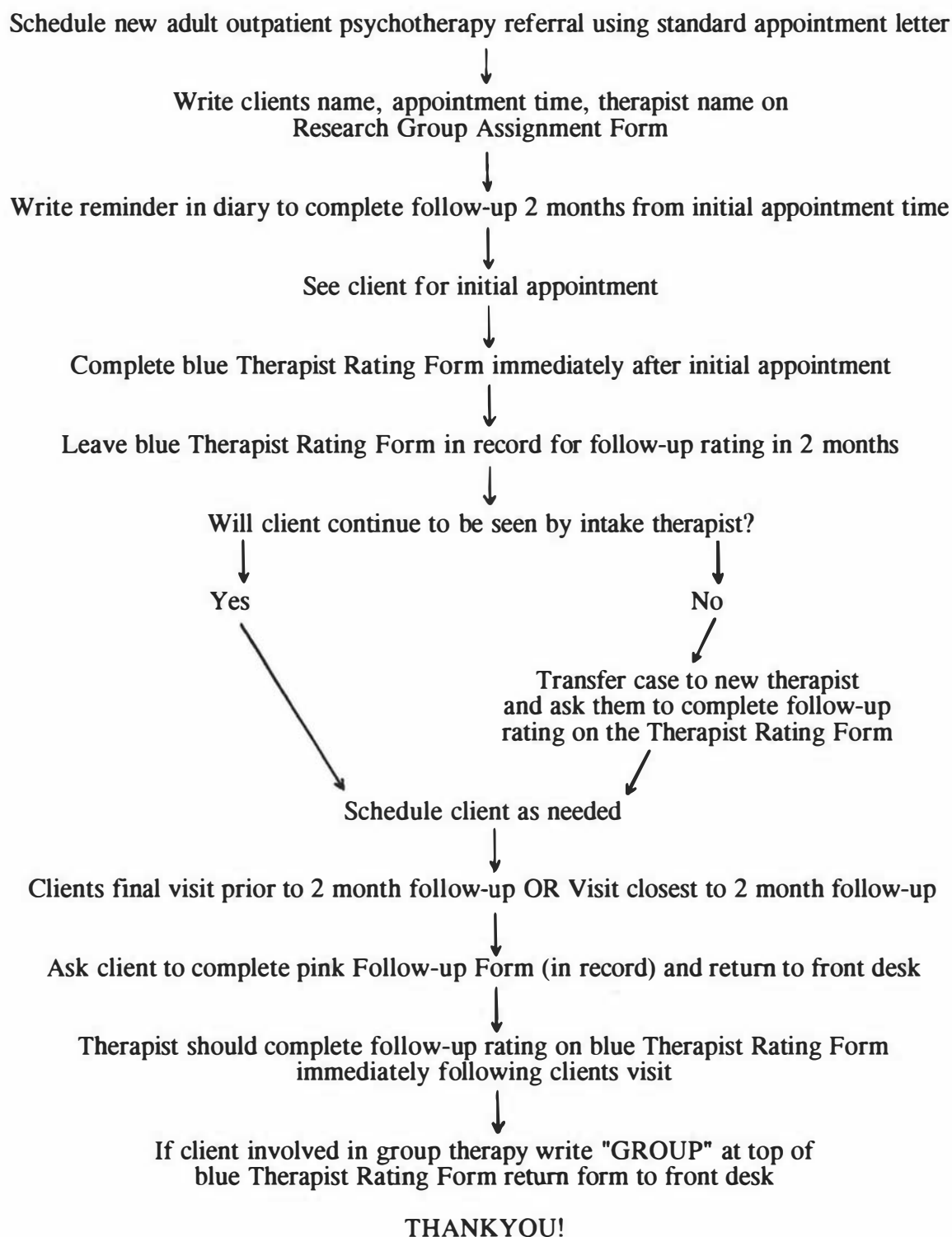
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## APPENDIX G

### PROCEDURAL INSTRUCTIONS FOR THERAPISTS AND RECEPTIONISTS

#### THERAPIST PROCEDURE



## Therapist Procedure

### Client inclusion criteria

New adult outpatient referrals to the psychology department. Clients must be 18 years or older. Their contact with the therapist must be at the centre. They must be referrals which are considered to lead to some form of psychotherapy. i.e. in cases where the contact is purely for psychological testing and it is clear there will be no psychotherapy contact these clients will not be eligible. If it is unclear whether there will be any therapy contact then clients should be included as being eligible to participate in the research.

