The Effects of an Educational CD-ROM on

Expectations and

Fears about Therapy

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Literature has consistently supported educating clients about therapy prior to their first session. A CD-ROM program was developed by incorporating general knowledge about therapy with re-enacted therapy sessions in an interactive format. Ninety undergraduates at a Midwestern school participated in this two-part study, and were asked to simulate the role of clients about to see a therapist for the first time. Block randomization was used to assign thirty participants to each of the three groups: the CD-ROM group, an information-only group, and a no-treatment control group. Results indicate that the CD-ROM decreased the amount of anxiety associated with therapy, and changed expectations about client roles and the process and outcome of therapy for the better when re-assessed two days after the intervention. Future research will focus on altering the CD-ROM so that it may encompass a greater number of expectations, and will aim to test these hypotheses with actual clients.

Approved: Timothy Anderson

Associate Professor of Psychology
Dedication

To my parents, John and Carol, for their constant love and support.
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An Analogue Study of Expectations and Levels of Anxiety about Therapy

Pre-treatment variables have been an important part of psychotherapy research since the mid 1900’s. The popularity of this topic reached its peak around the 1970’s, with studies published by eminent researchers such as H.H. Strupp and H.E.A. Tinsley. Certain pre-treatment variables, for example, expectations about the therapeutic process and relationship and levels of anxiety, were found to be correlated with the therapeutic process and outcome, (Deane, Spicer, & Leathen, 1992; Docherty, 1989; McLeod & Deane, 1994). Over the years, these findings have been overshadowed by the current research focus on therapeutic process and outcome. Recently, however, researches have begun to re-examine the importance of clients’ pre-treatment expectations and levels of anxiety.

Researchers have begun to assess client expectations and their potential consequences in therapy (Glass & Arnkoff, 2000; Tinsley, Bowman & Ray, 1988). Specifically, pre-therapy client expectations are hypothesized to have some effect on the duration and quality of the therapeutic encounter. Results of more recent studies have shown that expectations can have a significant impact on therapeutic outcomes (Gaston, Marmar, Gallagher, & Thompson, 1989; Tinsley, Bowman, Barich, 1993), client compliance and participation (Docherty, 1989), and the level of anxiety experienced by the client (McLeod & Deane, 1994).
Recent emphasis has been on the identification and manipulation of client expectations in order to improve therapeutic outcomes. Researchers hypothesized that altering client expectations may affect outcomes. In order to accomplish this, multiple types of educational interventions in various types of formats have been utilized to prepare clients for therapy, such as individual pre-therapy interviews, video or audiotaped educational programs, brochures, etc. In an extensive review by Tinsley et al., (1988), the effectiveness of these interventions were reviewed, with audiotape or videotape rated as the most effective method for altering client expectations.

This study attempted to alter client expectations by using a more modern, interactive method of client education. A preparational program was developed based upon a comprehensive literature review and survey results. The program was presented to undergraduates in the form of an interactive CD-ROM in order to address possible expectations and misconceptions regarding the therapeutic process. This CD-ROM also contains re-enacted scenes from actual therapy sessions, to portray positive examples of therapist-client interactions within the therapeutic relationship. Undergraduates were asked to role-play the part of a client about to see a therapist for the first time, and their perceptions of therapy processes were recorded. After a two-day delay, one of three interventions were randomly assigned (CD-ROM condition, information-only condition, or no-intervention condition) and administered, and participants’ expectations and fears were reassessed. Additionally, the quality of the program was evaluated, and suggestions for modification were solicited from the undergraduates.
**Expectations**

One aspect to consider in the development of a pre-therapy client program is the various expectations that a client brings to therapy. There is some evidence that these expectations might influence therapeutic processes and outcome. However, research suggests that these expectations are often not effectively communicated in therapy. For example, in one study Korsch et al (1968) found that 65% of the client’s expectations were not communicated to health care providers. It is not possible to address expectations that are not communicated to health care providers. If these uncommunicated expectations are influential in terms of therapeutic process and outcome, and they are not discussed between patient and provider, then they must be addressed in a different manner. It’s possible that these expectations could be altered to be more accurate and representative of the therapeutic process, and by altering these expectations, therapeutic process and outcome may be influenced in a positive manner. This is a realm of uncharted territory; while there have been many studies that have sought to understand the nature of expectations, there has been little work focusing on how to manipulate (and possibly change) specific individual client expectations.

In the review that follows, the definition of expectations and how it relates to other constructs will be considered. Next, possible explanations for the formation of these expectations will be examined (e.g., gender, personality factors). Finally, the possible influences of expectations on the process and outcome of therapy will be
analyzed. In addition, the effects of anxiety and fears about psychotherapy will be assessed.

The definition of expectation has been evolving even before the onset of formal psychotherapy research, since Kulpe and Titchner (1909, in Boring, 1950, pp401-402) defined it as a “cognitively mediated preparatory set or disposition to behave in a particular way in a given situation.” Over time, definitions of expectation varied to include not only the client’s thoughts about what he/she realistically believes will happen, to what he/she wants and idealizes to happen in therapy.

Goldstein (1962) posited that there were two types of client expectations: the expectation of treatment efficacy, and expectations of the contribution of both parties (client and therapist) to the process of therapy. In other words, clients’ expectations focused on the process and outcome of therapy. In the present study, several specific types of client expectations were investigated; including those regarding the roles of the client and therapist, the preconceived notions clients may have about what occurs in therapy, and what the client expects to get out of therapy.

To facilitate the development of a questionnaire for the assessment of expectations, client expectations about counseling were operationalized by Tinsley, Workman, and Kass (1980) into four factors: (1) Personal Commitment, defined as self-expectations about motivation, openness toward counseling, and responsibility in the process, (2) Facilitative Conditions, which refer to client’s expectation towards acceptance, genuineness, trustworthiness, and confrontations, (3) Counselor Expertise, which are the client’s expectations that the counselor will be knowledgeable,
empathetic, and directive, and (4) Nurturance, the client’s expectations for support and care from the counselor.

In order to identify and assess expectations using these four factors, the authors developed a questionnaire that was designed to measure “all of the theoretically important expectancies a prospective client might have about counseling” (Tinsley et al, 1980, p. 563). This questionnaire is the Expectations About Counseling (EAC) questionnaire. Client expectancies were obtained through a literature review on research as well as previously developed questionnaires on client expectations. A number of client expectations were addressed, including: client attitudes and behaviors, counselor attitudes and behaviors, counselor characteristics, features of the counseling process and quality of the counseling process.

Four hundred and forty-six college students that were enrolled in introductory psychology courses completed the questionnaire. To control for prior knowledge about therapy, scores were included only from students who reported having no prior experience with counseling. An ANCOVA showed that women were more likely than men to expect facilitative conditions during the therapy process. It was also revealed that correlation between scores on the Personal Commitment factor and the realistic items (items relating to events clients might expect to happen in therapy, such as taking psychological tests or seeing a trainee or intern) indicate a client expectancy to dedicate time and energy to the counseling process. However, the authors hypothesized that very high total expectation scores may be indicative of perfectionist tendencies in the client, while extremely low scores may reflect an expectation that the
therapist will cure the client without the client’s involvement. Other hypotheses included the idea that moderately high scores on the Facilitative Conditions would denote good outcomes (Tinsley et al, 1980).

Subsequent factor analyses on the dataset aided the development of these four factors. First, all 205 items in the questionnaire were submitted to analyses on convergent and discriminant validity, as well as item variance and item mean, with a value of internal consistency set between .70 and .85. The degree of overlap between scales was closely observed. As a result of these careful analyses, sixty-eight items were dropped from the original scale, and three scales (respect, analytic and realism) were dropped. Seventeen scales were left, each with an internal consistency that fell between .78 to .89. Several different factor solutions were available, including three factors accounting for 70% of the variance, to six factors accounting for 81% of total variance. However, the most replicable option across subscales was selected, a four-factor analysis accounting for 75% of total variance. These factors were named by examining the specific items that each factor represented (Tinsley et al, 1980).

A later literature review by Tinsley et al (1988), organized client expectations into five general categories: (1) Counselor expertness, helpfulness, attractiveness, and trustworthiness, (2) Prognosis for therapy, (3) Therapist behavior and/or type of therapy, (4) Client behaviors and role expectations, and (5) General counseling process and procedures. This was done in order to facilitate a review of forty-six articles, each of which examined different sets of client expectations (Tinsley et al.,
1988). These categorizations will be discussed later in further detail, as they mirror the five subscales of Tinsley’s (1980) questionnaire about expectations.

The Expectations About Counseling-Brief (EAC-B) questionnaire developed by Tinsley, Workman, and Kass (1980) can be scored using either the four factor scales or the five general categories (or subscales) of client expectations previously discussed. The sixty-six items on the questionnaire can be combined to create either the four factors or the five subscales; therefore the same content about expectations is present in both computations. Neither the factors nor the subscales are given priority in the description of this measure. Consequently, it is up to the researcher to select either on the four factors or the five categories of this scale to suit their experimental purposes. For the purpose of this study, the rationally derived five categories (or subscales) were chosen as the focus, as they seemed to represent well-defined categories that were also inclusive of many types of expectations.

The definition of client expectations has become increasingly precise, as additional research has been carried out. A deeper understanding of the subject has allowed researchers to agree upon and more consistently use the same general definition of expectations. Most researchers examining client expectations have utilized the questionnaire developed by Tinsley et al. (1980). Additionally, no researcher has suggested an alternative method for grouping client expectations as presented by Tinsley et al., (1988). Tinsley’s studies (1980, 1988) represent the most recent definitions of expectations.
Development of Expectations

Although many studies have investigated the development of expectations, few have arrived at a satisfactory conclusion. Researchers have examined the influence of traditional doctor-patient relationships in medicine, gender, personality type, type of diagnosis, and current stage of change with varying degrees of success. The mechanisms for the development of certain types of expectations are unclear, although these studies have shed some light on the subject.

The traditional view of the doctor-patient relationship in medicine has been one in which the patient is seen as passive (Docherty, 1989). This patient role includes accepting the doctor’s advice and, in general, behaving in an unquestioning manner, and having complete faith in the doctor’s decisions. These role expectations have carried over to the mental health profession, giving clients the impression that the therapist knows what is best for the client. However, in recent years, there has been a focus on consumer issues. There is a movement towards a change in the traditional roles, with more focus on collaboration and cooperation between client and therapist. These things are thought to add to positive alliance and outcome (Docherty, 1989). Many prospective clients may be unaware that, in general, the traditional views of therapist-client roles no longer apply. This can lead to misconceptions and inaccurate expectations on the part of these prospective clients.

Some studies have focused on the factors that are associated with certain client expectations, such as gender, personality type, diagnosis, and current stage of change in order to pinpoint how expectations develop. Craig & Hennessy (1989) found that
both gender and personality structure can have an effect on expectations regarding the role of the counselor that the client brings with them to therapy. The authors also determined that the degree to which these expectations are either realized or refuted could be seen to have an impact not only on the initial progress of counseling, but also on the ultimate outcome of counseling. This study highlights two important ideas.

First of all, different people bring different expectations with them to the therapy session, and the particular type of expectation can depend on several factors, like the ones examined here. Secondly, the authors mention the importance of these expectations in regard to the outcome of therapy.

When related to the “stages of change” model (Prochaska, 1979), Satterfield, Buelow, Lyddon, & Johnson (1995) found that the stage of change that the client was experiencing was related to the client’s expectations about therapy. Clients in the precontemplation stage were more likely to have lower expectations for facilitative conditions. College-age clients entering counseling in the contemplation and maintenance stages had expectations relating to counselor responsibility in facilitating change. By assessing client expectations, counselors may be able to get a good idea about the stage of change the client is experiencing, and plan accordingly (Satterfield et al., 1995). With this knowledge, the therapist could have some idea of what issues the client might be most concerned with, and can plan to specifically address those issues with the client in session.

Although these possible catalysts for the development of client expectations have been considered in the research literature, results in this area are inconclusive.
The use of personality characteristics, gender, and diagnosis are inconsistent at best when trying to predict client expectations, as many studies have found conflicting or unreplicable results. The implications of this research certainly are interesting; nonetheless, they fail to explain the development of expectations using these variables.

One might wonder how expectations can be altered if their development remains a mystery. Unlike other features clients may bring to therapy, it may not be necessary to know how expectations develop before attempting to alter them. As will be seen later, studies have shown that client expectations can and have been altered without knowledge of how they come into being. If expectations can be changed, then that would imply that they are not permanent, and while understanding their development is important, it may not be crucial. It may be more advantageous to extend our efforts into altering client expectations while concurrently investigating their origins.

*Related Constructs*

There are several constructs that are similar or related to expectations, such as the level of client’s psychological mindedness, and what clients would prefer as an ideal therapy session. The term “psychological mindedness” was most recently defined by Conte, Plutchik, Jung, Picard, Karasu, and Lotterman (1990). Clients described as having “psychological mindedness” tend to be able to incorporate many aspects that are vital to therapy, such as motivation, capacity to make change, interest in the connection between feelings and behaviors, openness or willingness to share one’s problems, and interest in the meaning of one’s behavior as well as the behavior
of others. In general, psychologists agree that psychological mindedness is a desirable quality that may contribute to good outcomes. However, psychological mindedness is different from expectations about therapy in that it refers more to a skill that a person may or may not possess. A person’s level of psychological mindedness may be related to the kinds of expectations they have about therapy, although this relationship is yet untested in the literature.

In a more related area, some researchers have investigated what clients would prefer as ideal experiences in therapy. While most researchers investigating client expectations ask about what the client realistically expects to happen, these researchers are more interested in what the client would prefer to happen in therapy. This study does not specifically address client’s idealized expectations for therapy; however, these preferences may help explain how expectations develop in clients.

Common Factors

The role of common factors in the therapeutic process should not be overlooked. Common factors, generally speaking, are variables that are common to all forms of psychotherapy. It is strongly suspected that common factors may be significantly related to client improvement in therapy (Horvath, 1993). Common factors can include aspects such as client participation and the therapeutic alliance. One goal of the CD-ROM is to be used as a priming mechanism for these common factors through the use of role induction. It may be reasonable to assume that through role induction, clients would be more likely to take advantage of beneficial common
Role Induction. Numerous strategies for enhancing treatment participation through education have been developed. Two of the most widely used types tend to be preparatory techniques and motivational enhancement. Both of these methods are empirically supported, succinct, and can be easily incorporated into existing treatment systems (Walitzer, Dermen, & Connors, 1999). The program developed for this study can be considered a preparatory technique, which is generally known to provide a rationale for therapy, and familiarize clients with the process of therapy (Walitzer et al, 1999). More specifically, this program can be considered a form of role induction, which consists of didactic instruction that focuses on educating clients about the rationale for therapy, the therapeutic process, realistic expectations for change, prognosis, and examples of positive therapist and client behaviors.

While this program can be categorized as a type of role induction, it is comprised of an additional element, which is known as vicarious therapy pretraining, by including examples of actual therapy sessions (Walitzer et al, 1999). In a review by Walitzer et al. (1999), only five experiments run between the years of 1966-1985 had examined the effects of vicarious therapy pretraining. Two of these studies (Truax, Shapiro, & Wargo, 1968; Truax & Wargo, 1969, as cited in Walitzer et al, 1999) utilized a 30-minute audiotaped session between a client and therapist that included client exploration of problems and therapist responses, and showed that those who
listened to this intervention had better treatment outcome scores, as compared to a control group. Connell and Ryback (1978, as cited in Walitzer et al, 1999) used a 17-minute videotape to explain typical in-session client and therapist behaviors, and contrasted this with providing written materials, both, or none to clients. Results indicated that groups receiving the interventions displayed more facilitative therapeutic behaviors (Connell and Ryback, 1978; as cited in Walitzer et al, 1999).

