The Effects of a Pre-Therapy Client Orientation on Clients in Psychotherapy

Nels Sather
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THE EFFECTS OF A PRE-THERAPY CLIENT ORIENTATION ON CLIENTS IN PSYCHOTHERAPY

by

Nels Sather

A dissertation submitted in partial fulfillment of the requirements for the degree of

DOCTOR OF PHILOSOPHY

in

Psychology

Approved:

UTAH STATE UNIVERSITY
Logan, Utah

1987
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Nels Mario Sather
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The Effects of a Pre-Therapy Client Orientation on Clients in Psychotherapy

by

Nels Mario Sather, Doctor of Philosophy
Utah State University, 1987

Major Professor: Dr. Elwin Nielsen
Department: Psychology

The purpose of this research was to assess the effects of a pre-therapy client orientation on clients admitted to a mental health center. A secondary purpose was to develop an effective and brief audio-visual orientation that would positively influence clients in therapy. It was hypothesized that a pre-therapy orientation would significantly reduce client no shows and cancellations, increase client fee payment, increase client level of psychological functioning, and increase client satisfaction with mental health services. None of the four hypotheses was supported by the research. A questionnaire filled out by the therapists involved in the study, after the data were collected, revealed that all of the therapists oriented their clients to therapy to varying degrees. This may account, in part, for the lack of results. Implications for future research suggest investigation into the development and evaluation of training programs for individual therapists to orient their clients in the most systematic, optimal fashion. Research should also focus on the magnitude of change after a
pre-therapy orientation and the development of instruments of sufficient sensitivity to detect that change.
CHAPTER I

STATEMENT OF THE PROBLEM

Introduction to the Problem

Clients who are seeking psychotherapy for the first time may not know how to utilize the mental health system for their own benefit. They may have unrealistic expectations about psychotherapy and little, if any, understanding of the psychotherapeutic process. These misconceptions may contribute to client dissatisfaction with treatment, client inability to utilize therapy as a tool for change, and/or premature termination. This research was conducted to test the proposition that pre-therapy client orientation is a tool to help clients gain realistic expectations of the therapeutic process which will enable them to better utilize the mental health system.

Statement of the Problem

One of the major goals of the community mental health system is to help emotionally or psychologically dysfunctional people achieve an adaptive level of functioning in their community. A lack of adaptive psychological functioning may place undue burdens upon community support systems such as family and friends, neighborhood and church groups, and social and welfare agencies. Lack of adaptive functioning can result in loss of productivity on the job as well as lost tax revenue to local and state authorities. The financial burden becomes heavier when those same people apply for and receive public assistance free or at reduced cost.
from various state-funded agencies.

The emotional burden these clients place on family and/or friends can also result in loss of adaptive functioning in others. Such extensive demands can, in fact, leave social support systems shattered from extended use. Family and friends often find themselves in the unenviable position of turning away from loved ones to protect themselves. Mental health centers must continue to find ways to help those with emotional problems to achieve an adaptive level of functioning.

One source of difficulty that prevents clients from fully benefiting from mental health services may be that they have unrealistic or mismatched expectations of what therapy might do for them. Clients may not understand the role of the therapist or be unprepared for the course of the therapeutic process.

This research study proposed that clients who received a pre-therapy orientation would enter therapy with more realistic expectations than non-oriented clients and would be better prepared to utilize the psychotherapeutic process for growth and change. Underlying assumptions of the study were that the quality of service provided at the research facility (a community mental health center in which all therapists hold an advanced degree in the behavioral sciences) was adequate to provide therapeutic benefits and that the client's expectations and level of preparedness would directly affect the degree of therapeutic benefits. The following client variables were selected as measures of client utilization of therapy: (1) no shows and cancellations, (2) fee payment, (3) level of psychological functioning at termination or after three months of treatment, and (4) client satisfaction at termination or
after three months of treatment.

Rationale for Selection of the Dependent Variables

No shows and cancellations can be seen as an indicator of whether client expectations are being met and whether clients have been socialized to the client role. Clients whose expectations of therapy are not being met and who are dissatisfied with treatment are more likely to cancel and/or fail appointments. Likewise, clients who have not been adequately prepared to assume the client role (and appropriate "good-client" behaviors) are more likely to cancel and/or fail appointments.

Fee payment can be seen as a barometer of whether client expectations are being met and whether clients are satisfied that the therapy they receive is helping. Clients whose therapy is not meeting their expectations or who do not see therapy as beneficial are apt to be less willing to pay their fees.

Clients' level of adaptive functioning at termination or after three months of treatment was selected as a measure of the clients' ability to utilize therapy. It was proposed that a pre-therapy orientation would enable clients to better utilize therapy and that the increased therapeutic benefits would be reflected in higher levels of adaptive functioning than seen in non-oriented clients.

Client satisfaction (as assessed at termination or after three months of treatment) is a direct assessment of the client's opinion of the services he has received. It was proposed that clients whose expectations were shaped by a pre-therapy orientation would have higher levels of satisfaction than non-oriented clients whose expectations may
have been unclear.

These four dependent variables were also chosen because of the ease with which they could be incorporated into the research design. Data related to all four variables were readily available in the mental health system and were collected from documents currently in use at the research facility. Almost all required data were collected without bothering the client, insuring that the data collection process, for the most part, did not contaminate research outcomes. In addition to being relevant to the research study, the variables selected were of concern to the mental health system. Positive modification of cancellations and no shows, fee payment, client level of adaptive functioning, and client satisfaction have direct benefits to the mental health system. These direct benefits helped insure the cooperation of the administrators of the research facility and increased the probability that the results of this study could be utilized within the system.

Discussion of the Dependent Variables

The Problem of No Shows and Cancellations

The problem of no shows and cancellations in mental health centers is a concern for the following two reasons (Larsen, Nguyen, Green, and Attkisson, 1983). First, clients with no shows and/or cancellations underutilize existing services and receive less than optimal benefit. They may, in fact, develop negative reactions towards these services. Similarly, when prospective clients request services but do not come to receive them, for whatever reason, their needs may never be met.

Secondly, no shows and cancellations cause problems for the Mental Health Center as well. Because no shows and cancellations increase the
number of unfilled appointment hours, thereby reducing clinical staff productivity and increasing the amount of time clerical staff must spend on scheduling, these undesirable client behaviors increase the per-unit cost of service. When clients cause unfillable vacancies, they inadvertently reduce the Center's income via private and third-party payments. These Center-related concerns are legitimate, as clients cannot receive maximum therapeutic benefits from a mental health center in which services have been curtailed or eliminated as a cost containment measure.

The use of a pre-therapy orientation can decrease the rate of no shows and cancellations as reported by Albronda, Dean, and Starkweather (1964); Heilbrun (1972); Hoehn-Saric, Frank, Imber, Nash, Stone, and Battle (1964); Larsen, Nguyen, Green, and Attkisson (1983); Mosby (1972); and Sloane, Cristol, Pepernick, and Staples (1970).

The Problem of Fee Payment

In order for psychotherapy to be successful, the client must take an active role in striving for improvement and must assume a portion of the responsibility for therapeutic outcomes. The regular payment of fees is a tangible way in which the client can participate actively in his own healing. When clients pay their fees as required, they can come to their sessions free of uneasiness or guilt about the bill.

It has been established in the literature that clients who pay for services value their therapy more highly and tend to make better use of it (Allen, 1971; Balch, Ireland & Lewis, 1977; Davids, 1964; Nash & Cavenar, 1976; Paris, 1976; Robach, Webb, & Straussberg, 1974). Recent studies (Manos, 1982; Yoken and Berman, 1984) question the therapeutic
effects of paying a fee, but neither study makes a compelling case. Yoken and Berman (1984) studied the correlation between fee payment and reported levels of symptom and problem distress after only one therapy session with a graduate student therapist. Manos (1982) reported the results of a survey in which he asked student therapists and their patients whether not paying a fee affected the treatment process.

The issue of nonpayment of fees is a critical one for mental health centers. In a time of rising costs and decreasing federal money, mental health centers must depend upon third-party and client fee payments to remain financially stable. The financial stability of a mental health center is a legitimate concern, as clients cannot utilize services which are not available. There does not appear to have been any research on the effects of a pre-therapy client orientation on clients' payment of fees.

The Problem of Client Level of Adaptive Psychological Functioning

As previously stated, one of the major goals of a mental health center is to help people lead productive lives within their communities. The emotionally or psychologically disturbed person can place a significant burden on many segments of his environment. Therefore, the client's level of adaptive functioning affects not only his own quality of life but, ultimately, the quality of life in the community at large.

The client's level of adaptive functioning can be seen as a measure of his success in utilizing mental health services. A client who is unable to participate in and benefit from therapy is likely to experience a low level of adaptive functioning. Conversely, a client
who is able to utilize the mental health system to his own therapeutic advantage can be expected to set and reach realistic goals, thereby achieving an increased level of adaptive functioning and overall productivity in his environment.

Albronda et al. (1964), Hoehn-Saric et al. (1964), Larsen et al. (1983), and Sloane et al. (1970) have reported that clients who have received a pre-therapy client orientation have achieved a higher level of adaptive functioning than their control group counterparts. These authors postulate that clients whose expectations are shaped and who are prepared for therapy via pre-therapy orientation are better able to utilize the services available for their therapeutic benefit.

The Problem of Client Satisfaction

Client satisfaction is an important variable in successful psychotherapy. Dissatisfied clients may attend their sessions sporadically or terminate prematurely, thereby losing the benefits that could have been attained from therapy. Therefore, the enhancement of client satisfaction can be seen as a clinical issue.

Several studies have found that satisfaction with services received is related to the fulfillment of client expectations (Duckro, Beal, & George, 1979; Gladstein, 1969; Severinson, 1966). It could be said that a highly satisfied client is one whose expectations of therapy have been met. Since one of the purposes of an orientation is to shape the client's expectations to conform to the therapeutic process, the client orientation should have a positive impact on client satisfaction.

Heilbrun (1972) reported that female college students who were rated as high in counseling readiness and who received a pre-therapy
briefing were found to be more satisfied with their initial therapeutic interview than were their matched, nonbriefed counterparts. This researcher has been able to find no research regarding the effects of a pre-therapy client orientation on client satisfaction with ongoing psychotherapy. This question has yet to be addressed in the literature.

**Conclusion**

Clients who are seeking treatment may find it difficult to utilize mental health services due to unrealistic expectations of psychotherapy and lack of understanding of the treatment process. This study assumed that client behavior in the areas of no shows and cancellations, payment of fees, attained level of adaptive functioning, and client satisfaction is related to the client's pre-therapy expectations and knowledge of the therapeutic process. A pre-therapy client orientation which successfully shapes realistic expectations of the therapeutic process could impact positively on the above four problem areas.

**Objectives**

The major objective of this study was to assess the effects of a pre-therapy client orientation on new clients admitted to a mental health center. The specific objectives were to determine the effects of a pre-therapy client orientation on: (1) no shows and cancellations, (2) client fee payment, (3) level of adaptive functioning, and (4) client satisfaction.

The secondary objectives were: (1) to develop a pre-therapy client orientation that will positively influence clients in therapy, (2) to provide data to facilitate mental health policymakers in deciding to
utilize or not utilize pre-therapy orientation, and (3) to contribute to the research on pre-therapy client orientation.
CHAPTER II

REVIEW OF LITERATURE

Research into the effects of a pre-therapy client orientation appears to have been built upon the foundation of prior study of client expectations as related to psychotherapy. For this reason, the literature regarding client expectations will be discussed, followed by a review of the research regarding pre-therapy client orientation.

Client Expectations

Studies in psychology have suggested that certain effects in psychotherapy may depend on strengthening and activating a client's favorable expectations. Kelly (1955) pointed out that the behavior of the client is determined by the roles he expects himself and the therapist to play. Goldstein (1962) comprehensively reviewed the literature on the influence of role expectations in psychotherapy. On the basis of those data, he concluded that mutuality of participant role expectations has a significant influence upon psychotherapeutic outcomes. He argued that the available evidence indicated that when a client's expectations of the therapist's role are disconfirmed, adverse effects are created. Bednar (1970) indicated that client expectations for improvement play a significant role in the counseling process.

Because of the diversity of beliefs about mental illness and psychotherapy, clients come to treatment with a wide variety of attitudes and expectations. Only the most sophisticated clients may have a clear idea about what to expect. Less sophisticated clients may
have unrealistic expectations about therapy and may not understand their role in the therapeutic process (Kamin & Caughlan, 1963). Lennard and Bernstein (1960), in their investigation of the relationship between role expectations and therapist-client communication in psychotherapy, found a significant relationship between disconfirmed role expectations and the degree of dysfunction in the communication system. They concluded that when expectations were highly dissimilar, the resultant strain in the dyadic system created a high risk of disintegration. One manifestation of disintegration would be a client's premature termination.

Otto and Moos (1974) assessed the expectations of incoming clients into four treatment programs using the Copes scale. Staff members assessed the clients' use of the programs after one to two months' attendance in the program. Clients who were rated as attending regularly and participating well were found to have entered with realistic expectations. Clients who were rated as attending sporadically and having made poor use of the program were found to have entered with unrealistically high expectations. On the basis of these findings, the authors postulated that clients with unrealistically high expectations will make poor use of mental health services.

Lebow (1982) indicated that several studies have found client satisfaction related to the fulfillment of client expectations. Isard and Sherwood (1964) reported on a counseling program in which the three counselors employed dissimilar interview styles. Their analysis of client satisfaction questionnaires showed that client satisfaction was not related to the particular interview style of the therapist but was related to whether or not the client's expectations were realized in the
counseling session. Severinsen (1966) indicated that client satisfaction is related to how close the therapist met client expectations. Otto and Moos (1974) indicate that there is a tendency for all new mental health clients to have somewhat unrealistic expectations of psychotherapy. Gladstein (1969) points out that client expectations can be changed.

Orne and Wender (1968) suggested that the underlying assumptions for psychological treatment are expressly different than underlying assumptions in medical and surgical treatment: active vs. passive roles, client striving for self-understanding vs. the physician effecting a cure, dealing with clients' feelings as an important part of treatment vs. the disregarding of patients' feelings, and complex vs. simple causality. This may, in some part, account for prospective clients bringing unrealistic expectations into therapy.

Some authors suggested that one way to alleviate the dilemma of disconfirmed client expectations is to help clients gain realistic expectations of psychotherapy by orienting them prior to treatment. Frank (1968) suggested that client responses to treatment can be enhanced by pretreatment instructions (as described by Orne and Wender, 1968) that shape their expectations to conform more closely to the nature of the therapeutic process. Otto and Moos (1974) recommended that a socialization interview may increase the probability of a client making the best possible use of a treatment program. The findings of Sloane et al. (1970) suggested the need for congruence between what the patient expects from therapy and the therapist's own particular goals and attitudes towards treatment.
Research in Pre-Therapy Client Orientation

The literature on orienting prospective clients to therapy has yielded mixed results. In a critical review of the literature on the effects of disconfirmed client role expectations in psychotherapy, Duckro et al. (1979) reviewed eight research studies on the effects of a pre-therapy client orientation on various factors in psychotherapy. They wrote that "... a comprehensive review of the available literature suggests considerable ambiguity regarding the validity of the hypothesis that disconfirmed role expectations result in negative consequences" (p. 269). The authors reported that five studies (62%) found that pre-therapy orientation resulted in more positive consequences (i.e., decrease in no shows and cancellations, improved outcomes, decreased symptom levels) and that three studies (38%) found no effects of pre-therapy orientation. The authors postulated that the studies that showed positive influence were more due to the extra attention paid to the client by a senior clinician rather than to the information given in the orientation.

The following review of literature has been divided into two sections. The first section deals with those studies that use a "live" presentation (i.e., a clinician provides the orientation). The second section deals with those studies that use a "nonlive" presentation (i.e., slide/cassette, videotape, film, readings).