### Scheduling

Clients will be scheduled their initial appointment with the psychologist using the standard appointment letter kept at the front desk. When an appointment time is scheduled please enter this on the Research Group Assignment Form at the front desk. Write in the clients name, appointment time (to see you ie. not the 30 minutes early), and your last name under therapist.

When you enter the appointment time in your diary please enter a reminder to complete follow-up on the client at 2 months from the time of the initial appointment. This will serve as a cue to complete your follow-up ratings on the client and to give the client their Follow-up Form at this time.

Therapists are asked not to specifically bring the video up in the initial appointment, but may wish to discuss the video if the client initiates the discussion or has further questions about it.

### Completion of Therapist Measures and Follow-up

Therapists will complete the blue "Therapist Rating Form" as soon as possible after the initial appointment with the client. The Therapist Rating Form will be placed in the clients record for the therapist. If this is not in the record please obtain the form from the front desk and complete as soon as possible after the initial appointment.

After completing the form leave it in the clients record in preparation for the follow-up rating to be completed at 2 month follow-up. Therapists will be cued to complete the follow-up by the reminder entries that they have made in their appointment books and by the researcher where possible. Follow-up ratings should be completed at the end of the appointment closest to the 2 month follow-up date, for those clients who are still in therapy. The therapist should give the client the pink Follow-up Form to complete at this time. Follow-up ratings of clients who have finished therapy should occur at the end of the clients last appointment with the therapist. Therapists should give the client the pink Follow-up Form at this time. Both the blue Therapist Rating Form and pink Follow-up Form should be left at the receptionists desk where they will be stored until the researcher is able to collect the data. Those clients who are considered dropouts will be indicated by the therapist at the follow-up rating. Since these clients will be unavailable at the centre to complete the Follow-up Form the researcher will attempt to contact these clients in order to have them complete the follow-up. The therapist should still complete their follow-up ratings on the Therapist Rating Form at the 2 month follow-up and return the forms to the receptionist for storage.



Attendance and Prior Therapy Questions

Both of these "measures" are difficult to define with only a few questions, and therefore rely heavily on therapist judgement. The attendance questions are an attempt to determine whether the client "dropped out" of treatment or not. The therapist should indicate whether the client "Stopped coming to therapy when the therapist felt continued treatment was necessary". The first question "Did the client attend the last scheduled appointment?" attempts to determine whether the client has stopped attending. The second question "Was the client in need of further treatment at last visit?" attempts to determine whether the therapist felt continued treatment was necessary at the last contact with the client.

Since it is common in the initial appointment for therapists to attempt to determine whether a client has had any prior counselling or psychotherapy experience, information indicating whether the client has had prior therapy will be obtained through therapists. Your response to this should include previous sessions with a psychiatrist.

Please indicate whether this client has had any previous counselling or psychotherapy by a professional therapist or counsellor and the approximate number of visits.....