Combining results from all five studies show mixed results about the effects of this type of pretraining on self-concept, outcome, and attrition (Walitzer et al, 1999). It is hypothesized that by combining role induction with vicarious therapy pretraining into one pre-therapy program will have the maximum possible beneficial effect for those who view it, by altering expectations to be more realistic, and by giving potential clients a better understanding of the therapeutic process.

Client Compliance and Participation. Expectations about counseling are thought to affect the client’s compliance and participation, which have a significant impact on the quality and results of therapeutic sessions. Studies on client compliance originated in medical trials, with results showing that increased amounts of information and client participation correlated with better treatment outcomes. Researchers in psychology began to investigate this construct with hopes that the same types of conditions might generalize to mental health. They have found that the relationship between the amount of client involvement and compliance is a complex one.
In general, studies have found that in situations where the client has increased participation and responsibility, the result is increased compliance and reduced attrition, which leads to improved outcomes. The opposite scenario, decreased feelings of control, tends to result in decreases in psychological health and well being (Docherty, 1989). These discoveries led researchers to new tasks, determining why greater levels of participation increase compliance, and investigating which components of the therapeutic setting might cause clients to have greater levels of participation.

It is possible that increased client participation is related to higher amounts of perceived control by the client. Increased feelings of control have been shown to be beneficial for clients; many studies have found that greater feelings of control are positively related to psychological well-being and physical health. Feelings of control also tend to enhance client satisfaction and performance. In other words, increased participation may lead to greater amounts of perceived control, which is correlated with better compliance rates and enhanced outcomes. Therefore, increasing the amount of client participation might affect therapeutic outcome in a positive way.

Increasing client levels of participation can be achieved effectively through education. By providing clients with materials describing their role as active participants in therapy sessions, they may enter into therapy with greater levels of perceived control. Educational materials might also affect client expectations, making them more realistic. When a client’s expectations about therapy are met, this may result in a greater feeling of control. On the other side, clients with inaccurate
expectations may feel a loss of control over the situation, and this may lead to a
decline in levels of participation. Several studies described below have investigated
this phenomenon.

Schulman (1979) found patients in an “active patient orientation” had better
control of blood pressure and greater adherence to treatment regimen then those who
were not in the orientation. In light of these results, she strongly suggested considering
patients as active participants in their own treatment. Roter (1977) found that an
intervention that encouraged patients to ask more questions resulted in greater
attendance at clinic appointments over four months. In addition, those patients
involved in the intervention tended to ask more direct questions than those in the
control group. The interaction between provider and experimental patients was
described as mutually sympathetic, while relationships between control patents and
providers were characterized by negative affect, anxiety, and anger (Roter, 1977).
Furthermore, Tracy (1977) also discovered that increased negotiations between patient
and provider during treatment decreased attrition. These results indicate that by
increasing client’s awareness and opportunity for participation in decision-making,
clients become more involved in their treatment, and have more positive, open
relationships with their health care providers.

Eager to find additional evidence to support the idea that increased levels of
control affect client participation, Eisenthal, Emery, Lazare, and Udin (1979) looked at
amount of negotiation in the initial interview in relation to client adherence in therapy.
In this approach, clinicians used a model that emphasized eliciting and responding to
client concerns in the initial interview and throughout treatment in the hopes of attending to conflict experienced between the counselor and client, thus giving clients more control over what was discussed in-session. Results indicated that adherence was related to negotiation as well as the client getting the plan he or she wanted (Eisenthal et al., 1979). Researchers have attributed some of these results to the increase in the amount of control that the client may feel (Schorr and Rodin, 1982). In summary, it seems that giving clients an opportunity to participate in their treatment, instead of dictating the treatment to them, results in better compliance with treatment planning.

Effects of the amount of client control have also been examined within the psychotherapy research literature, using previously mentioned medical studies as models. It was hypothesized that a perceived lack of control on the part of the client might result in higher attrition levels. Several studies have investigated the relationship between levels of perceived client control and premature dropout rates. These studies on attrition find that clients and therapists have different ideas on how many sessions the client should attend. Typically, reported dropout rates are high, even for therapy that is intended to be short term. A recent review put this rate at about 47% (Wierzbicki and Pekarik, 1993). Most of the research in this area has been inconclusive, with the exception of an association between low SES and attrition. Many researchers propose that more complex interactions should be examined, for example, mutual expectations and interactions between client and therapist (Piper, Ogrodniczuk, Joyce, McCallum, Rosie, O'Kelly, & Steinberg, 1999).
Recent findings show an inverse relationship between early alliance and dropping out. Heine and Trosman (1960) found that the kind of expectations that the client has was related to the number of sessions the client expects to attend. Those who terminated early tended to place importance on passive cooperation, expected specific advice, and had the least accurate expectations of the therapist’s role. These conflicting expectations between client and therapist may contribute to early termination (Docherty, 1989). In one medical study, Svarstad (1974) found that the more communication was stressed as important, the greater the agreement between the doctor and patient about the patient’s task. Communication is important and must be stressed within the therapeutic relationship, and may contribute to the client’s feelings of control.

Alliance. Piper et al. (1999) investigated the therapeutic alliance, client work, and client exploration, with an additional focus on transference. Twenty-two dropouts were compared with an equal number of completers that were matched on several variables. The authors found that, for the dropouts, a weaker therapeutic alliance was reported by clients early in therapy and also by therapists at the last session of therapy. They also found evidence that dropouts engaged in less dynamic work early in therapy. Additionally, they found that dropouts engaged in less exploration of their problems and focused more on transference during the last session. Piper et al. (1999) commented that the clients and therapists seemed to be caught in a power struggle, and as a result of this, the therapists might have been unable to avoid countertransference reactions. It might be reasonable to assume that the power struggle between the clients
and therapists in the Piper et al (1999) study had differing expectations regarding the specifics of each other’s role in therapy. As the client felt a loss of control within the session due to clashing expectations, disagreements may have occurred between the client and therapist. This may have caused the client to withdraw from the session, and eventually terminate early.

Tinsley, Tokar, & Helwig theorized that clients’ expectations about counseling could affect their behavior during initial career-counseling interviews (Tinsley et al., 1994). These authors hypothesized that clients who have strong expectations of assuming personal responsibility and experiencing facilitative conditions would engage in a higher level of involvement during an initial career-counseling interview than clients who scored relatively low on these expectations. They found that the clients who had relatively positive expectations about counseling also had significantly higher levels of involvement than did comparison clients who had relatively negative experiences (Tinsley et al., 1994). This finding highlights the importance of the interaction between client expectations and involvement in therapy. It may be that encouraging clients to assume some personal responsibility and to engage in facilitative conditions might affect their level of involvement in sessions.

Expectations and the Client’s Fearfulness about Therapy

Studies mentioned previously have linked client expectations to client adherence and therapy outcome. Other studies have compounded upon this evidence by examining how clients’ levels of anxiety might relate to client adherence and therapy outcomes. Anxiety can result when a person is confronted by a feared or
unknown situation (Oehman & Mineka, 2001). This feeling of a loss of control in certain situations causes that person to experience fear or anxiety (Oehman & Mineka, 2001). In this case, the unknown aspect of therapy or inaccurate expectations regarding the therapeutic process may cause the client to fear this situation, and thus experience anxiety when confronted with this scenario.

Recent research has suggested that a client’s fears about undergoing psychotherapy appear to reduce attendance. It may be that inaccurate expectations about therapy lead to greater levels of fear or anxiety in potential clients. It is hypothesized that inaccurate or negative expectations of therapy and counseling contribute to fear of mental health services and subsequent avoidance. Research on client preparation for medical procedures has shown a great reduction in anxiety, while research in the psychotherapy literature has only begun to scratch the surface.

Leventhal and Johnson (1974) explored the effect client’s anxiety might play in adherence and outcome by conducting a field experiment in a threatening situation. Two types of preparatory messages were constructed for forty-eight hospitalized medical patients who received an endoscopic examination. One was created to reduce emotional reactions, and the other to increase performance of danger-control behaviors. Results show the behavioral instruction message significantly affected the indicators of control of danger. Leventhal et al. (1974) hypothesized that preparation for therapy might also reduce anxiety levels in clients.

Along those same lines, McLeod and Deane (1994) theorized that expectations might moderate the amount of anxiety that clients experience. This was based upon an
integration of self-regulation theory (Leventhal & Johnson, 1983) with the attentional-bias model of anxiety (Mathews & MacLeod, 1985). Self-regulation theory suggests that negative expectations or therapy situations perceived as threatening by the client may lead to increases in state anxiety. It also proposes that providing information in an accurate and non-emotional format before stressful procedures facilitates development of non-threatening expectations about the approaching event (McLeod & Deane, 1994).

To test this, undergraduate students’ expectations and anxiety levels were recorded both before and after therapy sessions. Confirmation and disconfirmation of expectations were then compared to reported anxiety levels. Results of this study show that disconfirmation of client’s expectations did not have a negative effect on therapy process and outcome. They also found that confirmation of expectation by itself was not enough to reduce state anxiety. Additionally, lack of verification of expectations tended to result in anxiety for the client. The authors suggest discrediting negative expectations while confirming positive expectations for the best effect on client’s anxiety levels (McLeod & Deane, 1994).

Deane, Spicer, and Leathen (1992), conducted a study with subjects that were recruited from a clinic in New Zealand. The authors sought to examine the effects of a ten-minute preparatory video on state anxiety in clients, by examining client anxiety directly before and after presentation of the intervention. The videotape addressed issues such as the portrayal of psychotherapy as a learning process that could prove to be challenging to the client, clarification on the roles of the client and therapist, and
the importance of client communication. A Solomon four-group design was used as a manipulation check for the video. Results show that the videotape preparation increased the accuracy of clients’ expectations and reduced state anxiety. However, there was no evidence that the video had a positive effect on therapy outcomes after two months. These results suggest that the preparatory video had an immediate effect, in that the accuracy of expectancies was increased and state anxiety was reduced, but overall outcomes were not affected by the video (Deane et al., 1992).

The research described previously seems to indicate that expectations and anxiety affect several factors that are important to the therapy process, such as the therapeutic alliance, attrition, fear of treatment, compliance, and perceived control. Again, it would appear that inaccurate or negative expectations or fearfulness about therapy could decrease the chance for successful outcomes in therapy. However, increasing the amount of information a client has about therapy may reduce the incidence of inaccurate or negative expectations and decrease fearfulness, and thus increase client participation in the session. By addressing these issues, it may be possible to improve therapeutic outcomes.

*The Effects of Expectations on Outcome*

What kinds of effects do these expectations have on the therapy session? Previous studies have linked client expectations to therapy outcome. The question that remains unanswered is how specific expectations (accurate or not) are able to influence therapy. It is possible that therapeutic outcomes are more positive when the expectations of the client match what actually occurs in therapy. Along the same lines,
it may be reasonable to assume that inaccurate or negative expectations of therapy and 
counseling could contribute to the fear and subsequent avoidance of mental health 
services. A widespread perspective hypothesizes that confirmation of client 
effects of the therapist’s role would lead to therapeutic gains, and 

disconfirmation would be detrimental.

Although popular, this view is not consistently supported by the literature. 
Gaston, Marmar, Gallagher, & Thompson, (1989), examined how the expectations of 
elderly depressed patients affected treatment outcomes. Participants were assigned to 
one of four treatment conditions: behavior therapy, cognitive therapy, brief dynamic 
therapy, or a 6-week delayed treatment control group. Client expectations of change 
processes were not found to be related to outcome as a whole. However, some within-
group differences were noted among the different treatments. The authors considered 
the possibility that while expectations do not affect therapy overall, they may have 
some importance when examined with the particular treatment being offered. Gaston 
et al. (1989) concluded that there was a complex interaction of treatment variables and 
client expectations, where confirmation of some expectations was helpful and 
disconfirmation of other expectations was somewhat detrimental.

For example, the participants in the cognitive therapy condition who had 
greater expectations of being helped through behavioral and cognitive changes tended 
to show greater symptomatic reduction. Also, for those who received dynamic therapy 
treatment, less expectation of receiving relief from depression through medication and 
environmental modifications was associated with better quality of interpersonal
relationships. The authors demonstrated that the expectation of changing through taking medication and making environmental change was differentially related to interpersonal functioning. In other words, those who came into therapy expecting medication and environmental change to be the least helpful tended to have better interpersonal relationships with their therapists (Gaston et al., 1989). This could suggest that these clients considered their relationship with their therapist to be the most influential factor in their recovery.

Tinsley, Bowman, Barich (1993), also have assessed practicing counselors’ perceptions of their clients’ unrealistic expectations, as well as the possible effects of the expectations on the therapy process. Seventy-two psychologists were surveyed with a questionnaire based off the Expectancies about Counseling-Brief Form (EAC-B) questionnaire developed by Tinsley (1982). The psychologists reported perceiving that at least some of their clients had unrealistic expectations. Some of the most prevalent expectations were that psychologists perceive their clients as underestimating their own role in therapy, and overestimating the abilities of the counselor. This finding suggests that clients may need to become more aware of these roles in therapy. However, the authors caution that some unrealistic expectations were actually helpful. For example, when the client overestimated their need to be motivated and participate, and had unrealistically low expectations for counselor directiveness, outcomes were more positive than negative (Tinsley et al., 1993).

Some misconceptions can have more serious implications in determining whether or not someone chooses to seek therapy. Bram (1997) sought to examine
undergraduate’s perceptions of psychotherapy and psychotherapists, citing media and
cinema portrayals of psychologists as prone to act on countertransference. Two
hundred and sixty-five undergraduates participated in the survey. Bram found that in
general, the undergraduates had favorable views of psychotherapists. However, there
was a strong sentiment that the therapists were unable to appropriately deal with the
range of emotions that were provoked by their clients. Possible implications include
fearfulness and avoidance of therapy by those who may benefit from the services. The
author suggests that therapists continue to act in an ethical manner, to help combat
these misconceptions. He also suggests using public education to address this issue,
including formal media campaigns by mental health organizations (Bram, 1997).

The studies described above highlight the kind of influence that expectations
can have in therapy. The Gaston et al. (1989) study established that clients who have
expectations that more closely match what will actually happen in session tend to have
better experiences in terms of symptom reduction and interpersonal relationships.
Additionally, the potential danger of unrealistic expectations was demonstrated by
Tinsley et al (1993) and Bram (1997). By combining these two research findings, one
can see that it is important to address client expectations as soon as possible. As
suggested by the Gaston et al (1989) study, clients may come to therapy with
preconceived notions that affect treatment outcomes, and prevent them from receiving
the full benefit from the treatment. It may be that the process of altering expectations
becomes more difficult if it is not addressed prior to the start of therapy. Perhaps the
most significant impact on client expectations could be made before therapy begins,
with the hope of increasing chances for better therapeutic process and outcome. Theoretically, if a client finds that their experience with therapy generally agrees with their expectations, they may become more invested in the process. This may lead to increased participation in the therapeutic process, and possibly better outcomes.