Research Using "Live" Presentations

Albronda et al. (1964) studied 348 lower class adult patients over five years at an outpatient clinic. They found that patients who were helped by intake psychiatric social workers to form accurate
expectations regarding therapy and the roles of the participants dropped out of treatment at a lesser rate (16% vs. 50% for comparison clinics providing similar services). This was a descriptive/comparative study rather than an experimental design.

Hoehn-Saric et al. (1964) researched the effects of a Role-Induction Interview (RII) based on Orne and Wender's (1968) Anticipatory Socialization Interview. A research psychiatrist offered the RII to one-half of 40 psychoneurotic patients in an outpatient clinic during the intake interview, prior to their first meeting with their own therapists. The patients were treated for a minimum of four months. Each patient was rated by the research psychiatrist after the intake interview and again by the therapist after the first session. Treatment behavior was rated on tapes. The patients rated themselves and were again rated by their therapist at the end of treatment. The authors found that the RII significantly improved therapy behavior, attendance, and treatment outcomes.

This was a meticulous study with many strengths. Design strengths included sufficient pre-testing of the RII to evaluate it as sufficiently promising to warrant further testing, an analysis for statistical significance of differences between the experimental and control groups (no significance was found), and a procedure to control for selection bias. Another strength was the use of heterogeneous outpatient subjects—a direct contrast to the majority of studies using a college population. Finally, data were collected and analyzed across three dimensions: behavior, attitude, and therapy outcomes over time. One weakness, as noted by Hoehn-Saric et al. (1964), was that the RII was used with clients already determined to be appropriate candidates
for therapy. The usefulness of the RII with less desirable clients remains to be established. Also, one cannot be sure if the results of the research are due to the information presented or to the extra attention given the client by an authoritative person perceived as senior to the therapist.

Doster (1970) investigated the effect of pre-interview preparatory procedures on 60 undergraduate college males. The subjects were exposed to one of six procedures prior to receiving therapy. They included: (1) live, detailed instructions; (2) on observational model (tape); (3) role rehearsal; (4) a combination of detailed instructions and observational model; (5) a combination of detailed instructions and role rehearsal; and (6) a control group that received minimal instructions. He found that the pre-interview preparation was effective in increasing self-exploration and personal disclosure. He also found that the level of instructions (detailed vs. minimal) and not the mode of demonstration (observational model and role rehearsal) made an impact on the extent to which subjects disclosed themselves. The use of undergraduate students makes the findings hard to generalize to an outpatient population.

Doster's study made an interesting contribution to the literature in that he was the first to use a random rather than matched sample. One strength of the study was that the interviewer had no preknowledge of the condition the client had received. Another strength of the study was that it assessed behaviors, which are more concrete and more reliably measured than attitudes.

One weakness of the study concerned the homogeneity of the subjects. All were male and all were college students, an overly researched population with questionable generalizability. Another
weakness concerned the interview itself. The design required that the 30-minute interview be broken into six 4-minute segments. Data were then collected from the six segments, and findings were based on the single 30-minute interview. There is no indication that pre-therapy orientation would produce the same significant behavioral results in an ongoing therapy situation.

In a study by Sloane et al. (1970), 36 psychoneurotics from an outpatient clinic were assigned to one of four groups: (1) the first group did not have pre-therapy preparation; (2) the second group was told they should feel and function better after four months; (3) the third group had psychotherapy explained to them, based on Orne and Wender's (1968) anticipatory socialization interview; and (4) the fourth group had psychotherapy explained to them and were told they should feel and function better after four months. The authors found that those who received an explanation of psychotherapy improved significantly, although the findings were not as impressive as those of Hoehn-Saric et al. (1964). The suggestion that the clients would feel better in four months had no effect. The authors suggested that the lack of impressive findings may be due to the subjects being younger and better educated than those subjects in the Hoehn-Saric et al. (1964) study and having had previous psychotherapy.

This study utilized a heterogeneous outpatient sample, though the sample was somewhat skewed in that 50% were college students. Significant strength included controls for assignment bias, controls for therapist influence of results (therapists were blind as to the procedures and aims of the research), and the variety of measures used to assess improvement. Findings are more readily generalized to other
clinical settings, as they were based on therapy of four months' duration.

Mosby (1972) sought to determine if the initial discrepant expectations of clients could be changed in the direction of greater mutuality with the expectations of the therapist. The patients and therapists were matched on the basis of two expectancy types: nurturant and critical. The experimental group was composed of patient-therapist pairings with discrepant expectations. The control group was formed in the same way. A comparison group was composed of pairings with similar expectations. The therapists in the experimental group were told to try to modify their client's expectations early in therapy to conform more closely with their own. The clients, although not as successful as intended, did change their expectations more quickly. The clients in the experimental group dropped out of therapy at a lesser rate than those clients in the control group.

One strength of Mosby's study was that it attempted to assess the impact of the independent variable over time (three sessions). It used three groups (experimental, control, and a comparison group) as a validity check of the hypothesis that discrepancies are an important factor. The research was clean cut and specific, as it focused on only one variable (client expectations). The major weakness of the study lies in the homogeneity of the population. Again, it is difficult to generalize from an undergraduate student population.

Childress and Gillis (1977) studied pre-therapy role induction as an influence process using two experimental groups and a control group. The first group received a standard role-induction interview (Orne & Wender, 1968) in a context that was high in social influence (i.e.,
beautifully decorated office; prestigious degrees on the wall; well-dressed, poised professional). The second group received the same standard role interview but in a low social-influence context (i.e., drab, unfurnished office; graduate student interviewer). The group receiving the high-influence condition was found to improve significantly on a patient-progress scale; low-influence and control conditions yielded no significant difference. The authors concluded that role induction does facilitate the psychotherapeutic process but through the enhancement of expectations rather than the conveying of knowledge. A major limitation of the study was the small sample (n = 17).

In a study by Holliday (1979) community mental health clients were divided into two groups upon admission. Both groups received a group intake session, but only the preparation group received training in the psychotherapeutic process and client/therapist roles. Client expectations were measured pre- and post intake and throughout four months of therapy. Client and therapist perceptions of client progress were measured at alternate therapy sessions for four months. Prepared clients showed more realistic expectations of the therapy process and showed slightly but nonsignificantly higher ratings on measures of client improvement. The author noted that nonprepared clients of low socioeconomic status fared more poorly in therapy than other groups. She interpreted her findings as showing limited support for client preparation and stressed the importance of preparation for clients of low socioeconomic status to enhance their potential for success in therapy. Strengths of the study included multiple measures over time and assessment from client's and therapist's viewpoint. The major
limitation was that the variables measured (i.e., client's attitude, therapist's or client's assessment of client progress) were all subjective. No behavioral measures were used.

Hoyt (1980) investigated the effects of role induction on discrepancies in client/therapist expectations and on premature termination. Subjects were divided into three groups: role-induction interview, control interview, and no interview. All were given questionnaires assessing expectation and symptom discomfort before and after the manipulation interview and prior to the first therapy session. All subjects completed symptom ratings after alternate therapy sessions for 10 sessions. Their therapists also completed expectancy measures and symptom-improvement ratings. Results of the study were mixed. While role-induced clients were rated as significantly more improved by their therapist, role induction was found to have no effect on premature termination. Nor did role induction impact upon discrepancies in client/therapist expectations. Strengths of the study included the use of multiple measures over time, client and therapist input, and behavioral as well as subjective measures. A major limitation was the use of a college student population.

In a 1980 study, Brisch compared the effects of "live" vs. audiotaped, pre-therapy orientation on 36 outpatients at a community mental health center. Each subject was administered the trait form of the State-Trait Anxiety Inventory, given one therapy session including either "live" or audiotaped orientation or no orientation, then administered the state form of the State-Trait Anxiety Inventory. Subjects completed a Client Rating Scale evaluating their therapy experience after the third session, when data regarding attendance and
termination were also collected. There were no statistically significant differences between groups with regard to anxiety or termination behaviors; however, cancellations and premature terminations were clearly lower (17% vs. 42%) in the therapist-prepared group. Differences between therapists may have been a confounding factor. The author interpreted the results as suggesting that clients who receive systematic preparation from their own therapists are more likely not to terminate and to continue in therapy for at least three sessions. While the study did correlate client preparation with decreases in early termination and increases in regular attendance, some major weaknesses are evident. The sample was too small and the time interval too short to produce reliable, generalizable results. Further research needs to include a larger sample over a time interval more representative of a course of therapy.

Barnett (1981) assessed the effect of pre-therapy client orientation on client involvement in the initial contact and attendance and dropout rates in therapy. Forty subjects at a community mental health center were exposed to either a structured client-preparation interview or a normal intake procedure, after which they completed the Adjective Checklist. Data regarding attendance and dropouts were collected at six and eight weeks. Results indicated that attendance was significantly higher in the experimental group and that dropout rates were almost double (although not statistically significant) in the control group. Counseling-readiness data did not differentiate between groups. A weakness of the study was its small sample size.

Johnson (1983) compared the effectiveness of client preparation via a role-induction film vs. an individual role-induction interview.
Fifty-four patients at a community mental health center were randomly assigned to one of three conditions (role-induction film, individual role-induction interview, or no preparation), following which they were placed in a short-term therapy group. Measures were obtained from both patients and therapists, and attendance data were collected. Results indicated that patients prepared by either method displayed significantly higher levels of motivation, demonstrated a better working alliance, and were rated as having a better prognosis than nonprepared patients. Patients receiving the individual role induction rated themselves as more willing to begin treatment than patients viewing the film. Client preparation was found to have no effect on dropout rates or attendance.

Larsen et al. (1983) randomly assigned 52 outpatient clients to one of two groups. Clients in the experimental group received a 15-minute "live" orientation interview tailored after the one described by Orne and Wender (1968). The dependent measures were collected at intake and again four weeks later. The authors found that oriented clients were less likely to drop out or to miss appointments during the first four weeks of treatment. Oriented clients were portrayed by their therapists as "better" or more-preferred clients. Client-reported symptom levels decreased more among oriented clients than among non-oriented clients. Again, the use of a "live" presentation makes it difficult to know if the results were due to the information presented or the extra personal attention paid to the clients.

Strengths of the study included use of a random sample, a variety of measures (both attitudinal and behavioral), and the assessment of therapy outcomes (after four sessions or longer). A weakness of the
study was that a portion of the data was collected 22 months in retrospect, too long after treatment to be confident of accurate therapist or client recollections.

Research Using "Nonlive" Presentations

Heilbrun (1972) used a booklet to instruct 85 undergraduate student clients that therapy of various styles could be equally effective and that the client should adapt his/her expectations to the therapist's style to maximize results. The author focused on client satisfaction with the first interview and on the dropout rate. He found that oriented clients previously rated as low in readiness for therapy dropped out of treatment at a lower rate than low-readiness clients not receiving the booklet. High-readiness clients were not affected. Heilbrun also found that college female clients, high in counseling readiness, were most satisfied with their initial contacts relative to their nonbriefed counterparts. The booklet failed to influence the level of satisfaction of clients rated low in counseling readiness.

The major weakness of the study was the content of the briefing itself. The focus upon the directive vs. nondirective therapy styles (to the exclusion of other types of therapy), the statement that client preferences could not be considered, and the instruction to the client to assume responsibility for the success of the interview and to accommodate to the style of the interviewer could all combine to generate the high levels of dissatisfaction noted in all subject groups but the high-readiness females. One wonders if the results were a reaction to the tactlessness of the briefing or to the presence or absence of a briefing per se. The college student sample and the one-
session format make generalization to a clinical setting with a heterogeneous population and ongoing treatment questionable. Patients in an outpatient clinic may also not have similar reading skills as the subjects in this study. That the booklet was not a comprehensive pre-therapy orientation may have affected the lack of results on the dropout rate in clients high in counseling readiness and the lack of results with initial satisfaction in clients with low counseling readiness.

Venema (1972) attempted to prevent client attrition from therapy with 48 lower class patients by using a videotaped pre-therapy orientation. Although he was able to document fewer role-expectancy disconfirmations in therapy, there was no evidence to suggest that clients stayed in treatment longer. The videotaped presentation may have been insufficient to prepare clients for therapy.

The strengths of Venema's study included the use of an outpatient sample and the consideration of therapeutic conditions in the interview (as rated independently) as well as the client component. Weaknesses included assessment of attitudinal dimensions only (no behavioral dimensions) and the timing of the assessment (before and after the initial interview). The study did not assess the effects of pre-therapy orientation on the course of therapy.

Orenstein (1974), using a role-preparation tape and an attraction-induction message on 32 undergraduate students, failed to show any significant effects. The author did suggest the importance of adequate client role preparation as clients who felt that they understood what was expected of them and who felt that their therapist was concerned tended to value therapy more positively. The author used a tape without visual aids, which may have affected his results. The subjects may have
become bored with an audio presentation. The author also suggested that client preparation be applied and evaluated under actual therapy conditions to determine its clinical usefulness.

Strengths of the study were that it collected a variety of measures (three measures of client attitudes, one of therapist attitudes) and that it assessed both client and therapist components. However, the study depended solely on measures of attitude; there were no behavioral measures. The time-limited (one-session) nature of the therapy and the undergraduate population make it difficult to generalize this study to a clinical setting.

Fernbach (1975) used a written, one-page document to attempt to change 32 clients' expectations of treatment in a university counseling center. The document briefed the client on expected therapist behaviors, expected client behaviors, and methods of dealing with difficulties encountered in therapy. Fernbach was unable to find any significant results. No hypotheses were supported. He suggested a one-page, written document was insufficient to prepare clients for treatment and that future research should focus on more extensive methods of client preparation.

A strength of Fernbach's study was that he assessed both behavioral and attitudinal components over time. An obvious weakness in the design was the lack of pre-testing to determine the potency of the independent variable. Another weakness involved the sample. There was no screening to discriminate unusually high or low levels of psychological sophistication. Greater attention to sample selection may have resulted in significance in some of the dependent variables.

Zarchan (1977) investigated the effects of social class and role
induction on dropout rates and client expectations in outpatient psychotherapy. His sample consisted of 55 patients at a Veterans' Administration outpatient clinic. Most had previous psychiatric treatment and were currently using psychotropic medication. All were considered to be significantly disturbed. Patients were randomly assigned to one of two conditions: role induction or nonrole induction. The effects of a role-induction film were evaluated by means of client self-report and therapist assessment immediately after the first therapy session and after the fourth session. After the tenth session or following termination, clients evaluated their therapy experience and therapists evaluated their clients' rate of improvement. Role induction was not found to significantly affect either client expectations and attitudes or dropout rates. Zarchan postulated that the lack of results was related to the severity and psychotherapeutic sophistication of the client population and lack of congruence between film content and actual client experience.

Strengths of the study included multiple measures over time, the inclusion of client and therapist data, and behavioral as well as attitudinal components. The major weakness of the study lay with the sample selection. The severity and psychotherapeutic experience of the subjects may have placed them beyond the influence of client training procedures. The homogeneity of the sample renders generalization invalid.

Friedlander (1981) investigated the effects of delayed role induction on client perception and verbal behavior. Experimental clients were exposed to an audiotaped induction prior to the second interview. Measures were taken on self-reported expectancies/
perceptions prior to treatment, post induction, at termination, and on variables relating to the counseling process. Results indicated that clients' perception of their therapists' activity and of skills achieved in counseling were enhanced by role induction. Experimental clients were seen as taking a more active role in therapy than control clients. However, in statistical analysis, the relationship between experimental condition and outcome yielded only a trend. The author interpreted her findings to mean that role induction is beneficial, primarily in shaping client perceptions.

The effectiveness of a 12-minute slide and cassette orientation entitled "Tell it Like it is" was investigated by Acosta, Evans, Yamamoto, and Skilbeck (1983). One hundred and seventy-three low income and minority adult outpatients at a large public psychiatric clinic were randomly assigned to one of two groups: oriented or non-oriented. Prior to the first therapy session, each patient filled out an Attitude Towards Therapy Questionnaire, then viewed either the orientation slide/cassette or an informative presentation about the mental health facility. Patients then completed a Knowledge Questionnaire and repeated the attitudes survey. Results indicated that oriented patients were more knowledgeable about therapy than non-oriented patients \((p < .01)\), and were more positive in their attitudes towards psychotherapy \((p < .05)\).