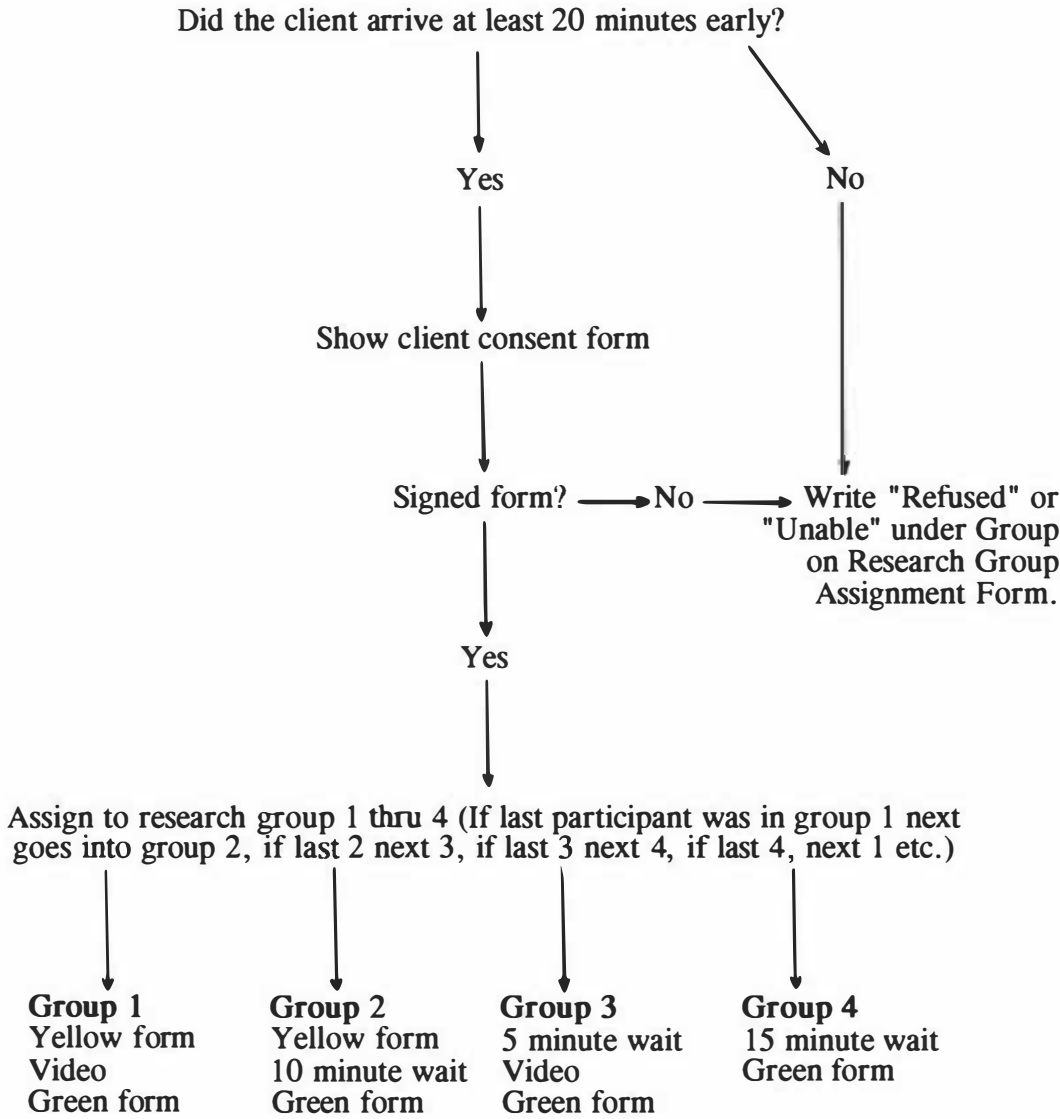
none      1-2      3-5      6-10      10+

The client was seen previously by a (e.g. social worker, psychologist, psychiatrist):.....

Therapist Procedure Summary

1. Schedule appointment time for all new adult outpatient referrals for psychotherapy using standard appointment letter at front desk.
2. Enter client name, appointment time and therapist name on Research Group Assignment Form.
3. Enter reminder to complete follow-up ratings in 2 months in your diary.
4. Complete the blue Therapist Rating Form as soon as possible after the initial appointment with the client.
5. Complete the follow-up rating on the Therapist Rating Form at 2 months.
6. Ask the client to complete the pink Follow-up Form at 2 month follow-up appointment.

RECEPTIONIST PROCEDURE



Please check all items have a response circled, and that the clients name and date are on the forms. Place the blue "Therapist Rating Form" in clients record.

### Assigning Clients to Groups

The following applies to the entries placed under the heading "Group" on the Research Group Assignment Form.

"Refused": Applies to all those clients who do not want to participate in the research. Clients who have already begun to complete forms but who then decide they no longer want to participate should also have refused placed on the Research Group Assignment Form.

"Unable": Applies to those clients who wanted to participate in the research but arrived too late to be able to participate, were unable to read the forms, or were too upset or disturbed to be able to participate.

All those clients who are able and want to participate will be assigned to one of the four groups. This is done by checking to see what the last group number was and then assigning the client to the next group number as follows:

1234123412341234....., so that if the last participant was assigned to group 4 the next participant would be assigned to group 1. If the previous participant was in group 1 the next would go into group 2, if the previous was in group 2 the next would go into group 3, and if the previous participant was in group 3 the next would go into group 4.

After the client has read and signed the consent form, they are assigned to the appropriate group as described above. In groups 2 and 4, which require the client to wait 10 or 15 minutes, when they have completed the consent form please state:

"Thank-you for participating. You are in the group which does not see the video if you could please wait I will return with a questionnaire for you to complete."

For groups 1 and 3 after they have completed the consent form state:

"Thank-you for participating. You are in the group which sees the video." Proceed with appropriate procedure.

After the client has seen the video have them return to the waiting area to complete the Green Form. The yellow and green forms should be completed in the waiting area.

