The Effects of Pretreatment Preparation with Clients in a Substance Abuse Treatment Program

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Abstract

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This study assessed the effects of a psychoeducational intervention on clients’ expectations and fears about psychotherapy, working alliance and therapeutic outcomes. Block randomization was used to determine intervention assignment: a multimedia program vs. a treatment-as-usual (TAU) group from two data collection sites. Pre and post intervention scores from the EAC-B, TAPS and OQ were assessed for changes in expectations, fears and outcome, pre-intervention vs. discharge scores from the EAC-B and TAPS were assessed for changes in expectations and fears over treatment, and initial vs. discharge scores from the WAI-SR were compared for changes in alliance ratings. Results showed that although clients demonstrated significant change over time, this change was not related to the intervention used in this study. Some pre-treatment differences were noted with this sample. Clinical implications of these differences and using educational interventions with a substance abuse treatment population are discussed.

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INTRODUCTION

For years clinicians and researchers alike have contemplated ways to influence the behavior of clients in therapy with the hopes of improving the therapeutic relationship. An often underused idea is the concept of providing clients with education prior to treatment that encourages them to adopt an appropriate and beneficial client role. By designing an optimal preparational program, therapists may be able to provide their clients with information about therapy, with the added benefit of inspiring realistic expectations and allaying fears about the therapeutic process. Improvements in the therapeutic relationship could lead to more satisfying process and outcomes for treatment, and could easily be worth the effort of preparing clients about therapy. Research has demonstrated that preparing clients for therapy can have multiple beneficial effects, including encouraging clients to decrease anxiety about treatment (McLeod & Deane, 1994), identify fewer fears about therapy, develop more realistic expectations, experience less role confusion, and develop more positive therapeutic relationships (Deane, Spicer, & Leathem, 1992; Docherty, 1989; Douglas, Noble, & Newman, 1999; Reis & Brown, 1999), resulting in sessions that may have a more collaborative atmosphere with better outcomes and less of a dropout rate (Deane et al., 1992; Gaston, Marmar, Gallagher, & Thompson, 1989; Tinsley Bowman, & Barich, 1993).

Preparatory programs may modify the initiation of treatment and thereby influence the remaining trajectory of the therapeutic process and outcome. A leading theoretical explanation for this is that preparatory programs influence pretreatment client role and outcome expectations, as well as fears about therapy. The examination of pre-
treatment variables has been an important part of psychotherapy research. Recently, researches have taken a closer look at clients’ pre-treatment expectations and fears about therapy in their work. Correlations have been noted between certain pre-treatment variables, for example, expectations about the therapeutic process and relationship and levels of anxiety with or fears about the therapeutic process and outcome, (Deane et al., 1992; Docherty, 1989; McLeod & Deane, 1994). Specifically, pre-therapy client variables like expectations and anxiety or fear levels 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 et al., 1989; Tinsley et al., 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 and fears may affect outcomes.

**Expectations, Fearfulness, Alliance and Outcomes**

Although researchers have found a link between client expectations, therapeutic process, and outcome, it is not known 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.
One possibility is that the positive or negative quality of the expectations is influencing therapeutic interactions. Data from the National Institute of Mental Health Treatment of Depression Collaborative Research Program (TDCRP; Krupnick, Elkin, Collins, Simmens, et al., 1994) indicate that clients’ positive outcome expectations predicted the probability of successful treatment and demonstrated reduced depressive symptoms at termination (Sotsky et al, 1991). These findings support a trend reported by other studies (Kirsch, 1999). Research has shown that the majority of clients improve across orientations; therefore the majority of clients can realistically expect their symptoms to improve as a result of therapy. Clients entering therapy with this positive and realistic expectation may have improved outcomes over those who are unaware of this information.

Researchers posit that if a client has positive expectations regarding outcome, then they will become more engaged in therapy (Meyer et al., 2002). Whiston and Sexton (1993) refer to client participation as a common experience for clients in psychotherapy, and assert that active client involvement is “very important to positive client outcome.” Research has confirmed that demonstrating a problem-solving attitude (Luborsky et al, 1998; O’Malley, Suh, & Strupp, 1983) and becoming actively involved in mastering problematic situations (Luborsky, Crits-Chistoph, Mintz & Auerbach, 1998) boosts treatment outcomes. Luborsky et al.(1998) found that the creating and sustaining client expectations for beneficial change in therapy was related to positive outcome. Additional research calls attention to the potential impact of positive and negative outcome expectations (Kirsch, 1999; Luborsky et al., 1998; Sotsky et al, 1991; Weinberger & Eig,
Based on this suggestion, it would seem advantageous to address client expectations prior to the first session, with the hope of increasing chances for better therapeutic process and outcome. In theory, a client whose positive expectations generally match their experience with therapy may have an easier transition into therapy. This may lead to increased participation in session, increased positive alliance and possibly better outcomes.