This study made a valuable contribution to the literature in that it found effective an inexpensive and easily adopted form of client orientation which can be easily utilized by mental health facilities. It is encouraging that these results were obtained with patients of the kind regularly served by public mental health agencies. One limitation
of the study was that it assessed the cognitive/attitudinal dimension only. No attempt was made to measure the effect of orientation on client behavior over time.

**Conclusion**

Past research has shown that client expectations play a large role in the psychotherapeutic process (Bednar, 1970; Goldstein, 1962; Kelly, 1955). Because of the diversity of beliefs about mental illness and psychotherapy, clients come to treatment with a wide variety of attitudes and expectations. It has been suggested that when clients' expectations about treatment are disconfirmed, adverse effects may appear. Otto and Moos (1974) postulated that clients with unrealistically high expectations will make poor use of mental health services. The authors also suggested that there is a tendency for new mental health clients to have unrealistic expectations of psychotherapy. Gladstein (1969) points out that client expectations can be changed.

Several authors (Frank, 1968; Otto & Moos, 1974; Sloane et al., 1970) have suggested that unrealistic client expectations of psychotherapy can be modified by orienting them prior to treatment, thereby increasing the probability of a client making the best possible use of mental health services.

**Research in Pre-Therapy Client Orientation**

The literature on orienting prospective clients to therapy has yielded mixed results. The major criticism of the research has been that those studies using "live" presentations (i.e., a senior clinician prepared the prospective client for treatment) achieved their results as
a consequence of clients receiving extra attention.

The mid-1960s saw the beginning of research into orienting new clients to therapy. Several studies used "live" presentations to varying degrees of success (Albronda et al., 1964; Barnett, 1981; Brisch, 1980; Childress & Gillis, 1977; Doster, 1970; Hoehn-Saric et al., 1964; Holliday, 1979; Hoyt, 1980; Johnson, 1983; Larsen et al., 1983; Mosby, 1972; Sloane et al., 1970). The use of a senior clinician appeared to be very effective in orienting prospective clients but also very cost inefficient.

The early 1970s saw a trend towards experimenting with "nonlive" presentations (audio-cassette, videotape, film, readings) to orient prospective clients to treatment (Fernbach, 1975; Friedlander, 1981; Heilbrun, 1972; Orenstein, 1974; Venema, 1972; Zarchan, 1977). These "nonlive" presentations (with the exception of Heilbrun, 1972) had nonsignificant effects on clients for a variety of possible reasons: poor quality of presentations, lack of sufficient detail, poor sampling techniques, and homogeneous samples (college populations). Two pieces of research which failed to achieve results used a college population, which may make it difficult to generalize their findings to an outpatient population. College students are relatively more sophisticated about issues relating to mental health and may have clearer ideas about what to expect from therapy.

The 1980s saw two studies which raised expectations for an effective "nonlive" presentation. Johnson (1983) compared the effectiveness of an individual role-induction interview with a role-induction film and found that patients prepared by either method showed significantly higher levels of motivation, demonstrated a better working
alliance, and were rated as having a better prognosis than nonprepared students. Acosta et al. (1983) successfully used a slide/cassette orientation and showed that oriented patients were more knowledgeable about therapy than non-oriented patients and were more positive in their attitudes towards psychotherapy. In a time of tight budgets and expanding use of mental health services, a successful "nonlive" presentation holds the promise for an inexpensive and brief method of orienting prospective clients to psychotherapy. Further research into the use of "nonlive" orientations appears to be an appropriate area of investigation.

This present study contributed to the literature in several ways. This study utilized a random sample of outpatients, professional therapists, and studied the effects of a pre-therapy orientation over time looking at behavioral as well as attitudinal measures.

No research has studied the effects of a pre-therapy orientation on payment of fees. With the exception of Heilbrun (1972), client satisfaction appears to have been ignored. The present study contributed to the body of knowledge, especially in these two areas.
CHAPTER III

HYPOTHESES, METHODOLOGY, AND PROCEDURES

Chapter III will present the research questions and hypotheses as well as the methods and procedures of the study. For the purpose of presentation the chapter has been divided into six sections: (1) Research Questions, Hypotheses, and Rationales; (2) Subjects; (3) Design; (4) Procedure; (5) Data and Instrumentation; and (6) Statistical Analysis.

Overview of the Study

One hundred and twenty-two (n = 122) new adult subjects were randomly assigned to one of four groups at the end of their individual intake interviews. Group 1 (n = 30) received a pre-therapy client orientation. Group 2 (n = 31) received a mental health center introduction orientation. Group 3 (n = 31) received both a pre-therapy client orientation and an introduction to the Mental Health Center orientation. Group 4 (n = 30) did not receive either presentation. Approximately three months after the intake interview, data were gathered from various Center documents and analyzed to determine whether there were any differences between the four groups in terms of client no shows and cancellations, rate of fee payment, clinical judgment of client's level of adaptive functioning, and satisfaction with mental health services. The therapists involved in this study did not know which treatment their clients had received.
Research Questions, Hypotheses, and Rationales

This study attempted to answer the following questions.

**Question #1:** Does a pre-therapy client orientation effect the number of client no shows and cancellations?

**Hypothesis:** Clients who receive a pre-therapy client orientation will have significantly fewer no shows and cancellations than clients who do not receive a pre-therapy client orientation.

**Rationale:** Clients who get their expectations met in therapy experience feelings of satisfaction and are more likely to attend their sessions. Clients who have unrealistic expectations of therapy may show their disappointment or frustration by not attending or by cancelling sessions. Clients cannot benefit from therapy when they do not attend their sessions. Clients who are socialized to the role will be more cooperative participants in therapy.

**Question #2:** Does a pre-therapy client orientation effect the rate of client payment of fees?

**Hypothesis:** Clients who receive a pre-therapy orientation will pay a significantly higher percentage of their fees than clients who do not receive a pre-therapy orientation.

**Rationale:** Pre-therapy orientation enables clients to form realistic expectations for therapy outcomes; clients with realistic expectations are more likely to feel satisfied with therapy and be willing to pay their fees. An increase in fee payment may also be due in part to the pre-therapy orientation's encouragement to clients to pay their fees on time. The orientation will teach clients that they are expected to pay at the time when services are rendered unless other arrangements are made.
Question #3: Does a pre-therapy client orientation effect the client's level of overall psychological functioning on a continuum from psychological or psychiatric sickness to health?

Hypothesis: Clients who receive a pre-therapy client orientation will have a significantly higher level of overall functioning on a continuum from psychological or psychiatric sickness to health than clients who do not receive a pre-therapy orientation.

Rationale: Clients who have realistic expectations of psychotherapy may experience an increase in overall psychological or psychiatric functioning. If the client knows what to expect from therapy, he can better utilize what he learns, possibly resulting in an increased level of functioning if not a return to a previously held level of functioning. If a client leaves treatment due to unrealistic expectations of therapy, he may continue at his current level of functioning.

Another benefit of a pre-therapy client orientation may be increased therapist involvement in treatment. Clients who have realistic expectations and have set and begun to achieve their goals appear highly motivated to their therapists. Therapists respond to motivated clients by investing more energy in the therapeutic process. Therapists tend to respond more favorably to clients who approach their criteria for "good" clients (Parloff, 1956; Wallach & Strupp, 1960). If a client's expectations are confirmed, then the treatment situation appears more rewarding and clients will work harder to achieve treatment goals. Increased therapist involvement and corresponding client motivation may help in increasing the overall level of psychological functioning.
Question #4: Does a pre-therapy client orientation effect client satisfaction with mental health services?

Hypothesis: Clients who receive a pre-therapy orientation will have significantly higher levels of satisfaction with mental health services than clients who do not receive a pre-therapy orientation.

Rationale: It is suggested that the more the outcomes of treatment match client expectations, the higher client satisfaction will be. Satisfaction has been found to be related to fulfillment of client expectations (Lebow, 1982).

Subjects

The target population for this study was mental health clients living in a semi-rural, moderately populated area. The sample was the first 122 adult clients who attended Bear River Mental Health Services, Inc. during the data collection period. This Center covers a three-county catchment area with a total population of approximately 100,000. Eighty-four clients, or 69% of the sample, were obtained from Cache County. Thirty-eight clients, or 31% of the sample, were obtained from Box Elder County. Rich County, which has 2% of the catchment population, was not used. Ninety-two subjects, or 75% of the sample, were women ranging in age from 18 to 77 years. Thirty subjects, or 25% of the sample, were men ranging in age from 18 to 52 years. Table 1 shows the number of subjects with data available on each dependent variable.

Table 2 shows a variety of subject demographics.

Excluded from the sample were all clients diagnosed as brain damaged, mentally retarded, psychotic, and alcoholic. These clients may
Table 1
Number of Subjects with Data Available on Each Variable

<table>
<thead>
<tr>
<th>No shows and cancellations</th>
<th>Fee payment</th>
<th>Level of functioning</th>
<th>Client satisfaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>122</td>
<td>94</td>
<td>122</td>
<td>52</td>
</tr>
</tbody>
</table>

not have been able to comprehend the pre-therapy client orientation.

Design

This study utilized the posttest-only control group design as described by Campbell and Stanley (1963). This is a true experimental design and is preferred for its simplicity of application. The posttest-only group design does not require a pretest which would have been impossible to gather in the present study as three of the four measures used to evaluate the experimental treatment (i.e., fee-payment behavior, no show or cancellation behavior, and client satisfaction scores) were not available prior to the application of the treatment. Figure 1 represents the design of the study.

Description and Development of the Pre-Therapy Client Orientation

The pre-therapy client orientation included an 11-minute slide presentation with cassette tape narration (see Appendix A for transcript). The text for the pre-therapy client orientation was based on Orne and Wender's (1968) Role-Induction Interview and included: (1) a discussion of the general nature of therapy, (2) a description and explanation of the expected behaviors of the client and therapist, (3) a
Table 2

Sample Demographics

<table>
<thead>
<tr>
<th></th>
<th>Pre-therapy orientation</th>
<th>Introduction to Center</th>
<th>Both</th>
<th>Neither</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>80% (24)</td>
<td>70% (22)</td>
<td>75% (23)</td>
<td>70% (21)</td>
</tr>
<tr>
<td>Male</td>
<td>20% (6)</td>
<td>30% (9)</td>
<td>25% (8)</td>
<td>30% (9)</td>
</tr>
<tr>
<td><strong>Average age</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>30.6</td>
<td>30.1</td>
<td>29.6</td>
<td>34.5</td>
</tr>
<tr>
<td><strong>Average years of education</strong></td>
<td>11.8</td>
<td>12.8</td>
<td>12.9</td>
<td>13.4</td>
</tr>
<tr>
<td><strong>Marital status</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>10% (3)</td>
<td>22% (7)</td>
<td>22% (7)</td>
<td>13% (4)</td>
</tr>
<tr>
<td>Married</td>
<td>53% (16)</td>
<td>58% (18)</td>
<td>48% (15)</td>
<td>69% (18)</td>
</tr>
<tr>
<td>Divorced</td>
<td>33% (10)</td>
<td>19% (6)</td>
<td>25% (8)</td>
<td>23% (7)</td>
</tr>
<tr>
<td>Widowed</td>
<td>3% (1)</td>
<td>0</td>
<td>3% (1)</td>
<td>3% (1)</td>
</tr>
<tr>
<td><strong>Average monthly income</strong></td>
<td>$671 (24)</td>
<td>$791 (20)</td>
<td>$849 (26)</td>
<td>$871 (24)</td>
</tr>
<tr>
<td><strong>Diagnosis</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adjustment disorders</td>
<td>50% (15)</td>
<td>54% (17)</td>
<td>32% (10)</td>
<td>46% (14)</td>
</tr>
<tr>
<td>Dysthymic</td>
<td>20% (6)</td>
<td>12% (4)</td>
<td>22% (7)</td>
<td>3% (1)</td>
</tr>
<tr>
<td>Major depression</td>
<td>10% (3)</td>
<td>6% (2)</td>
<td>12% (1)</td>
<td>3% (1)</td>
</tr>
<tr>
<td>Anxiety disorders</td>
<td>3% (1)</td>
<td>6% (2)</td>
<td>3% (1)</td>
<td>13% (4)</td>
</tr>
<tr>
<td>Other*</td>
<td>17% (5)</td>
<td>22% (6)</td>
<td>58% (18)</td>
<td>73% (22)</td>
</tr>
<tr>
<td>Previous mental health care</td>
<td>70% (21)</td>
<td>67% (21)</td>
<td>58% (18)</td>
<td>73% (22)</td>
</tr>
</tbody>
</table>

*Includes marital problems, intermittent explosive disorders, personality disorders, etc.
preparation of the client for the typical course of therapy, and (4) a realistic expectation for improvement.

The text was reviewed by four doctoral-level, licensed, practicing therapists: a psychiatrist, two psychologists, and one clinical social worker. The reviewers judged the adequacy of the test by responding to a set of questions related to the material (see Appendix B). The text had to be rated at a three or higher on the questionnaire in order to proceed to the next step. The text was rated at three or higher by all the raters.

The text was made into an audio-visual presentation by a media professional. This presentation was reviewed by this researcher's five committee members along with two licensed Ph.D. psychologists, one psychiatrist, and one licensed clinical social worker. The reviewers judged the adequacy and quality of the presentation by responding to a set of questions related to the material (see Appendix C). The presentation had to be rated at a three or higher on the questionnaire in order to proceed with the research. The presentation was rated at three or higher by all the raters.
To determine if the presentation corrected any misconceptions about therapy, it was shown to five adult males and five adult females who had never received therapy from a mental health professional. A set of true/false questions (see Appendix D) was administered immediately prior to viewing the presentation and readministered at the presentation's conclusion. The sample was the first 10 people who came to the Center for services and who met the above requirements. The data were analyzed for any difference at the .05 level of significance. The difference between the pre-test and post-test was significant.

Description and Development of the Center Introduction

The text for the Center introduction (see Appendix E) covered: (1) a statement of Center goals, (2) types of problems treated at the Center, (3) types of professional staff and what they do, (4) types of services offered, and (5) funding source. The text was made into an audio-visual presentation by a media professional. The presentation was reviewed by five Center staff (three from Cache County and two from Box Elder County). The reviewers judged the adequacy and quality of the presentation by responding to a set of questions related to the material (see Appendix F). The judges had to rate the presentation at three or higher in order to proceed to the next step. All the judges rated the presentation at three or higher.

Procedure

When the prospective client finished the intake interview, the intake worker assigned the client to one of the four groups based on a table of random numbers (see Appendix G). Those clients assigned to
Groups 1, 2, or 3 had the appropriate presentation administered individually at the completion of his or her routine intake. No presentation was administered to Group 4. Each intake worker in Cache and Box Elder offices was trained in the assignment of clients to the groups and in the administration of the presentations. The intake workers were allowed to answer questions clients may have had.

An intake interview at Bear River Mental Health Services, Inc. is normally the first contact a client has with the Center. Gill, Newman, Redlich, and Sommers (1954) have pointed out how important the first interview is in determining the future course of therapy. The client describes in some detail the nature and history of the presenting problem. The client completes a Personal History (Adult) and a Client Self-Assessment (CSA) form. The intake worker collects demographic information, informs the client of his/her rights, gathers any necessary releases of information, and sets the fee for service. The intake worker later dictates an intake report detailing a general description of the client, presenting problem, clinical impression, preliminary diagnosis, and an interim treatment plan until the client meets with the therapist. All these forms are included in the client's file. Thus, the intake interview proved to be an ideal time for a client to receive a pre-therapy client orientation. This researcher periodically met with each intake worker to work out any procedural difficulties. Each client was asked to sign an Informed-Consent Document (see Appendix H). Client assignment was based on therapist availability. Consideration was given in matching client problems with therapists who are skilled in treating those problems. The therapist assigned to the case did not know which orientation procedure the client had received.
Fourteen professional therapists took part in the research. Five of the staff had Ph.D. degrees while the others had master's degrees. Four of the staff were female therapists. The Ph.D.s worked with 39 subjects (32%) while the master's-level staff worked with 83 subjects (68%). Table 3 reflects the breakdown of subjects by group for the professional staff.