**Educational Programs**

Mental health care providers often provide education to clients in many different forms, the most popular being low-cost, informative brochures that are often available in the waiting room. Nevertheless, there are other ways to address client expectations that may alter them more successfully, such as a more in-depth or interactive educational program. This kind of educational program can have a variety of effects, which can range from a better understanding of the therapeutic process to more desirable in-session behaviors. It is hoped that these interventions help prepare clients by providing them with a general idea of the therapeutic process.

A review by Reis & Brown (1999) shows that prepared clients tend to show decreased approval-seeking expectations and report a better understanding of the therapeutic process and the role of the client than non-prepared statements (Strupp & Bloxom, 1973, Talbot, 1981, as cited in Reis & Brown, 1999). They display more desirable in-therapy behavior, such as self-exploration and initiation of communication, develop better relationships with therapists, and see therapists as more interested, respectful, accepting, and report greater satisfaction. Prepared clients complete therapy in higher numbers, display higher attendance rates, and are less likely to miss appointments or terminate unilaterally (Heitler, 1973, as cited in Reis &
Brown, 1999). Therefore, giving clients information about therapy before their first session would seem like a good idea. Consider the alternative scenario, where clients are uninformed, or have inaccurate expectations about the therapeutic process. This would lessen those clients’ opportunities to reap the full benefit of therapy, and might even be have a negative impact on outcome. For these reasons, it seems important to identify negative or inaccurate client expectations so that they increase their chances of remaining in therapy, attending more sessions, and continuing to a mutually agreed-upon termination. The next step is to choose the best technique to disseminate information to potential clients.

Several different methods of preparing pre-therapy clients about the nature of the therapeutic process have been developed over the years. Manipulations used to try to influence client’s pre-therapy expectations include interviews, films, audiotapes, videotapes, and brochures. For example, Webster (1992) used an information sheet to describe what would occur during the initial assessment interview, and how intervention decisions would be made. Conversely, Zwick and Attkisson (1995) used a short videotape intervention to educate clients in their study.

In a comprehensive literature review, Tinsley et al., (1988) assessed different methods for manipulating clients’ expectations for therapy. They found that clients’ particular expectancies could influence three areas; who the client chooses as a help-giver (friend vs. therapist), the amount of persistence a client demonstrates in therapy, and assuming clients enter therapy and maintain appropriate contact, the effectiveness of therapy. The authors reviewed a total of forty-six articles, and arrived at three
conclusions. First, the use of complicated experimental interventions to alter expectations is unnecessary, such as verbal interventions, counseling interviews where the focus is manipulating clients’ expectations, or interventions that utilize multiple methods. Audiotapes and videotapes seem to be the most effective methods for educating clients. Second, confounding factors may affect the success shown with client education programs. For example, experience in actual counseling sessions may have an effect on clients’ expectancies, but it is unclear whether these changes are a function of counseling or due to some interaction between the session and the education sessions. Finally, the authors concluded that further research is necessary to determine the specific conditions under which manipulations are most effective (Tinsley et al., 1988).

Previously, Larsen, Nguyen, Green, & Attkisson (1983) found that clients who underwent a therapy preparation program reported greater symptom reduction 4 weeks after intake, and were less likely to drop out of therapy or miss appointments than the group without the intervention. These results were obtained using orientations that were tailored to the individual clients. Zwick and Attkisson (1985) examined the effects of a standardized informational videotape orientation with the goal of enhancing client response to therapy, as reflected by client symptom levels and functioning. The videotape consisted of eleven different points, which included describing psychotherapy as a learning process that could prove to be challenging to the client. The roles of the client and therapist were also highlighted, and the importance of client communication was stressed. The authors also examined effects
of preparation on client knowledge about therapy, and satisfaction with services at a community mental health facility. Questionnaires were given to clients at intake and at a one-month follow-up. Researchers found that the oriented clients were able to understand and recall the information presented in the video at both times. The oriented clients also reported a greater decrease in self-reported symptoms at the one-month follow-up (Zwick et al., 1985) indicating improved outcomes.

In another study utilizing an educational program focusing on client misconceptions, clients from a psychiatric clinic were asked to identify their expectations regarding therapy (Douglas, Noble, & Newman, 1999). These clients identified several misconceptions, ranging from psychiatrist’s role to outcomes of different types of therapy to concerns about stigma associated with mental health problems. After identifying misconceptions, participants in the study were shown a standardized ten-minute educational video about therapy, which discussed the roles of the client and therapist, as well as confidentiality, the content of the initial interview, causes of psychological problems and possible outcomes. The control group viewed a videotape providing information about healthy eating. After the video, the experimental group showed significantly more accurate expectations. Significant differences were also found between the groups for state or trait anxiety and satisfaction. In addition, most clients indicated that the video was useful and that it had prepared them for the consultation (Douglas et al., 1999). The video seemed to improve the accuracy of client’s expectations, and no negative associations were found with showing the videotape to clients. Although the authors caution that some
of the success of this intervention is due to limitations (a few participants had prior contact psychiatric services, and ceiling effects were observed on some measures) it would seem that videos are effective means of educating clients about therapy (Douglas et al., 1999).

Many medical studies have found that the more similar the expectations between doctors and clients, the more positive the effect on compliance. In particular, they found that congruence with the client’s expectations was the most salient predictor in terms of compliance (Docherty, 1989). Additionally, Kasl (1975) notes “the crucial element… is probably not the exchange of information and facts but the nature of the expectation each one has about his own role and the role of the other person in the dyad, the congruence and mutuality of such expectations and the potential for exploring and revising these expectations.” In other words, Kasl believes that matching expectations between the therapist and client should increase chances for a good outcome, more than the client and therapist simply exchanging information about their respective roles. Therefore, it seems important for the client to have a good understanding about the nature of therapy before it begins.

Researchers in this area suggest interventions such as clarifying roles, facilitating positive transference, providing early support for increasing alliance, and minimizing early dropouts. Preparational tools can increase client awareness of the therapeutic process, and this may help avoid common problems such as role confusion during sessions. With this prior knowledge, the client and therapist would be able to focus on their alliance and not be distracted by misconceptions. Conversely,
information on client roles may make them more active participants, thus increasing likelihood that expectations would be discussed. By increasing knowledge of the therapeutic process, and promoting the alliance between client and therapist, dropout rates may decline (Piper et al., 1999). Therefore, preparational tools may be useful in addressing a variety of issues.

Preparational tools may also be effective in reducing fearfulness associated with psychological treatment. Often, those who are most in need of psychological services are also those who are less likely to seek help. Public outreach programs or preparation for psychological treatment might be beneficial for those people who are in the early stages of help seeking. These interventions may reduce negative attitudes and treatment fearfulness, which contributes to mental health service avoidance. Giles and Dryden (1991) suggested that if “clients were to be desensitized to the fears that they may be likely to have about the therapeutic process before beginning therapy, its possible that premature termination…may cease to arise” (p. 91).

*The Content of a Preparational Pre-therapy CD-ROM*

A few studies have concentrated on assessing the types of expectations that clients and therapists have prior to attending therapy sessions. These studies have identified a wealth of assorted client expectations as well as misconceptions regarding various aspects of therapy. As mentioned previously, a literature review done by Tinsley, Bowman, & Ray (1988) attempted to categorize the different types of client expectations into five general categories. The categories consisted of expectations relating to: (1) Therapist expertness, helpfulness, attractiveness, and trustworthiness,
(2) Prognosis for therapy, (3) Therapist behavior and/or type of therapy, (4) Client behaviors and role expectations, and (5) General counseling process and procedures. As noted previously, the Tinsley et al (1988) categories serve as the expectation categories used in the present study. However, a more in-depth review of these categories and especially why it might be important for clients to be aware of these issues is provided below.

*Therapist Expertness.* Studies on counselor expertness, helpfulness, attractiveness, and trustworthiness have found that these misconceptions are prevalent in clients today. Glass and Arnkoff’s (2000) review of several papers indicate that some clients believe that the therapist is an “expert” that should not be questioned. Clients in other studies tended to express similar viewpoints, indicating those therapists are viewed as problem-solving experts (Schulman, 1979). These ideas imply that the client may feel unable to make his or her own decisions, and it would be acceptable for an “expert” therapist to force treatment upon clients who refuse. Clients also tend to feel that there is no hope of changing the mental health system (Glass & Arnkoff, 2000).

These viewpoints may have detrimental effects on a client’s willingness to attend therapy, and to achieve the type of relationship with the therapist that would be necessary for successful outcomes. There is reason to believe that there may be negative consequences associated with client assumptions about therapist power (i.e., exaggerated beliefs about expertise). For example, Bram’s (1997) research suggests that the general public is wary of therapists engaging in forms of unethical behavior,
such as improper sexual advances or relationships with their clients. However, Murstein and Fontaine (1993) found that survey respondents rated their level of comfort with physicians and psychologists at about an equal level. This suggests that the general public is perhaps slowly becoming more accepting of psychologists (Murstein & Fontaine, 1993), even though negative feelings remain. These results imply that negative impressions of psychologists can be changed or altered for the better.

_Prognosis for Therapy_. Prognosis in therapy is another important aspect as indicated by clients. Some clients may believe the myths that a lifetime of psychiatric drugs is essential for the treatment of mental illnesses for symptom control and management (Glass & Arnkoff, 2000). Mental illnesses are considered by some to be lifelong and irreversible, they believe there is no such thing as recovery or cure; therefore, the focus is on maintenance of the disorder. These myths may cause people to develop a hopeless attitude toward their problems (Glass & Arnkoff, 2000).

Even more disturbing, in comparing therapist and client expectations, Schulman (1979) found differences between the degree of expected change and expected duration of psychotherapy. Researchers have noted a correlation between higher rates of attrition and less accurate expectations (Heine & Trosman, 1960), and a weaker therapeutic alliance and less problem exploration in therapy (Piper et al, 1999). Obviously, therapy cannot progress if the client terminates treatment early. These concerns highlight the need for clear communication between therapist and client on the subject of treatment duration and goals.
Therapist Behavior. Other clients have expectations about the behavior of the therapist and/or the type of therapy that is used in session. Douglas et al., (1999) found that clients had different outcome expectations regarding talking therapy vs. taking medication. Clients in the Douglas et al (1999) study identified several misconceptions in this area, including the role of the psychiatrist and the difference between psychiatrists and psychologists.

In terms of what happens during the session, Glass and Arnkoff (2000) found that clients expect an overemphasis on the medical or disease model of mental illness, and fear that the focus in therapy will be on defects, pathology, the importance of diagnosis, and possible misconceptions that the clinician may have. Bachelor (1991) found a correlation between therapist exploratory interventions and client ratings of a positive alliance, suggesting that greater involvement on the part of the therapist is important to clients. Additionally, information about the workings of therapy may dispel expectations related to in-session focus.

Client Behavior. Client behaviors and role expectations were examined by Schulman (1979). He found that clients tended to indicate an appreciation of the active role of the client in psychotherapy and were aware of the importance of the self in problem-solving. Furnham and Wardley (1990) found that subjects felt pressure to do something for themselves, although this had a negative connotation in this particular study. It may be that some clients are afraid that they will not succeed in therapy no
matter how hard they try, or it may reflect client frustration due to a lack of understanding of the therapeutic process.

Their own mental health status and concerns about confidentiality are also very important to clients (Douglas et al, 1999). These represent issues that should be directly communicated to the client by the therapist. As an active participant in therapy, clients should also be assured that they may ask questions about these issues at any time.

*General Counseling Process and Procedures.* Finally, clients often bring up concerns about general counseling process and procedures. These concerns include financial issues, (Schulman, 1979), the content of the intake interview, and the stigma of mental illness (Douglas et al, 1999). Other studies have included client unease about the act of labeling, pointing to concerns that this label would stick with that person for their lifetime, issues of stigma, prejudice, and discrimination (Glass & Arnkoff, 2000). The authors recommended forming groups to look at ways to fight the stigma and stereotypic portrayals of mental illness, help change discriminatory views of the terminally ill, and change laws and social policies. This compounds upon Schulman’s (1979) suggestion that greater efforts be made to educate the general public as well as individual clients about the realities of psychotherapy.

Additional areas of confusion seem to be a general uncertainty of when it is appropriate to seek psychological services. Faberman (1997) collected information from focus groups and a random telephone survey, and found that people would go to see a therapist if they experienced the loss of a job, a serious illness, death, stress,
family issues, and divorce, but were not aware that therapy could be sought for other issues, such as depression and anxiety. More than seventy-five percent of the respondents wished to have a better understanding of when it is appropriate to seek psychological help (Faberman, 1997). This data clearly illustrates the need for educational materials about therapy.

_A Preparational / Interactive Program_

A CD-ROM program was created for this study for educational purposes, and was shown as one of the possible three conditions. This program was developed to build upon previously used programs as well as to incorporate new aspects. These new aspects include a more modern CD-ROM format, and the addition of re-enacted scenes from actual therapy sessions to provide potential clients with examples of positive client-therapist interactions.

*Pre-therapy Interactive CD-ROM.* For the purpose of this study, an interactive CD-ROM was designed and created with the intention of providing information about therapy to those who are unfamiliar with the process. To begin, a thorough literature review was conducted, to assess possible aspects of therapy that would be useful for clients to know. Areas of consideration ranged from confidentiality issues to therapist-client role concerns (Table 1). Compounding upon this information, a survey was developed from the topics gathered in the literature review and distributed among faculty members at Ohio University. Results of the literature review and survey were
then combined to create a comprehensive interactive CD-ROM for pre-therapy clients (Table 2).
Table 1

*Research Related to Expectations*

<table>
<thead>
<tr>
<th>Expectation</th>
<th>Related Research on Client Expectations</th>
</tr>
</thead>
</table>
- Bram’s (1997), general public is wary of therapists engaging in unethical behavior,  
- Murstein and Fontaine (1993) level of comfort with physicians and psychologists at about an equal level.                                                                                       |
| 2. Prognosis for therapy                                                   | - Glass & Arnkoff (2000), treatment involves a lifetime of drugs, mental illness is lifelong and irreversible  
- Schulman (1979), therapist and client have different expectations for levels of change and duration of therapy  
- Heine & Trosman (1960), correlation between higher rates of attrition and less accurate expectations  
- Piper et al (1999) a weaker therapeutic alliance and less problem exploration in therapy                                                                                                      |
| 3. Therapist behavior and / or type of therapy                             | - Douglas et al (1999), different outcome expectations for “talking” vs. drug therapy, role confusion between psychologists and psychiatrists  
- Glass & Arnkoff (2000), overemphasis on medical or disease model, clients fear a focus on defects and pathology, and fear possible therapist misconceptions  
- Bachelor (1991) correlation between therapist exploratory interventions and client ratings of a positive alliance                                                                                   |
| 4. Client behaviors and role expectations                                  | - Schulman (1979), clients have some appreciation for taking an active role in therapy, are aware of the importance of problem-solving  
- Furnham and Wardley (1990) subjects felt pressure do to something for themselves  
- Douglas et al (1999) Client’s mental health status and concerns about confidentiality                                                                                                             |
| 5. General counseling process and procedures | - Schulman (1979), client concerns include financial issues  
- Glass & Arnkoff (2000), client issues of stigma and stereotypic media portrayals of mental illness, discrimination, laws and social policies  
- Douglas et al (1999), client concerns about the content of the intake interview and the stigma of mental illness |
Table 2

*Expectation Categories and the CD-ROM*

<table>
<thead>
<tr>
<th>Expectation Category</th>
<th>CD-ROM category</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Counselor expertness, helpfulness, attractiveness, and trustworthiness</td>
<td>Client and Therapist Roles / Expectations</td>
</tr>
<tr>
<td>(Counselor Characteristics)*</td>
<td></td>
</tr>
<tr>
<td>2. Prognosis for therapy</td>
<td>Establishing Goals</td>
</tr>
<tr>
<td>(Counseling Process and Outcome)*</td>
<td>Talking Openly</td>
</tr>
<tr>
<td>3. Therapist behavior and / or type of therapy</td>
<td>Client and Therapist Roles / Expectations</td>
</tr>
<tr>
<td>(Counselor Attitudes and Behaviors)*</td>
<td></td>
</tr>
<tr>
<td>4. Client behaviors and role expectations</td>
<td>A Safe Place</td>
</tr>
<tr>
<td>(Client Attitudes and Behaviors)*</td>
<td></td>
</tr>
<tr>
<td>5. General counseling process and procedures</td>
<td>Privacy</td>
</tr>
<tr>
<td>(Client Characteristics)*</td>
<td>First Session</td>
</tr>
<tr>
<td></td>
<td>Diagnosis and Labeling</td>
</tr>
</tbody>
</table>

* Indicates the corresponding subscale on the EAC-B
Informal Content Analysis. A survey of client concerns was created from the information gathered from the literature review for the purpose of providing some expert assessment of the practical importance of the weight of the expectation categories. The survey tapped into five general categories of expectations: (1) Counselor expertness, (2) Prognosis for therapy, (3) Therapist behavior, (4) Client behavior, and (5) General counseling process and procedures. Within each of these categories, a number of items were addressed, based upon literature reviews of similar studies. These identified items were to be rank ordered to the extent of helpfulness in addressing the particular issue with a client. The Likert-type scale ranged from one to five, with one being the “least important” and five being the “most important.” Four colleagues reviewed this survey prior to distribution. Then, the surveys were circulated among “experienced” psychologists – those with a Ph.D or Psy.D in Psychology, and several years of experience with clients. Upon completion, the surveys were returned to the author. The average of the ratings given to each item by the psychologists were taken. Ratings for individual items averaged from 4.4 to 2.5.