Studies mentioned previously have discussed the effects of client expectations. An additional pre-treatment variable that may affect therapy process and outcomes is the level of fears or anxiety clients may have about therapy. Kushner and Sher (1991) suggest that fears about mental health services can influence some to evade these resources or act as barriers to seeking services. Treatment fearfulness has been defined as “a subjective state of apprehension that arises from aversive expectation about the seeking and consumption of mental health services,” (Kushner & Sher, 1989). These same authors cite potential sources of treatment fears as: fear of embarrassment, fear of change, fears involving treatment stereotypes, fears associated with past experience with the mental health service system, fears of negative judgment (stigma), and fear of treatment associated with specific problem types (Kushner & Sher, 1989).

Recent research has discovered that reduced attendance may be related to a client’s fears about undergoing psychotherapy. While research on client preparation for medical procedures has shown a great reduction in anxiety, investigations in this same topic in the psychotherapy literature has only begun to scratch the surface. Leventhal and Johnson (1983) explored the effects of patient’s anxiety in treatment adherence and
outcome by conducting a field experiment in a threatening situation. The researchers found that the behavioral instruction message significantly affected the indicators of control of danger in patients. Based on these findings, Leventhal and Johnson (1983) hypothesized that preparation messages for therapy might also reduce anxiety levels in clients. Deane et al. (1992) conducted a study that examined the effects of a ten-minute preparatory video on state anxiety in clients prior to therapy. Results indicated that the preparatory video had the immediate effect of increasing accuracy of expectancies and reducing state anxiety, but overall outcomes were not affected by the video (Deane et al., 1992).

Some researchers hypothesize that inaccurate or negative expectations of therapy and counseling contribute to fear of mental health services and subsequent avoidance. McLeod and Deane (1994) and Deane and Chamberlain (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). This theory also closely relates to Bandura’s (1977) theory, discussed in detail earlier, which suggests that providing exposure to a feared situation can reduce anxiety.
Previously reviewed literature suggests that expectations and fears about therapy interact to affect both process and outcome of therapy. Specifically, negative or inaccurate expectations about therapy increase fears associated with seeking services, and lead to poor process and outcomes. Conversely, clients with positive, realistic expectations show increased participation and better process and outcomes. Confirmation of positive, realistic expectations also leads to good process and outcomes, while disconfirmation of expectations without appropriate discussion leads to anxiety and poor outcomes. These findings suggest a need to attend to the expectations and fears of clients, especially those who may not have good understanding of therapy.

Decades of research have revealed the importance of the therapeutic alliance in relation to therapeutic process and outcomes. This research has identified many factors which can have powerful effects on the type and quality of therapeutic alliance that is created. Some of these factors include misconceptions, expectations, and fears that people have about therapy. It is possible that these factors contribute to higher attrition rates, poor alliances, and poor therapeutic process and outcomes. As a strong alliance seems to be important to the therapeutic process, it would appear important to use whatever tools necessary to facilitate the development of a strong, productive alliance between therapist and client. Educational tools that address misconceptions, expectations, and fears about therapy might set the stage for building a better alliance by helping to familiarize the client with therapy.

The literature also suggests that clients who have more realistic expectations and fewer fears about therapy develop a stronger therapeutic alliance more rapidly. Some
researchers have demonstrated a significant effect size (.22) for the therapeutic alliance, indicating that the strength of the therapeutic alliance has a great amount of influence over outcomes (Martin, Garske & Davis, 2000). According to the literature, the therapeutic alliance is one of the most important predictors of outcomes; therefore, it makes sense to promote a strong, healthy therapeutic alliance between therapist and client. Data lend support for the development of a preparatory program created to address expectations and fears about therapy that is easy to disseminate to potential clients. Such a program could influence the development of a better alliance and result in more positive outcomes.

