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Presentation of a standard Intervention During the Intake Interview

Gregory Burns
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PRESENTATION OF A STANDARD INTERVENTION DURING
THE INTAKE INTERVIEW

by

Gregory Burns

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

of

DOCTOR OF PHILOSOPHY

in

Psychology

UTAH STATE UNIVERSITY
Logan, Utah
1992
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Gregory Burns
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ABSTRACT

Presentation of a Standard Intervention
During the Intake Interview

by

Gregory Burns, Doctor of Philosophy
Utah State University, 1992

Major Professor: Elwin C. Nielsen, Ph.D.
Department: Psychology

The provision of psychotherapeutic services has undergone many changes in its history. Recently the field of therapy has seen an increased emphasis on providing services in briefer periods of time, which has resulted in greater investigation into the parameters that influence rapid therapeutic growth by clients. Despite this push for quick results, many service agencies continue to utilize initial intake interviews that focus exclusively on gathering diagnostic and demographic information. Therapeutic intervention is therefore reserved for some later time when the clients can be accommodated from the agency's waiting list. The present study investigated the influence of a standard intervention presented during the intake interview on reported psychological distress, therapeutic alliance, and dropouts from therapy. In
addition, the relationship of self-efficacy to these dimensions was investigated.

Eighty subjects who were clients at a university counseling center in the Rocky Mountain region of the United States were split into two groups. One group received the intervention while the other experienced a standard intake without the intervention. Results indicated that the experimental subjects decreased more in their reported levels of distress between the time of the intake interview and their first counseling session than did the control subjects. Similarly, the experimental subjects reported significantly greater feelings of alliance with their therapists than did the control subjects. The number of dropouts from therapy (defined as those who failed to show for the first counseling session) was similar for the groups. Finally, high versus low levels of self-efficacy did not further explain changes in psychological distress or group differences in therapeutic alliance, although level of self-efficacy was related to level of distress.

The results of this study suggest that a client's initial contact with a service agency (i.e., the intake interview) can be utilized to initiate therapeutic gain. It is notable that the observed changes occurred regardless of presenting problems and diagnosis. It was
speculated that the therapeutic effects could be enhanced further by expanding this approach to provide specific interventions to individual clients based on initial diagnostic impressions.
Psychotherapeutic outcome research is a popular and important segment of psychological investigation. Receiving increased attention in the past few years are briefer forms of therapy that emphasize fewer overall therapy sessions and generally focus on resolving specific problems rather than emphasizing global personality change.

Among the reasons for the increased emphasis on brief, time-limited therapy are a willingness by third-party payers to reimburse therapists for fewer sessions, a growing belief by therapists that they are ethically bound to provide relief to clients as quickly as possible, and research data that indicate clients attend fewer sessions than deemed appropriate by therapists.

**The Problem**

Although many researchers have attempted to describe the elements of therapy which contribute to rapid client change, the first contact a client has with many mental health agencies (i.e., the intake interview) has been ignored in the bulk of the outcome literature. Because the intake interview has not received a great deal of research attention, there exists little information about how to begin the process of positive change from this
initial contact, while preserving the ability of the intake person to gather necessary diagnostic and background information from the client.

Many service agencies utilize an intake session prior to the beginning of formal therapy and this practice is unlikely to be eliminated in the near future. Intake sessions are relied on to gather important historical information and to introduce the new client to the specifics of the system the agency has developed to provide services. However, the need of the agency to collect initial personal information, and the need of the client to begin the change process, are too often considered to be separate events that must occur at different times. Furthermore, because the intake interview is separate from therapy, clients can become discouraged with the delay of the therapy. Therefore, a problem exists regarding how providers might continue the use of intake procedures while also beginning the process of therapy from a client's first contact with the service agency.

Purpose of the Study

The need for changing the intake procedure to include a therapeutic component is clear based on the high percentage of clients who fail to report for therapy following an initial intake (Pekarik, 1985), and because
of increased pressure on therapists to provide service in briefer periods of time. The present study was designed to structure the initial intake session differently so that changes would begin from the client's first contact rather than his or her first "official" therapy session. This change was expected to lead to rapid client growth, decreased client discouragement and subsequent premature termination, and decreased utilization of agency resources. Specifically, this study investigated the effectiveness of presenting a standard intervention to therapy clients during the initial intake interview, regardless of the presenting problem.
CHAPTER II
REVIEW OF LITERATURE

Rapid Therapeutic Change

Whereas the psychoanalytic tradition from which modern psychotherapy evolved encouraged long-term and penetrating interactions between client and therapist, more recently there has been a shift toward briefer forms of therapy involving fewer therapy sessions and increased emphasis on symptom amelioration (Prochaska, 1984). Because of the current pressure in our society, time-limited approaches to therapy are being widely advocated in the hope that they will result in lowered clinical costs and availability of services to a larger number of people. Thus, brief therapy is becoming the treatment of choice in many situations (Koss & Butcher, 1986). In addition, the increasingly common practice of third-party payers (i.e., insurance companies) to reimburse providers of psychological services for a limited number of therapy sessions that are focused on clearly defined goals has led to greater interest in brief therapy (Shectman, 1986). Finally, many mental health practitioners have realized (both through demonstrated research and personal experience) that consumers of social services expect, and follow-through with, only a few therapy sessions (Pekarik,
Some researchers have commented on the phenomenon of rapid therapeutic change over the past few decades; however it is only in the last 20 years or so that a body of literature has developed around the concept of brief therapy. In the early 1970's a group of investigators at the Mental Research Institute (MRI) in Palo Alto, California began publishing results from their work with clients who had experienced time-limited therapy. They claimed to find significant decreases in client-reported problems in 75% of those cases that involved 10 or fewer therapy sessions (Weakland, Fisch, Watzlawick, & Bodin, 1974). Further, although it has been common for psychotherapists to discount rapid changes in symptoms as spontaneous remission or flights-into-health, an alternative interpretation of rapid improvements has been formulated by a group of psychodynamically oriented psychiatrists (Malan, Heath, Bacal, & Balfour, 1975). These authors promoted the uncommon belief that genuine and durable changes often occurred in clients as a result of one or two sessions of psychotherapy. Indeed, the durability of such rapid changes has been evidenced by reports of continued improvement for as long as 12 months following the end of such brief treatment (Fisher, 1984).

Moshe Talmon (1990), curious about the reasons that a
large number of clients fail to return following a single session of psychotherapy, placed phone calls to each of his previous clients that had failed to appear for a second session. He discovered (much to his relief) that 78% of those contacted "got what they wanted out of the single session and felt better or much better about the problems that had led them to seek therapy" (p. 9). Talmon proceeded to investigate this phenomenon of single-session therapy and demonstrated that many clients make significant positive changes in their lives following a single therapeutic experience, and long-term follow-up data demonstrated that many of these changes endure for periods of time greater than 12 months.

The Problem of Therapy Dropouts

Many clients who request psychotherapeutic services ultimately discontinue their sessions prior to the point in the therapy process when the therapist judges them to be finished with their therapeutic work. This finding has been the focus of considerable research and concern over the past generation as scientists and practitioners have attempted to understand the "dropout" phenomenon and to address the issue of treatment failure. For example, Pekarik (1985) wrote that as many as 40% of clients receiving therapy from community mental health centers (CMHC's) attended only one or two sessions. He claimed
that CMHC's incur considerable costs as a result of clients dropping out of therapy. These costs include lost income, inefficient use of therapist time when scheduled appointments fail to show, decreased community credibility when clients terminate prematurely, and lowered self-esteem of therapists when clients disappear from therapy.

Besides the costs to CMHC's, clients themselves have been thought to suffer when they drop out of treatment after one or two sessions because of inadequate resolution of their interpersonal difficulties. However, the assumption that early terminators have not benefitted from their brief experience with therapy has been questioned. Rockwell and Pinkerton (1982) speculated that many of those clients who leave therapy before the therapist feels they are ready may actually be satisfied consumers who have already received what they desire from the experience and are not, therefore, accurately labeled as "dropouts."

Clients and therapists often have different opinions regarding the minimum number of sessions that are necessary to effect positive changes (Pekarik & Wierzbicki, 1986). Pekarik (1983) found that, on average, therapists claimed 20-40 sessions are required for successful short-term therapy and 10-20 sessions for brief work. These beliefs are in contrast to data that reveals clients attend an average of only six sessions in all
settings (Garfield, 1986; Koss & Butcher, 1986) and an average of eight if one looks specifically at private practice settings (Koss, 1979). In light of these different beliefs, it seems prudent for therapists to emphasize effecting changes early in the therapy process because clients tend to leave sooner than the therapist expects.

When the adjustment of treatment dropouts was investigated three months after intake, it was found that clients who ended treatment after one session generally demonstrated poorer adjustment than those who had terminated therapy appropriately (i.e., those clients that ended therapy by mutual agreement with their therapists, Pekarik, 1983). However, it is interesting to note that those clients who were also judged to be premature terminators, but attended three or more sessions, demonstrated symptom improvements equal to those who terminated appropriately. Further, it has been reported that approximately 15% of clients show significant improvement between the time they call for an appointment and their first session (Howard, Kopta, Krause, & Orlinsky, 1986).

These findings suggest that therapists not only have limited time at their disposal, but important changes can occur in these brief periods of time. A current problem
in the field is that the crucial elements of such rapid therapeutic changes have not been clearly identified. As Pekarik (1983) stated, "There [is] a need to design and systematically evaluate the effectiveness of interventions aimed at improving the impact of treatment on the early dropout group" (p. 509).