Table 3

<table>
<thead>
<tr>
<th></th>
<th>Pre-therapy orientation</th>
<th>Introduction to Center</th>
<th>Both</th>
<th>Neither</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ph.D.</td>
<td>9</td>
<td>8</td>
<td>13</td>
<td>9</td>
<td>39</td>
</tr>
<tr>
<td>Master's</td>
<td>21</td>
<td>23</td>
<td>18</td>
<td>21</td>
<td>83</td>
</tr>
<tr>
<td>Combined</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>122</td>
</tr>
</tbody>
</table>

Within three weeks after the completion of the intake interview, a case staffing was completed by the assigned therapist and reviewed by a group of professional peers. Each client's current level of adaptive functioning during the previous week was determined. Client assessment and treatment goals were formulated at this time. Three months after the initial case staffing, the process (called a 90-Day Review) was repeated. A Client Survey Instrument (CSI) form, in which each client rates his or her level of well being and satisfaction with mental health services, was sent to the client at 90 days after the intake or at termination, whichever came first. All nonresponders to the Client Survey Instrument were sent up to two extra questionnaires, and if the client did not respond he/she was called on the phone up to two times.
and asked to send back one of the questionnaires. After the completion of each client's 90-Day Review, this researcher collected the data.

The information gathered about each subject remained confidential. All nonclinical papers containing personal information were destroyed after the study was completed.

Data and Instrumentation

Each question and its hypothesis was tested by gathering data from documents used in routine Center procedures. These documents include the client's file, Client Survey Instrument, and the client's record of payment. With the exception of the Client Survey Instrument, which was sent to all clients, the measures used were unobtrusive. The data were collected in the following manner.

Hypothesis #1: To test the first hypothesis, the number of no shows and cancellations was compared between the four groups.

After the 90-Day Review was completed, the data were collected from the Progress Note section of each client's file by counting the number of no shows and cancellations. The lower the number of no shows and cancellations, the more each client was believed to be benefiting from therapy.

Hypothesis #2: To test the second hypothesis, the percentage of fees paid was compared between the four groups.

After the 90-Day Review was completed, the amount a client paid was correlated with the amount a client was expected to pay. These figures were collected from Computer Center printouts.

Hypothesis #3: To test the third hypothesis, the Global Assessment Scale (GAS) (see Appendix I) was compared between the four groups.
After the 90-Day Review was completed, the therapist rated the client's current level of functioning according to the GAS. Each client had a single GAS score. The higher the GAS score, the more functional the client was evaluated to be. The GAS score was found on the 90-Day Review form (see Appendix J) located in the Problem List section of the client's file.

Description of the Global Assessment Scale (GAS)

The GAS is a single-rating scale for evaluating the overall functioning of a client, usually during the past week. The client is rated on current level of functioning regardless of the prognosis, diagnosis, use of medication, or other form of help. The client is evaluated on a continuum of psychological health-sickness. The range of scale values is from 1, which suggests the lowest possible level of functioning, to 100, which suggests the healthiest possible level of functioning. It is divided into 10 intervals ranging from 1-10 to 91-100.

The defining characteristics of each 10-point range comprise the scale. For example, the two highest ranges suggest a client who is without significant symptomatology and exhibits many of the characteristics of a mentally healthy individual with a wide range of interests and who is functioning extremely well in social and work areas. Although some individuals in the top range may seek psychological help, the majority of clients will be given ratings in the 1-70 range. Most outpatients will be found in the 31-70 range, while most inpatients on admission will be found in the 1-40 range. Because the GAS covers the entire range of severity, it could be utilized in
this study where an overall assessment of severity of illness was needed. The client's therapist made the rating and chose the range which described the lowest level of functioning during the past week.

Reliability and Validity of the GAS

Endicott, Spitzer, Fleiss, and Cohen (1976), who developed the GAS, reported on five studies of interjudge reliability with correlation coefficients of .91, .85, .76, .69, and .61 on ratings of inpatients, of aftercare patients, and from case notes. In a diagnostically heterogeneous inpatient sample, reliability ranged from .80 to .90. The diversity of the outpatient population affects the reliability of the GAS. The more heterogeneous the population, the higher the reliability and correlation. The Mental Health Center has a heterogeneous mental health population. The authors discussed validity in terms of correlations with other independently rated measures of overall severity, relationship to rehospitalization, and sensitivity to change. GAS ratings showed moderate correlations with measures of overall severity (seven-point rating scales and total scores derived from a multi-dimensional rating procedure).

Endicott et al. (1976) measured concurrent validity by gathering data on patients admitted for hospitalization. All the patients were evaluated at admission and six months later by the patient's therapist and an independent research assistant. The correlations of the GAS scores with each other and with other assessment measures were stronger at six months (.67) than at admission (.37). This can be accounted for by the greater heterogeneity of scores at six months. Almost all the patients at admission were below 50 on the GAS, which is to be expected as hospitalized patients are usually rated within the 1-40 range.
In terms of content validity, the GAS covers most important dimensions of psychotherapy and mental health. In terms of construct validity, higher GAS scores correlated with lower amounts of intervention planned by therapists. Significantly higher scores were obtained for continuing versus noncontinuing outpatients. Achievers of treatment outcomes showed higher GAS scores at six months follow-up than nonachievers.

The authors found that the GAS may be useful in identifying clients who are at high risk for inpatient readmission. In reference to sensitivity to change (the major use of the GAS is detection of change), the authors stated that "both the therapists' and the research interviewers' GAS ratings yielded the greatest sensitivity to change of all the overall severity and symptom dimensions ratings studied" (p. 771).

The majority of clinical staff who participated in this study was trained in the use of the GAS in July 1983 by a team of mental health professionals under the direction of the Utah Council of Mental Health Programs. The average single-rater reliability was .819 (Owen, 1983). Seventy-two percent of all the ratings were within 10 points of each other. The clinical staff who participated in this research study were again trained by this researcher in the use of the GAS in August 1985. The average single-rater reliability was .98.

Hypothesis #4: To test the fourth hypothesis, the Client Survey Instrument of client satisfaction was compared between the four groups.

After the 90-Day Review was completed or at termination of services (usually when the client's file is closed), whichever came first, A Client Survey Instrument (see Appendix K) was sent to each client. The
responses on the Client Survey Instrument were compared between the groups for significant differences. These questionnaires were filed by the clinical secretary in secure file cabinets.

**Description of the Client Survey Instrument (CSI)**

The CSI is a 29-item questionnaire that asks: (1) 11 questions about general well being (see General Well Being Scale below), and (2) 16 closed-ended and 2 open-ended questions about client satisfaction with Center services. Twenty-six of these questions were used for the statistical analysis. Each subject ranked his or her response along a continuum from one to four on 3 questions, one to five on 13 questions, and one to six on 11 questions. Each response under each question received a value ranging from one to five, with the most positive response receiving a value of five and the most negative response receiving a value of one. For example, question number nine has six responses, with response number one being the most positive. Response number one received a value of five, while response number six received a value of one. Response numbers three and four were combined and received a value of three. All the response values were added up to achieve one score per CSI. Each client obtained a single score. The higher the score, the more satisfied the client was believed to be. Cronbach's Alpha on the CSI was .8987.

**General Well Being Scale (GWB)**

The 11 questions about general well being on the CSI (items 7-17) come from the General Well Being Scale (GWB) by Dupuy (Ciarlo, Edwards, Kiresuk, Newman, & Brown, 1981). (These 11 questions are the same questions in the Client Self-Assessment [CSA] given to the client at
intake.) The GWB is a 33-item, self-administered, self-report questionnaire about symptoms, personal functioning, and occurrence of significant problems in a general population. The measure has two distinct content areas: (1) overall psychological adjustment over the past month (18 items), and (2) a criteria section assessing more specific instances of psychological distress over the past year and attempting to deal with this distress through mental health services (15 items). Many variations exist, including a 68-item research edition, a 22-item edition, and a brief 5-item measure. Each item has between 2 and 10 response options. Higher scores indicate positive adjustment. Ratings are summed to yield: (1) six subscale scores (anxiety, depression, positive well being, self-control, general health, and vitality), (2) a full-scale adjustment score (0-110), and (3) several derived scores. The usual points of collection are at intake and three months afterwards. It is used on adults and appears appropriate for older adolescents as well.

The 11 questions about general well being on the CSI are also administered at intake and called the Client Self-Assessment (CSA) (see Appendix L).

Reliability and Validity for the GWB

In terms of internal consistency, the GWB's reliability for median item-total score correlations is .65, with total-scale estimated internal consistency at .87. Total-Scale Alpha was .94. Average inter-item correlations ranged from .47 to .63 for subscales and .41 for total scale. Other studies reported by Ciarlo et al. (1981) had alphas of from .90 to .95.

In terms of content validity, GWB items were selected as
operational measures of the general concept "well being" and its polar opposite, "psychological distress." All subscale content areas appear to have been adequately sampled with good face validity, although the GWB may not clearly differentiate between mental and physical health or illness.

In terms of criterion validity (Ciarlo et al., 1981), the GWB discriminated mental health clients from population samples (r's were at .43 and .56). GWB scores differentiated clients from nonclients at intake at the .001 level.

The GWB appears sensitive to change, as was shown in a study (Ciarlo et al., 1981) on follow-up data on 41 college students (after three months of treatment), 67 community residents (after three months of treatment), and 22 clients (after two weeks of treatment). Results showed significant positive change in the patient group only, indicating sensitivity to treatment effects.

Cronbach's Alpha on questions 7-17 (which comprise the well being part of the CSI used in this research study) is .9049. These 11 questions used at intake and called the Client Self-Assessment (CSA) had Cronbach's Alpha computed at .8552.

Collection of the CSI

All clients were sent the CSI at termination or at three months after intake, whichever came first. Those that did not reply were sent up to two more CSIs. Those that did not reply to the mailing of additional CSIs were called on the telephone up to two times and asked to mail one of the CSIs sent to them. Each mailed CSI included a self-addressed, stamped envelope to facilitate client response.
Statistical Analysis

To test the first hypothesis, a Chi-Square was used to evaluate no shows and cancellations. A Chi-Square was used since the means for both no shows and cancellations were located at the low end of the score scale with the curve skewed to the right. Several subjects had more than one no show or cancellation. For statistical purposes, whenever a client had more than one no show or cancellation, it was treated as if the client had only one no show or cancellation.

To test the second hypothesis, what clients were expected to pay was correlated with what clients did pay for each group using the Pearson Correlation Coefficient. The four correlation coefficients were tested for significant differences using a formula found in Glass and Hopkins (1970). A review of the raw data revealed that several subjects paid more than what was expected of them. This is not unusual as some clients pay ahead in anticipation of future sessions. If the personal fee per session is small (for example, $5), it is easy to see how this situation may occur. For statistical purposes, whenever a client paid more than what was expected, it was treated as if what was paid was equal to what was expected as payment.

To test the third hypothesis, a 2X2 analysis of covariance, with GAS scores at intake as a covariate, was used to analyze GAS scores three months after intake between the groups. The GAS scores comparison three months after intake only indicated how the four groups were different after the experimental treatments were administered. Because these differences might have been present before the experimental treatments were given, it was necessary to adjust the GAS scores three months after intake for the GAS scores at intake. These adjusted score
comparisons (using GAS scores at intake as covariates) had the effect of allowing this study to compare the GAS scores three months after intake after initial differences had been controlled.

To test the fourth hypothesis, a 2X2 analysis of variance was used to analyze the Client Survey Instrument scores for differences among the four groups. The ANOVA was chosen because this method permits the evaluation of more than one variable at a time and makes possible the assessment of possible interaction between and among variables. The assumptions underlying the use of ANOVA were believed to be met in this study as the samples were independent random samples from normally distributed and equally variable populations having the same means. To test for differences among Client Self-Assessment scores three months after intake, a 2X2 analysis of variance was used. All data were analyzed for significance at the .05 level.
CHAPTER IV

RESULTS

No Shows and Cancellations

Of the entire sample (n = 22), 43 subjects or 35.2% had at least one or more no shows (Table 4). The sample had 63 no shows compared with 806 sessions overall. The average number of no shows per subject was .5 (63 no shows divided by 122 subjects). The mode was one no show.

Table 4
Chi Square Analysis of No Shows from Intake to Three Months After Intake

<table>
<thead>
<tr>
<th>Legend: Count row PCT</th>
<th>Pre-therapy orientation</th>
<th>Introduction to Center</th>
<th>Both</th>
<th>Neither</th>
</tr>
</thead>
<tbody>
<tr>
<td>No no shows</td>
<td>20</td>
<td>20</td>
<td>17</td>
<td>22</td>
</tr>
<tr>
<td></td>
<td>25.3%</td>
<td>25.3%</td>
<td>21.5%</td>
<td>27.8%</td>
</tr>
<tr>
<td>One or more no shows</td>
<td>10</td>
<td>11</td>
<td>14</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>23.3%</td>
<td>25.6%</td>
<td>32.6%</td>
<td>18.6%</td>
</tr>
<tr>
<td>Column</td>
<td>30</td>
<td>31</td>
<td>31</td>
<td>30</td>
</tr>
<tr>
<td>Total</td>
<td>24.6%</td>
<td>25.4%</td>
<td>25.4%</td>
<td>24.6%</td>
</tr>
</tbody>
</table>

$X^2 = 2.35, \ 3 \ df, \ p = .50$

It was hypothesized that clients who received a pre-therapy client orientation would have significantly fewer no shows and cancellations
than clients who did not receive a pre-therapy client orientation. Using Chi Square, analysis of the data revealed no significant differences between the groups for no shows ($x^2 = 2.35, 3 \text{ df}, p = .5$) (see Table 4).

Of the entire sample ($n = 122$), 30 subjects or 23.6% had at least one or more cancellations (Table 5). The sample had 50 cancellations compared with 806 sessions overall. The average number of cancellations per subject was .4 (50 cancellations divided by 122 subjects). The mode was one cancellation.

Table 5

| Chi Square Analysis of Cancellations from Intake to Three Months After Intake |

<table>
<thead>
<tr>
<th>Legend: Count row PCT</th>
<th>Pre-therapy orientation</th>
<th>Introduction to Center</th>
<th>Both</th>
<th>Neither</th>
</tr>
</thead>
<tbody>
<tr>
<td>No cancellations</td>
<td>25</td>
<td>24</td>
<td>21</td>
<td>22</td>
</tr>
<tr>
<td></td>
<td>27.2%</td>
<td>26.1%</td>
<td>22.8%</td>
<td>23.9%</td>
</tr>
<tr>
<td>One or more cancellations</td>
<td>5</td>
<td>7</td>
<td>10</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>16.7%</td>
<td>23.3%</td>
<td>33.3%</td>
<td>26.7%</td>
</tr>
<tr>
<td>Column</td>
<td>30</td>
<td>31</td>
<td>31</td>
<td>30</td>
</tr>
<tr>
<td>Total</td>
<td>24.6%</td>
<td>25.4%</td>
<td>25.4%</td>
<td>24.6%</td>
</tr>
</tbody>
</table>

$X^2 = 2.13, 3 \text{ df}, p = .54$

Using Chi Square, analysis of the data revealed no significant differences between the groups for cancellations ($X^2 = 2.13, 3 \text{ df}, p = .54$).
The average monthly income for each group ranged from $671 to $871. The amount of money the client was expected to pay ranged from $1 to $580 for each subject's three-month period. The average amount each subject was expected to pay was $77.90. The average amount each group was expected to pay is shown in Table 6.