Results of the informal survey show that informing the client about their role in therapy is the most helpful aspect for the client to be aware of before beginning therapy. Additionally, the raters indicated that out of all given topics, client awareness of possible negative repercussions for being in therapy is the least helpful to know about prior to therapy.
Hypotheses

This study tested the following hypotheses:

1. Participants who watched the video-enhanced CD-ROM will show less fearfulness towards mental health services than participants who watched the information-only presentation and the no-treatment control group.

2. Participants watching the video-enhanced CD-ROM will show a better understanding of therapy expectations than participants who watched the information-only presentation and the no-treatment control group.

3. Participants watching the video-enhanced CD-ROM will indicate that they are more likely to seek professional counseling than participants who watched the information-only presentation and the no-treatment control group.

4. Participants watching the video-enhanced CD-ROM will rate it as more helpful, and containing more information they did not know, as compared to the ratings given to the information-only presentation.

5. Participants with prior mental health experience will have higher, more accurate expectations, and show less fearfulness towards mental health services, regardless of the group to which they are randomly assigned.

Methods

CD-ROM Creation. According to the findings of the literature review and the results of the survey, the content of the interactive CD-ROM were chosen. A written
text was developed to educate prospective clients in more detail. In addition to showing on the screen, the text is also narrated throughout the program.

In order to give viewers an example of good therapeutic interaction, it was decided to include short segments of actual therapy sessions to highlight some examples of good working relationships that are described in the text of the video. Videotape-recorded sessions from the Vanderbilt II study (Strupp, 1993) were examined for cases of good therapist-client interaction on the topics chosen for the CD-ROM. Scores from the Vanderbilt Psychotherapy Process Scale (VPPS) were used to help determine appropriate sessions. The VPPS is a scale used to assess significant aspects of client-therapist interactions in counseling or psychotherapy, and is applicable to a wide range of interactions within therapy sessions. Sections were chosen to represent examples of client confidentiality concerns, the therapist and client collaborating on role definitions, and the therapist making sure they were working on topics relevant to the client.

Once the sessions were chosen, theater students from Ohio University were hired to re-enact the selected therapy sessions on videotape in order to preserve confidentiality of the original session. The students were closely monitored to assure the therapist, clients, and content of the sessions were accurately represented. The CD-ROM program itself is an integration of the narrated and printed educational text with the video clips (Appendix A). The video clips serve to highlight the main points, as well as to provide examples of appropriate interactions.
The original format of the CD-ROM program is interactive. The material contained in the CD-ROM is grouped according to content. Viewers may choose the topics that they wish to view, and may also choose the order in which they are viewed. In addition, an optional menu provides additional information available at the viewer’s discretion. For the purposes of this study, the information available on the main menu of the CD-ROM was streamlined to run as a program, to assure that each participant viewed all of the material. The length of this program is approximately twenty minutes.

To contrast the effects of the CD-ROM program, an information-only PowerPoint presentation was created. This presentation is a collection of information taken from literature made available to all clients in leaflet form by the Ohio University Psychology and Social Work Clinic, brochures from the Counseling and Psychological Services at Ohio University, and information provided online by the American Psychological Association (APA). It consisted of black and white slides, and was presented to participants as a timed sequence to mimic the CD-ROM presentation. Unlike the CD-ROM program, there is no narration of the text in the information-only presentation. The length of this presentation is approximately ten minutes.

Participants. A total of ninety undergraduate students at Ohio University participated in this study. Undergraduates were chosen as a “test audience” for the CD-ROM program to test validity as well as ease of administration. Research has
shown that study results pertaining to attitudes and beliefs of undergraduates and nonfaculty university staff tend to be similar, allowing for the belief that samples involving college students are “generalizable to at least some other adult populations” (Wong, 1994).

In the first stage of the experiment, undergraduates’ expectations about fears about therapy, and levels of social desirability were assessed, and demographic information. At the second stage of the experiment, participants were assigned to one of three conditions by drawing a number representing the condition out of a tin. Block randomization was used, so that each condition was closed after thirty people had drawn that number. The first group (Group 1) viewed the interactive CD-ROM. The second group, (Group 2) viewed the information-only presentation. The third group (Group 3) did not receive any type of intervention. All groups filled out questionnaires.

The study was administered to groups of up to 15 people at a time. The total length of the experiment was about two hours, with one hour allotted for each separate stage. The length of the interactive CD-ROM intervention is about twenty minutes, the information-only presentation is approximately ten minutes, and it took participants about thirty minutes to fill out questionnaires.

*Measures*

*Expectations About Counseling-Brief Form (EAC-B; Tinsley, Workman & Kass, 1980).* The EAC-B was developed as a 153-item questionnaire to measure
students’ expectations about counseling. In 1982 Tinsley developed a brief version of the questionnaire, the EAC-B. The EAC-B consists of 66 items rated on a 7-point Likert-type scale with response options that range from “not true” (1) to “definitely true” (7). The EAC-B consists of five different scales: Client Attitudes and Behaviors, Client Characteristics, Counselor Attitudes and Behaviors, Counselor Characteristics, and Counseling Process and Outcome. These five scales directly relate to the five general categories of client expectations discussed earlier: Client behaviors and role expectations, General counseling process and procedures, Therapist behavior and/or type of therapy, Counselor expertness, helpfulness, attractiveness, and trustworthiness, and, Prognosis for therapy, respectively (please refer to Table 2 for clarification). Scales are calculated by summing the responses to the items assigned to several smaller subscales, and dividing these subscales into their respective categories. The range of possible scores on each scale is as follows: Client Attitudes and Behaviors (10-70), Client Characteristics (13-91), Counselor Attitudes and Behaviors (21-147), Counselor Characteristics (12-84), and Counseling Process and Outcome (10-70). A total expectation score may be obtained by adding the scale scores; however this score is of limited usefulness due to differences in scale calculations.

Item responses can also be used to calculate factor scores. The EAC-B has four factors: Personal Commitment (responsibility, openness, motivation, attractiveness, immediacy, concreteness, and outcome); Facilitative Conditions (acceptance, confrontation, genuineness, trustworthiness, tolerance, and concreteness); Counselor Expertise (directiveness, empathy, and expertise); and Nurturance (acceptance, self-
disclosure, nurturance, and attractiveness). Factor scores are calculated by summing the responses to scale scores assigned to each factor. These scale scores are then added together and divided by the number of scale scores per factor. The range of possible scores on each scale is as follows: Personal Commitment (23-161), Facilitative Conditions (18-126); Counselor Expertise (9-63); and Nurturance (12-168).

Secondary analyses of data from six investigations resulted in subscale scores that correlated at .83 or better. Internal consistency reliability, tested by Tinsley (1982), ranged from .69 to .82 based on ratings done by 446 undergraduates, with a median reliability of .77. Test-retest reliabilities for a 2-month interval range from .61 to .87, with the exception of .47 on one scale, and a median of .71. Further research has also demonstrated that the EAC-B discriminates between client expectations about counseling and two other client constructs, perception and preference (Tinsley and Westcot, 1990).

*Thoughts about Psychotherapy Survey (TAPS; Kushner & Sher, 1989).* The TAPS is used to assess the amount of fear the participants have of mental health services. Fearfulness of treatment can result from aversive expectations surrounding seeking and utilizing mental health services (Kushner & Sher, 1989). This survey was developed by Kushner & Sher (1989) from the Thought About Counseling Survey by Pipes, Schwarz and Crouch (1985). Those filling out the questionnaire are asked to imagine that they are seeing a therapist for the first time, and must rate a number of
questions on a five point Likert-type scale, ranging from 1 (I have not been concerned about this) to 5 (I am very concerned about this).

The TAPS looks at three main factors: therapist responsiveness, image concern, and coercion concerns. Therapist responsiveness deals with fears about therapist competence and professionalism, image concerns refer to fears of negative judgment by therapist or oneself for seeking treatment, and coercion concerns are regarding fear about being pushed to think, do, or say things related to their problems in a new way. Deane and Chamberlain (1995) later added a fourth scale to represent social stigma concerns that consisted of eleven items. These fears included being judged negatively by friends, family or employers for seeking treatment. Additional tests revealed a Cronbach’s alpha for all four scales ranging from .92 to .87, indicating reliability among all scales.

Marlowe-Crowne Social Desirability Scale (SDS-short form; Reynolds, 1982)
The SDS was developed as a 33-item scale to measure socially desirable behaviors (Marlowe & Crowne, 1960). The items consisted of a list of socially undesirable behaviors that are unlikely to occur, rated as either true or false. The scale is scored by adding up points based on the rater’s responses. Scores range from 0 (little socially desirable responding) to 13 (high on socially desirable responding). Reliability is shown at 0.75. The short form of this scale was created by Reynolds, (1982) from 608 undergraduates' responses to the Marlowe-Crowne Social Desirability Scale, (MCSDS). Item factor loadings, short form with MCSDS total scale correlations, and
correlations between MCSDS short forms and the Edwards Social Desirability Scale were conducted. Internal consistency reliability was shown at .07. Results indicate that the 13-item short form can be used as a viable substitute for the regular 33-item MCSDS (Reynolds, 1982). This measure was chosen to control for possible effects due to social desirability in undergraduate responses.

Demographic Information. All subjects were given a demographic questionnaire (Appendix B) to gather personal information, such as age, gender, major, ethnicity, personal use of mental health services, if they knew anyone who had been in therapy, if they had ever felt like they needed counseling services, and how well they understand the process of therapy. If the participant indicated that they had personally been in therapy before, they were asked additional questions, such as rating the level of satisfaction with the services they receive(d) and the likelihood they would recommend therapy to others. If the participant answered that they had not utilized mental health services in the future, they were asked how likely they are to seek therapy in the future.

Post-treatment Questionnaires. Subjects in Groups 1 and 2 were given a post-treatment questionnaire (Appendix C) that assessed the usefulness of the treatment they received in their group. Questions addressed issues such as the helpfulness of the information presented, the amount of information presented that the participants did not know, and the length of time in which the information was presented. Participants were also asked for suggestions on how to improve the intervention, whether the
intervention changed their opinion of therapy, and if they are more likely to consider therapy in the future.

*Short Quiz Material.* Participants in Groups 1 and 2 filled out a short quiz that was tailored to their assigned intervention (Appendix D). The questions are multiple-choice and refer to information that was directly presented during the relevant intervention. Participants in Group 3 did not receive this questionnaire.

*Follow-up Questionnaire.* The follow-up questionnaire (Appendix E) assessed how much the subject’s expectations about therapy changed since the first part of the study. They were asked what, if anything, affected their expectations, and how likely they are to seek psychological services in the future.

Time One questionnaires consisted of the EAC-B, TAPS, SDS-short form, and a demographic questionnaire. Time Two questionnaires consisted of the EAC-B, TAPS, a short quiz that corresponded to the particular type of treatment (Appendix D) and a follow-up questionnaire designed by the researcher (Appendix E). Groups that receive information about therapy also filled out a post-treatment questionnaire asking about the effectiveness of the intervention they received.

*Procedure*

This experiment was conducted at two time intervals, spaced approximately two days apart. Each meeting lasted for approximately one hour. Participants were chosen based upon sign-up sheets posted on the first floor of Porter Hall, asking for volunteers for an experiment about expectations and reactions. At Time One, all
participants filled out the EAC-B, TAPS, Marlowe-Crowne short form, and a demographic questionnaire. Each participant received a folder, with a consent form, the demographic questionnaire and the SDS-short form on top. Upon finishing these forms, the participants were instructed to open the folder and fill out the remaining forms. These forms included a page of instructions, the EAC-B questionnaire booklet, an EAC-B answer form, and the TAPS. These questionnaires were secured with a paper clip, with printed instructions on the top. The instructions were as follows, adapted from Tinsley et al (1980):

“Please think of a stressful life event that you have experienced, one that you might have wanted to talk about with a counselor or therapist. Now, pretend that you are about to see a psychologist for your first interview. We would like to know just what you think counseling will be like. The following questionnaires have statements about therapy. In each instance you are to indicate what you expect therapy to be like. The rating scale we would like you to use is printed at the top of each questionnaire.

Your responses will be kept in strictest confidence. Your answers will be combined with the answers of others like yourself and reported only in the form of group averages. Your participation, however, is voluntary. If you do not wish to participate in this research, just hand over the questionnaire and unmarked answer sheets back to me. You will still receive one hour of credit for your time. When you are ready to begin, answer each question as quickly
and as accurately as possible. Finish each page before going on to the next.

After you finish your questionnaires, please bring them to me.”

Upon completion of all questionnaires, participants were reminded to discontinue their role as a client and given a copy of the consent form and a reminder about the second part of the study.

At Time Two, students were randomized into one of three groups by drawing a number out of a box, which corresponded to their condition assignment. Participants were assigned to one of three groups. The first group (Group 1) viewed the interactive CD-ROM. Sets of headphones were available at each CD-ROM station to allow for private listening of the program. The second group (Group 2) watched the information-only presentation. The third group (Group 3) did not receive any intervention. Participants sat in an assigned section of the computer lab according to their group assignment. After completing the intervention, all participants filled out Time Two questionnaires, beginning with a short quiz pertaining to their intervention group, and then the EAC-B, TAPS, and a follow-up questionnaire. Participants in the pre-therapy interactive CD-ROM group and the literature group also filled out a post-treatment questionnaire designed to assess the usefulness of the interventions.