Enhancing Therapy and Therapy Retention by Promoting Collaboration

A variety of suggestions has been made for decreasing the dropout rate, including briefing clients in the first contact regarding what activities and experiences to expect in therapy (Heilbrum, 1972) and clarifying the respective roles of the client and therapist (Baekeland & Lundwall, 1975). Such procedural maneuvers would presumably influence the dropout rate by enhancing the involvement of clients in the therapeutic process and increasing their sense of active collaboration in the therapy. Talmon (1990), in response to his finding that a large percentage of clients failed to return after the first session, attempted to circumvent the dropout problem altogether by deliberately treating appropriate clients within a single-session framework. He discovered that many clients are able to benefit from brief therapeutic interactions that provide them a foundation upon which to make positive changes in their lives.
The importance of a sense of collaboration between client and therapist has become clear as researchers began looking at the characteristics of therapy that promote rapid positive changes. In 1978, for instance, Gomes-Schwartz reported active client involvement as the process variable that was the best predictor of therapy outcome. She wrote,

Patients who were involved in the therapy process from the outset of treatment - acknowledging their own responsibility for changing their behavior and actively examining their feelings and experiences - were most likely to improve. (p. 1025)

Marziali, Marmar, and Krupnick (1981) reported similar findings making reference to the "therapeutic alliance" as the variable that was most predictive of therapy outcome.

Recent research findings provide further evidence of an association between a client's active involvement in therapy and the outcome of the therapy. Harcum (1989), for instance, described clients' Commitment to Collaboration (CTC) as being a key ingredient to positive therapeutic outcome. Likewise, Kivlighan (1990) reported a series of studies that demonstrated superior therapy outcome when a strong alliance was present between client and therapist. He stated that "the working alliance is enhanced when clients take more active responsibility for the content and direction of the interaction" (p. 31).

This relationship between therapeutic alliance and therapy
outcome was also discussed by Orlinsky and Howard (1986), who concluded that preparing clients to work collaboratively with therapists serves to improve outcome by enhancing the alliance.

Gelso and Carter (1985) claimed one of the three components that is characteristic of all therapeutic relationships is the working alliance: "[T]he working alliance is crucial to the success of therapies across diverse theoretical perspectives" (p. 162). They discussed the importance of establishing a strong therapeutic alliance early on in the therapy process, and claimed an effective means of producing a close alliance is through the establishment of agreements of the goals and tasks of therapy. Irvin Yalom (1980) likewise stressed the importance of collaboration, discussing it in terms of the client's assumption of responsibility for his or her actions and changes. That is, when a client is working in a collaborative manner with a therapist, he or she necessarily accepts responsibility for current and future behavior and also for any positive changes that occur as a result of such behavior. Yalom presented research results that revealed increases in clients' sense of personal responsibility as they improved during therapy, indicating an association between outcome and responsibility.
The alliance literature suggests that clients benefit more from a therapy experience if they feel a strong sense of involvement and personal commitment to the process of therapy. Westerman, Tanaka, Frankel, and Kahn (1986) claimed that this sense of involvement develops as a client actively participates in therapy and feels he or she is collaborating with the therapist rather than merely receiving expert opinion and advice. This conceptualization is congruent with the thoughts of Lambert, Shapiro, and Bergin (1986) who wrote,

> The likelihood of maintenance [of change] will be increased if patients see change and maintenance as a result of their own efforts and if they are helped to anticipate future life crises and their reactions to them. (p. 165)

Similarly, Orlinsky and Howard wrote in 1967 that a major characteristic of therapy sessions rated by clients as "good therapy hours" is a feeling of collaboration between the client and the therapist.

Feelings of collaboration, or lack thereof, may thus provide a partial explanation for the variability in the number of clients who return for therapy following an intake interview. For instance, Tryon (1990) has been investigating the engagement that may or may not occur between client and therapist during intake, and has concluded that feelings of engagement bear strongly on clients' feelings of satisfaction with initial interviews.
Not surprisingly, initial interviews provide a context for therapy and have a profound influence on the consequent therapeutic interactions (Noel and Howard, 1989). Thus, what transpires during intake interviews, although subject to minimal experimental investigation, is crucial to understanding the components of the therapeutic process.

**Intake Interviews and the Importance of Early Intervention**

Beyond the pressure from third-party payers to provide quick and efficient therapeutic services is the belief many therapists hold that they are ethically bound to provide effective treatment in as short a period of time as possible. As deShazer (1985) stated,

> [I]f the average length of treatment is six to ten sessions, then I (or any other therapist) am ethically compelled to make the most use possible of that limited contact. (p. 5)

Pekarik (1985) suggested that therapists adopt a principle from the crisis intervention model in which all clients receive some form of actual treatment in the very first contact, "thus ensuring some assistance for the large percentage of clients who attend only one or two sessions" (p. 119).

When clients come to an agency, they are usually seeking assistance with their problems and are hoping to
receive some immediate relief during their first appointment (Noel & Howard, 1989). Similarly, clients often expect they will receive direct advice from an active therapist (Pekarik, 1985). However, most intake interviews (especially in community-based agencies) involve a focus on history-taking and problem exploration with little, if any, therapeutic interventions being offered by the professional. Talmon (1990) claimed that many therapists have been trained in the medical model, which designates the first one or two sessions as diagnostic rather than therapeutic. Although such an approach is appropriate for medical interventions that rely minimally on a proper relationship for symptom amelioration, it can result in significant interference in the development of rapport, trust, and collaboration in psychotherapy. This difference between client expectations and actual experience can lead to initial disappointment in the client and possibly the discontinuation of therapy. It has been suggested that the client's desire for an instant cure can be utilized in therapy if the associated motivational energy of the client is accessed during the first contact between client and service agency (Weltner, 1982).

Most persons who seek treatment from publicly supported agencies do not begin therapy immediately, but
instead, complete an intake session during which they provide information about themselves to someone who may not even conduct the actual therapy. An unfortunate result of this is the loss of valuable time between the diagnostic intake session and the beginning of therapy. This underutilization of the initial contact is not only inefficient, but potentially harmful to the progress of therapy because first impressions have a decided impact upon clients even if these impressions are based only on interrogative questions asked by an intake person (Tomm, 1987). That is, the initial contact has lasting effects on the therapy, whether intended or not. As Strupp and Binder (1984) have written,

Therapy proper begins from the first moment the patient meets the therapist. We believe that the traditional dividing line between diagnosis and therapy is largely artificial. (p. 51)

In order to develop the therapeutic collaboration as quickly as possible it has been suggested that agencies refrain from using intake persons who are different from the future therapist (Koss & Butcher, 1986). Also, Weltner has claimed that an initial session in which the client is minimally involved and realizes therapy will "come later" can lead to a passive stance in which the client defers his expectations for help to some future (and undefined) time. Such passivity tends to undermine the establishment of a collaborative and client-involved
relationship (Strupp & Binder, 1984). In response to these concerns, Weltner (1982) has called for therapists to "seize upon the initial therapeutic encounter as a time to encourage the [client's] activity and problem-solving capacity" (p. 289).

Although the call to eliminate separate intake interviewers from the therapy process is well-conceived, it is unlikely to occur in the near future because of the heavy demands that are currently placed upon the time of most therapists in busy public agencies. Therefore, the problem remains: How to structure the intake interview in such a way that the business of the intake can be completed while the process of therapeutic engagement and client growth can be initiated?

Use of a Standard Intervention

A recently published study revealed that a significant number of clients demonstrate changes in their presenting complaints prior to the initiation of therapy (Weiner-Davis, deShazer, & Gingerich, 1987). By asking clients about such changes at the beginning of therapy, the authors speculated that clients will be encouraged to develop the sense that they are responsible for their own behavior and capable of resolving their own difficulties. In a similar vein, Furman and Ahola (1988) urged therapists to pay increased attention to explanations
clients bring with them to the first session because therein may lie important insights that can be invaluable for generating appropriate solutions to their problems. By utilizing the thoughts, ideas, and suggestions of clients a sense of collaboration between therapist and client can be encouraged from the beginning of therapy.

Weber, McKeever, and McDaniel (1985) found that an effective means of helping anxious clients to relax in the initial session is by assigning a homework task. They claimed immediate interventions not only decrease anxiety, but also encourage clients to commit to defining goals for therapy and working towards change. Although one remains unaware of many details about a client and his or her background after only one session, extensive knowledge about a client may not be necessary before a therapeutic intervention can be effectively presented.

For instance, deShazer (1985) reported giving his clients a standard homework assignment in the first session even though he knew very little about the problems that had brought them in for therapy. Nonetheless, he found 57% of clients rated themselves as being "better" following this standard intervention. Talmon (1990) has also presented a case for the use of simple interventions during the initial contact. He stated that immediate interventions may be small steps in the right direction.
that "may prove sufficient, and it makes little sense to begin with an elaborate intervention before knowing whether the patient will stay for further treatment" (p. 53).

These findings suggest that therapeutic interventions can be designed that have a positive effect on clients even before there is a complete understanding of the client's history and background. Immediate interventions presumably enhance the collaborative nature of the therapeutic relationship, as well as focus the client's attention upon inner resources that can be the source of possible solutions to the presenting problems.

A Focus on Solutions

A focus on solutions to problems, rather than on problems themselves, has become increasingly popular recently, especially with strategic psychotherapists. Jay Haley (1976) promoted this direction for therapy when he wrote, "If therapy is to end properly, it must begin properly - by negotiating a solvable problem" (p. 9). He further said a therapist will be greatly aided in the task of designing interventions if a specific destination has been described, upon which the therapeutic tasks can be focused. One means of generating possible solutions to problems is to encourage the client to orient his or her thinking toward the future and to create a vision of a
future time which does not include the client's complaint. "[Some] solutions develop through the construction of alternative futures that do not include the complaint" (deShazer et al., 1986). Penn (1985) described a technique he used with families called "feed-forward" which was a means for pushing families to see their difficulties as being bound to the present-context, but not necessarily a part of their future. Through this process many of his clients realized that the future could include positive solutions, and not merely be a continuation of the present problems.