If clients have questions about why they are in a particular group, i.e. the video or no video group. Explain that this is decided by chance and is important for the design of the study. Some clients may be concerned that some of the items are repeated in the yellow and green form. Reassure them that this is not a mistake and is also a part of the way that the study is designed.

APPENDIX H  
MISCELLANEOUS FORMS

- 1. *Appointment letter*
- 2. *Research group assignment form*
- 3. *Consent form*
- 4. *Demographic sheet*

APPOINTMENT LETTER

Dear \_\_\_\_\_,

\_\_\_\_\_ has recommended you be seen in the Psychology Department. Your appointment time is \_\_\_\_\_ am/pm, \_\_\_\_\_ day the \_\_\_\_\_ of \_\_\_\_\_ with \_\_\_\_\_.

If this appointment time is unsuitable please ring me as soon as possible at 80106 so other arrangements can be made.

We also invite you to participate in a project which we are running at the centre, aimed at understanding what helps clients do better in therapy. You will be asked to complete a questionnaire and then randomly allocated to watch a video telling you about psychotherapy or to wait 15 minutes. Information from the questionnaire may also be helpful during therapy. Your information will be confidential and participation is voluntary. Declining to participate will not affect the services you receive. Should you want further information about the study contact Frank Deane, Research Psychologist, at 69099 Extension 8404. If you want to be a part of the study

PLEASE COME TO YOUR APPOINTMENT 30 MINUTES EARLY AT \_\_\_\_\_

Your participation will be much appreciated, and I look forward to seeing you at your appointment.

Sincerely,

Clinical Psychologist.



CONSENT FORM

These forms are part of a study by the Department of Psychology at Massey University. The study aims to understand what helps people do better in therapy.

The forms should take about 20 minutes to complete. You may also be asked to watch a short video telling you about the centre's services and psychotherapy. If you agree to take part you will be asked to complete similar forms at a later date. If you should decide not to keep coming to the centre we would like to contact you so that you can complete the forms.

The information that you give will be seen only by the staff who treat you and the researcher. The information on the forms may also be useful during your treatment. The researcher will need to get some information from your records. **YOUR INFORMATION WILL BE CONFIDENTIAL.**

You do not have to be a part of the study to get the centres services. If you do not want to be a part of the study give the form back to the receptionist. Signing the form will tell us you agree to be in the study. You may withdraw from the study at any time. If you are interested in the results of the study these will be available at the centre when the project is finished. Thank-you for your help.

If you would like further information about the study please contact the researcher: Frank Deane, Research Psychologist, at 69099 Extension 8404.

I have read the above and have had an opportunity to have my questions answered. I agree to take part in the study.

CLIENT SIGN HERE: \_\_\_\_\_

<sup>a</sup>I have discussed the purpose of the study with the client and answered the clients questions about the study.

RESEARCH PSYCHOLOGIST SIGN HERE \_\_\_\_\_

WITNESS SIGN HERE: \_\_\_\_\_

<sup>a</sup> Not included in consent form where receptionist administered forms.

DEMOGRAPHIC SHEET

ID #:

Record #:

CLIENTS NAME \_\_\_\_\_

AGE \_\_\_\_\_

OCCUPATION \_\_\_\_\_

REFERRAL SOURCE \_\_\_\_\_

Please cross one for each variable

SEX	1 Male	2 Female			
RACE	1 European	2 Maori	3 Pacific Islander	4 Other	
MARITAL STATUS	1 Single	2 Married	3 Widowed	4 Divorced	
	5 Separated	6 Defacto			
EDUCATION	High School	1yr	2yrs	3yrs	4yrs
	Tertiary	1-2yrs		3-4yrs	5yrs
					5yrs+

DIAGNOSTIC CATEGORY (based on DSM-III-R)

- 1 Organic mental syndromes and disorders
- 2 Psychoactive substance use disorders
- 3 Sleep disorders
- 4 Schizophrenic disorders
- 5 Delusional (paranoid) disorders
- 6 Psychotic disorders not elsewhere classified
- 7 Mood (affective) disorders without psychotic features
- 8 Mood (affective) disorder with psychotic features
- 9 Anxiety disorders
- 10 Somatoforms disorders
- 11 Dissociative disorders
- 12 Gender and sexual disorders
- 13 Factitious disorder
- 14 Disorders of impulse control not elsewhere classified
- 15 Adjustment disorder
- 16 Eating disorder
- 17 Personality disorder
- 18 Conditions not attributable to a mental disorder that are the focus of attention or treatment (V codes)
- 19 No diagnosis
- 20 Other \_\_\_\_\_