Table 6
Expected Fee Payment, Amount Paid, Percentage of Amount Paid, and Number of Medicaid Subjects per Group

<table>
<thead>
<tr>
<th></th>
<th>Pre-therapy orientation</th>
<th>Introduction to Center</th>
<th>Both</th>
<th>Neither</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average monthly income</td>
<td>$671.00</td>
<td>$791.00</td>
<td>$849.00</td>
<td>$871.00</td>
</tr>
<tr>
<td>Average amount expected to pay</td>
<td>$ 64.37</td>
<td>$ 87.25</td>
<td>$ 89.76</td>
<td>$ 70.79</td>
</tr>
<tr>
<td>Average amount client paid</td>
<td>$ 20.29</td>
<td>$ 29.35</td>
<td>$ 66.03</td>
<td>$ 25.75</td>
</tr>
<tr>
<td>Average percent paid</td>
<td>48.28%</td>
<td>41.17%</td>
<td>67.15%</td>
<td>45.63%</td>
</tr>
<tr>
<td>Number of Medicaid clients</td>
<td>6</td>
<td>11</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

The amount of money the client paid ranged from $1 to $373 for each subject's three-month period. The average amount each subject paid was $36.26. The average amount each subject paid is shown in Table 6. Any money paid by a client's health insurance plan was not included in these totals.
The average percent paid on their bills by the entire sample \((n = 122)\) was 51.15%. The average percents paid are shown in Table 6. The average percent of fees paid for Group 3 was 67.15%, a difference of 18.87% over the next highest group.

It was hypothesized that clients who received a pre-therapy orientation would pay a significantly higher portion of their fees than clients who did not receive a pre-therapy orientation. Of the entire sample \((n = 122)\), 28 subjects or 23% had a Medicaid card which the Center is obligated to accept from the state of Utah as payment in full. Because those 28 subjects did not owe the Center any money, they were not included in the statistical analysis for this hypothesis. After Medicaid cases were removed for the analysis, the Pearson Correlation Coefficient was used to correlate expected fee payment with actual fee payment. The coefficients were then analyzed for differences, and Group 3 (both presentations) was significantly different than the other groups \((X^2 = 24.86, 3 \text{ df}, p < .001)\), suggesting that clients in Group 3 were significantly more likely to have paid what was expected of them (see Table 7).

After the Pearson Correlation Coefficients for the four groups were analyzed for any significant differences, Group 3 (both presentations) was pulled out and the correlation coefficients for the other three groups were re-analyzed for any significant differences. There were no differences \((X^2 = 2.16, 2 \text{ df}, p = .5)\).

**Psychological Functioning**

The average GAS score for all groups after three months of therapy was 61.4 (on a scale of 0 to 100). The average GAS scores, adjusted
Table 7
Correlation of Actual Fee Payment to Expected Fee Payment

<table>
<thead>
<tr>
<th></th>
<th>Pre-therapy orientation</th>
<th>Introduction to Center</th>
<th>Both</th>
<th>Neither</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pearson Correlation Coefficient</td>
<td>.46</td>
<td>.52</td>
<td>.95</td>
<td>.66</td>
</tr>
<tr>
<td>Number of subjects (n = 94)</td>
<td>24</td>
<td>20</td>
<td>26</td>
<td>24</td>
</tr>
<tr>
<td>Level of significance</td>
<td>p = .02</td>
<td>p = .01</td>
<td>p = .001</td>
<td>p = .00</td>
</tr>
</tbody>
</table>

\[ x^2 = 24.86, 3 \text{ df}, p < .001^* \]

With Group 3 (both presentations) excluded from the calculations, the results were:

\[ x^2 = 2.16, 2 \text{ df}, p = .5 \]

*See Glass and Hopkins (1970), pp. 309-310 for formula used to calculate for differences among several independent correlation coefficients.

means, and standard deviations for each of the groups are shown in Table 8. The GAS scores for each group at the end of three months was an average of seven points higher than the GAS scores for each group at intake. The GAS scores ranged from 22 to 95, with the score 70 appearing most frequently (\( n = 15 \)).

It was hypothesized that clients who received a pre-therapy client orientation would have a significantly higher level of psychological functioning, as rated by their therapist three months after intake, than clients who did not receive a pre-therapy orientation. Using a 2X2 Analysis of Covariance, analysis of the data revealed no significant main effect for pre-therapy orientation (\( F = .2, 1 \text{ df}, p = .65 \)). There
Table 8
Means, Adjusted Means, and Standard Deviations for Global Assessment Scale (GAS) Scores Collected Three Months After Intake

<table>
<thead>
<tr>
<th>Introduction to the Center</th>
<th>Pre-therapy orientation</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
<td>Total</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>$\bar{X} = 59.7$</td>
<td>$\bar{X} = 59.0$</td>
<td>$\bar{X} = 59.35$</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$SD = 11.2$</td>
<td>$SD = 11.6$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>$\bar{X} = 61.1$</td>
<td>$\bar{X} = 66.0$</td>
<td>$\bar{X} = 63.57$</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$SD = 9.9$</td>
<td>$SD = 9.0$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>$\bar{X} = 60.39$</td>
<td>$\bar{X} = 62.46$</td>
<td>$\bar{X} = 61.43$</td>
<td></td>
</tr>
</tbody>
</table>

was, however, a significant main effect for the introduction to the Center ($F = 5.0$, 1 df, $p = .02$). It appeared that those groups who received an introduction to the Center had significantly lower levels of psychological functioning than those who did not. There was no significant main effect for the interaction of the pre-therapy orientation and the introduction to the Center ($F = 3.2$, 1 df, $p = .07$). See Table 9.

Client Satisfaction

All 122 subjects were asked to respond to the Client Survey Instrument (CSI). Of those 122 subjects, 28 or 23% had moved away leaving no forwarding address and 42 or 34% refused to respond to the CSI after receiving three questionnaires in the mail and two follow-up telephone calls. Fifty-two subjects or 42% responded to the CSI.
Table 9

2X2 Analysis of Covariance of Global Assessment Scale (GAS) Scores Collected Three Months After Intake with GAS Scores at Intake as a Covariate

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>Mean square</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covariate: GAS</td>
<td>1</td>
<td>5802.531</td>
<td>88.832</td>
<td>.000</td>
</tr>
<tr>
<td>Pre-therapy orientation</td>
<td>1</td>
<td>13.198</td>
<td>.202</td>
<td>.654</td>
</tr>
<tr>
<td>Introduction to Center</td>
<td>1</td>
<td>327.226</td>
<td>5.010</td>
<td>.027</td>
</tr>
<tr>
<td>PTO X Introduction to Center</td>
<td>1</td>
<td>212.513</td>
<td>3.253</td>
<td>.074</td>
</tr>
<tr>
<td>Error</td>
<td>117</td>
<td>65.320</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The CSI global scores ranged from 54 to 128, with the score 101 appearing the most frequently (n = 3). The average CSI global score for the entire sample (n = 52) was 100.4. The average group CSI score, standard deviation, and number of subjects per group are shown in Table 10.

It was hypothesized that clients who received a pre-therapy orientation would have significantly higher levels of satisfaction with mental health services than clients who did not receive a pre-therapy orientation. Using a 2X2 Analysis of Variance, analysis of the data revealed no significant main effect for pre-therapy orientation (F = 1.77, 1 df, p = .19). There was, however, a significant main effect for the introduction to the Center (F = 6.18, 1 df, p = .01). It appeared that those groups who received an introduction to the Center had significantly lower levels of satisfaction with mental health services than those who did not. There was no significant main effect
Table 10

Means and Standard Deviations for Client Survey Instrument (CSI) Scores Collected Three Months After Intake

<table>
<thead>
<tr>
<th>Introduction to the Center</th>
<th>Pre-therapy orientation</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
<td>Total</td>
</tr>
<tr>
<td>Yes</td>
<td></td>
<td>$\bar{x} = 99.9$</td>
<td>$\bar{x} = 92.14$</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>$SD = 9.9$</td>
<td>$SD = 17.5$</td>
<td>$\bar{x} = 96.17$</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$n = 15$</td>
<td>$n = 14$</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
<td>$\bar{x} = 106.7$</td>
<td>$\bar{x} = 104.9$</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>$SD = 13.6$</td>
<td>$SD = 13.4$</td>
<td>$\bar{x} = 105.83$</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$n = 12$</td>
<td>$n = 11$</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>$\bar{x} = 102.93$</td>
<td>$\bar{x} = 97.76$</td>
<td>$\bar{x} = 100.44$</td>
</tr>
</tbody>
</table>

for the interaction between the pre-therapy orientation and the introduction to the Center ($F = .6, 1 df, p = .44$). See Table 11.

Client Self-Assessment (CSA)

Scores on the CSA (which is comprised of questions 7-17 on the CSI and had also been administered at intake) were compared between the groups. The average score for the CSA at three months for the entire population ($n = 52$) was 38.19. These scores ranged from 18 to 50. Both the median and mode were 39. The mean and standard deviation for each group are shown in Table 12.

Using a 2X2 Analysis of Variance, analysis of the data revealed no significant main effect for pre-therapy orientation ($F = 37, 1 df, p = .54$). There was, however, a significant main effect for the
Table 11
2X2 Analysis of Variance of Client Survey Instrument (CSI) Scores
Collected Three Months After Intake

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>Mean square</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-therapy orientation</td>
<td>1</td>
<td>340.692</td>
<td>1.770</td>
<td>.190</td>
</tr>
<tr>
<td>Introduction to Center</td>
<td>1</td>
<td>1184.661</td>
<td>6.181</td>
<td>.016</td>
</tr>
<tr>
<td>PTO X Introduction to Center</td>
<td>1</td>
<td>116.527</td>
<td>.605</td>
<td>.440</td>
</tr>
<tr>
<td>Error</td>
<td>48</td>
<td>192.463</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 12
Means and Standard Deviations for Client Self-Assessment (CSA) Scores
Collected Three Months After Intake

<table>
<thead>
<tr>
<th>Introduction to the Center</th>
<th>Pre-therapy orientation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Yes</td>
<td>( \bar{X} = 36.7 )</td>
</tr>
<tr>
<td></td>
<td>SD = 6.9</td>
</tr>
<tr>
<td></td>
<td>n = 15</td>
</tr>
<tr>
<td>No</td>
<td>( \bar{X} = 41.3 )</td>
</tr>
<tr>
<td></td>
<td>SD = 5.5</td>
</tr>
<tr>
<td></td>
<td>n = 12</td>
</tr>
<tr>
<td>Total</td>
<td>( \bar{X} = 39.7 )</td>
</tr>
</tbody>
</table>
introduction to the Center ($F = 12.3, 1 \text{ df}, p = .001$). It appeared that those groups who received an introduction to the Center had significantly lower levels of well being than those who did not. There was no significant main effect for the interaction between the pre-therapy orientation and the introduction to the Center ($F = 1.4, 1 \text{ df}, p = .22$). See Table 13.

Table 13

2X2 Analysis of Variance of Client Self-Assessment (CSA) Scores Collected Three Months After Intake

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>Mean square</th>
<th>$F$</th>
<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-therapy orientation</td>
<td>1</td>
<td>18.293</td>
<td>.371</td>
<td>.545</td>
</tr>
<tr>
<td>Introduction to Center</td>
<td>1</td>
<td>610.714</td>
<td>12.386</td>
<td>.001</td>
</tr>
<tr>
<td>PTO X Introduction to Center</td>
<td>1</td>
<td>73.447</td>
<td>1.490</td>
<td>.228</td>
</tr>
<tr>
<td>Error</td>
<td>49</td>
<td>49.306</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

An analysis of covariance on CSA scores three months after intake with CSA scores at intake as a covariate was calculated. Because the CSA scores as a covariate were not significant ($F = 1.9, 1 \text{ df}, p = .16$), the analysis of variance of CSA scores three months after intake was thought to be sufficient for this study. (See Appendix M for the ANCOVA of CSA scores three months after intake with CSA scores at intake as a covariate.)

Summary of the Results

Four hypotheses were advanced and tested in this study. No
significant main effects for pre-therapy orientation were found for no shows and cancellations, level of psychological functioning, and client satisfaction. No significant main effects for the introduction to the Center were found for no shows and cancellations. However, significant main effects for the introduction to the Center were found for level of psychological functioning and client satisfaction, suggesting that those subjects who received an introduction to the Center had significantly lower levels of psychological functioning and satisfaction with mental health services. Group 3 (both presentations) was found to be significantly different than the other groups in regard to fee payment, suggesting that clients who received both presentations were significantly more likely to have paid what was expected of them.
CHAPTER V
DISCUSSION

This study had two major objectives: first, to develop an effective audio-visual presentation about orienting clients to therapy which was both inexpensive and brief; and second, to determine if the audio-visual presentation increased clients' ability to utilize mental health services as measured by decreased no shows and cancellations, increased payment of fees, increased level of psychological functioning, and increased client satisfaction.

Analysis of the data regarding fee payment found Group 3 to be significantly more likely to have paid what was expected of them, even though the group's average monthly income was not the highest among the four groups. While neither presentation had a significant effect alone, the combination of a pre-therapy orientation and an introduction to the Mental Health Center appeared to significantly influence fee payment behavior. It may be that the combination of giving clients a rationale for fee payment (as was done in the pre-therapy orientation) and educating clients as to the comprehensive public service nature of the Center and the Center's complicated funding base (as was done in the introduction to the Center) increased the motivation of these clients to pay their fees. This result is very promising when viewed in light of past research literature since there appears to have been no previous study addressing the joint effects of a pre-therapy orientation and an introduction to a treatment facility on client fee payment.

This result could be beneficial to mental health centers wishing to
increase client fee payment. The presentations take approximately 20 minutes to view, use relatively inexpensive equipment, and can be administered by support staff with a minimum of training. As both presentations were relatively inexpensive to produce and can be easily adapted (changing slides, etc.), the merging of a pre-therapy orientation and an introduction to the Mental Health Center into one slide/cassette presentation becomes a distinct possibility.

That the pre-therapy orientation did not appear to significantly decrease no shows and cancellations, increase level of psychological functioning, or increase satisfaction with mental health services was a major disappointment to this researcher. That the introduction to the Center significantly lowered psychological functioning and client satisfaction with mental health services was particularly puzzling. The results of this study may be due, in part, to one or more of the following possibilities.

Limitations

Previous Mental Health Care

A factor affecting the results of this study may have been the previous mental health care received by the subjects. A review of the characteristics of the sample (see Table 2) reveals that overall, 67% of the subjects had received previous mental health treatment. This suggests that two-thirds of the sample may have already had some ideas about the nature of therapy based on previous experience in therapy. To these clients a pre-therapy orientation may have been redundant or perhaps, in some cases, in direct contradiction to their experience and, therefore, not credible. Had these clients been excluded from the
The results may have been different.

Sample Characteristics

Another factor affecting the results of this study appears to be initial group differences. Although randomly assigned, the groups do appear to be different (see Table 2). For example, Group 4 appears to be older, be more educated, be more stable (more are married), make more money, be less depressed, need fewer sessions (5.5 vs. 6.6 overall), and understand therapy better (73% vs. 67% overall having had previous treatment). Group 3, in contrast, appears to be less stable (fewer are married), be more depressed, and have less experience with therapy (58% vs. 67% overall having previous treatment) than the other groups. That there appears to be differences among the groups, in terms of demographics, may have contributed to the lack of significant results. No attempt was made by this researcher to determine if these sample characteristics were significantly different among the four groups.

Therapist Preparation of Clients

That the therapists in the study routinely prepared their clients for therapy individually may contribute to this study's lack of results. Eleven therapists in the study filled out a questionnaire (see Appendix N) after data collection was completed, exploring the extent to which they prepare (or do not prepare) their clients for treatment. (Of the 14 therapists involved in the study, one therapist had left the Center, one was abroad and could not be contacted, and a third failed to respond.)

All 11 therapists who responded reported that they prepare their clients for therapy to some degree. (See Table 14 for a breakdown of
Table 14
Responses to Therapist Questionnaire: The Degree to Which Therapist Prepares His/Her Client for Therapy

<table>
<thead>
<tr>
<th></th>
<th>None</th>
<th>A little</th>
<th>Average</th>
<th>A lot</th>
<th>Thoroughly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Role of the client</td>
<td>0</td>
<td>2</td>
<td>5</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Role of the therapist</td>
<td>0</td>
<td>1</td>
<td>6</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>General description of therapy</td>
<td>0</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Course of therapy</td>
<td>4</td>
<td>4</td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Estimate of when patient will feel better</td>
<td>0</td>
<td>5</td>
<td>5</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

n = 11 therapists.