Milton H. Erickson was among the first to promote a future-oriented intervention when he developed the "Crystal Ball" technique. Erickson's procedure involved making a suggestion during hypnosis that a future time would be clearly envisioned that was free of the client's presenting complaint. The intent was to help the client reduce the constraints placed upon him or her by the problems and, instead, to begin focusing on solutions and how to achieve them (Gilligan, 1989).

A standard intervention that is oriented towards solutions is more appropriate for presentation during an initial intake than one focusing on problems because the interviewer will necessarily lack an adequate understanding of the dynamics involved in the evolution
and maintenance of the client's problems. Conversely, by providing a homework assignment at intake that asks the client to consider a future time that is free of the presenting problems, he or she is encouraged to take responsibility for the direction and goals of the therapy from the very beginning. Such an intervention would likely encourage a sense of collaboration between client and therapist, and possibly generate tangible solutions to some of the therapeutic issues that brought the client to therapy. For these reasons, the intervention utilized in the present study was a variant of Erickson's Crystal Ball technique.

Self-Efficacy Theory and Usefulness of a Standard Intervention

While there is some reason to believe that the use of a carefully designed initial standard intervention would increase the value of therapy and decrease premature dropouts, consideration must be given to the ability of clients to profit from such a procedure. That is, clients who request counseling services differ in their abilities to complete, and thereby benefit from, the various interventions that are provided to them by therapists. Although many client variables may contribute to this variability, one of the most salient client characteristics is speculated to be the client's feelings
of self-efficacy (Bandura, 1978). Self-efficacy has been described by Bandura and others as a self-referent expectancy system that regulates much human behavior through sets of beliefs about one's conviction that desired behaviors can be successfully performed in specific situations (Desharnais, Bouillon, & Godin, 1986). Self-efficacy beliefs are speculated to affect cognitions and contribute to the generation of both self-aiding and self-hindering thought patterns (Bandura, 1989), thereby exerting influence on motivation and physiological arousal (i.e., anxiety) in the face of stressful situations (Ozer & Bandura, 1990).

Bandura further speculated that this self-reflection predicts behavioral change resulting from influential forces in one's life, including therapy (Bandura, Adams, Hardy, & Howell, 1980). He claimed that social learning theory relies on the concept of self-efficacy to postulate a common mechanism of psychological change. That is, different modes of influence alter coping behavior partly by creating and strengthening self-percepts of efficacy. Perceived efficacy thus enhances psychosocial functioning through its effects on choice behavior, effort expenditure, persistence, and self-guiding thought.

As an example of these relationships, the authors reported research results that demonstrated increases in
perceived self-efficacy following successful therapy with phobic clients (Bandura et al., 1980). Their data indicated that perceived self-efficacy not only predicts the level of behavioral change that results from different modes of treatment, but also predicts the differences in coping behavior that is produced by different individuals receiving similar interventions.

Social learning theory thus provides specific predictions regarding the course of therapy with individuals who differ in their levels of self-efficacy beliefs. Relative to the use of standard interventions, the theory predicts that clients who view themselves as inefficacious will tend to produce failure scenarios that will have a negative affect on goal-setting and goal-oriented behavior. Conversely, those high in self-efficacy beliefs will tend to construct positive scenarios that function as helpful guides for future behavior. Thus, a client's initial (i.e., pretherapy) level of self-efficacy should have a measurable impact upon the ability to complete the standard intervention utilized in the present study, namely imagining and describing a future that is free of the current problems. Indeed, the person who holds inefficacious beliefs may be largely unable to even consider the possibility that current problems can be resolved at some future time.
As regards the use of a variant of the Crystal Ball technique specifically, social learning theory also provides a rationale for its use in that the intervention encourages clients to set initial goals for therapy that will act as guides for future behavior. As Bandura (1989) has written:

> People initially motivate themselves through proactive control by setting themselves valued challenging standards that create a state of disequilibrium and then mobilizing their effort on the basis of anticipatory estimation of what it would take to accomplish them...it is partly on the basis of self-beliefs of efficacy that people choose what challenges to undertake. (p. 1180)

**Summary and Objectives**

Because the field of psychotherapy is moving toward a briefer model of service, and since initial contacts with clients have traditionally been underutilized, the current study proposed one method for enhancing the therapeutic value of the first client contact with a service agency.

The approach undertaken was the design and implementation of a standard intervention that was presented to the experimental subjects, regardless of the presenting problem or historical background, during the intake interview. Restructuring the intake interview to include this component has the potential of affecting the client in a variety of ways. For example, because this intervention immediately shifts the focus of the client to
the generation of therapeutic goals, it was presumed that clients who received the intervention during their first contact with the service agency would make positive changes more rapidly than those who received only a standard intake. Thus, it was expected that initial levels of psychological distress would ameliorate to a greater extent for those subjects receiving the intervention. It was further expected that this focus on goals early on in the therapeutic process would induce in clients a mindset that therapy requires personal involvement, collaboration between therapist and client, and responsibility on the part of the client. If this experimental treatment produces a powerful effect on distress and alliance, then it seems reasonable to assume that dropouts from therapy will be minimized in the experimental group as compared to the control group.

The unique aspect of this study was the utilization of a standard intervention as part of the intake interview. The traditional intake session provides for contact to be made quickly with a client, although the client may be required to go on a waiting list following the intake until he or she can be seen by a therapist. In many public agencies intake workers are not therapists and do not presume to provide therapeutic interventions during the initial session. Therefore, the intake session
typically involves the collection of demographic information and orientation of the client to the agency itself, while therapy is assumed to begin at some later time after the intake interview has been completed.

Therapeutic interventions utilized early in the process are best directed at enhancing the client's sense of involvement and collaboration with the therapeutic change process, as well as generating possible solutions to presenting problems. The standard intervention utilized in this study was a variant of Milton Erickson's Crystal Ball technique and is consistent with the above goals. The task required the client to (a) imagine him or herself at a future time when the problems for which therapy was sought had been resolved, and (b) describe this scene in terms of the behaviors, emotions, and cognitions that would be different from those the client was experiencing at the time of the intake session. It was expected that encouraging clients to look toward a future time when they were free from their complaints would result in the initiation of positive changes for many clients in a relatively short period of time by rapidly establishing a sense of involvement, collaboration, and responsibility on the part of clients.

Finally, it was expected that clients who differed in their percepts about their own self-efficacy would differ
in the benefits they realized from the standard intervention. That is, inefficacious subjects would be less able to adequately complete the standard intervention assignment, thus realizing less benefit from it than those who were high in self-efficacy.
Experimental Hypotheses

The following comprise the experimental predictions:

1. Subjects in the experimental group (i.e., those who received the intervention at intake) would demonstrate greater decreases in their scores on a measure of distress between intake and initial counseling session than would subjects in the control group (i.e., those who received the standard intake without the intervention).

2. Subjects in the experimental group would demonstrate an enhanced sense of therapeutic alliance, when measured after the third counseling session, relative to subjects in the control group.

3. Of those subjects that agreed to participate in the study and who completed the initial intake forms, a greater number of experimental subjects would report for their initial counseling session than would control subjects.

4. The experimental subjects who were high in self-efficacy beliefs would demonstrate greater decreases in distress scores between intake and initial counseling session than would those low in self-efficacy.
Subjects

Recruitment of subjects was accomplished by asking each student who requested services from the Utah State University Counseling Center to cooperate with the research study.

Of 275 students asked to participate, 111 signed the consent form. Twenty of these subjects subsequently completed the initial assessment instruments but failed to appear for the first counseling session, and 12 of the remaining subjects dropped out of treatment prior to the third therapy session. Thus, 80 subjects remained who were randomly assigned to the two experimental conditions. Randomization was accomplished by placing successive subjects into one group or the other following a list of previously randomized group assignments. These 80 subjects comprised a sample from the larger population of persons that utilize counseling services during their tenure as college students.

Design and Procedures

The study was designed to conform to the requirements of a pretest-posttest control-group design (Campbell & Stanley, 1963).

Each person who requested counseling at the USU Counseling Center during the data collection phase was
asked to participate in the study. Those who agreed
signed a consent form after which random assignment to
either the experimental or the control group occurred.
All subjects initially completed the Brief Symptom
Inventory (Derogatis & Melisaratos, 1983) and the Self-
Efficacy Scale (Sherer et al., 1982) which were provided
to them as part of the standard intake paperwork packet.
After completing the paperwork, each subject participated
in a standard intake interview with a staff member of the
Counseling Center. In addition, those subjects in the
experimental condition were given the standard
intervention during the intake session by the staff
person.

Following intake, each subject was assigned to a
waiting list until an opening with a staff counselor
became available. This counselor may or may not have been
the same person who conducted the intake interview. When
the subject returned for the initial therapy session, he
or she completed the Brief Symptom Inventory (BSI) a
second time, prior to the therapy session.

After the third counseling session each client was
asked to complete the Working Alliance Inventory (Horvath
& Greenberg, 1989).

Besides the completion of paper-and-pencil
instruments at the specified times, the subjects in this
study had counseling experiences that were identical to those clients who were not a part of the study and requested services from the Utah State University Counseling Center.