All questionnaire data was entered into an SPSS spreadsheet for analysis. An ANCOVA was performed on the time one questionnaires, with group assignments as the independent variables, and the questionnaire scores as dependent variables. For the post and follow-up data, a repeated measures ANCOVA was performed to assess change over time.
Results

Demographic information (age, year, gender, and ethnicity) was examined using a chi-square analysis to ensure that the three groups were statistically similar. The average age was 20.34 years, with a range from 18 to 55 years. Of the ninety participants, seventy-seven (86%) identified themselves as Caucasian, six (7%) as African American, two (2%) as Asian or Pacific Islander, two (2%) as Hispanic, one (1%) as American Indian, and two (2%) as “other.” The majority of the participants (39%) were freshman, followed by sophomores (24%), juniors (18%) and finally seniors (15%). Twenty-eight (31%) of the sample were male, and sixty-two (69%) were female. Identified majors that represented more than two percent of the responses included early childhood education (9%), psychology (9%) sport industry (4%) and undecided (7%). There were no significant differences between groups with regard to these demographic variables (Table 3). Therefore, there was no need for statistical manipulation of these variables. Next, the individual hypotheses were examined.

Omnibus tests were run on the dependent variables TAPS, which measured level of fearfulness towards mental health services, and for each of the five subscales of the EAC-B, which measured client expectations, with group assignment as the independent variable (Table 4). If the results were significant, orthogonal planned comparisons were run using one-way ANCOVAs to determine which group was significant. Only significant planned comparisons were reported (Table 5). For each test, the Marlowe-Crowne was run as a covariate. All reported means represent the
adjusted means provided by this analysis. In order to see if gender or previous experience with therapy had an influence on our hypotheses, both of these variables were included in all analyses as well. No gender effects were found, therefore, these effects were not included in our data analysis. However, previous experience with therapy did have a significant effect on hypothesis number two, and is discussed in that section.

To examine whether participants who watched the interactive CD-ROM showed less fearfulness towards mental health services than participants who watched the information-only presentation and the no-treatment control group, an omnibus test was performed that included TAPS as the dependent variable. Tests were run with scores from the Marlowe-Crowne social desirability scale as a covariate.

The repeated-measures ANCOVA revealed a significant interaction between overall TAPS scores from pre to post intervention and group assignment, $F(2, 86) = 8.99, p < .001$. To examine this group interaction over time on the TAPS scores, a planned comparison analysis using a one-way ANCOVA was run on the change in scores from pre to post intervention for each group (post-intervention scores subtracted from pre-intervention scores). This analysis revealed significant findings. The mean change in scores for the CD-ROM group ($M = 20.8, SD = 22.16$) was greater than the mean change in scores for the information-only group ($M = 11.4, SD = 15.62$), $F(2, 89) = 4.62, p = .034$. The mean change in scores for the CD-ROM group was greater than the mean change in scores for the control group ($M = 2.47, SD$
60

= 11.2), $F(2, 89) = 17.57, p < 0.001$. Additionally, the mean change in scores for the information-only group was greater than the mean change in scores for the control group, $F(2, 89) = 4.17, p = 0.044$. There were no significant interactions between TAPS scores and the Marlowe-Crowne.

Next, the data were examined to assess whether participants watching the educational CD-ROM demonstrated a better understanding of therapy expectations than participants who watched the information-only presentation and the no-treatment control group. An omnibus test was set up to include the level of client expectation from each of the five EAC-B subscale scores as the dependent variable, and group assignment as the independent variable. Again, tests were run with scores from the Marlowe-Crowne social desirability scale as a covariate. The five subscales of the EAC-B were then tested with a within-subjects repeated measures ANCOVA to determine differences between pre and post intervention scores.

Two of the five subscales showed group interactions as the result of the omnibus repeated-measures ANCOVA. Client Characteristics showed a significant group interaction over time, $F(2, 86) = 7.93, p = 0.001$. A one-way ANCOVA planned comparison analysis was run to identify the location of this effect. This analysis uncovered a significant difference between pre and post intervention scores for the CD-ROM group ($M = -5.77, SD = 7.03$) and the information-only group ($M = -0.43, SD = 8.17$), $F(2, 89) = 9.56, p = 0.003$. There was also a significant difference between the scores from the CD-ROM group and the control group ($M = 0.73, SD = 4.25$), $F(2,
(2, 89) = 14.16, \( p < .001 \). There was no significant difference between the information-only group and the control group.

The Process and Outcome of Therapy subscale also demonstrated a significant group interaction over time, \( F(2, 86) = 3.09, \ p = .050 \), when pre- and post-intervention results were compared using a repeated-measures ANCOVA. A one-way ANCOVA planned comparison analysis was run to compare results between groups. These analyses showed that there were significant differences in the pre to post intervention scores between the CD-ROM group (\( M = 2.38, SD = 5.95 \)) and the control group (\( M = -.73, SD = 5.09 \)), \( F(2, 89) = 5.98, \ p = .016 \). The CD-ROM group was not significantly different from the information-only group, nor was the information-only group different from the control group.

The Counselor Attitudes and Behaviors scale was not significantly different in group change over time, \( F(2, 86) = .911, \ p = .406 \). However, there was a significant difference in scores for those who previous experience with therapy verses those who did not, \( F(1, 87) = 4.681, \ p = .03 \). The scores from those with previous experience increased by 2.92, while those without experience changed by only .41 from Time 1 to Time 2. The two final scales, Counselor Characteristics, \( F(1, 86) = .148, \ p = .702 \), and Client Attitudes and Behaviors, \( F(1, 86) = .211, \ p = .647 \) were nonsignificant in the group over time interaction.

A one-way ANCOVA was used to determine whether or not participants in the CD-ROM group were more likely to seek professional counseling then participants in
the information-only and control group. Results indicated that differences between groups were non-significant, $F(2, 89) = 2.38, p = .099$.

The next hypothesis stated that participants watching the educational CD-ROM would rate it as more helpful, and containing more information they did not know, as compared to the ratings given to the information-only presentation. A one-way ANCOVA showed that differences in “helpful” ratings between the CD-ROM and information-only groups was non-significant, $F(1, 58) = 2.39, p = .127$.

Finally, it was hypothesized that participants with prior mental health experience would have higher, more accurate expectations, and show less fearfulness towards mental health services, regardless of the group to which they are randomly assigned. A one-way ANCOVA revealed that there were no pre-treatment differences on the TAPS and EAC-B between those who had seen a therapist (N=25) and those who had not (N=65), $F(1, 89) = .936, p = .336$, and $F(1, 89) = .013, p = .909$ respectively.

Participants in both the CD-ROM and information-only groups were given short quizzes following the intervention as a manipulation check. The quiz for the CD-ROM group was twelve questions in length, and the questionnaire for the information-only group was six questions long. Upon examining results, one of the twelve questions on the CD-ROM questionnaire was thrown out due to researcher error. Of the thirty participants in the CD-ROM group, 30% (n=9) answered all eleven questions correctly, 57% (n=17) missed one question, 10% (n=3) missed two
questions, and 3% (n=1) missed seven questions. Seventy percent (n=21) of participants who filled out questionnaires following the information-only intervention answered all six questions correctly, 27% (n=8) answered five correctly, and 3% (n=1) answered four correctly. Since 92% of the participants (n=55) missed one or no questions, it was determined that most paid attention to their respective interventions.
Table 3

*Chi-Square Analyses of Demographic Data*

<table>
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<tr>
<th>Variable</th>
<th>Mean</th>
<th>Standard Deviation</th>
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<th>df</th>
<th>P value</th>
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</thead>
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<td>32.51</td>
<td>22</td>
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<tr>
<td>Year</td>
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<td>1.21</td>
<td>14.60</td>
<td>8</td>
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<tr>
<td>Major</td>
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<td>-</td>
<td>110.5</td>
<td>112</td>
<td>.522</td>
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<td>Gender</td>
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<td>.726</td>
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<td>.696</td>
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<td>.349</td>
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<tr>
<td>Understand (therapy)</td>
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<td>5.92</td>
<td>10</td>
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<tr>
<td>Seen (a counselor)</td>
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<td>.450</td>
<td>.111</td>
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<td>.946</td>
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<td>Need (counseling)</td>
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<td>1.94</td>
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<td>.378</td>
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<td>Seek (counseling)</td>
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<td>8</td>
<td>.097</td>
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<tr>
<td>Know (understand counseling)</td>
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<td>.493</td>
<td>2.5</td>
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<td>.287</td>
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Table 4

Revised Measures ANCOVA Results

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<th>df</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
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<tr>
<td>Fears</td>
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<td></td>
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</tr>
<tr>
<td>TAPS</td>
<td>2</td>
<td>8.99</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Expectations (EAC-B Subscales)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Client Characteristics</td>
<td>2</td>
<td>7.93</td>
<td>.001</td>
</tr>
<tr>
<td>Process and Outcome</td>
<td>2</td>
<td>3.09</td>
<td>.050</td>
</tr>
<tr>
<td>Counselor Attitudes and Behaviors</td>
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<td>.911</td>
<td>.406</td>
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<td>Client Attitudes and Behaviors</td>
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<td>.647</td>
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<td>Additional Questions</td>
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<td>Seek Professional Counseling</td>
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<td>.099</td>
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<tr>
<td>CD-ROM Better than Information-Only</td>
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<td>2.39</td>
<td>.127</td>
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<td>Previous Experience vs. None</td>
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<td>TAPS</td>
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<td>.936</td>
<td>.336</td>
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<tr>
<td>EAC-B</td>
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<td>.013</td>
<td>.909</td>
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Table 5

**Significant Planned Comparisons**

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<td><strong>Fears</strong></td>
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<td></td>
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<tr>
<td>TAPS (group*time)</td>
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<td>&lt;.001</td>
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<tr>
<td>CD-ROM vs. Information-only</td>
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<td>4.62</td>
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<td>CD-ROM vs. Control group</td>
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<td><strong>Expectations (EAC-B Subscales)</strong></td>
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<tr>
<td>Client Characteristics (group*time)</td>
<td>2</td>
<td>7.93</td>
<td>.001</td>
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<tr>
<td>CD-ROM vs Information-only</td>
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<td>9.56</td>
<td>.003</td>
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<td>CD-ROM vs. control group</td>
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<td>14.16</td>
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<td>Process and Outcome (group*time)</td>
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<td>.050</td>
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<td>CD-ROM vs. control group</td>
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<td>5.98</td>
<td>.016</td>
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Table 6

**ANCOVA Means and Standard Deviations at Time 1**

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<th>( G_2 )</th>
<th>( G_3 )</th>
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<tbody>
<tr>
<td></td>
<td>( M )</td>
<td>( SD )</td>
<td>( M )</td>
</tr>
<tr>
<td>TAPS (Fears)</td>
<td>88.93</td>
<td>20.49</td>
<td>86.47</td>
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<tr>
<td>Client Characteristics</td>
<td>41.81</td>
<td>1.46</td>
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<td>Process and Outcome</td>
<td>55.81</td>
<td>1.38</td>
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<tr>
<td>Counselor Attitudes and Behaviors</td>
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<td>64.85</td>
<td>1.89</td>
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<td>Client Attitudes and Behaviors</td>
<td>56.98</td>
<td>1.717</td>
<td>52.96</td>
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\( G_1 = \) CD-ROM group  
\( G_2 = \) Information-only group  
\( G_3 = \) Control group  
\( M = \) Mean  
\( SD = \) Standard deviation
Table 7

**ANCOVA Means and Standard Deviations at Time 2**

<table>
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<td>Client Attitudes and Behaviors</td>
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</table>

$G_1$ = CD-ROM group  
$G_2$ = Information-only group  
$G_3$ = Control group  
$M$ = Mean  
$SD$ = Standard deviation
Table 8

One-Way ANCOVA Means and Standard Deviations

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<th>Variable</th>
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<th>$G_2$</th>
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<td>$SD$</td>
<td>$M$</td>
<td>$SD$</td>
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<td>$SD$</td>
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<td>1.65</td>
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<td>$M$</td>
<td>$SD$</td>
<td>$M$</td>
<td>$SD$</td>
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</table>

$G_1$ = CD-ROM group
$G_2$ = Information-only group
$G_3$ = Control group
M = Mean
SD = Standard deviation
Discussion

This study assessed the effects of two pre-therapy interventions on undergraduates’ expectations and fears about therapy. As hypothesized, the CD-ROM program did have significant effects on fears associated with therapy, as well as certain types of expectations about the therapeutic process. In addition, this study allowed for closer examination of the CD-ROM program itself, as participants in the study were asked to provide feedback on various aspects of this intervention. These results will be instrumental in the continued development of the CD-ROM program.

The main purpose of this study was twofold: to examine the effectiveness of a video-enhanced CD-ROM against the more basic types of information that are already available to potential clients, and to test the content of the CD-ROM so that improvements could be made to the program. This CD-ROM program was created with the hopes that it might provide information to potential clients that would ease fears that are associated with the therapeutic process, as well as encourage more open communication between the therapist and client. Ultimately, it is hoped that these interventions would then increase the alliance between the therapist and client, leading to better outcomes.

Before these theories could be investigated in a clinical population, however, the content of the CD-ROM needed to be tested. To accomplish this, an examination of the effectiveness of that material in altering fears and expectations associated with therapy was necessary. For this reason, undergraduates were chosen to view the CD-
ROM program, and their results were compared with undergraduates in two other conditions, an information-only and no-intervention group on measures of expectations and fears. Comments were elicited from both intervention groups: the CD-ROM and the information-only group. This qualitative information will also be analyzed to assist with the revision of the CD-ROM program.

Fears

As hypothesized, the data suggest that the video-enhanced CD-ROM was effective in reducing undergraduate’s fearfulness about therapy. Both the scores from the CD-ROM and information-only conditions were significantly lower than the scores from the control group. In this particular setting, the information provided by the CD-ROM and the information-only intervention was sufficient to ease undergraduates’ fears by perhaps giving the client information about a previously unknown situation, or by altering inaccurate expectations that the undergraduate may have had about the therapeutic process. Analyses show that both the CD-ROM and information-only interventions reported significantly reduced fearfulness about therapy after their respective intervention. These results are consistent with self-regulation theory, which proposes that when information is presented in an accurate and non-emotional format before stressful procedures, it facilitates development of non-threatening expectations about the approaching event for those who may hold negative expectations about counseling, or consider the process of therapy to be threatening (McLeod & Deane, 1994).
The data indicate that providing a video-enhanced or information-only intervention describing the therapeutic process does alter clients’ fears about therapy. Similar to the study by Deane, Spicer, and Leathen (1992), it was found that the information content of the CD-ROM (psychotherapy as a learning process, role clarification, encouraging communication), was appropriate for addressing client fears. This idea is supported by the data, showing that the information-only presentation was also successful in significantly reducing fears about therapy. This is not surprising, since the information in both the CD-ROM program and the information-only presentation is similar in regard to content. It may be reasonable to assume that the information contained within the CD-ROM and information-only presentations were relevant to the types of fears that some people may have about psychotherapy, while the video-enhanced qualities of the CD-ROM had little impact on fears about therapy. This indicates that fears about therapy may be reduced by methods which provide only information (without the video-enhancement) to prospective clients, such as brochures and leaflets.