When asked if their preparation is formal (involving structured use of time at the beginning of therapy to address specific treatment issues) or informal (involving role modeling or the discussion of treatment issues as they arise), the majority of therapists stated that their client preparation was formal. (See Table 15 for a breakdown of therapist responses.) Content reportedly covered in formal preparation included client/therapist roles and a general description of therapy. The majority of therapists reported that they informally (i.e., as the issue arises) teach their clients about the course of therapy and about appropriate expectations. It should be noted that the response categories (None, A little, etc.) were not defined, possibly resulting in each therapist interpreting the response categories differently.
Table 15
Responses to Therapist Questionnaire: Therapist Responses as to Whether They Prepare Their Clients Formally (Time is Used at the Beginning of Therapy to Address These Issues Specifically) or Informally (Through Role Modeling or When a Relevant Therapy Issue Arises During the Course of Therapy)

<table>
<thead>
<tr>
<th></th>
<th>Formally</th>
<th>Informally</th>
<th>Neither</th>
</tr>
</thead>
<tbody>
<tr>
<td>Role of the client</td>
<td>7</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Role of the therapist</td>
<td>6</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>General description of therapy</td>
<td>7</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Course of therapy</td>
<td>1</td>
<td>9</td>
<td>1</td>
</tr>
<tr>
<td>Estimate of when patient will feel better</td>
<td>2</td>
<td>8</td>
<td>1</td>
</tr>
</tbody>
</table>

n = 11 therapists.

That all therapists queried used client preparation to one degree or another may have negated some of the potential findings of the study. Groups 2 (introduction to the Center), 3 (both presentations), and 4 (no presentations) may have received enough individual preparation from their own therapists to eliminate differences which may have arisen had no additional preparation beyond the study's pre-therapy orientation occurred. Had therapist preparation behavior been adequately controlled, the differences between Group 1 and the other groups may have achieved significance.

Most research projects have some limitations which affect the generalizability of results, and this study is no exception. A concern
was the low response rate to the Client Survey Instrument which was sent to all subjects three months after intake. Client Survey Instruments were difficult to retrieve, despite considerable effort on the part of the researcher. Nonrespondents were mailed up to two additional CSIs with self-addressed, stamped envelopes, and those who did not respond to the repeated mailings were called on the telephone up to two times. Of the 122 subjects asked to respond to the CSI, 28 (23%) had moved away and 42 (34%) refused to respond. Fifty-two subjects (42%) responded to the CSI.

Theoretical and Clinical Implications

The results of this study raise two issues which must be addressed. First, the possibility must be considered that formal pre-therapy orientation, particularly "nonlive" presentations, has achieved such limited results as to be considered fairly useless (Acosta et al., 1983; Heilbrun, 1972; and Johnson, 1983; notwithstanding). If, as the present study suggests, client orientation is a crucial part of the initial treatment phase for most therapists, it may be superfluous to add pre-therapy orientation to the intake procedure. Second, this study suggests that while most therapists orient their clients during therapy, there is little consistency as to the content and timing. This study makes no clear-cut case for how pre-therapy orientation can best be accomplished (via a separate intake process or structured into the therapy sessions). However, this study's data on therapist orienting behavior suggests that therapists could orient their clients in a more systematic manner.

The clinical staff who participated in this research project are
considered well-trained, experienced professionals. Therapists of this professional caliber may routinely be able to anticipate and deal adequately with issues related to the therapeutic process. Outpatient clinics employing only seasoned clinicians may have no need for consistent, systematic, pre-therapy orientation. However, agencies that routinely hire recent graduates, utilize practicum students and interns, or engage bachelor's-level professionals as therapists may have a greater need for formalized, consistent, pre-therapy orientation. A slide/cassette orientation such as the one utilized in this study provides a cost-efficient method of delivering information.

It may very well be that the most appropriate use of a "nonlive" pre-therapy orientation would be: (1) in facilities that use or employ new or relatively inexperienced therapists, (2) with clients who have not had previous mental health care, and (3) used in combination with an introduction to the facility using the pre-therapy orientation to boost client fee payment.

Of concern to this researcher is the ethical issue of using an introduction to the Center as part of a pre-therapy orientation, in particular to boost client fee payment, as the introduction to the Center significantly lowered level of psychological functioning and client satisfaction with mental health services. A rush to use a combination of pre-therapy orientation and an introduction to the treatment facility should be tempered with careful decision making and efforts to continue further research in this area.

Implications for Future Research

All too often researchers ignore replication of previous research. This present study needs to be replicated to determine if a combination
of a pre-therapy orientation and an introduction to the treatment facility do indeed increase client fee payment behavior.

The present study appears to be the first research to-date to examine the influence of pre-therapy orientation on fee payment behavior. That the subjects who received both a rationale for paying fees and information about the structure and funding of the Mental Health Center paid a significantly higher proportion of their fees than their less-informed counterparts is an encouraging finding. Further study needs to focus exclusively on the effects of a combined presentation, utilizing both traditional pre-therapy content and pertinent information about the service agency on client payment behavior.

That the lack of significant differences between the groups for no shows and cancellations, level of psychological functioning, and client satisfaction may be attributed to differences among the sample characteristics, regardless of random assignment, argues for the study's replication. Consideration might be given to systematic replication, matching the sample of such characteristics as diagnosis, income, marital status, and previous mental health care.

Past and current research has focused on the question of whether or not pre-therapy orientation is effective in preparing clients for therapy. With the exception of the "live" vs. "nonlive" comparison studies, little attention has been paid to the degree of effectiveness. A potential future area of research would be to investigate the degree of effectiveness of audio-visual presentations with differing lengths, amounts of detail, visual appeal, and varying language levels in order to develop criteria for an optimally effective audio-visual
presentation. Such a presentation could then be evaluated for significant effects.

Data from this study suggested that most therapists may include some degree of client preparation, whether formal or informal, in the normal course of therapy. If this is the case, a more fruitful area of investigation may lie in the development and evaluation of a program designed to assist individual therapists in orienting their clients in the most systematic, optimal fashion. The most appropriate question for study may no longer be whether or not pre-therapy orientation is useful but how therapists can best disseminate the information needed by their clients to successfully utilize mental health services.
REFERENCES


Venema, J. (1972). The effects of expectancy training, commitment, and therapeutic conditions upon attrition from outpatient psychotherapy. Dissertation Abstracts International, 32, 6664B-6665B. (University Microfilms No. 72-15871)


Appendix A

Text of Pre-Therapy Client Orientation
Welcome to Bear River Mental Health Services, Inc. Since you have decided to get help for the problem that you are experiencing, you may be having some questions about what therapy is like. I would like to take a few minutes of your time and talk to you about what you can expect from therapy.

First, you should know that your therapist may be either a man or a woman. He or she may be a psychologist, clinical social worker, or other mental health professional. However, your experience will be similar to the therapy which will be shown in this slide presentation.

You may have asked yourself, "What is therapy?" Therapy is a learning process in which you learn new skills to help you cope with your problems. The goal of therapy is to help people like yourself to realistically achieve their goals. However, this success is achieved only with time and practice.

There are many forms of therapy. You may be asking, "Which one is best?" Your therapist is a trained professional who has studied and learned how to use these various forms of therapy. Your therapist has helped many others just like you to achieve their goals. Allow your therapist to use the form of therapy that he feels is the best to help you manage your situation. If you feel uncomfortable with the form of therapy he is using, discuss your concerns with him.

The relationship you begin with your therapist will be different from the relationships you have with other people. When you are with him, your therapist's major concern will be your growth and development.
He is there to help you reach your goals. While your therapist can't solve your problems—no one but you can do that—he will guide you and give you suggestions. Your therapist will help you as you think through your problem and develop new ways to handle your particular situation. He may help you recognize feelings of which you have previously been unaware. In return for his efforts on your behalf, your therapist will expect you to work hard in learning how to manage your situation.

One of the most important things in making your therapy work is that you have confidence in your therapist. If you don't, no amount of his professional skill will help you get better. You may be angry at what your therapist tells you, or you may not have confidence in him, or both. Try to decide which one it is. Talk to your therapist about the situation. If you still have serious doubts about him, then talk to the intake worker about a possible change of therapist.

If therapy is to work for you, you will need to be open and honest with your therapist. This is crucial! The more open and honest you are able to be, the more successful treatment will be. We all kid ourselves sometimes. Your therapist is there to help you be honest with yourself. Sometimes your therapist will point out how two things you are saying or doing just don't add up.

Your therapist will be a very accepting person who has probably heard problems similar to yours. He will keep your confidences and cannot release any information without your written permission. You should discuss what is bothering you even if it is painful or embarrassing to you or you think it might embarrass your therapist. Tell him that this subject is very hard to talk about, and your therapist will help you feel more comfortable.
Your therapist may not comment about your problems much at first. He is there to listen to you and to learn about your problems. Many people worry about explaining their situation correctly and don't know where to begin. Just start where it is most comfortable. Your therapist will help you by asking questions until he has the story straight. It is your therapist's job to help you talk about your problems until he understands what is troubling you.

As you talk about your problem, you really shouldn't be expecting advice from your therapist. You've probably gotten a lot of that from friends and family members. Usually people who give advice provide solutions that work for them but not necessarily for the person who has the problem. Your therapist will help you look at your problems from every angle and help you generate alternative solutions. Your therapist may talk about the pros and cons of each alternative and may even suggest the ones he feels are best. In the end YOU must make the final decision about what to do.

One of the nice things about talking to your therapist is that he has no axe to grind about you or your problem. Your therapist won't have any preconceived ideas about what you should do. He will help you find out what is best for you.

Your therapist may give you an assignment to complete outside the session. Assignments are to help you practice new skills. The more you do your assignments, the faster the treatment will go. If the assignment goes against your value system, then you should refuse to do it. Tell your therapist why the assignment is wrong for you, and he will help you think of another way to confront the problem.

You may be wondering when you can expect improvement. Everyone is
different, and people change at different rates, but realistically you can expect some improvement within three months if you come to your sessions, work hard on exploring your problems, and do your assignments. If you are dissatisfied with how treatment is progressing, discuss it with your therapist. Don't drop out of therapy without talking it over first.

Almost everyone who enters therapy goes through a period when they feel discouraged about their progress. For apparently good reasons you may find it impossible to go to a particular session. Maybe other things like work or family responsibilities will seem to keep you from your appointments, and you may start feeling that you are too busy to continue in therapy. Progress in therapy will not be steady but will have many ups and downs. All this means is that you are working hard and that it's uncomfortable. You are probably getting to the source of some of your difficulties, and it may feel very threatening or painful.

When you feel stuck it is especially important not to let anything keep you from coming to your appointments. The best way to overcome these potential feelings is to decide beforehand that you will come to your sessions no matter what else is happening. Once in a great while you may need to make an exception and miss an appointment. If you discuss this with your therapist beforehand, and both of you plan around it, it should not interfere with treatment.

Therapy will cause change in your life. The time when you are giving up your old ways of solving problems and just beginning to learn new ways will be especially tricky. You may feel uncertain or confused. This stage is only temporary, but during this time it is important not to make major decisions without discussing them with your therapist.
While your therapist won't tell you what to decide, he will help you look at every possibility carefully and help you use your new problem-solving skills.

As people progress in their therapy, they may temporarily find it more difficult to deal with their loved ones. If you find this happening to you, do not worry. One of the reasons is that you have changed, and they are unsure about how to treat you. Give them time to adjust to the new changes in you. Be patient. These changes may seem puzzling and strange to those around you, and they may feel you are getting worse when actually you are improving.

There are some other things you should know about your therapy that may help you understand it better. For example, each therapy session lasts 50 minutes unless you and your therapist have made other arrangements. The remaining 10 minutes is for case notes and treatment planning. In most cases, therapy can be best accomplished by scheduling weekly appointments. Depending upon your current situation, sometimes you will need more appointments during the week and sometimes you will need less. If you have concerns about how your appointments are scheduled, discuss them with your therapist.

When you come to the office, make sure the receptionist knows you have arrived. She will then alert your therapist of your arrival. Come on time so that you can make the most of your session. If you should happen to be late, your time will be cut short as your therapist will have to go on to his next appointment.

Most of the problems you face can be worked on during your session. If you experience a crisis, then you should call your therapist if it is during working hours. If it is at night, call the Center number and a
trained crisis worker will help you. Try not to call about matters that can wait, but if you feel you need immediate help--call.

One way to keep feeling good about your therapy is to keep your bill with us up-to-date. Pay your fee before or after every session unless you have made arrangements to pay monthly. You will feel better about coming back for your next appointment. You will feel you have the right to get the most out of your therapy. We also know from research that people who pay their bill improve faster.

There will come a point in therapy when you have nothing to talk about with your therapist because your new coping skills make your problems more manageable. This will be a signal to you that termination is near. Discuss with your therapist how best to terminate and what you should do if the problem reoccurs or new ones come up. You may wish to come in every few weeks or just when you feel the need to insure that what you have learned in therapy continues to be a part of your life. Remember, you will still have problems, but you will also be able to handle them better.

As a center, we are glad you have come to us for help. We hope your time with us will be productive for you. Good luck!
Appendix B

Questionnaire Rating the Text of the
Pre-Therapy Client Orientation
August 6, 1984

Bill Dobson, Ph.D.
Utah State University
Education Building
Department of Psychology
Logan, UT 84322

Dear Bill:

I would like to get your help on a research project that I am developing. I plan to test the effects of a pre-therapy client orientation on clients at our Center through an audio-visual presentation. The orientation will attempt to help clients develop realistic expectations about therapy. If you would, I would like you to review the enclosed text of that presentation and answer a set of attached questions.

The text attempts to (1) discuss the general nature of therapy, (2) give a description and explanation of the expected behaviors of the client and therapist, (3) prepare a client for the typical course of therapy, and (4) give a realistic expectation for improvement. I need to know how well the text addresses these issues. I would very much appreciate your critical comments about its contents. The more the better.

I have enclosed a self-addressed, stamped envelope for your convenience. If you have any questions, please feel free to contact me at 734-9449. I look forward to receiving your answers and comments as soon as possible.

Sincerely,

Nels Sather, M.Ed.
Mental Health Specialist

NS:kw
RATING SCALE (TEXT)

Please circle the appropriate number. Thank you.

1. Does this text appear to be easy to understand?

<table>
<thead>
<tr>
<th>No</th>
<th>Somewhat</th>
<th>Essentially</th>
<th>Very well</th>
<th>Extremely well</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Please comment if your answer is 3 or lower.

2. Does this text present its material in a logical manner?

<table>
<thead>
<tr>
<th>No</th>
<th>Somewhat</th>
<th>Essentially</th>
<th>Very well</th>
<th>Extremely well</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Please comment if your answer is 3 or lower.

3. Does this text answer the typical questions a prospective client may have about therapy?

<table>
<thead>
<tr>
<th>No</th>
<th>Somewhat</th>
<th>Essentially</th>
<th>Very well</th>
<th>Extremely well</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Please comment if your answer is 3 or lower.

4. Does this text help prospective clients develop realistic expectations about therapy?

<table>
<thead>
<tr>
<th>No</th>
<th>Somewhat</th>
<th>Essentially</th>
<th>Very well</th>
<th>Extremely well</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Please comment if your answer is 3 or lower.

5. Does this text clearly discuss the general nature of therapy?

<table>
<thead>
<tr>
<th>No</th>
<th>Somewhat</th>
<th>Essentially</th>
<th>Very well</th>
<th>Extremely well</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Please comment if your answer is 3 or lower.
6. Does this text clearly describe and explain the expected behaviors of the client and therapist? -

<table>
<thead>
<tr>
<th>No</th>
<th>Somewhat</th>
<th>Essentially</th>
<th>Very well</th>
<th>Extremely well</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
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Please comment if your answer is 3 or lower.

7. Does this text clearly prepare a client for the typical course of therapy?

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8. Does this text clearly give a realistic expectation for improvement?