Data and Instrumentation

Three instruments were used to collect the data in this study. Each was a published and standardized measure with adequate reliability and validity data. Each instrument used a five-point response range that generated a single score when the total score was divided by the number of individual items. These global scores permitted analysis of group differences between single or successive administrations.

Standard intervention. The standard intervention was presented by the intake interviewer to each subject in the experimental group by giving him or her a sheet of paper upon which the following was printed at the top:

On this sheet of paper please write a detailed description of what you will be like when the problems which have brought you in for counseling have been resolved. Include examples of how you will feel differently, how you will think differently, and how you will behave differently, than is true for you right now. Be as specific and elaborate as you can (using the back side of the sheet if necessary). Please be sure to bring this with you to your first counseling session.

Brief Symptom Inventory (BSI). There is a variety of approaches that can be used to assess therapeutic change,
the most common being to ask clients for a verbal report of whether or not they have improved. This method is attractive because it directly assesses the customer's sense of satisfaction, which is the most relevant dimension of therapeutic change (Derogatis, Lipman, Rickels, Uhlenhuth, & Covi, 1974). However, these types of global self-reports are notoriously unreliable because the majority of people report improvement regardless of their actual experience (Green, Gleser, Stone, & Seifert, 1975). Alternately, it has been suggested that clients be asked to rate themselves on a variety of dimensions (Beutler & Crago, 1983) perhaps through the use of multiple checklists which tend to be more standardized and rigorous than open-ended questionnaires (Lambert et al., 1986).

Of the checklists available, the Hopkins Symptom Checklist (HSCL) and its variants, the SCL-90-R and the BSI (Derogatis & Spencer, 1982), have been widely used and extensively researched. These instruments have been recommended for outcome studies because they provide accurate indications of client change (Lambert, Christensen, & DeJulio, 1983), and because they have demonstrated validities ranging from .75 - .84 on individual dimensions (Derogatis et al., 1974) to greater than .80 on the overall (global) score (Conoley & Kramer,
In addition to recommending the use of these instruments in outcome studies (Roberts, Aronoff, & Lambert, 1983) it has been suggested the overall scores should be used as global indices of psychological distress (Hoffman & Overall, 1978). It is noted that the demonstrated reliability and validity of this family of instruments led a government-sponsored committee, charged with the task of designing a standard battery for assessing therapeutic change, to include the HSCL as one of its core instruments (Kolotkin & Johnson, 1983).

In a preliminary report on the BSI (Derogatis & Melisaratos, 1983) it was written that the Global Severity Index (GSI) is the "single best indicator of current distress levels and should be utilized in most instances where a single summary measure is required" (p. 597). The authors reported a test-retest value for the GSI over a two-week period of .90, which indicates good reliability for this measure. Conversely, because of this stability, if client changes in GSI scores occur over a short period of time, one is supported in the belief that such changes may be partially explained by intervening therapeutic experiences.

Because of the demonstrated reliability, validity, and widespread acceptance of the HSCL and its derivatives, it was decided to utilize the BSI in the present study.
The BSI has been used in previous pre-post designs (e.g., Pekarik, 1983) and has been judged a good substitute for the SCL-90-R by a reviewer for the Mental Measurements Yearbook (Conoley & Kramer, 1989). Further, norms have recently been published that are appropriate for college students (Cochran & Hale, 1985). Other research has verified that internal consistencies of the BSI, when administered to college counseling center clients, are similar to those originally reported in the manual for adult patients (Broday & Mason, 1991). Therefore, because the BSI is an adequate substitute for the other instruments, it takes significantly less time to complete, and the target population for this study is college students, the BSI was utilized to generate summary scores of psychological distress (i.e., GSI).

**Self-Efficacy Scale (SES).** To assess pre-therapy levels of self-efficacy, the Self-Efficacy Scale (Sherer et al., 1982) was administered to each subject in the study. This instrument was designed to reflect a person's general expectations of personal self-efficacy, regardless of the situation, by asking for a response (on a five-point scale) that describes the degree to which he or she agrees or disagrees with a series of 23 statements.

The authors of the SES scale reported results of a factor analysis of 376 subjects that yielded an acceptable
internal consistency value of .86 for the overall scale. Concurrent validity was likewise found to be adequate by correlating SES scores with other personality characteristics such as locus of control, ego strength, self-esteem, and so on. The resultant correlations were moderate (e.g., .30 - .50) but not sufficiently high to suggest that any of these other instruments measured precisely the same underlying characteristic as the SES. This study also demonstrated good predictive validity of the SES by showing that subjects with higher levels of self-efficacy achieved greater success in present and past employment, education, and military rank.

Working Alliance Inventory (WAI). Each subject's sense of involvement and collaboration in the therapeutic process was assessed by completion of the Working Alliance Inventory (Horvath & Greenberg, 1989) after the third counseling session. The WAI includes a series of 36 statements about the counseling experience and asks the subject to rate the applicability of each statement to him or herself, also on a five-point scale.

The authors of the WAI described the reliability and validity of their instrument as adequate (Horvath & Greenberg, 1989). Internal consistency, as measured by Cronbach's alpha, was .93, while test-retest reliability coefficients for the individual scales ranged from .68 to
.89. Concurrent validity was demonstrated to be statistically significant at the .05 level by comparing WAI client-reported scores to counselor-reported scores which yielded coefficients ranging from .53 to .80. Additional analyses of concurrent and predictive validity were conducted by comparing the WAI with other measures of the counselor-client relationship and measures of counseling outcome. These analyses yielded coefficients ranging from .37 to .46, each of which was significant at the .05 level.
CHAPTER IV
RESULTS

The data were analyzed with the SPSS/PC+ (Statistical Package for the Social Sciences/Personal Computer enhanced edition) software package to answer the four research questions. Changes in psychological distress were assessed by testing mean group differences in the Global Severity Index (GSI) both at pretest and posttest with a multivariate analysis of variance (MANOVA) for repeated measures. Mean group differences in therapeutic alliance between experimental and control subjects were tested with a t-test for independent samples using global scores from the Working Alliance Inventory. In order to determine if a greater number of experimental subjects reported for the initial counseling session than control subjects, frequency data were used to generate a chi-square statistic. Finally, the relationships between levels of perceived self-efficacy and subsequent changes in distress and levels of therapeutic alliance were assessed, respectively, by repeated measures MANOVA and ANOVA, with two independent variables. A significance level of .05 was adopted for all analyses.

Changes in Psychological Distress

It was predicted that presentation of the standard
intervention to the experimental subjects during the intake interview would result in a lowering of reported levels of distress when measured again just prior to the initial therapy session. Furthermore, it was expected that overall decreases in distress would be greater for the experimental subjects than for those in the control condition.

Table 1 presents mean values, by group, of the distress and alliance scales. Again, each of these instruments utilizes a response scale ranging from one to five. The mean GSI values, when compared to published norms, indicate that the subjects in the present study presented levels of distress that were similar to those reported for other outpatient samples and higher than those for normal nonpatients. Examination of the mean scores in Table 1 reveals that both groups decreased in GSI levels between the pretest and posttest, with the control group decreasing an average of 0.2% and the experimental group an average of 5%.

The results of the repeated measures MANOVA, which tested the significance of these findings, are found in Table 2. The repeated measures MANOVA revealed a main effect for time, indicating there were significant differences between the pretest and posttest scores independent of group membership. However, the significant
Table 1

Mean Values, Standard Deviations, and Effect Sizes of Dependent Variables by Group

<table>
<thead>
<tr>
<th>Group</th>
<th>Pre-GSI</th>
<th>Post-GSI</th>
<th>WAI</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control</td>
<td>1.26 (.71)</td>
<td>1.25 (.79)</td>
<td>3.11 (.62)</td>
<td>40</td>
</tr>
<tr>
<td>Experimental</td>
<td>1.14 (.63)</td>
<td>.96 (.64)</td>
<td>3.37 (.42)</td>
<td>40</td>
</tr>
<tr>
<td>Effect Size</td>
<td>.25</td>
<td>.49</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

interaction of time and group reveals the greatest decrease in distress occurred for those subjects in the experimental group. The lack of main effect for the grouping variable indicates relative equivalence of the groups at pretest.

Table 2

Repeated Measures MANOVA of Group Differences of the Global Severity Index

<table>
<thead>
<tr>
<th></th>
<th>SS</th>
<th>df</th>
<th>MS</th>
<th>F</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between Subjects</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group</td>
<td>1.659</td>
<td>1</td>
<td>1.659</td>
<td>1.869</td>
<td>.176</td>
</tr>
<tr>
<td>Error</td>
<td>69.221</td>
<td>78</td>
<td>.887</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Within Subjects</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>.360</td>
<td>1</td>
<td>.360</td>
<td>5.065</td>
<td>.027*</td>
</tr>
<tr>
<td>Time X Group</td>
<td>.300</td>
<td>1</td>
<td>.300</td>
<td>4.223</td>
<td>.043*</td>
</tr>
<tr>
<td>Error</td>
<td>5.544</td>
<td>78</td>
<td>.071</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: n = 80.
*p < .05.
Group Differences in Therapeutic Alliance

All subjects completed the Working Alliance Inventory immediately following their third session of counseling. To determine if the experimental subjects differed from control subjects in their reported sense of alliance, a t-test for independent samples was conducted with the mean scores. This analysis revealed a significant difference between groups ($t (78) = -2.17, p = .035$), with the experimental group producing a higher mean score than the control group (see Table 1). Thus, the subjects receiving the standard intervention reported a greater sense of alliance and collaboration with the therapeutic process than did those subjects who did not receive the intervention.