Expectations

The data collected have shown that, consistent with the literature, informative materials are helpful in altering expectations and fears related to therapy. This study shows that both the CD-ROM and information-only groups were successful in altering fears about the therapeutic process as well as some specific types of expectations. The effects of these interventions on the sum total undergraduate expectations were less
successful since there was no significant change in the total expectations score in any of the three groups. These results may indicate that that scope of information provided in each of the two active interventions was insufficient to address all of the five general categories of client expectations. It may also be a function of the how the five subscales interact to affect the total score. In four of the subscales, an increase in scores on expectations at post-intervention would represent a more realistic change of expectations (i.e., Client Attitudes and Behaviors, Counselor Attitudes and Behaviors, Counselor Characteristics, and Counseling Process and Outcome). However, on Client Characteristics, a decrease of scores on expectations at post-intervention would indicate a more realistic change of expectations in this setting. Therefore, the total expectations score is not as useful as examining the five subscales of expectations.

The Client Characteristics subscale, also referred to as the “Realism” scale, is considered by the authors to be the most experimental. That is, the scale must be scored in a way that reflects specifics of psychological procedures that are not universal to a client’s experience and therefore may be unique to the local situation. For example, college students can expect to “take psychological tests” as well as “see practicum students and interns for counseling.” However, this may not be the case for many clients seeking services at a private practice or other setting, which means that the results from this subscale might best be individually tailored to the context of the area in which it is administered.
Data analyses show that when the five subscales of the EAC-B were examined individually, some significant results were found. Tests on subscales revealed significant change in group scores over time on two other subscales, Client Characteristics and Counseling Process and Outcome, and near overall significant change over time on one subscale, Counselor Attitudes and Behaviors. Two other subscales, Client Attitudes and Behaviors and Counselor Characteristics, appear to be unaffected by either intervention utilized in this study.

In terms of affecting expectations, the CD-ROM displayed increased (more realistic) expectations scores over the information-only and control groups on one subscale, Client Characteristics, and decreased (more realistic) expectations scores over the control group on the Counseling Process and Outcome scale. However, the information-only group did not show changes in scores that were significantly different than the control group on any subscale. In no instance was the information-only intervention rated significantly better than the CD-ROM in affecting scores related to expectations. These results indicate that video-enhanced CD-ROM programs such as this one are altering the fears and expectations of those who view them. It may be reasonable to assume that a similar effect will be found in pre-therapy clients.

When the five subscales of the EAC-B were examined, data revealed that one of the subscales, Client Characteristics, showed a significant group interaction from pre to post intervention. In this case, the scores from the CD-ROM group were significantly lower at post-intervention (indicating more accurate expectations), while
the scores from the information-only and control groups remained relatively similar. Therefore, the CD-ROM was significantly more effective than the information-only intervention in altering these types of expectations. In this scale, participants rate items such as [I expect to] “Never need counseling again,” “Go to counseling only if I have a very serious problem,” and “Find that the interview is not the place to bring up personal questions.” A decreasing score for this scale generally indicates that the participants feel these events are less true.

Counseling Process and Outcome, the fifth subscale of the EAC-B, was also rated significantly different by groups over time. The scores from the CD-ROM group, which increased (indicating more accurate expectations), were found to be significantly different from the scores for the control group, which remained relatively similar. The scores of the information-only group also did not exhibit significant change, and showed no significant difference from the two other groups. Thus, only the CD-ROM program was able to affect this particular category. This section consists of questions such as [I expect the counselor to] “Help me identify particular situations where I have problems,” [I expect to] “Find that the counseling relationship will help the counselor and me identify problems on which I need to work,”, and “Gain a better understanding of myself and others.” In this case, an increase of scores indicates a more positive outlook regarding counseling process and outcome, as participants rate these situations as more true.
One possible reason for the greater success on the CD-ROM over the information-only presentation in affecting expectations is the way the information is provided. While both have similar basic informational content, the CD-ROM has audio narration that accompanies the information presented on the screen. Furthermore, there is additional information contained on the CD-ROM. This is exemplified by the length of the video-enhanced CD-ROM, which at about twenty minutes, is twice as long as the ten minute information-only presentation, due entirely to the video addition. This extra content on the CD-ROM consists of the re-enacted scenes from actual therapy sessions described previously. The videos shown in the CD-ROM may also help explain the differences found between the two experimental groups in terms of altering client expectations, although this was not directly assessed.

Another subscale, Counselor Attitudes and Behaviors, showed significant group differences over time when participants were divided by their previous experience with therapy. Those with previous experience showed significantly increased scores over those with no experience, suggesting that the actual experience of therapy provides an important basis for altering expectations related to this scale. Sample items for this scale include that the participant expects the counselor to “Tell me what to do,” “Know how I feel even when I cannot say quite what I mean” and “Talk freely about himself or herself.” Decreasing scores indicate that participant feel these statements are less true.
The two other scales, Client Attitudes and Behavior, and Counselor Characteristics, did not show significant differences from pre to post intervention. It may be that the scope of the CD-ROM and the information-only interventions was not comprehensive enough to address these particular scales. Both of these interventions were based off of literature searches as well as local brochures and online information. It may be the case that Client Attitudes and Behaviors and Counselor Characteristics are not well represented by these two mediums. Certainly these two headings are discussed within the literature; (see [Glass and Arnkoff’s, 2000; Schulman, 1979; Bram, 1997; & Murstein and Fontaine, 1993] and [Schulman, 1979; Furnham and Wardley, 1990; Douglas et al, 1999], respectively) however, they may not be as well represented in the CD-ROM and information-only materials. In other words, these concepts may be more theoretical than applied, due to the nature of their content.

In addition, these two constructs may be comprised of trait characteristics, thus making them more difficult to be altered in a single twenty-minute preparational program. Client Attitudes and Behaviors are generally described by Tinsley using such phrases as motivation, openness, and responsibility. These types of characteristics seem unlikely to be changed by any short intervention aimed at acculturating clients to the therapeutic process. Counselor Characteristics consist of categories such as attractiveness, expertise, tolerance, and trustworthiness. These are also features that may be difficult to alter with a short intervention, and may represent areas that the client would prefer to assess for themselves once they come face-to-face with their therapist.
The most optimistic possibility allows that there may be no room for improvement in these two areas. Ceiling effects may not have allowed for much alteration to be possible in these areas. For the Client Attitudes and Behaviors scales, the largest percentage of participants endorsed sixes and sevens at pre-intervention (seven is the highest possible rating), for almost all of the questions (Questions 5, 8, 9, 14, 15, 19, 25, & 29), while rating a five for two other questions (18 & 30) indicating that there was little room for improvement that could be measured significantly on this scale. For Counselor Characteristics, one particular grouping of items stood out, questions 2, 11, and 17, described as “attractiveness,” were consistently rated as “4” by the largest percentage of the participants at time one and at time two. The rest of the items assigned to this scale (Questions 36, 42, 45, 47, 50, 58, 60, 63, & 66), were rated with a 6 or 7 by the largest percentage of participants at time one, also indicating that a ceiling effect may have affected the results. The only exception to this was question 66, which was rated a 4 or 5 at time one by the greatest percentage of participants, and a 7 at time two by the greatest number of participants. Future revisions of the CD-ROM program will need to consider each of these aspects, and adjust accordingly.

Finally, the most simplistic explanation may be that the CD-ROM intervention did not enjoy a greater success rate due to the complexity of its design. Tinsley et al., (1988) found that more complicated interventions were unnecessary when attempting to disseminate information about the process of therapy. In some cases, results from this study demonstrate that the CD-ROM intervention was no better than the information-only intervention, suggesting that simpler methods of educating clients
are just as effective. These results imply that the original concept behind the design of the CD-ROM (tailoring the program to individual clients) might not show superior results to the current CD-ROM program, or even the information-only presentation, in some instances.

One of the more disappointing findings was that group assignment did not significantly impact the likelihood of a particular participant to seek mental health services in the future. While participants in the CD-ROM group were not significantly more likely to seek professional counseling as the other two groups, there may be several explanations for this occurrence. With a p value at .099, it may be that the sample was inadequate to determine differences between groups in this case. Additionally, the question itself may be flawed. The purpose of the CD-ROM as well as the information-only group is to dispel common misconceptions about the counseling process, while at the same time encouraging the prospective client to actively participate in the sessions. It is hoped that this process will encourage those who may have been ambivalent or apprehensive about counseling to seek services; however, it is not intended to encourage everyone to seek therapy. Future research will need to examine the effects of the CD-ROM on those who are apprehensive about attending therapy.

Data also showed that participants watching the CD-ROM were not likely to rate it as more helpful than those in the information-only presentation. These results may be due to the fact that this question did not involve a direct comparison between the two interventions. Participants watching the CD-ROM intervention were unaware
of the information only-intervention, and vice versa. Perhaps if the participants were able to make a direct comparison between the two different interventions, then the results may have been quite different. In this study design, participants did not have an identified intervention with which to make a comparison. Future studies will need to incorporate a more direct method of comparison to assess the relative utility of these two interventions. However, an item on the Follow-up questionnaire asked participants to rate how much their expectations about therapy had changed since the first part of the study. Those in the CD-ROM group (M = 3.87, SD = 1.69) rated their expectations as more different than those in the control group (M = 4.83, SD = 1.41), $F(2, 89) = 5.79, p = .017$. Expectations ratings form the information-only group (M = 1.51, SD = 1.42) showed marginal significance over the scores from the control group, $F(2, 89) = 3.63, p = .058$.

Finally, data also indicated that there were no discernable differences on either the TAPS or the EAC-B when comparing those with prior mental health experience (N=25) and those without (N=65). This is a very interesting finding, as previous tests of the EAC-B indicated this measure’s ability to discriminate between these two populations. Several different factors may be responsible for this finding. First of all, it may be that the sample sizes of these two populations were too disproportionate to allow for proper statistical procedures. Interestingly, those who had experience with mental health care (M=2.96, SD=.98) rated themselves as having a significantly higher understanding of the process of therapy as compared to those with no prior experience (M = 3.63, SD = 1.14), $F(1, 89) = 6.74, p = .011$. It could also be the case
that those with prior experience simply felt they had a greater understanding, when this was not actually the case.

Another aspect that may be important to consider is that all participants were currently enrolled in an introductory psychology class, which may have provided some with a basic understanding of the therapeutic process, without ever having attended a session. The title of the sign-up sheet was worded to advertise an experiment about “Expectations and Reactions,” to prevent possible self-selection based on knowledge of therapy; however, this precaution cannot control for word-of-mouth advertisement between classmates. Finally, since these data are based on self Report only, there is no way to verify that participants did or did not actually attend therapy.

Expectations and the CD-ROM

The sections of the CD-ROM were tailored to address each of the five categories of expectations, as described in Table 2. Therefore, it may be reasonable to draw some preliminary conclusions about the relative success of the CD-ROM program based on these sections (Table 9). Non-significant change in a category of expectations might indicate that certain parts of the CD-ROM need further revision. The Client Attitudes and Behaviors subscale was represented by “A Safe Place” on the CD-ROM. This section may not be sufficient to affect expectations relating to client attitudes and behaviors. However, some aspects of this data might suggest that
participants in this study may have already been familiar with this aspect of therapy, as suggested by possible ceiling effects on the EAC-B for this subscale.

Client Characteristics were represented by the sections on “Privacy,” “Establishing Goals” and “Talking Openly” sections of the CD-ROM. The content in this area, which included two video clips, may have been less familiar to the participants in this study. The video clips may have actively reassured clients that these topics were safe to discuss in therapy by effectively modeling appropriate interactions between the client and therapist.

The section on “Client and Therapist Roles / Expectations” was created to counteract unrealistic expectations relating to Counselor Attitudes and Behaviors and Counselor Characteristics. The content in this section may not be focused enough on the role of the therapist to be useful to those who view the CD-ROM. This represents a dilemma in terms of what to show in the CD-ROM. Information in this area was intentionally kept general in order to allow for the great amounts of variability in individual counselors’ personalities and style of therapy. However, it seems that this section of the CD-ROM might be more effective if the information presented included more details.

Finally, several sections of the CD-ROM address issues concerning Counseling Process and Outcome. These sections include “First Session,” and “Diagnosis and Labeling.” The amount of information concentrated in this area might be responsible for the success of the CD-ROM altering expectations about counseling
process and outcome. In fact, it seems that there was simply more information available in both subscales where the CD-ROM was able to significantly impact participants’ expectations. Following this hypothesis, it may be reasonable to assume that the addition of more detailed content about the three other types of expectation would yield significant results.
Table 9

*Expectations and the CD-ROM: Effectiveness of the Intervention*

<table>
<thead>
<tr>
<th>Expectation Category</th>
<th>CD-ROM category</th>
<th>Significant effects? Why?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Counselor expertness, helpfulness, attractiveness, and trustworthiness (Counselor Characteristics)*</td>
<td>Client and Therapist Roles / Expectations</td>
<td>No. 1. Insufficient content to address therapist characteristics. 2. Clients may withhold judgment until meeting with the therapist.</td>
</tr>
<tr>
<td>2. Prognosis for therapy (Counseling Process and Outcome)*</td>
<td>Establishing Goals Talking Openly</td>
<td>Yes. 1. This sections contains video clips 2. There is more information available than in some other areas.</td>
</tr>
<tr>
<td>3. Therapist behavior and / or type of therapy (Counselor Attitudes and Behaviors)*</td>
<td>Client and Therapist Roles / Expectations</td>
<td>No. 1. Insufficient content to address therapist behaviors. 2. Clients may withhold judgment until meeting with the therapist.</td>
</tr>
<tr>
<td>4. Client behaviors and role expectations (Client Attitudes and Behaviors)*</td>
<td>A Safe Place</td>
<td>No. 1. This section may not contain sufficient information to affect expectations relating to client attitudes, behaviors, and role expectations. 2. There may be ceiling effects on this subscale.</td>
</tr>
<tr>
<td>5. General counseling process and procedures (Client Characteristics)*</td>
<td>Privacy First Session Diagnosis and Labeling</td>
<td>Yes. 1. Included two video clips, which may have actively reassured undergraduates about a less-familiar topic by modeling appropriate interactions between client and therapist.</td>
</tr>
</tbody>
</table>

* Indicates the corresponding subscale on the EAC-B.
Limitations

There are several limitations to this study that must be taken into consideration while drawing conclusions. First, there are some limitations within the methods of this study that must be addressed. Perhaps the greatest limitation is that, as an analogue study, participants were role-playing the part of a client. Therefore, these findings may not be generalizable to clinical populations. Further studies will be necessary to determine the effects of the CD-ROM program on clinical populations. In addition, block randomization was used when participants were assigned to groups; therefore, the process was not completely random.

Another important aspect to consider is the clinical applicability of the CD-ROM intervention. One might consider the value of changing peoples’ expectations about the therapeutic process. What effects, if any, does this have on people’s cognitions or behavior? It is hoped that this intervention will positively affect those who watch it by increasing their likelihood of seeking therapy, as well as decreasing attrition and improving outcomes of therapy. The CD-ROM program did have significant effects on two of the expectations subscales, Client Characteristics, and Counseling Process and Outcome, as well as fears about the therapeutic process. However, is this enough to affect attrition levels and outcomes of therapy? The scope and design of this study is not broad enough to give a satisfactory answer to these questions.
Other concerns include the feasibility of providing pre-therapy clients with this intervention. One must wonder whether or not they will be likely to use such an intervention. There is some concern regarding the length and set-up of the current version of the CD-ROM. The original plans for the CD-ROM program specified a more interactive format enabling the user to choose the sections that held personal interest for them. For the purposes of this study, the different sections of this program were streamlined to run as one entire program, ensuring that each participant viewed all available material. In this conversion, the original concept behind the creation of the CD-ROM program was lost, and therefore the more “interactive” component of the CD-ROM cannot be assessed using the results of this study.