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Please comment if your answer is 3 or lower.

9. Please make any suggestions for additions and/or deletions. Thank you.
Appendix C

Questionnaire Rating the Pre-Therapy Client Orientation

Audio-Visual Presentation
RATING SCALE (AUDIO-VISUAL)

Please circle the appropriate number.

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Please comment if your answer is 3 or lower.

2. Does this presentation present its material in a logical manner?

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3. Does this presentation answer the typical questions a prospective client may have about therapy?

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4. Does this presentation help prospective clients develop realistic expectations about therapy?

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5. Does this presentation clearly discuss the general nature of therapy?

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6. Does this presentation clearly describe and explain the expected behaviors of the client and therapist?

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7. Does this presentation clearly prepare a client for the typical course of therapy?

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8. Does this presentation clearly give a realistic expectation for improvement?

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Please comment if your answer is 3 or lower.

9. Please make any suggestions for additions and/or deletions. Thank you.
Appendix D

Questionnaire Rating the Pre-Therapy Client Orientation

by Prospective Clients
QUESTIONNAIRE RATINGS THE PRE-THERAPY CLIENT ORIENTATION
BY PROSPECTIVE CLIENTS

Please mark whether the following statements are True or False.

1. The goal of therapy is to teach people new skills for coping with their problems. True or False?

2. If he understands exactly what is happening to you, your therapist will be able to solve your problems. True or False?

3. You should not discuss painful or embarrassing problems with your therapist until you are positive he will keep your confidences. True or False?

4. Your therapist will not give you advice or make your decisions for you. True or False?

5. You should do every assignment your therapist gives you, even if you disagree with it. True or False?

6. If you do your part in therapy, you can expect some improvement within three months. True or False?

7. If you get discouraged about your progress or feel stuck, it is a good time to take a short break from therapy. True or False?

8. When you are in the middle of therapy, you should not make major decisions without discussing them with your therapist. True or False?

9. As you make progress in therapy, you may find it harder to deal with your loved ones. True or False?

10. You should terminate therapy as soon as you feel better. True or False?
Appendix E

Text of the Center Introduction
INTRODUCTION TO THE MENTAL HEALTH CENTER

Welcome to Bear River Mental Health Services, Inc. Since you have decided to come to us for help, you may be wondering who we are. You may also have some questions about the type of services we offer and about our staff. The following is a brief introduction into who we are and what we do.

First of all, we work on many different kinds of problems. Among our clients are people who are experiencing depression, anxiety, low self-esteem, memories of abuse and trauma, uncontrollable anger, or other overwhelming and discouraging feelings. In fact, we work on any kind of psychological, social, or emotional problem an individual can have. We also work on marital and family problems. These problems often center on poor communication or problem-solving skills. Bear River Mental Health Services exists as a resource to the community, insuring that highly professional and effective services are available to those in need. Our goal is to help those with psychological and/or social problems lead more productive lives within their families and communities. In order for you to know us better, I would like to introduce you to the staff and describe what they do.

The Center is composed of a number of well-trained and licensed professionals. They come with different degrees and different titles. The first group of professionals is psychiatrists. They are medical doctors who are trained in psychology. They usually receive three years of training in psychiatry after medical school. They can prescribe medication and provide medical, diagnostic, and treatment
recommendations. They do not usually see patients on a weekly basis but act as consultants to the therapists.

Another group of professionals is psychologists. They are usually trained at the doctoral level, having completed from seven to nine years of university studies. Psychologists are expert in understanding the mind and the emotions. They are sophisticated in the collection and analysis of data, such as psychological tests, to help others understand why people think, feel, and behave as they do.

The third group of staff is mental health specialists. Included are clinical social workers who have six years of university training emphasizing the behavior of individuals within their environment. Clinical social workers have been prepared to understand human dynamics and to offer clinical treatment appropriate to the needs of clients.

Another category of professionals is that of social service workers. These individuals have completed four years of university preparation, and they work in our transitional programs (which I will mention later) and as intake workers.

Because many mental health problems have a physical component and can be treated, at least in part, through medications, the Center employs psychiatric nurses who have received special preparation in the use of medications to treat mental health problems. These nurses help coordinate medical issues between the psychiatrists, hospital, and nonpsychiatric medical community.

Another group of individuals who performs invaluable service at the Center is paraprofessionals. These staff members help in the transitional program in a variety of ways under the supervision of a professional staff member.
Last, but certainly not least, the Mental Health Center has an outstanding group of very talented and dedicated individuals who form the support staff. They act as receptionists, secretaries, and financial clerks, helping the Center to function smoothly and efficiently.

You may be asking, "What do all these people do?" "What are the services they offer?" There are five basic services offered at the Mental Health Center.

The first is called outpatient services and happens to be the primary program at the Center. Outpatient services includes individual therapy, marriage counseling, family therapy, group therapy, and medications management. Many of the individuals who come to the Center are experiencing some situation in their life that is painful for them or their loved ones. Desperate and often depressed, they seek outpatient help. In individual therapy, a person meets alone with a therapist in face-to-face sessions. In marriage therapy, a therapist meets with the husband and wife to find new methods to resolve their difficulties. In family counseling, members of the family join together with a therapist's help to resolve common difficulties. It has been found that families who work together to improve their relationships, to increase harmony, and to better understand why they behave as they do with each other gain strength and tend to become more united in their efforts to develop quality family life.

Another outpatient service is group therapy. Led by a therapist, a group of individuals comes together by virtue of common problems and works to help each other resolve these problems. One of the advantages of group therapy is that members discover that others have experienced
similar difficulties. Sometimes a group member's best learning comes from others in the group who have experienced the same problem.

Medication checkups are a service required periodically for those clients whose treatment includes medication.

Our second basic service is inpatient care. These services are provided in the mental health unit at Logan Regional Hospital. This unit is for those individuals who are in a temporary state of crisis so severe that they need 24-hour care. The inpatient unit provides an environment in which they can become stabilized before returning home. The inpatient unit is a short-term facility; the average length of stay is five days. The Center does not provide long-term inpatient treatment but refers patients requiring long-term hospitalization to appropriate facilities.

For those people who do not need long-term inpatient treatment but who need more than one hourly contact with the staff, the Center provides a transitional program, our third basic service. This program meets daily in a clublike setting. The atmosphere is relaxed and allows the individual to feel at home and have a sense of well being among friends. The program includes group activities designed to help individuals with their social and emotional adjustment.

The fourth basic service offered by the Center is crisis intervention. A crisis is any situation that has to be dealt with immediately. Sometimes those situations happen after working hours. A crisis worker who is a mental health professional can be reached by calling the Mental Health number 24 hours a day.

The last major service offered by the Center is providing consultation and education to the public. Bear River Mental Health
Services offers a speaker's bureau of professional staff members who can address a wide variety of topics. The speaker's bureau is popular with social, religious, and cultural groups who want to learn more about mental health issues. The Center also provides periodic newspaper columns in local newspapers on mental health issues.

The Center functions under the direction of the commissioners of Box Elder, Cache, and Rich Counties. They are required to make sure that the Mental Health Center is responsive to community needs. The Center is funded with local, state, and federal money, but not all of our funds come from these sources. We utilize a variety of grants, such as one from Juvenile Court, to help cover the cost of operating the Center. A significant portion of our funds comes through the collection of fees from you and the other third-party payers, such as your health insurance plan.

Well, that's who we are and what we do. As a center, we are glad you have come to us for help. We hope your time with us will be productive for you.
Appendix F
Questionnaire Rating the Center Introduction

Audio-Visual Presentation
RATING SCALE (PRESENTATION)

Please circle the appropriate number. Thank you.

1. Does this presentation appear to be easy to understand?

No  Somewhat  Essentially  Very well  Extremely well
1    2        3          4          5

Please comment if your answer is 3 or lower.

2. Does this presentation present its material in a logical manner?

No  Somewhat  Essentially  Very well  Extremely well
1    2        3          4          5

Please comment if your answer is 3 or lower.

3. Does this presentation answer the typical questions a prospective client may have about the Mental Health Center?

No  Somewhat  Essentially  Very well  Extremely well
1    2        3          4          5

Please comment if your answer is 3 or lower.

4. Does this presentation clearly make a statement about the Mental Health Center's goals?

No  Somewhat  Essentially  Very well  Extremely well
1    2        3          4          5

Please comment if your answer is 3 or lower.

5. Does this presentation clearly describe the types of problems treated at the Mental Health Center?

No  Somewhat  Essentially  Very well  Extremely well
1    2        3          4          5

Please comment if your answer is 3 or lower.
6. Does this presentation clearly discuss the types of personnel found at the Mental Health Center?

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7. Does this presentation clearly discuss the types of services offered at the Mental Health Center?

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8. Does this presentation clearly discuss funding sources for the Mental Health Center?

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Please comment if your answer is 3 or lower.

9. Please make any suggestions for additions and/or deletions. Thank you.
Appendix G

Form Used for Random Assignment of Clients to Groups and

Table of Random Numbers Used to Determine Assignments
Please do NOT include clients who are children, brain damaged, mentally retarded, clearly psychotic, or alcoholic. THANK YOU!

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*This table is reprinted from J. G. Peatman's and R. Schafer's "A Table of Random Numbers from Selective Service Numbers," copyright 1942 by Jour. Psychol., 14, 296-297, and used by permission of the authors and editor.
Appendix H

Informed Consent
INFORMED CONSENT

I understand that, as a part of a research project conducted at Bear River Mental Health Services, Inc., statistical information will be collected from my records. I also understand that this information will be identified by a number rather than by name and will be destroyed at the completion of the study.

I agree to the procedure described above.

Signature ___________________________________________________________________

Date ______________________________________________________________________

Witness ___________________________________________________________________

Date ______________________________________________________________________
Appendix I

Global Assessment Scale (GAS)
GLOBAL ASSESSMENT SCALE (GAS)

Robert L. Spitzer, M.D.; Miriam Gibbon, M.S.W.; Jean Endicott, Ph.D.

Rate the subject's lowest level of functioning in the last week by selecting the lowest range which describes his functioning on a hypothetical continuum of mental health-illness. For example, a subject whose "behavior is considerably influenced by delusions" (range 21-30), should be given a rating in that range even though he has "major impairment in several areas" (range 31-40). Use intermediary levels when appropriate (e.g., 35, 58, 62). Rate actual functioning independent of whether or not subject is receiving and may be helped by medication or some other form of treatment.

Name of Patient ____________  ID No. ________  Group Code ________

Admission Date ________  Date of Rating ________  Rater ________

GAS Rating: ____________

100 Superior functioning in a wide range of activities, life's problems don't seem to get out of hand, is sought out by others because of his warmth and integrity. No symptoms.

91 Good functioning in all areas, many interests, socially effective, generally satisfied with life. There may or may not be transcient symptoms and "everyday" worries that only occasionally get out of hand.

80 No more than slight impairment in functioning, varying degrees of "everyday" worries and problems that sometimes get out of hand.

71 Minimal symptoms may not be present.

70 Some mild symptoms (e.g., depressive mood and mild insomnia) OR some difficulty in several areas of functioning, but generally functioning pretty well, has some meaningful interpersonal relationships, and most untrained people would not consider him "sick."

61 Moderate symptoms OR generally functioning with some difficulty (e.g., few friends and flat affect, depressed mood and pathological self-doubt, euphoric mood and pressure of speech, moderately severe antisocial behavior).
Any serious symptomatology or impairment in functioning that most clinicians would think obviously requires treatment or attention (e.g., suicidal preoccupation or gesture, severe obsessional rituals, frequent anxiety attacks, serious antisocial behavior, compulsive drinking, mild but definite manic syndrome).

Major impairment in several areas, such as work, family relations, judgment, thinking, or mood (e.g., depressed woman avoids friends, neglects family, is unable to do housework), OR some impairment in reality testing or communication (e.g., speech is at times obscure, illogical, or irrelevant) OR single suicide attempt.

Unable to function in almost all areas (e.g., stays in bed all day) OR behavior is considerably influenced by either delusions or hallucinations OR serious impairment in communication (e.g., sometimes incoherent or unresponsive) or judgment (e.g., acts grossly inappropriately).

Needs some supervision to prevent hurting self or others, or to maintain minimal personal hygiene (e.g., repeated suicide attempts, frequently violent, manic excitement, smears feces), OR gross impairment in communication (e.g., largely incoherent or mute).

Needs constant supervision for several days to prevent hurting self or others (e.g., requires an intensive care unit with special observation by staff), makes no attempt to maintain minimal personal hygiene, or serious suicide act with clear intent and expectation of death.
Appendix J

90-Day Review Form
INITIAL CASE STAFFING or 90-DAY REVIEW MEDICAID CLIENT?

Yes ___ No ___

Client's Name ___________________________ File No. __________ Date __________

Prob. No. Goal Lttr. Goals (long- and short-term), progress toward goals, AND/OR changes

Treatment Method: Time Frame:

Treatment Method: Time Frame:

Treatment Method: Time Frame:

Treatment Method: Time Frame:

Review with client deemed clinically inappropriate

Therapist's Signature

Licensed Psychologist's Signature

Date Reviewed with Client

Physician's Signature

Client's Signature
DSMIII Diagnosis: Axis I

Axis II

Axis III

Axis IV

Prognosis: Poor ____ Fair ____ Good ____ Excellent ____ Guarded ____

GAS Rating: First Appointment ____________ Current Rating ____________

Is client on medications? Yes _____ No _____

(If yes, see medication section of this file)

Prescribed by Mental Health Center's M.D.? Yes _____ No _____

Services to be provided by other agencies (list agency and type of service):

Discharge Planning:

☐ Discharge upon completion of goals with follow-up PRN

☐ Other (describe) ________________________________

CASE STAFFING or 90-DAY REVIEW

STAFF PRESENT: ________________________________ Degree and Lic. No. _____________________
Appendix K

Client Survey Instrument
CLIENT SURVEY INSTRUMENT

CONFIDENTIAL: Your questionnaire will be kept confidential. However, it may be shared with your therapist if you give permission to do so. Please check the box below if you give permission for your therapist to see your returned questionnaire.

Please check the box below if you give permission for your therapist to see your returned questionnaire.

113

ID # ____________________________ Date ____________________________

It is important for us to find out how you feel about your experiences at our mental health agency and how you are currently doing. If you will answer the questions below, it will help us improve our services. Both positive and negative feelings about your experiences will be helpful. Please check the blank which most closely matches your feelings.

Values

1. The problems, feelings, or situations which brought me to the mental health program are:

   - 5 1. Much improved.
   - 4 2. Improved.
   - 3 3. About the same.
   - 1 5. Much worse.

2. Because of my therapy, I will be able to manage my problems in the future.

   - 5 1. Strongly agree.
   - 4 2. Agree.
   - 3 3. Neither agree nor disagree.
   - 1 5. Strongly disagree.