Dropouts from Therapy

To assess the presence of differential rates of dropout from therapy dependent on group membership, frequencies were generated involving those subjects who appeared for the initial intake and the first counseling session, along with counts for those subjects who did not appear for the first session. These frequency data are presented in Table 3.

Table 3 reveals that the number of no-shows for each group was similar and, indeed, when the frequency data
Table 3

Frequencies of Show versus No-Show for Intake and First Session

<table>
<thead>
<tr>
<th></th>
<th>Show Intake</th>
<th>Show First Session</th>
<th>No-Show</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control</td>
<td>54</td>
<td>45</td>
<td>9</td>
</tr>
<tr>
<td>Experimental</td>
<td>57</td>
<td>46</td>
<td>11</td>
</tr>
</tbody>
</table>

were used to calculate a chi-square statistic, the difference between groups was not statistically significant \( \chi^2 (1, N = 111) = 0.12, p > .05 \). Thus, it cannot be concluded, based on these data, that the two groups differed in number of subjects that returned following their initial intake.

The Effects of Self-Efficacy on Distress and Alliance

All subjects completed a self-report instrument to assess perceptions of self-efficacy (SE) prior to the intake interview. The scores on this instrument were used to partition each group into low and high values of SE (i.e., a median split) for the purpose of analyzing possible differences in therapeutic alliance and changes in psychological distress by level of SE. Mean partition scores for the dependent variables are found in Table 4.
Table 4

Mean Values, Standard Deviations, and Effect Sizes of Dependent Variables by Level of Self-Efficacy

<table>
<thead>
<tr>
<th>Group</th>
<th>SE Level</th>
<th>Pre-GSI</th>
<th>Post-GSI</th>
<th>Effect Size</th>
<th>WAI</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Low</td>
<td>1.54 (.69)</td>
<td>1.53 (.77)</td>
<td>.01</td>
<td>3.01 (.61)</td>
</tr>
<tr>
<td></td>
<td>High</td>
<td>.95 (.62)</td>
<td>.93 (.70)</td>
<td>.03</td>
<td>3.24 (.61)</td>
</tr>
<tr>
<td>Con.</td>
<td>Low</td>
<td>1.43 (.61)</td>
<td>1.21 (.68)</td>
<td>.34</td>
<td>3.25 (.44)</td>
</tr>
<tr>
<td></td>
<td>High</td>
<td>.86 (.52)</td>
<td>.72 (.50)</td>
<td>.27</td>
<td>3.49 (.36)</td>
</tr>
<tr>
<td>Exp.</td>
<td>Low</td>
<td>1.43 (.61)</td>
<td>1.21 (.68)</td>
<td>.34</td>
<td>3.25 (.44)</td>
</tr>
<tr>
<td></td>
<td>High</td>
<td>.86 (.52)</td>
<td>.72 (.50)</td>
<td>.27</td>
<td>3.49 (.36)</td>
</tr>
<tr>
<td>Overall Effect Size for SE level:</td>
<td>.88</td>
<td>.50</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note. n = 20 for each level of SE.

A repeated measures MANOVA with two independent variables was performed on the GSI data to determine if changes in distress could be explained by the different levels of self-efficacy. This analysis revealed significant differences between levels of SE independent of time (F (1,76) = 17.02, p < .001) indicating that subjects with different levels of SE differed in GSI both at pretest and at posttest, with the low SE subjects consistently producing higher GSI scores. A significant main effect for time reveals that there were differences between pretest and posttest scores (F (1,76) = 5.55, p = .021), but these differences resulted primarily from decreases in GSI scores for subjects in the experimental group. The nonsignificant results for both the SE level X
time interaction \((F(1,76) = .12, p = .731)\), and the group X SE level X time interaction \((F(1,76) = .37, p = .547)\), indicates that the changes in distress between pretest and posttest are due to overall group differences and are not further explained by differential changes in distress between levels of perceived self-efficacy.

Differences in therapeutic alliance based on the SE partitions and group membership were analyzed by ANOVA. The results of this analysis are presented in Table 5. This analysis revealed a significant main effect for group membership (consistent with the differences reported earlier), and a main effect for level of SE.

Table 5

ANOVA of Working Alliance Inventory by Group and Level of Self-Efficacy

<table>
<thead>
<tr>
<th>Source</th>
<th>SS</th>
<th>df</th>
<th>MS</th>
<th>F</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group</td>
<td>1.20</td>
<td>1</td>
<td>1.20</td>
<td>4.49</td>
<td>.037*</td>
</tr>
<tr>
<td>SE Level</td>
<td>1.16</td>
<td>1</td>
<td>1.16</td>
<td>4.35</td>
<td>.040*</td>
</tr>
<tr>
<td>Group X SE Level</td>
<td>.001</td>
<td>1</td>
<td>.001</td>
<td>.002</td>
<td>.960</td>
</tr>
</tbody>
</table>

Note. \(n = 80\).
*\(p < .05\).

These results indicate that low SE subjects produced lower scores on the WAI, on average, than did the high SE subjects. Also, as expected from the earlier analysis,
the experimental subjects produced greater average WAI scores than did the control subjects. However, the results did not reveal different WAI scores based on group and level of SE. This is demonstrated by comparing the WAI scores of the two SE levels within the experimental group alone. This analysis showed that those experimental subjects with high levels of SE did not produce statistically greater WAI scores than those with low levels of SE ($t(38) = -1.93, p = .061$). Thus, the differences in alliance are explained by group and SE level main effects with no interaction between them. The lack of a significant Group X SE level interaction confirms that the experimental subjects did not respond differentially to the treatment based on their level of self-efficacy.

Overall, these analyses indicate that both self-efficacy and the experimental treatment contribute independently to the development of therapeutic alliance, and the greatest alliance was demonstrated by those subjects that were both efficacious and exposed to the standard intervention.

**Summary**

The two main experimental hypotheses were supported by the data analysis. Decreases in psychological distress between intake (pretest) and first counseling session
(posttest) occurred for both groups, but the decreases for the experimental subjects were statistically greater than were those demonstrated by the control subjects. There were also statistically significant group differences in therapeutic alliance measured after the third counseling session, with the experimental group producing higher alliance scores in comparison to the control group.

The two remaining hypotheses were not generally supported by the data. First, there was not a significant difference between groups in the number of subjects that attended an intake interview but subsequently failed to show for the initial counseling session. Second, although subjects in both groups that were low in perceived self-efficacy produced greater scores on the distress scale than those high in SE at both the pretest and the posttest, the different levels of SE did not explain differences in distress change for those subjects exposed to the experimental treatment. That is, the amount of distress score change by the experimental subjects did not depend on the level of SE. The effect of self-efficacy on development of therapeutic alliance was similar in that those subjects high in SE produced higher alliance scores than those low in SE. Also, exposure to the standard intervention increased the alliance scores for the experimental subjects regardless of their level of SE, but
the magnitude of response to the treatment did not depend on level of SE. The data suggest that both the intervention utilized in this study and level of SE contribute to a client's sense of therapeutic alliance.

The results of this study suggest that a standard intervention presented during the intake interview is effective in promoting decreases in distress and in enhancing therapeutic alliance. The effects of a client's perceived self-efficacy likewise are important to consider because low SE clients may tend to present with higher levels of distress than those who are more self-efficacious. Finally, both the standard intervention and a high level of SE enhance therapeutic alliance; thus it appears that alliance is most powerfully influenced when highly efficacious clients are presented with a standard intervention during the intake interview.
The purpose of this study was to investigate a means of enhancing the therapeutic value of a client's first contact with a service agency. This was accomplished by designing and implementing a standard therapeutic intervention that was provided to each of the experimental subjects during the intake interview at a university counseling center. The control subjects were exposed to a typical intake without the intervention.

Each subject was assessed for level of psychological distress before intake and again before the first counseling session. After the third counseling session each subject completed an instrument designed to measure therapeutic alliance. Data analysis described the relationships between the experimental treatment and changes in distress, differences in alliance, and differences in therapy dropout rates. Perceived self-efficacy was also included to determine if this construct provided additional explanation of the relationships between the variables.

**Psychological Distress**

Subjects in both the experimental and control groups reported decreased distress between the time of the intake
and the first counseling session. However, the decreases reported by the experimental subjects were statistically greater than those by the control subjects.

Comparison of the mean pretest scores of the subjects to the published norms revealed similar levels of distress between the subjects in this study and other outpatient groups. Although the scores at posttest had decreased for the experimental subjects, they remained elevated in comparison to normal nonpatient norms. This is not surprising because no therapy other than the standard intervention occurred prior to the posttest.

Calculation of effect sizes (i.e., standardized mean differences) for changes in distress were small but measurable. Thus, the data suggest that the reported changes in psychological distress, while being of small magnitude, nonetheless reflect real changes that are of some practical significance. This claim is bolstered by the fact that all consenting subjects were included regardless of their presenting problems and level of discomfort. As with most psychological interventions there are certain procedures that are best suited to specific clients and complaints. The finding of significant distress changes and measurable effect sizes despite the deliberate inclusion of large subject variability is compelling testimony for the power of this
procedure.

The differences in distress levels were consistent with predictions, presumably because of the presentation of a therapeutic task (i.e., the standard intervention) designed to focus the attention of the experimental subjects on a future time when their psychological problems had been resolved. By encouraging the subjects to focus on the future in this manner, it was predicted that possible solutions to problems would be generated and the subjects would develop the expectation that changes could occur rapidly. In other words, it was expected that the experimental subjects would feel that the process of therapy had begun immediately during intake, rather than being delayed until the time of the first official therapy session.