Finally, there is some speculation whether or not it is reasonable to begin testing this CD-ROM program with a clinical population based on the results of this study. Based on these results, specific improvements are planned for the program, including adding additional information and cutting the speaking parts, thus enabling viewers to proceed at their own pace. These changes can be tested again on undergraduates, however, it may not be possible to know that true effects of the CD-ROM without examining its effects on a clinical population.
References


Appendix A

Script for the Pre-therapy Interactive CD-ROM

INTRODUCTION:

The purpose of this CD-ROM is to give you some general information about therapy or counseling, and to dispel common misconceptions caused by media portrayal. We would also like to demonstrate some ways to make the most of your time should you ever seek counseling services. Many people are not familiar with the way that therapy works, and therefore can go into their first counseling session not knowing what to expect, from either the therapist or themselves. Other people have worries or concerns about what exactly will happen during the session, for example, worries about confidentiality, the therapist, or how to talk about their problem. Of course, not every therapy session will be the same, and not every therapist will use the same techniques. However, this program will provide general information that you may find useful.

Many misconceptions brought into therapy can revolve around paperwork issues. One of the biggest issues can be confidentiality. Clients may be confused about the extent of privacy in the session. This confusion may lead clients to be more guarded during initial sessions. The relationship that exists between the client and therapist is a confidential one. The therapist cannot break that confidentiality unless it is clear that the client intends to hurt his or her self or someone else. That means that the therapist will not discuss whatever the client says later when they go home, or while they are having lunch with their colleagues.

Next, we have a short clip that is a re-enactment of a real therapy session. In this clip, the client and therapist demonstrate an appropriate discussion regarding paperwork and confidentiality concerns.

Video Clip #1

P: What do you do after we talk? Do you write up notes, or is it, or do you just sort of keep a running tally in, in your head of where we’re going since it’s all on tape, or like what?
T: Uh, no. I, I write up a short note. Um, but it often doesn’t have very much in it.
P: Uh-hmm.
T: Um, I always have wondered about, you know, if you put it down on paper, what could happen to it. So I, I try not to put much in notes, I do keep most of it in my head. Uh, I don’t normally listen to the tapes over. I tried that for a while, um, and I found it didn’t help very much. Uh, it took a lot of time, but it didn’t seem to, I didn’t seem to learn very much from listening to the tapes over.
P: Uh-hmm.
T: I had, I’d not tried it with yours.
P: Yeah.
T: It was another patient that I did that with.
P: Uh huh.
T: But I, I didn’t find it, I didn’t find it as helpful as I expected it to be. So I stopped doing it. So I, I do pretty much what I would do, uh, in therapy, uh if there were no tape. That is, I would just try to
remember what happened. Uh, you know, when a topic comes up again, I try to remember well, what did we say about this last time we talked. [ten second pause] What are you wondering about, what I would write or say or something?

P: Well, I, I guess, if, if it was just written up as a, like as a case study, in a clinic, I just wondered what sort of jargon might be, uh, applied to me. Uh, but I guess more generally, how, I guess, how you would, view my progress.

T: Uh-hmm.

P: And, knowing what you know about how it’s progressed, how you might think it would progress further.

Another area that can create confusion is the nature of initial therapy sessions. For example, the first session usually consists of a more structured interview so that the therapist can get some background information on the client. After that, the focus of the therapy sessions will be on the tasks and goals the client and therapist created together. Many clients may not be expecting to have an assessment interview during the first session. They may also be surprised that the structure or content of the next session is different.

Some clients may be concerned about diagnostic issues with managed care. They may be wary of receiving a diagnosis that will “label” them, and also will dictate the number of sessions that will be covered by insurance. Or, clients may not even be aware that managed care companies control these issues. Knowing this may reduce frustration aimed at the therapist.

Establishing goals early in the session is a key aspect of successful therapy. Some clients may expect the therapist to provide all the answers, and not expect to be working collaboratively on shared goals. Working collaboratively with the therapist to establish these goals can make it clear to the client that their involvement is a necessary component for good therapy outcomes. With this knowledge, the client may become a more active participant in therapy. This is related to better outcomes in therapy.

Next, we will show a re-enacted segment from an actual therapy session highlighting a discussion of therapeutic goals.

*Video Clip #2*

P: But, um, I was thinking about what is going to happen here, when I come to see you, you know. If you remembered, I had seen a therapist before, a few years back, and like, will this time be different? And like how do I want to be different at the end of all this.

T: So you’re wondering about how to do this and what will happen. Maybe you could just tell me a little more about how you want to be like or how you want this to go.

P: Oh, I see, well, well, I won’t get into a big discussion about hoping that, uh,

T: Go ahead, don’t be afraid to ask today.

P: Well, no, I just know that, uh, I think it’s good if it can be condensed, you know, ‘cause seems like such a long time, I mean I know that a life time of problems can’t be fixed in a real short time. (T: Uh huh.) But, uh, if it can be condensed, you know, there’s some life left to live out there.
T: Are there some things even after our two sessions that seem to be coming out to be important, or clear cut for you as far as goals?

P: Um, I seem to be feeling better about myself. And, it’s kind of, I can’t really put my finger on anything, except that maybe, um, that I am doing something about my problems, (T: Uh-hmm.) instead of sitting around thinking about them, and letting them, you know, overwhelm me. Um, a lot of things we’ve talked about, I’ve been aware of, and know that, you know, that maybe they’ve caused me to be the way that I am, things about my past, and you know, my childhood, and all that stuff. But, uh, so far, um, I’m not so sure that, uh, I know how to deal with it all yet. I mean, I’m hoping that I can deal with it better in the future because of this. But, uh, I mean, but, like when I’m doing something, I can recognize, well, you know, maybe I’m doing this because of this or that, you know. Well it does happen sometimes, but, um, I’m hoping that it will get where I can recognize it and do away with it, you know.

T: Uh-hmm.

One of the most important aspects of therapy is the relationship that develops between the client and the therapist. The relationship that develops has the potential to affect the outcome of therapy. Clients sometimes are not sure how they are supposed to act in their role as “client” or “patient” in therapy. Clients also may not understand the nature of the work that is done. The role expectations of clients can dictate how therapy will progress. It is more beneficial for both the therapist and client to know what is expected of each of them.

This also true of the therapist’s role in the sessions. Clients sometimes do not know what to expect from the therapist, or what kind of treatment they will receive. It is not the therapist’s role to tell the client what to do, or to judge the client. Therapists are there to help the client sort out their thoughts and feelings, and to help guide them with any issues that may come up in therapy. Discussing these issues with the therapist can help the clients evaluate whether therapy is right for them.

There are guidelines that all psychologists must follow when treating clients. In order to behave in an ethical or appropriate manner, a therapist may not have a romantic or any other kind of relationship with a client outside of therapy. This also means that therapist should not treat family members or close friends. Therapist should always behave in a professional manner with their clients. Their responsibility to the client is that of a listener and to serve as a guide for the client.

Next, we have an additional segment that demonstrates a discussion of role expectations.

Video Clip #3

T: You know, I’m interested in your question and your wanting to make progress quickly.

P: [laugh] Well, I just didn’t know [laughs]. I don’t know, I feel like I’m supposed to be the one that talks, you know, or something. (T: Uh-hmm.) And, um, I just didn’t know, um, if I was supposed to [laughs], that sounds kind of silly, I guess. Um, I remember when I was in the hospital, and I had a psychologist, (T: Uh-hmm.) who, he wouldn’t say anything no matter what I said. It was real strange and real uncomfortable. And, uh, I just, uh, I got where every time I’d go in, I wouldn’t say anything either, you know, I’d say hello, and then we’d both sit down in chairs, and that was it. And he let me do
that, you know, and, uh, I don’t know what good it did, if it did any at all. And, uh, I guess maybe I just sort of had in the back of my mind that I’m supposed to be the one that does all the talking, and I, I know I do [laughs].

T: What do you expect of me, though?
P: Oh, well, I don’t know [laugh].
T: [laughs]
P: Uh, just some kind a response, you know, uh, some kind of feedback that might make me, uh, have some insight, or just, you know, a grunt or a nod is better than just nothing at all. I mean, the guy I’m talking about was sitting reading papers, not newspapers, but, you know, typed up memo’s it looked like, (T: Uh-hmm.) and not even look at me, or anything. And it was, uh, kind of hard to talk to him. (T: Uh-hmm.) But, you respond, you’re more human, it seems [laughs].

T: More human [laugh]?
P: Well, I mean, you talk.

T: In other words, you would like me to show some sort of response to what you’re saying, or struggling with, or trying to communicate.
P: Um, well, just some response, I mean, (T: Uh-hmm.) something, not necessarily to, uh, evaluating or something, or put words into my mouth, I don’t mean something like that.
T: Uh-hmm.
P: Because, um, I think a lot of what goes on up here, I mean, everybody thinks right up here, and even if I sat and talked to you for the rest of my life, there’s, you’d still have a different way of seeing it than I do.
T: Uh-hmm
P: And, uh, you know, maybe just a little encouragement to, to dig, and stuff, is what I’m looking for.

One essential thing for clients to remember is that therapy is structured as a safe place to talk about issues that bother or upset them. Clients need to know that they can share personal aspects of their lives without fear of being judged by the therapist. The therapist may make suggestions, but those comments are not absolutes. If the client can trust the therapist to not judge them, then they can be more relaxed in therapy, and perhaps more open to suggestions that the therapist might make. This would hopefully facilitate better communication between the client and therapist.

Next, we have a segment that shows the therapist and client discussing trust.

Video Clip #4
T: But then we come back the issue of trust. Could you really trust what I give back to you?
P: [five second pause] Well I think I could take it, and consider it, and evaluate it, (T: Uh-hmm.) and maybe figure out whether it fit or not.
T: Uh-hmm, so you could,
P: I think I could.
T: pick and choose,
P: Yeah, I guess.
T: to decided whether it was good information, or good suggestions, or not, huh?
P: Well, you know, I think I’d at least give it a chance, but [laugh], but I guess, uh huh.

As an active participant in therapy, clients also need to know that they have the right to make corrections, or ask for clarification of statements that the therapist might make. Many times clients are unsure or afraid to correct statements the therapist
makes that they don’t agree with. This can be because clients are not assertive enough, or they trust the therapist to know what is “right” for them. Clients should not be afraid to interrupt the therapist to clarify feelings or situations that seem to be incorrect. One of the many advantages to correcting the therapist is that it creates a better understanding between the client and the therapist. It’s easier for the therapist to try and help clients if they have a good understanding of what is bothering the client.

Some clients may be unsure as to how to present their problem to the therapist. Sharing different aspects of their problems can be a key issue for the outcome of therapy. It is essential for clients to give as much information as possible about the reason for their visit. This helps the therapist to understand what the client is worried about. It is helpful for clients to share everything they can about their problems, including details and background information. It is not necessary for clients to know exactly what is bothering them. Still, clients should share any information that they do have. Clarification of details is very helpful to the therapist. Some clients expect the therapist to understand them better than they understand themselves. Knowing that this is not the case may foster better communication between the therapist and client.

Next, we have a segment that exemplifies a therapist expressing concerns about addressing issues that are relevant to the client, and the therapist is making sure they’re getting all relevant information.

*Video Clip #5*

T: Giving away control, in some ways over your life, or how you feel?
P: Hmm, giving it away?
T: Or, relinquishing it.
P: Control over what? Anything? Me?
T: Uh-hmm.
P: Yeah. I don’t, wait a minute. What do you mean? Giving? Yeah I am controlled, sure I’m controlled. I went and picked her up, I could have said, “I don’t feel like it,” ‘cause initially, I really didn’t.
T: Uh-hmm.
P: Um, uh, last Saturday, they made plans for me to spend time at the skating rink, and I went. But it wasn’t so terrible, I even went skating, it was fun with the kids.
T: Uh-hmm.
P: I mean those are little, insignificant kinds of things.
T: Uh-hmm.
P: But, yeah, I do give control away.
T: How about here?
P: With you?
T: Uh-hmm.
P: You’re probing that a lot today, aren’t you?
T: Uh-hmm.
P: Um, control, giving you control, how? In terms of my direction?
T: Yeah.
P: You controlling what happens to me, is that what you mean?
T: Uh-hmm.
P: I don’t see that.
T: An example might be, um, the things we’re talking about today.
P: Uh-hmm.
T: Are we talking what you wanted to talk about?
P: Yeah. Yeah, I wanted, I thought about telling you about the adult-child support group. And I told you a little bit about that,
T: I guess I’m wondering if, when you get out to the parking lot, or you’re driving home, there will be any, well regrets is too strong a word, but like,
P: About what I didn’t say?
T: Yeah. Like, gosh, I wish...?
P: No, I, I came with an agenda to tell you about the, the adult-child support group, and to get your opinion about it.
T: Uh-hmm.
P: And, well, I can say this, too, and also to see how you would respond to the adult-child thing, because the folks in the group felt like, you haven’t really said what you think of it, I don’t know if I should say this to you or not. But, they felt like if you didn’t support it, that maybe I need to look at that. They were very supportive of it. And I think what they wanted me to hear was that you would reaffirm that. And you have, basically.

Some clients may enter therapy with unrealistic expectations regarding the outcome of therapy. For example, a client may wish to change the behavior of someone else. Other clients may worry that fundamental aspects of their personality will be changed. If a client wants to change a fundamental aspect of their personality, that is something they should discuss with the therapist. Otherwise, it is not necessary for a client to make major changes in therapy. It is up to the client to decide the level of involvement or change that is comfortable for his or herself. Clients need to be aware that the focus will be on themselves, and can be reassured that any changes will be mutually agreed-upon between client and therapist.

Next, we have a segment that demonstrates a client and therapist collaborating on a topic, with the therapist working with the client about making a decision.

Video Clip #6
T: Did you want to hear more from me, about that?
P: Yeah. Yes I do, as a matter of fact. Yeah, I do.
T: Okay.
P: There’s a whole lot to be said about, um, doctor’s, M.D.’s and whatnot, not, um, buying in the disease concept of chemical dependency, and, that whole addict thing.
T: Uh-hmm.
P: And doctor’s being addicts themselves, and whatnot. I’m interested in your opinion about that.
T: I’m not clear what you want my opinion on.
P: Um, do you think, just directly, do you think that the adult-child experience will be a good one for me, from what you know of it?
T: I know very little about that part of the AA program.
P: Uh-hmm.
T: Um, I think it’s, um, a reasonable model,
P: Uh-hmm.
T: in terms of thinking about alcoholism and also understanding the family roles and the dynamics that
you are a part of.
P: Uh-hmm.
T: And I think it’s worth checking out.
P: Yeah.
T: And, you’ll know if it fits or not.
P: Yeah, and that’s kind of what I expected you to say.
T: Uh-hmm. You’re right.

Many clients have different worries or concerns regarding therapy that are not
addressed during the first session, either because they are not discussed by the
therapist, or the client is too shy to voice these concerns. For instance, before coming
to therapy, some clients may believe that only “crazy” people go to therapy. Such
clients may wonder if they are also “crazy” or if something is seriously wrong with
them for seeking therapy. Reassurance in this area can make clients less anxious and
lead to better outcomes.