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

   - 5 1. Almost all of my needs have been met.
   - 4 2. Most of my needs have been met.
   - 3 3. Only a few of my needs have been met.
   - 1 4. None of my needs have been met.
<table>
<thead>
<tr>
<th></th>
<th>Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>4. If you were to seek help again, would you come back to our program?</td>
</tr>
<tr>
<td></td>
<td>__ 1. No, definitely not.</td>
</tr>
<tr>
<td></td>
<td>__ 2. No, I don't think so.</td>
</tr>
<tr>
<td></td>
<td>__ 3. Yes, I think so.</td>
</tr>
<tr>
<td></td>
<td>__ 4. Yes, definitely.</td>
</tr>
<tr>
<td></td>
<td>5. In an overall, general sense, how satisfied are you with the service you received?</td>
</tr>
<tr>
<td></td>
<td>__ 1. Very satisfied.</td>
</tr>
<tr>
<td></td>
<td>__ 2. Mostly satisfied.</td>
</tr>
<tr>
<td></td>
<td>__ 3. Indifferent or mildly dissatisfied.</td>
</tr>
<tr>
<td></td>
<td>__ 4. Quite dissatisfied.</td>
</tr>
<tr>
<td></td>
<td>6. Overall, my experience at the mental health program was:</td>
</tr>
<tr>
<td></td>
<td>__ 1. Very harmful to me.</td>
</tr>
<tr>
<td></td>
<td>__ 2. Harmful to me.</td>
</tr>
<tr>
<td></td>
<td>__ 3. Neither helpful nor harmful to me.</td>
</tr>
<tr>
<td></td>
<td>__ 4. Helpful to me.</td>
</tr>
<tr>
<td></td>
<td>__ 5. Very helpful to me.</td>
</tr>
<tr>
<td></td>
<td>7. How have you been feeling in general during the past week?</td>
</tr>
<tr>
<td></td>
<td>__ 1. In excellent spirits.</td>
</tr>
<tr>
<td></td>
<td>__ 2. In very good spirits.</td>
</tr>
<tr>
<td></td>
<td>__ 3. In good spirits mostly.</td>
</tr>
<tr>
<td></td>
<td>__ 4. I have been up and down in spirits a lot.</td>
</tr>
<tr>
<td></td>
<td>__ 5. In low spirits mostly.</td>
</tr>
<tr>
<td></td>
<td>__ 6. In very low spirits.</td>
</tr>
<tr>
<td></td>
<td>8. Have you been bothered by nervousness or your &quot;nerves&quot; during the past week?</td>
</tr>
<tr>
<td></td>
<td>__ 1. Extremely so--to the point where I could not work or take care of things.</td>
</tr>
<tr>
<td></td>
<td>__ 2. Very much so.</td>
</tr>
<tr>
<td></td>
<td>__ 3. Quite a bit.</td>
</tr>
<tr>
<td></td>
<td>__ 4. Some--enough to bother me.</td>
</tr>
<tr>
<td></td>
<td>__ 5. A little.</td>
</tr>
<tr>
<td></td>
<td>__ 6. Not at all.</td>
</tr>
<tr>
<td></td>
<td>9. Have you been in firm control of your behavior during the past week?</td>
</tr>
<tr>
<td></td>
<td>__ 1. Yes, definitely so.</td>
</tr>
<tr>
<td></td>
<td>__ 2. Yes, for the most part.</td>
</tr>
<tr>
<td></td>
<td>__ 3. Generally so.</td>
</tr>
<tr>
<td></td>
<td>__ 4. Not too well.</td>
</tr>
<tr>
<td></td>
<td>__ 5. No, and I am somewhat disturbed.</td>
</tr>
<tr>
<td></td>
<td>__ 6. No, and I am very disturbed.</td>
</tr>
</tbody>
</table>
Values

10. Have you felt so sad, discouraged, hopeless, or had so many problems that you wondered if anything was worthwhile during the past week?

1. Extremely so--to the point that I have just about given up.
2. Very much so.
3. Quite a bit.
4. Some--enough to bother me.
5. A little bit.
6. Not at all.

11. Have you been under or felt you were under any strain, stress, or pressure during the past week?

1. Yes--almost more than I could bear or stand.
2. Yes--quite a bit of pressure.
3. Yes--some, more than usual.
4. Yes--some, but about usual.
5. Yes--a little.
6. Not at all.

12. How happy, satisfied, or pleased have you been with your personal life during the past week?

1. Extremely happy--could not have been more satisfied or pleased.
2. Very happy.
3. Fairly happy.
4. Satisfied--pleased.
5. Somewhat dissatisfied.
6. Very dissatisfied.

13. Have you had any reason to wonder if you were losing control over the way you talk, think, or feel during the past week?

1. Not at all.
2. Only a little.
3. Some--but not enough to be concerned or worried about.
4. Some, and I have been a little concerned.
5. Some, and I am quite concerned.
6. Yes, very much so, and I am very concerned.
14. Have you been anxious, worried, or upset during the past week?

1. Extremely so—to the point of being sick or almost sick.
2. Very much so.
3. Quite a bit.
4. Some—enough to bother me.
5. A little bit.
6. Not at all.

15. Have you been bothered by fears about your health during the past week?

1. All the time.
2. Most of the time.
3. A good bit of the time.
4. Some of the time.
5. A little of the time.
6. None of the time.

16. Have you felt downhearted and blue during the past week?

1. All the time.
2. Most of the time.
3. A good bit of the time.
4. Some of the time.
5. A little of the time.
6. None of the time.

17. Have you been feeling emotionally stable and sure of yourself during the past week?

1. All the time.
2. Most of the time.
3. A good bit of the time.
4. Some of the time.
5. A little of the time.
6. None of the time.

Questions 18-27 ask your feelings about staff and how your case was handled. Please answer each question.

18. I think my therapist(s) was(were):

1. Very easy to talk with.
2. Easy to talk with.
3. Neither easy nor hard to talk with.
4. Hard to talk with.
5. Very hard to talk with.
19. The interest shown by my therapist(s) in helping me solve my problem was:

<table>
<thead>
<tr>
<th>Values</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>1. Very satisfactory.</td>
</tr>
<tr>
<td>4</td>
<td>2. Satisfactory.</td>
</tr>
<tr>
<td>3</td>
<td>3. Neither satisfactory nor unsatisfactory.</td>
</tr>
<tr>
<td>2</td>
<td>4. Unsatisfactory.</td>
</tr>
<tr>
<td>1</td>
<td>5. Very unsatisfactory.</td>
</tr>
</tbody>
</table>

20. I was treated with courtesy and respect by my therapist(s):

<table>
<thead>
<tr>
<th>Values</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>1. Nearly always.</td>
</tr>
<tr>
<td>4</td>
<td>2. Generally.</td>
</tr>
<tr>
<td>3</td>
<td>3. Sometimes and sometimes not.</td>
</tr>
<tr>
<td>1</td>
<td>5. Hardly ever.</td>
</tr>
</tbody>
</table>

21. In general, I found my therapist(s) to be:

<table>
<thead>
<tr>
<th>Values</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1. Very ineffective.</td>
</tr>
<tr>
<td>2</td>
<td>2. Ineffective.</td>
</tr>
<tr>
<td>3</td>
<td>3. Neither effective nor ineffective.</td>
</tr>
<tr>
<td>4</td>
<td>4. Effective.</td>
</tr>
<tr>
<td>5</td>
<td>5. Very effective.</td>
</tr>
</tbody>
</table>

22. I feel that the orientation I received about therapy and related services was:

<table>
<thead>
<tr>
<th>Values</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>1. Very satisfactory.</td>
</tr>
<tr>
<td>4</td>
<td>2. Satisfactory.</td>
</tr>
<tr>
<td>3</td>
<td>3. Neither satisfactory nor unsatisfactory.</td>
</tr>
<tr>
<td>2</td>
<td>4. Unsatisfactory.</td>
</tr>
<tr>
<td>1</td>
<td>5. Very unsatisfactory.</td>
</tr>
</tbody>
</table>

23. I feel that the information I received about fees and payment for services was:

<table>
<thead>
<tr>
<th>Values</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>1. Very satisfactory.</td>
</tr>
<tr>
<td>4</td>
<td>2. Satisfactory.</td>
</tr>
<tr>
<td>3</td>
<td>3. Neither satisfactory nor unsatisfactory.</td>
</tr>
<tr>
<td>2</td>
<td>4. Unsatisfactory.</td>
</tr>
<tr>
<td>1</td>
<td>5. Very unsatisfactory.</td>
</tr>
</tbody>
</table>

24. I feel the fee set for me was fair and considered my needs:

<table>
<thead>
<tr>
<th>Values</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>1. Strongly agree.</td>
</tr>
<tr>
<td>4</td>
<td>2. Agree.</td>
</tr>
<tr>
<td>3</td>
<td>3. Neither agree nor disagree.</td>
</tr>
<tr>
<td>2</td>
<td>4. Disagree.</td>
</tr>
<tr>
<td>1</td>
<td>5. Strongly disagree.</td>
</tr>
</tbody>
</table>
Values

25. I found the program staff other than therapists (for example: secretaries, intake interviewers, etc.) to be:

5  1. Very helpful and pleasant.
4  2. Helpful and pleasant.
3  3. Neither helpful and pleasant nor unhelpful and unpleasant.
2  4. Unhelpful and unpleasant.
1  5. Very unhelpful and unpleasant.

26. I would recommend the mental health program to others needing help.

5  1. Definitely.
4  2. Probably.
3  3. Maybe.
2  4. Probably not.
1  5. Definitely not.

27. How long has it been since your last visit to our program?

1. Less than one month.
2. One or two months.
3. Three or four months.
4. Five or six months.
5. Seven months or more.
COMMENTS AND SUGGESTIONS

We would like your comments on anything which may have caused you concern or inconvenience or which you felt was especially good or helpful.

I. Specific problems, concerns, or complaints:

II. Things you felt were especially good or helpful:
Appendix L

Client Self-Assessment (CSA)
CLIENT SELF-ASSESSMENT

Name ___________________________ Date ___________ ID # ______

For each question below, please check the answer which most closely matches your own feelings or situation.

1. How do you feel about coming here for help?
   __ 1. I very much wanted to come.
   __ 2. It seemed like a good idea to come.
   __ 3. I didn't care one way or the other.
   __ 4. I was reluctant to come.
   __ 5. I was opposed to coming.

2. How have you been feeling in general during the past week?
   __ 1. In excellent spirits.
   __ 2. In very good spirits.
   __ 3. In good spirits mostly.
   __ 4. I have been up and down in spirits a lot.
   __ 5. In low spirits mostly.
   __ 6. In very low spirits.

3. Have you been bothered by nervousness or your "nerves" during the past week?
   __ 1. Extremely so--to the point where I could not work or take care of things.
   __ 2. Very much so.
   __ 3. Quite a bit.
   __ 4. Some--enough to bother me.
   __ 5. A little.
   __ 6. Not at all.

4. Have you been in firm control of your behavior during the past week?
   __ 1. Yes, definitely so.
   __ 2. Yes, for the most part.
   __ 3. Generally so.
   __ 4. Not too well.
   __ 5. No, and I am somewhat disturbed.
   __ 6. No, and I am very disturbed.
5. Have you felt so sad, discouraged, hopeless, or had so many problems that you wondered if anything was worthwhile during the past week?

   1. Extremely so— to the point that I have just about given up.
   2. Very much so.
   3. Quite a bit.
   4. Some--enough to bother me.
   5. A little bit.
   6. Not at all.

6. Have you been under or felt you were under any strain, stress, or pressure during the past week?

   1. Yes-- almost more than I could bear or stand.
   2. Yes-- quite a bit of pressure.
   3. Yes-- some, more than usual.
   4. Yes-- some, but about usual.
   5. Yes-- a little.
   6. Not at all.

7. How happy, satisfied, or pleased have you been with your personal life during the past week?

   1. Extremely happy-- could not have been more satisfied or pleased.
   2. Very happy.
   3. Fairly happy.
   4. Satisfied-- pleased.
   5. Somewhat dissatisfied.
   6. Very dissatisfied.

8. Have you had any reason to wonder if you were losing control over the way you talk, think, or feel during the past week?

   1. Not at all.
   2. Only a little.
   3. Some-- but not enough to be concerned or worried about.
   4. Some, and I have been a little concerned.
   5. Some, and I am quite concerned.
   6. Yes, very much so, and I am very concerned.

9. Have you been anxious, worried, or upset during the past week?

   1. Extremely so— to the point of being sick or almost sick.
   2. Very much so.
   3. Quite a bit.
   4. Some-- enough to bother me.
   5. A little bit.
   6. Not at all.
10. Have you been bothered by fears about your health during the past week?
   _ _ 1. All the time.
   _ _ 2. Most of the time.
   _ _ 3. A good bit of the time.
   _ _ 4. Some of the time.
   _ _ 5. A little of the time.
   _ _ 6. None of the time.

11. Have you felt downhearted and blue during the past week?
   _ _ 1. All the time.
   _ _ 2. Most of the time.
   _ _ 3. A good bit of the time.
   _ _ 4. Some of the time.
   _ _ 5. A little of the time.
   _ _ 6. None of the time.

12. Have you been feeling emotionally stable and sure of yourself during the past week?
   _ _ 1. All the time.
   _ _ 2. Most of the time.
   _ _ 3. A good bit of the time.
   _ _ 4. Some of the time.
   _ _ 5. A little of the time.
   _ _ 6. None of the time.

13. My coming here was:
   _ _ 1. Completely voluntary on my part.
   _ _ 2. Voluntary but strongly recommended by my family, physician, clergy, other professional or agency.
   _ _ 3. Voluntary but with a lot of pressure on me to come in.
   _ _ 4. I probably would not have applied for services if I had not been pressured to do so.
   _ _ 5. I would not have applied for services if I had not been forced to do so.
Appendix M

2x2 Analysis of Covariance of Client Self-Assessment (CSA)

Scores Collected Three Months After Intake with CSA

Scores at Intake as a Covariate
## Appendix M. 2x2 Analysis of Covariance of Client Self-Assessment (CSA) Scores Collected Three Months After Intake with CSA Scores at Intake as a Covariate

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>Mean square</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covariate: CSA</td>
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<td>99.721</td>
<td>1.994</td>
<td>.165</td>
</tr>
<tr>
<td>Pre-therapy orientation</td>
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<td>20.490</td>
<td>.410</td>
<td>.525</td>
</tr>
<tr>
<td>Introduction to Center</td>
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<td>533.141</td>
<td>10.661</td>
<td>.002</td>
</tr>
<tr>
<td>PTO X Introduction to Center</td>
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<td>63.079</td>
<td>1.261</td>
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</tr>
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<td>Error</td>
<td>47</td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix N

Therapist Questionnaire
THERAPIST QUESTIONNAIRE

1. Do you prepare your individual clients for psychotherapy with you?
   ___ Yes ___ No

2. If yes, in what area(s) do you prepare them and how much?
   A. ___ Role of the client:
      ___ None ___ A little ___ Average ___ A lot ___ Thoroughly

   B. ___ Role of the therapist:
      ___ None ___ A little ___ Average ___ A lot ___ Thoroughly

   C. ___ General description of therapy:
      ___ None ___ A little ___ Average ___ A lot ___ Thoroughly

   D. ___ Explanation of the course of therapy (i.e., transference, resistance, etc.):
      ___ None ___ A little ___ Average ___ A lot ___ Thoroughly

   E. ___ Estimate of when the client will feel and function better:
      ___ None ___ A little ___ Average ___ A lot ___ Thoroughly

3. Do you prepare your clients formally (time is used at the beginning of therapy to address these issues specifically) or informally (through modeling or when a relevant therapy issue arises during the course of therapy)?
   A. ___ Role of the client:
      ___ Formally ___ Informally

   B. ___ Role of the therapist:
      ___ Formally ___ Informally
C. ___ General description of therapy:
    ___ Formally ___ Informally

D. ___ Explanation of the course of therapy (i.e., transference, resistance, etc.):
    ___ Formally ___ Informally

E. ___ Estimate of when the client will feel and function better:
    ___ Formally ___ Informally

Thank you for your help!

Nels
VITA

Nels Mario Sather

Candidate for the Degree of

Doctor of Philosophy

Dissertation: The Effects of a Pre-Therapy Client Orientation on Clients in Psychotherapy

Major Field: Psychology

Biographical Information:

Personal Data: Born at Bari, Italy, March 31, 1946, son of Thomas Marius and Maria Sather; married Heather Hawkins June 20, 1970; children--Matthew, Megan, Courtney, and Noah.

Education: Received the Bachelor of Science degree from Brigham Young University, Provo, Utah, with a major in Sociology and Asian Studies, 1969; 1974 completed requirements for the Master of Education degree at Idaho State University, Pocatello, Idaho, with an emphasis in counseling psychology; 1987 completed the requirements for the Doctor of Philosophy degree at Utah State University, with a major in Psychology.

Professional Experience: 1974-77, Mental Health Specialist, Four Corners Mental Health Center, Price, Utah; 1977-78, Mental Health Specialist, Bear River Mental Health Services, Inc., Brigham City, Utah; 1978-86, Director of Services, Bear River Mental Health Services, Inc., Brigham City, Utah.