Again, it is noteworthy that the measurable decreases in psychological distress were obtained despite the fact that no allowance was made for differences in diagnosis or presenting problems. Although students with severe symptoms requiring medications were referred to the local mental health center for treatment, all others that agreed to participate in the study were included. Thus, even though individual subjects presented a wide range of symptoms and distress, the intervention was sufficiently powerful to induce decreased distress averaged across all
experimental subjects.

**Therapeutic Alliance**

Although both the experimental and control groups reported relatively high levels of alliance when assessed after the third counseling session, the mean score for the experimental group was statistically greater than the mean score for the control group. The practical significance of this difference is indicated by the moderate effect size of .49. This finding suggests that the subjects who experienced a therapeutic event immediately at intake subsequently developed a greater sense of involvement and cooperation with their therapist later in the therapeutic process.

It has been demonstrated that the best predictor of a positive therapeutic outcome is the degree to which a client feels involved and personally responsible for changes (Gomes-Schwartz, 1978; Harcum, 1989; Marziali, Marmar, & Krupnick, 1981). Thus, it is logical to focus one's therapeutic energy on enhancing a client's sense that he or she is actively involved in therapy and that his or her input is critical to the growth process. In this light, it appears imperative that a client's first impression of the process of therapy (i.e., the intake interview) be utilized in such a way that this message of personal involvement and alliance be communicated clearly
and experientially. The results of the data analysis suggest that the present method has been successful at achieving this goal.

Therapy Dropouts

The number of clients that completed the intake interview but then failed to appear for the initial counseling session was shown to be similar for each group. Hence, the prediction that those subjects exposed to the experimental condition would demonstrate a lower dropout rate than the subjects in the control condition was not supported by the data. This prediction was made based on the assumption that if the standard intervention actually resulted in decreased distress and greater personal involvement, then increased client satisfaction would develop which should result in a greater number of experimental subjects than control subjects returning for their initial counseling session. However, upon reflection it seems equally plausible that some clients may drop out of therapy upon realizing that they will be expected to shoulder the majority of responsibility for their therapeutic progress. Conversely, some clients may drop out because the intervention assisted them in generating possible solutions to their own problems, thus obviating their desire for continued counseling. In essence, predicting differences in dropout rates is a
complex issue that is not adequately addressed by the present research design and not fully explained by the data.

The Self-Efficacy Construct

When considering the willingness and ability of clients to take personal responsibility for their therapeutic changes, one must wonder about individual differences. In this study it was predicted that different levels of self-efficacy (i.e., the belief that one can successfully perform desired behaviors in specific situations) would affect subjects' responses to the experimental treatment. Because the treatment involved imagining the resolution of one's difficulties, it was expected that inefficacious subjects would be less able to complete the experimental task effectively and thus would produce less change in distress and develop lower levels of therapeutic alliance than the efficacious subjects.

The predicted differences in distress change based on level of self-efficacy (SE) and presentation of the standard intervention were not demonstrated by the data. That is, those with high levels of SE did not decrease their distress levels more than those with low levels of SE.

One interesting finding is the consistency with which the low SE subjects in each group reported higher levels
of distress than the high SE subjects. This was a strong finding as reflected by the large effect size of .88. Although such differences in distress based on SE level were not predicted, it makes intuitive sense that those clients who feel less confident in their abilities to put desired changes into action will experience greater distress. The data in the present study demonstrated that even though subjects with different levels of SE presented differing average amounts of distress, they responded similarly to the experimental treatment regardless of the level of SE.

Therapeutic alliance was also investigated to determine if different levels of SE would lead to the development of different degrees of alliance. The data indicate that the more efficacious subjects developed greater levels of therapeutic alliance whether or not they received the intervention. However, exposure to the standard intervention increased the alliance reported by subjects with both high and low levels of self-efficacy by similar amounts. Therefore, although level of SE appears to influence the development of therapeutic alliance (with efficacious clients developing greater alliance), it does not differentially modulate the effectiveness of the experimental treatment.
Implications of the Results

The results of this study clearly indicate that it is possible to modify the intake interview in a way that promotes rapid therapeutic growth and enhances the collaborative nature of the therapist-client relationship. These findings are important to any agency providing therapeutic services in which cost containment and limited resources are relevant issues.

Recent changes in the mental health field, especially with regard to severe limitations in third-party reimbursements, have increased providers' awareness of the need to provide services in as brief a period of time as possible. Although it is still common practice to gather diagnostic and demographic information from new clients during an initial intake interview (often by paraprofessionals) with the understanding that therapy will begin at some later time, this delay can be an inefficient use of the limited time available to effect therapeutic changes. The results of this study demonstrate that interventions can be designed that initiate the therapeutic process even before the beginning of formal therapy. In addition, because the procedure designed for this study was successfully utilized with clients regardless of their diagnosis or presenting problem, this approach is appropriate when intake
interviews are conducted by paraprofessionals. This study thus provides evidence that a minor modification in the typical intake procedure can lead to small but measurable therapeutic changes, specifically decreases in psychological distress and enhanced therapeutic alliance.

The present study relied on a standard intervention based on a technique developed by Milton Erickson. This specific technique was chosen because it was judged to be one that would lead clients to generate possible solutions to their problems and enhance the clients' feelings of working collaboratively with the therapist. It is doubtful, however, that the positive results of this study are dependent on the use of this particular intervention. That is, a multitude of possible therapeutic tasks that provide a therapeutic component to the intake interview would likely serve the same function and assist clients in making rapid therapeutic changes and enhanced alliance. This project can thus be considered a pilot study in which the notion of modifying the intake interview to include a formalized therapeutic component has been shown to be a useful change that social service agencies might consider adding to their procedure manuals.

It has been suggested that asking clients questions such as how they will know when their problems have been resolved and how their lives will be different is similar
to that which many therapists commonly do as they begin therapy with new clients. While certainly appropriate and useful, these questions have not been studied systematically and applied formally to the intake interview. It is recommended based on the current results, that these questions as well as a variety of other questions and interventions be included as homework tasks in order to clearly convey to the new client that he or she is responsible for change, that change is an expectation of therapy, and that such changes will begin from the first contact.

Although the predictions regarding the self-efficacy construct were not supported by the data, there remain important issues that pertain to the practice of therapy. For instance, if it is generally the case that inefficacious clients possess higher levels of distress than efficacious clients, it may prove useful to assess new clients for level of self-efficacy in order to design the most appropriate therapeutic strategies for management of distress. It is noted that the inefficacious subjects benefitted as much as the efficacious subjects in terms of distress change, but the former nonetheless maintained higher levels of distress at the time of the posttest. Thus, even though the nature of the relationship between self-efficacy and the experimental treatment was not
elucidated by this study, it is clear that there exists a relationship between self-efficacy and distress which may be useful information for therapists to consider.

Suggestions for Future Research

Although this study revealed the overall effectiveness of a standard intervention regardless of diagnosis, it is likely that a variety of interventions chosen for specified client populations would lead to even greater changes. One area of potential research is the description of the degree to which different populations respond in variable ways to specific standard interventions.

For instance, anxious clients may benefit most from an approach that encourages a focus on symptom amelioration. Conversely, depressed persons might respond best to an intervention that asks them to generate ways in which their activities and behavior will change when the depression dissipates. This notion is supported by the therapy outcome literature that suggests some therapeutic orientations are better-suited to certain client populations than others (e.g., cognitive-behavioral strategies for phobic clients). Future research is needed to describe if such relationships exist between diagnosis and appropriate standard interventions and how to maximize the therapeutic benefits realized by clients during their
initial intake interview.

Another interesting facet to investigate involves the long-term effects of these standard interventions. That is, what happens to the therapeutic relationship beyond the third session? Are the demonstrated increases in alliance maintained at termination, or do the control subjects "catch up" as the process of therapy proceeds? Similarly, it would be instructive to determine if the measured changes in psychological distress are maintained to the conclusion of therapy such that the experimental subjects continue to demonstrate greater decreases in distress than the control subjects.

Yet another area of potential inquiry involves the description of the specific changes that underlie the decreased distress. It is assumed that these distress changes are the result of clients changing the focus of their thinking from helplessness to expectations for positive change. Specifically, it is probable that preliminary solutions to problems and goals for therapy begin to form as a result of the standard intervention. These assumptions need to be tested to verify whether or not the experimental subjects do, in fact, have an advantage in terms of increased goal-setting, a change to a solution orientation, and greater expectations that their current problems are solvable.
The outcome measures in the present study provided data only with regard to the clients' self-reports. Future studies could also be designed that investigate therapist reports of client improvement, goal generation, and therapeutic alliance. Therapist ratings would be interesting to include in continuing investigations in order to demonstrate that these client changes are significant enough to be noticed by outside observers. Also, because therapy is an interpersonal relationship, an increased sense of collaboration and alliance should be sensed by both clients and therapists. Indeed, it may be found that a client's increased sense of alliance serves to impact the therapist's own sense of alliance, thus enhancing each individual's satisfaction with the therapy experience. Of course, such investigations require a more cumbersome experimental design because the therapist would need to remain blind to the group membership of the subjects.

Finally, an additional area where these findings might be utilized and extended is in the domain of family therapy. For example, it is common for therapists to ask children to draw pictures as a means of expressing feelings and thoughts, and it is consistent with the present study to have children draw pictures of their future selves or family after their problems have been
resolved. Similarly, it might be useful to ask each of
the family members to individually complete the same task,
and then process the differences and similarities in order
to gain an understanding of how each member views the
strengths and weaknesses of the family. These drawings
can be used as a focal point for the initial therapy
sessions in establishing common goals for therapy.
Perhaps an appropriate goal for such an intervention would
be the production of a single drawing of a better future
that is generated by all of the family members working
together. Activities such as these would likely result in
increased alliance among family members as well as with
the therapist and may also serve to decrease initial
levels of distress. This is yet another example of how
the present results can be used to design a variety of
standard interventions that can be incorporated with
different populations, yet still promote rapid therapeutic
gains.