Clients could also be concerned about negative repercussions for being in therapy.
They may be worried that whatever diagnostic “label” they receive will follow them
throughout their life. They may also worry that people (e.g. family members,
employers, etc.) will react differently to them now that they are in therapy. A client
may be comfortable with their diagnosis, but still be concerned about the negative
repercussions from others for having sought out mental health services. This is a good
topic to bring up and discuss with the therapist.

Clients may also wonder about possible causes of psychological problems. This could
include how and why problems can develop. Clients may not realize that some
disorders have organic causes, while other disorders are actually normal reactions to
stress or trauma. It may relax the client to know they are not necessarily responsible
for the development of their disorder, and they can feel reassured to know that it can
be treated. Worries or concerns of this nature should be brought up and discussed
with the therapist.
Appendix B

Demographics Questionnaire

1. Age: ____________

2. What year are you? Freshman  Sophomore  Junior  Senior  Other:_____________

3. What is your major? _____________________________________

4. Gender: Male  Female

5. Ethnicity: Caucasian  African American  Asian/Pacific Islander  Hispanic  American Indian

   Multicultural  Other:_____________

6. How well do you understand the process of therapy?

   Very Well  Well  Somewhat Well  Neutral  Somewhat Poorly  Poorly  Very Poorly

7. Do you know anyone who has had treatment for psychological or emotional problems? Yes  No

8. Have you ever felt like you needed psychological services? Yes  No

9. Have you ever been to a therapist or counselor, either currently or in the past? Yes  No

   A. If yes, what was/is your level of satisfaction with the services you receive(d)?

      (choose one)

      Very Satisfied  Somewhat Satisfied  Neutral  Somewhat Unsatisfied  Very Unsatisfied

   Would you recommend therapy to others? Yes  No

   B. If no, how likely are you to seek counseling services in the future? (choose one)

      (choose one)

      Very Likely  Satisfied Likely  Somewhat Neutral  Somewhat Likely  Unsatisfied Unlikely

      Would you recommend therapy to others? Yes  No
Appendix C

Post Questionnaire

1. Did you feel like the information presented to you was helpful?

<table>
<thead>
<tr>
<th>Very Helpful</th>
<th>Somewhat Helpful</th>
<th>Neutral</th>
<th>Somewhat Unhelpful</th>
<th>Very Unhelpful</th>
</tr>
</thead>
</table>

2. Did it contain any information that you were unaware of?

<table>
<thead>
<tr>
<th>A lot</th>
<th>More than some</th>
<th>Some</th>
<th>Very little</th>
<th>None</th>
</tr>
</thead>
</table>

3. This program was designed as an orientation to psychotherapy. Having just viewed it, what do you think about it’s length?

<table>
<thead>
<tr>
<th>Too long</th>
<th>About right</th>
<th>Too short</th>
</tr>
</thead>
</table>

4. Please give some suggestions for making it useful as a pre-therapy orientation program.

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

5. Do you feel like the information presented changed your opinion of therapy?

<table>
<thead>
<tr>
<th>A lot</th>
<th>More than some</th>
<th>Some</th>
<th>Very little</th>
<th>None</th>
</tr>
</thead>
</table>

6. Are you more likely to consider therapy in the future?

<table>
<thead>
<tr>
<th>A lot</th>
<th>More than some</th>
<th>Some</th>
<th>Very little</th>
<th>None</th>
</tr>
</thead>
</table>
Appendix D

Short Quiz Material: CD-ROM

1. When can a therapist break confidentiality:
   a. To other therapists at a party
   b. At lunch with colleagues
   c. Only when it is clear that the client intends to hurt his or herself or someone else
   d. All of the above.
   Answer: C

2. What is the role of the therapist?
   a. To help explore client’s thoughts and feelings.
   b. To make helpful suggestions.
   c. To help guide them with any issues that come up in therapy.
   d. All of the above.
   Answer: D

3. Some clients are concerned that:
   a. Only “crazy” people go to therapy.
   b. They will be labeled by the therapist.
   c. Others will judge them negatively for going to therapy.
   d. All of the above.
   Answer: D

4. Which of the following are true for the client’s role?
   a. The client should ask for clarification of statements that therapist might make.
   b. The client should correct the therapist if the therapist doesn’t seem to understand what the
      client said.
   c. The client should share as much information as possible about their problems.
   d. All of the above.
   Answer: D

5. The first session usually consists of:
   a. Only tasks and goals discussions.
   b. A structured assessment interview.
   c. The same kind of content as in all other sessions.
   d. The client spending the session on one topic.
   Answer: B

6. Goals are established by:
a. The client acting as a passive participant.
b. Expecting the therapist to provide all of the answers.
c. The client and therapist working collaboratively.
d. The end of the first session.
Answer: C

7. True or False: Psychological problems can arise from organic causes or normal reactions to stress or trauma. (True)

8. True or False: A client can always expect therapy to change fundamental aspects of his or her personality as a result of psychotherapy, whether they want these changes or not. (False)

9. For a client, what should be considered a realistic expectation as a result from therapy?
   a. Changing the behavior of someone else.
   b. Gaining a better understanding of his/her self and relationships.
   c. Achieve instant happiness.
   d. None of the above.
   e. all of the above.
Answer B

10. True or False: One of the roles of the therapist is to make moral judgments about client behavior. (False)

11. The purpose of this program was to:
   b. Help the client know what to expect in therapy.
   c. Give the client an idea of how to participate in therapy.
   d. Prevent the client from suing the therapist.
   e. A, B, & C only.
Answer E

12. Which of these best describe the relationship between the client and therapist?
   a. The therapist is responsible for what takes place in therapy.
   b. The client is responsible for what takes place in therapy.
   c. The therapist and client collaborate on in-session issues.
   d. No one is responsible
Answer C
Short Quiz Material: Information Packets:

These questions will be about the information provided by Counseling and Psychological Services (CPS) and the Ohio University Psychology and Social Work Clinic (PSWC).

1. What services are offered by CPS?
   a. Vocational testing
   b. Personal counseling and psychological services
   c. Group counseling
   d. Couples’ counseling
   e. All of the above
   Answer E

2. True or False: In an emergency situation, usually an appointment can be made on the same day a person calls CPS. (true)

3. True or False: Most situations are emergencies. (false)

4. Which of the following will the counselor ask a client during the first session?
   a. The reason for seeking therapy.
   b. The circumstances involved in the client’s concerns.
   c. The client’s previous experience(s) with therapy.
   d. All of the above
   Answer D

5. Therapists are required to break confidentiality under which circumstances:
   a. Life threatening situations
   b. Cases of suspected child or elderly abuse
   c. As required by law
   d. As part of a student’s educational record
   Answer A, B, C

6. Counseling is NOT effective under which conditions:
   a. The client is willing to think about their goals.
   b. The client follows all of the therapist’s instructions.
   c. The client tries out new behaviors.
   d. The client discusses successes and failures with the therapist.
   Answer B
Appendix E

Follow-Up Questionnaire

1. How much have your expectations about therapy changed since the first part of the study? (choose one)

Very Different       Different       Somewhat Different       Neutral       Somewhat Similar       Similar       Very Similar

2. What, if anything, has affected your expectations?

_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

3. How likely are you to seek psychological services in the future? (choose one)

Very likely       Likely       Somewhat Likely       Neutral       Somewhat Unlikely       Unlikely       Very Unlikely
TAPS

In filling out the following survey, we would like you to imagine that you have decided to see a therapist for a personal problem. Please answer the following questions using this scale:

I 2 3 4 5
I have not been concerned about this
I am very concerned about this

1. Is psychotherapy what I need to help me with my problems?
   1 2 3 4 5

2. Will I be treated more as a case than as a person in psychotherapy?
   1 2 3 4 5

3. Will the therapist be honest with me?
   1 2 3 4 5

4. Will the therapist take my problems seriously?
   1 2 3 4 5

5. Will the therapist share my values?
   1 2 3 4 5

6. Will everything I say in psychotherapy be kept confidential?
   1 2 3 4 5

7. Will the therapist think I'm a bad person if I talk about everything I have been thinking and feeling?
   1 2 3 4 5

8. Will the therapist understand my problem?
   1 2 3 4 5

9: Will my friends think I'm abnormal or weird for coming?
   1 2 3 4 5

10. Will the therapist think I'm more disturbed than I am?
   1 2 3 4 5

11. Will the therapist find out things I don't want him/her to know about me and my life?
   1 2 3 4 5

12. Will I learn things about myself I don't really want to know?
   1 2 3 4 5

13. Will I lose control of my emotions while in psychotherapy?
   1 2 3 4 5

14. Will the therapist be competent to address my problem?
   1 2 3 4 5

15. Will I be pressured to do things in psychotherapy I don't want to do?
   1 2 3 4 5

16. Will I be pressured to make changes in my lifestyle that I feel unwilling or unable to make right now?
   1 2 3 4 5
17. Will I be pressured into talking about things that I don't want to?
   1 2 3 4 5

18. Will I end up changing the way I think or feel about things or the world in general?
   1 2 3 4 5

19. The thought of seeing a therapist would cause me to worry, experience nervousness or feel fearful in general.
   1 2 3 4 5

20. Whether seeking treatment would affect my job or job prospects if an employer found out about it.
   1 2 3 4 5

21. Whether an employer will question my ability if she/he knows I’m attending therapy.
   1 2 3 4 5

22. Whether attending therapy will create a psychiatric label that might stay with me.
   1 2 3 4 5

23. Whether friend and family will see my future behavior as being attributable my having had psychological therapy.
   1 2 3 4 5

24. Where some people will like or respect me less if I say I am receiving psychological treatment.
   1 2 3 4 5

25. Whether people treat me differently if they know I have been receiving therapy.
   1 2 3 4 5

26. Whether people will think I’m weak because I can’t solve my own problems.
   1 2 3 4 5

27. Whether I will lose friends from my seeing a therapist.
   1 2 3 4 5

28. Where being in therapy will affect my relationship with those closest to me (partner, family, close friends).
   1 2 3 4 5

29. Whether those closest to me (my family, partner, close friends) will think less of me for seeing a therapist.
   1 2 3 4 5

30. Whether those closest to me will feel guilty as a result of therapy.
   1 2 3 4 5
Pretend that you are about to see a psychologist for your first interview. We would like to know just what you think therapy will be like. On the following pages are statements about therapy. In each instance you are to indicate what you expect therapy to be like. The rating scale we would like you to use is printed at the top of each page. Your ratings of the statements are to be recorded on the answer sheets provided. For each statement, darken the space corresponding to the number which most accurately reflects your expectations. Do not make any marks in the questionnaire booklet.

Your responses will be kept in strictest confidence. Your answers will be combined with the answers of others like yourself and reported only in the form of group averages. Your participation, however, is voluntary. If you do not wish to participate in this research, just hand over the questionnaire and unmarked answer sheets back to the person in charge.

When you are ready to begin, answer each question as quickly and as accurately as possible. Finish each page before going on to the next.

NOW TURN THE PAGE AND BEGIN
ANSWER THE FOLLOWING QUESTIONS ON THE ANSWER SHEET

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not</td>
<td>Definitely True</td>
<td>Slightly True</td>
<td>Somewhat True</td>
<td>Fairly True</td>
<td>Quite True</td>
</tr>
</tbody>
</table>

I EXPECT TO...

1. Take psychological tests.
2. Like the counselor
3. See a counselor in training.
4. Gain some experience in new ways of solving problems within the counseling process
5. Openly express my emotions regarding myself and my problems.

I EXPECT TO...

6. Understand the purpose of that happens in the interview.
7. Do assignments outside the counseling interviews.
8. Take responsibility for making my own decisions.
9. Talk about my present concerns.
10. Get practice in relating openly and honestly to another person within the counseling relationship.

I EXPECT TO...

11. Enjoy my interviews with the counselor.
12. Practice some of the things I need to learn in the counseling relationship.
13. Get a better understanding of myself and others.
14. Stay in counseling for at least a few weeks, even if at first I am not sure it will help.
15. See the counselor for more than three interviews.

I EXPECT TO...

16. Never need counseling again.
17. Enjoy being with the counselor.
18. Stay in counseling even though it may be painful or unpleasant at times.
19. Contribute as much as I can in terms of expressing my feelings and discussing them.
20. See the counselor for only one interview.

**I EXPECT TO…**

21. Go to counseling only if I have a very serious problem.
22. Find that the counseling relationship will help the counselor and met identify problems on which I need to work.
23. Become better able to help myself in the future.
24. Find that my problem will be solved once and for all in counseling
25. Feel safe enough with the counselor to really say how I feel.
ANSWER THE FOLLOWING QUESTIONS ON THE ANSWER SHEET

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
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<th>5</th>
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</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>Not Definitely True</td>
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<td>Somewhat True</td>
<td>Fairly True</td>
<td>Quite True</td>
<td>Very True</td>
</tr>
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</table>

I EXPECT TO…

26. See an experienced counselor.
27. Find that all I need to do is to answer the counselor’s questions.
28. Improve my relationships with others.
29. Ask the counselor to explain what her or she means whenever I do not understand something that is said.
30. Work on my concerns outside the counseling interviews.
31. Find that the interview is not the place to bring up personal problems.

THE FOLLOWING QUESTIONS CONCERN YOUR EXPECTATIONS ABOUT THE COUNSELOR

I EXPECT THE COUNSELOR TO…

32. Explain what’s wrong.
33. Help me identify and label my feelings so I can better understand them.
34. Tell me what to do.
35. Know how I feel even when I cannot say quite what I mean.

I EXPECT THE COUNSELOR TO…

36. Know how to help me.
37. Help me identify particular situations where I have problems.
38. Give encouragement and reassurance.
39. Help me to know how I am feeling by putting my feelings into words for me.
40. Be a “real” person not just a person doing a job.

I EXPECT THE COUNSELOR TO…

41. Help me to discover what particular aspects of my behavior are relevant to my problems.
42. Inspire confidence and trust.
43. Frequently offer me advice.
44. Be honest with me.
45. Be someone who can be counted on.

I EXPECT THE COUNSELOR TO…

46. Be friendly and warm towards me.
47. Help me solve my problems.
48. Discuss his or her own attitudes and relate them to my problem.
49. Give me support.
50. Decide what treatment plan is best.
ANSWER THE FOLLOWING QUESTIONS ON THE ANSWER SHEET

<table>
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<tr>
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<tr>
<td>Definitely True</td>
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<td>True</td>
<td>True</td>
<td>True</td>
<td>True</td>
<td>True</td>
</tr>
</tbody>
</table>

I EXPECT THE COUNSELOR TO…

51. Know how I feel at times, without my having to speak.
52. Do most of the talking.
53. Respect me as a person.
54. Discuss his or her experiences and relate them to my problems.
55. Praise me when I show improvement.

I EXPECT THE COUNSELOR TO…

56. Make me face up to the differences between what I say and how I behave.
57. Talk freely about himself or herself.
58. Have no trouble getting along with people.
59. Like me.
60. Be someone I can really trust.

I EXPECT THE COUNSELOR TO…

61. Like me in spite of bad things that he or she knows about me.
62. Make me face up to the differences between how I see myself and how I am seen by others.
63. Be someone who is calm and easygoing.
64. Point out to me the differences between what I am and what I want to be.
65. Just give me information.
66. Get along well in the world.