Replications that provide greater structure and
control over compliance and follow-through with the
intervention are indicated as well. In the present study
no provision was made to ensure that experimental subjects
complied uniformly with the therapeutic task.
Consequently, there was wide variability in the amount of
effort expended by different subjects in completing the
task. This lack of control inevitably led to greater variance in the results and probably decreased the magnitude of the effects. Therefore it is suggested that future studies implement procedures that will result in greater uniformity of effort in completion of the standard intervention.

Limitations of the Study

Although statistical significance was demonstrated for some of the experimental results in this study, the practical significance is unclear even though effect size calculations revealed that measurable changes occurred. This lack of clarity is partly the result of the sample not being a random selection of psychotherapy clients. That is, generalization of the results to the general population of psychotherapy clients is unwarranted without further replication and extension of the findings. The sample utilized consisted of university counseling center clients who typically presented with developmental issues, adjustment disorders, and mild affective disturbances, rather than with more severe psychopathology. Consequently, the subjects were relatively high functioning and may have been more responsive to the standard intervention than severely impaired individuals might have been.

Many of the subjects in this study had intake
interviews with a staff person who ultimately became their therapist. However, similar numbers of subjects saw different persons for intake and therapy. It seems likely that the therapeutic alliance would be somewhat enhanced if the intake were conducted by the person who subsequently served as the therapist. Since this was not the case in this study, the demonstrated positive results in alliance are probably deflated. That is, it is expected that future studies in which the therapy and intake are conducted by the same person will demonstrate even greater differences in therapeutic alliance between experimental and control groups.

Clearly, the lack of a specified waiting period between intake and first therapy session is a confound in the data. Controlling this parameter by the experimental design was deemed unreasonable, and statistical control was achieved through the random assignment to groups. This assured that, on average, the groups did not differ in the elapsed time between intake and initial therapy session. It is possible, nonetheless, that greater benefit of the intervention was realized by many of those subjects who had a longer waiting period because of the increased opportunity to process and incorporate any insights they generated. Conversely, it is also possible that too long a delay resulted in some subjects forgetting
about their new psychological revelations and reverting back to their previous levels of distress. Future research should focus on these possibilities and elucidate the relationship between standard intake interventions and waiting periods.

The lack of termination data also restricts the conclusions that can be drawn from this study. For instance, it is unknown from the data if the changes in psychological distress and differences in alliance are maintained until the end of therapy or if they merely represent a temporary acceleration of natural therapeutic developments. That is, it is unknown if the experimental subjects retain their advantage over the control subjects at termination in terms of decreased distress and increased alliance. Similarly, because it is presumed that the experimental treatment encourages goal-setting and a solution focus, it would be instructive to investigate whether the experimental subjects do actually demonstrate greater success at generating and meeting their goals.

The fact that the therapists were not blind to group membership can be considered a limitation to this study, although the effects on the data were probably minimal as none of the data were generated by the therapists themselves. In fact, any bias on the part of the
therapist could only have influenced the development of therapeutic alliance. Further, it is not expected that therapist bias based on group membership was a major influence because the intervention was presented to the subjects prior to the beginning of therapy and before the establishment of a specific therapist-client relationship. At any rate, if a similar study were to be conducted utilizing therapist ratings as well as client ratings, then clearly the therapists should remain uninformed regarding which subjects are in the experimental and control groups.

Conclusions

In summary, the primary experimental hypotheses received support from the data generated by the study. First, those subjects that received and completed the standard intervention demonstrated significantly greater decreases in psychological distress than did those subjects who were exposed to an intake interview without the standard intervention when these changes were assessed prior to the beginning of therapy. Second, the experimental subjects reported enhanced therapeutic alliance with their therapists when assessed after the third counseling session, in comparison to those subjects in the control group.

The relationship of the subjects' perceived self-
efficacy to changes in distress and development of alliance was less clear, but interesting insights were generated nonetheless. Different levels of self-efficacy were not shown to impact the effects of the experimental treatment differentially. That is, both efficacious and inefficacious subjects responded similarly in their distress change and alliance, but they achieved differing amounts of each. The data revealed that inefficacious subjects reported higher levels of distress at both the pretest and posttest than efficacious subjects. Alternately, the efficacious subjects developed greater alliance with their therapists than did inefficacious subjects. As one might expect, then, subjects that were high in self-efficacy achieved the greatest decreases in distress and the greatest levels of therapeutic alliance. It is somewhat curious that the efficacious subjects did not realize greater benefit from the intervention than did the inefficacious subjects, because of the requirement that the subjects project themselves to a future time when their problems had been resolved. Perhaps the similarity of response by these groups is indicative of the strength of this type of intervention. Again, it would be useful to replicate these findings with other interventions to see if specific treatments will prove superior with different levels of self-efficacy.
The present study provides strong evidence that a minor modification to the typical intake interview, in the form of a clinical intervention, can effect significant positive changes in many clients. Although this can be considered pilot data because a nonrandom sample from the population was used and a single intervention independent of diagnosis was studied, the positive findings suggest that further research needs to be done to expand the repertoire and specificity of such interventions. The purpose of this project was to demonstrate the usefulness of including a clinical component to the intake that would promote rapid positive change in clients, thereby accelerating the improvements one would expect from the therapeutic process. The analysis of group differences indicate that this approach leads to decreases in psychological distress and to enhancement of the therapeutic alliance. Therefore, it is recommended that mental health administrators and practitioners consider including similar interventions in their initial contacts with new clients.
REFERENCES


APPENDICES
Appendix A
Informed Consent
RESEARCH CONSENT FORM

I.D. Number________________

The USU Counseling Center is cooperating with the Psychology Department in a study to improve the services available to USU students. We need the cooperation of students like yourself, and would be very appreciative of your involvement. Be assured, however, that participation is not required. That is, the full range of counseling services will be available to you whether or not you agree to assist us with this study, and refusal to participate will not affect the services you receive.

The information gathered will be provided to your counselor as part of the intake information. The time that will be required of you is minimal, involving a total of 10-15 minutes on four of your regular visits to the Counseling Center. On each of these visits you will be asked to complete one or two brief questionnaires. Your answers to these questionnaires will remain confidential and will not be shared with anyone outside of this research project.

Thank you for your consideration. If you are willing to participate in this study, please read and sign the statement below.

______________________________

I agree to be a research subject in the project described above at the USU Counseling Center. I understand that I will be asked to complete four brief questionnaires during the time that I am receiving counseling services at the Counseling Center, and I agree to complete these instruments to the best of my ability. I further understand that I may withdraw from participation in this study at any time.

______________________________
Signature
Appendix B
Standard Intervention
On this sheet of paper please write a detailed description of what you will be like when the problems which have brought you in for counseling have been resolved. Include examples of how you will feel differently, how you will think differently, and how you will behave differently, than is true for you right now. Be as specific and elaborate as you can (using the back side of the sheet if necessary). Please bring this with you to your first counseling session.
Appendix C
Self-Efficacy Scale
ATTITUDE SURVEY

I.D. Number ________

This questionnaire is a series of statements about your personal attitudes and traits. Each statement represents a commonly held belief. Read each statement and decide to what extent it describes you. There are no right or wrong answers. You will probably agree with some of the statements and disagree with others. Please indicate your own personal feelings about each statement below by marking the number that best describes your attitude or feeling. Please be very truthful and describe yourself as you really are, not as you would like to be.

<table>
<thead>
<tr>
<th>Statement</th>
<th>1</th>
<th>2</th>
<th>3</th>
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<tbody>
<tr>
<td>1. I like to grow house plants.</td>
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<td>2. When I make plans, I am certain I can make them work.</td>
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<td>3. One of my problems is that I cannot get down to work when I should.</td>
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<td>4. If I can't do a job right the first time, I keep trying until I can.</td>
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<td>5. Heredity plays the major role in determining one's personality.</td>
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<td>6. It is difficult for me to make new friends.</td>
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<td>7. When I set important goals for myself, I rarely achieve them.</td>
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<td>8. I give up on things before completing them.</td>
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<td>9. I like to cook.</td>
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<td>10. If I see someone I would like to meet, I go to that person instead of waiting for him/her to come to me.</td>
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<td>11. I avoid facing difficulties.</td>
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<td>12. If something looks too complicated, I will not even bother to try.</td>
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<td>13. There is some good in everybody.</td>
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Disagree
Strongly
Neither
Agree
Strongly

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<tr>
<td>14. If I meet someone interesting who is very hard to make friends with, I'll soon stop trying to make friends with that person.</td>
<td>1</td>
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<tr>
<td></td>
<td>Disagree</td>
<td>Neither</td>
<td>Agree</td>
<td>Strongly</td>
<td>Strongly</td>
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<tr>
<td>15. When I have something unpleasant to do, I stick to it until I finish it.</td>
<td>1</td>
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<tr>
<td></td>
<td>Disagree</td>
<td>Neither</td>
<td>Agree</td>
<td>Strongly</td>
<td>Strongly</td>
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<tr>
<td>16. When I decide to do something, I go right to work on it.</td>
<td>1</td>
<td>2</td>
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<td>4</td>
<td>5</td>
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<tr>
<td></td>
<td>Disagree</td>
<td>Neither</td>
<td>Agree</td>
<td>Strongly</td>
<td>Strongly</td>
</tr>
<tr>
<td>17. I like science.</td>
<td>1</td>
<td>2</td>
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<tr>
<td></td>
<td>Disagree</td>
<td>Neither</td>
<td>Agree</td>
<td>Strongly</td>
<td>Strongly</td>
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<tr>
<td>18. When trying to learn something new, I soon give up if I am not initially successful.</td>
<td>1</td>
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<tr>
<td></td>
<td>Disagree</td>
<td>Neither</td>
<td>Agree</td>
<td>Strongly</td>
<td>Strongly</td>
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<tr>
<td>19. When I'm trying to become friends with someone who seems uninterested at first, I don't give up very easily.</td>
<td>1</td>
<td>2</td>
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<tr>
<td></td>
<td>Disagree</td>
<td>Neither</td>
<td>Agree</td>
<td>Strongly</td>
<td>Strongly</td>
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<tr>
<td>20. When unexpected problems occur, I don't handle them well.</td>
<td>1</td>
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<tr>
<td></td>
<td>Disagree</td>
<td>Neither</td>
<td>Agree</td>
<td>Strongly</td>
<td>Strongly</td>
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<tr>
<td>21. If I were an artist, I would like to draw children.</td>
<td>1</td>
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<tr>
<td></td>
<td>Disagree</td>
<td>Neither</td>
<td>Agree</td>
<td>Strongly</td>
<td>Strongly</td>
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<tr>
<td>22. I avoid trying to learn new things when they look too difficult for me.</td>
<td>1</td>
<td>2</td>
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<td>5</td>
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<tr>
<td></td>
<td>Disagree</td>
<td>Neither</td>
<td>Agree</td>
<td>Strongly</td>
<td>Strongly</td>
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<tr>
<td>23. Failure just makes me try harder.</td>
<td>1</td>
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<tr>
<td></td>
<td>Disagree</td>
<td>Neither</td>
<td>Agree</td>
<td>Strongly</td>
<td>Strongly</td>
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<tr>
<td>24. I do not handle myself well in social gatherings.</td>
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<tr>
<td></td>
<td>Disagree</td>
<td>Neither</td>
<td>Agree</td>
<td>Strongly</td>
<td>Strongly</td>
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<tr>
<td>25. I very much like to ride horses.</td>
<td>1</td>
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<tr>
<td></td>
<td>Disagree</td>
<td>Neither</td>
<td>Agree</td>
<td>Strongly</td>
<td>Strongly</td>
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<tr>
<td>26. I feel insecure about my ability to do things.</td>
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<tr>
<td></td>
<td>Disagree</td>
<td>Neither</td>
<td>Agree</td>
<td>Strongly</td>
<td>Strongly</td>
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<tr>
<td>27. I am a self-reliant person.</td>
<td>1</td>
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<tr>
<td></td>
<td>Disagree</td>
<td>Neither</td>
<td>Agree</td>
<td>Strongly</td>
<td>Strongly</td>
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<tr>
<td>28. I have acquired my friends through my personal abilities at making friends.</td>
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<tr>
<td></td>
<td>Disagree</td>
<td>Neither</td>
<td>Agree</td>
<td>Strongly</td>
<td>Strongly</td>
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</table>
29. I give up easily.

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<tr>
<td>Disagree</td>
<td>Neither</td>
<td>Agree</td>
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<tr>
<td>Strongly</td>
<td>Strongly</td>
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30. I do not seem capable of dealing with most problems that come up in my life.

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<tr>
<td>Disagree</td>
<td>Neither</td>
<td>Agree</td>
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<td>Strongly</td>
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Appendix D
Working Alliance Inventory
The Working Alliance Inventory

I.D. Number

Please circle the number that corresponds to the way you feel about each of the following statements.

1. I feel uncomfortable with my counselor.
   - 1: Not true
   - 2: Somewhat true
   - 3: Very true

2. My counselor and I agree about the things I will need to do in therapy to help improve my situation.
   - 1: Not true
   - 2: Somewhat true
   - 3: Very true

3. I am worried about the outcome of these sessions.
   - 1: Not true
   - 2: Somewhat true
   - 3: Very true

4. What I am doing in therapy gives me new ways of looking at my problems.
   - 1: Not true
   - 2: Somewhat true
   - 3: Very true

5. My counselor and I understand each other.
   - 1: Not true
   - 2: Somewhat true
   - 3: Very true

6. My counselor perceives accurately what my goals are.
   - 1: Not true
   - 2: Somewhat true
   - 3: Very true

7. I find what I am doing in therapy confusing.
   - 1: Not true
   - 2: Somewhat true
   - 3: Very true

8. I believe my counselor likes me.
   - 1: Not true
   - 2: Somewhat true
   - 3: Very true

9. I wish my counselor and I could clarify the purpose of our sessions.
   - 1: Not true
   - 2: Somewhat true
   - 3: Very true

10. I disagree with my counselor about what I ought to get out of therapy.
    - 1: Not true
    - 2: Somewhat true
    - 3: Very true

11. I believe the time my counselor and I are spending together is not spent efficiently.
    - 1: Not true
    - 2: Somewhat true
    - 3: Very true

12. My counselor does not understand what I am trying to accomplish in therapy.
    - 1: Not true
    - 2: Somewhat true
    - 3: Very true

13. I am clear on what my responsibilities are in therapy.
    - 1: Not true
    - 2: Somewhat true
    - 3: Very true

14. The goals of these sessions are important to me.
    - 1: Not true
    - 2: Somewhat true
    - 3: Very true
15. I find what my counselor and I are doing in therapy is unrelated to my concerns.  
16. I feel that the things I do in therapy will help me to accomplish the changes that I want.  
17. I believe my counselor is genuinely concerned for my welfare.  
18. I am clear as to what my counselor wants me to do in these sessions.  
19. My counselor and I respect each other.  
20. I feel that my counselor is not totally honest about his/her feelings toward me.  
21. I am confident in my counselor's ability to help me.  
22. My counselor and I are working towards mutually agreed upon goals.  
23. I feel that my counselor appreciates me.  
24. We agree on what is important for me to work on.  
25. As a result of these sessions I am clearer as to how I might be able to change.  
26. My counselor and I trust one another.  
27. My counselor and I have different ideas on what my problems are.  
28. My relationship with my counselor is very important to me.  
29. I have the feeling that if I say or do the wrong things my counselor will stop working with me.  
30. My counselor and I collaborate on setting goals for my therapy.

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31. I am frustrated by the things I am doing in therapy.

32. We have established a good understanding of the kind of changes that would be good for me.

33. The things that my counselor is asking me to do don't make sense.

34. I don't know what to expect as the result of my therapy.

35. I believe the way we are working with my problems is correct.

36. I feel my counselor cares about me even when I do things that he/she does not approve of.
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EDUCATION:

Ph.D. Candidate: Combined Professional-Scientific Psychology (Clinical Specialty).
Utah State University, Logan, Utah.

Minor in Counseling.
Montana State University, Bozeman, Montana.

B.E.S.: Psychology/Pre-Medicine, December 1977.
University of Minnesota, Minneapolis, Minnesota.

PROFESSIONAL AFFILIATIONS

American Psychological Association
Student affiliate

Psi Chi
National Honor Society in Psychology

PUBLICATIONS


PROFESSIONAL PRESENTATIONS


Clinical Case Presentation. Formal presentation of clinical and assessment data to graduate faculty and students, Department of Psychology, Utah State University, March, 1991.

CLINICAL WORK EXPERIENCE:

**VETERANS AFFAIRS MEDICAL CENTER, Portland, OR**

Position: Psychology Intern

Rotations: 1) Neuropsychology. Administration of comprehensive neuropsychological assessments, completion of intake interviews, consultation with medical personnel, and the writing of assessment reports.

2) Outpatient Mental Health/Chemical Addiction Rehabilitation Section (CARS). Provide psychotherapeutic services to individuals and couples, and group treatment to chronic mentally ill veterans in the Day Treatment Program.

3) Chronic Pain Management. Facilitation of a hospital-based program addressing the psychological aspects of chronic pain.
DEVELOPMENTAL CENTER FOR HANDICAPPED PERSONS, Logan, UT
Position: Psychology Specialist

The primary responsibility of this position involved serving as the coordinator of multidisciplinary teams that conducted extensive evaluations of children and adults. Referral questions typically involved academic, behavioral, intellectual, medical, and developmental difficulties as well as psychological and emotional problems.

UTAH STATE UNIVERSITY COUNSELING CENTER, Logan, UT
Position: Staff therapist

The primary responsibility of this position involved the provision of counseling services to university students and their dependents. This university-based site offered exposure to a wide variety of presenting problems and diagnoses including anxiety, depression, personality disorders, eating disorders, and adjustment disorders.

BEAR RIVER MENTAL HEALTH SERVICES, Brigham City, UT
Position: Staff Therapist

Primary responsibility of this position involved the provision of psychotherapy services to persons from the local community. This training site offered exposure to the full spectrum of diagnoses including schizophrenia, depression, psychotic disorders, bipolar disorder, and personality disorders.

MONTANA STATE UNIVERSITY, Bozeman, MT
Position: Graduate Teaching & Research Assistant

Teaching Duties:
- lecturing to undergraduate psychology classes
- teaching laboratory sections
- supervising undergraduate laboratory section leaders
- member of an interdepartmental team that developed a unique program for teaching introductory psychology.

Research Duties:
- assisted in establishing and managing an environmentally-controlled animal laboratory that included a state-of-the-art PC-based fluid intake system-collected, manipulated, and analyzed data with an IBM-PC
- presented experimental results at a national convention.
- coauthored two publications