Preparatory Interventions

The majority of literature that focuses on preparatory or educational interventions concludes that these tools can be useful in reaching out to potential or first-time clients. Researchers suggest using preparational interventions such as role clarification may facilitate positive transference, and provide early support for a strong alliance, thus possibly 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 (Anderson & Strupp, 1996; Reis & Brown, 1999). Prepared clients may be able to use information about their role as a client to become a more active participant, using self-exploration and initiation of communication thus enhancing satisfaction with treatment (Heitler, 1973, as cited in Reis & Brown, 1999). Preparational tools may reduce treatment fearfulness or negative feelings about treatment that would interfere with seeking mental health services (Giles & Dryden, 1991) they also may
increase the knowledge of the therapeutic process, and promote the alliance between client and therapist, resulting in declining dropout rates (Piper et al., 1999). Therefore, preparational tools may be useful specifically for clarifying roles, increasing participation, and reducing attrition, therefore building a stronger alliance and improving outcomes.

Preparatory programs have been developed for a broad range of populations, including those entering group therapy, those seeking individual therapy, immigrants, etc. Their common link as preparational programs is that these programs strive to provide clients with helpful information about the services they will receive prior to their first session. Research on preparatory programs is limited in that few contain standardized content, (i.e. role description, information about confidentiality, etc) and there are a wide variety of formats in which they are presented, including brochures, videos, and individualized structured interviews. It is true that most mental health care providers use preparational methods, usually in the form of brochures that briefly advertise and describe the services that are offered. However, anecdotal evidence suggests that brochures are not often read by prospective clients. Additionally, a previous research study done by this author suggests that the information included in these brochures is not sufficient to change the expectations held by some people (Guajardo & Anderson, 2007). The most familiar style of preparatory intervention is a role induction, which is defined as a form of didactic instruction that aims to educate clients about the basis for therapy, create realistic expectations for change, address the therapeutic process and outcomes,
and provide examples of appropriate therapist and client behaviors (Walitzer, Dermen, & Connors, 1999).

Katz et al. (2004) describe a role induction as a technique that “seek(s) to enhance client engagement by clarifying client and staff role demands and by addressing misperceptions about treatment” (p. 227). More comprehensive forms of intervention are known as vicarious therapy pretraining programs. Although similar to role induction, where a client is presented with an education-based intervention, vicarious therapy pretraining builds on role induction interventions by providing the client with actual examples of a therapy session in addition to role-induction information (Walitzer et al, 1999).

Katz et al. (2004) used a role-induction technique to address low retention rates and treatment outcomes in a drug treatment facility. The authors developed a role-induction that the counselors provided to clients during the first session, and typically lasted about 30-45 minutes. The role induction included such areas as an overview of treatment, clients’ expectations, client/counselor roles, reasons for seeking treatment, and problem-solved potential barriers to treatment. Results showed that when this role-induction was presented to clients during the first session, retention rates were higher, clients were more likely to attend at least one session after the orientation, and clients tended to reported higher levels of satisfaction with the program after three months than those assigned to standard treatment (Katz et al., 2004). Walitzer et al. (1999) also examined the effects of vicarious therapy pretraining. Several researchers have investigated this avenue, with effects ranging from increased attendance (France & Dugo,
1985), to improved therapeutic process (Connell & Ryback, 1978), and better outcome (Truax, Wargo & Volksdorf, 1970).

Results indicate that some form of role induction usually results in improved outcomes versus standardized care. Additionally, researchers have found that filmed or standardized versions of role inductions have had equal or superior results to individualized role inductions. Based on these results, it would appear that a combination of a role induction mixed with vicarious therapy pretraining examples would be an optimal mix for a preparational program for clients.

Substance Abuse

Many researchers have designed interventions to help clients that may have had less knowledge of therapy, i.e., immigrants or those court-referred for drug and alcohol counseling. It may be important to target many different segments of the population to examine the effects of preparational programs. With the way that therapy is currently portrayed in the media, one may be able to argue that most people have at least a few misconceptions about the therapeutic process (Schneider, 1987).

Katz et al. (2004) has demonstrated that clients entering treatment for substance abuse identify having similar misconceptions about therapy as general outpatients. These misconceptions included the client’s role during the treatment planning process, the length of treatment, client’s responsibilities in therapy including attending sessions and punctuality, and the counselor’s responsibilities, including helping the client meet his or her identified goals. Verinis (1993) reported similar findings; noting that clients entering treatment for alcoholism identified similar misconceptions about client and therapist roles
as well as the process of treatment. Therefore, it seems that expectations about therapy identified in the research literature in general are similar to those held by those in treatment for substance abuse.

Other researchers have published the importance of the therapeutic alliance specifically in substance abuse treatment. A structural model proposed by Simpson (2004) posits that the therapeutic alliance is an important factor in substance abuse treatment. He describes early engagement as the “first major step toward recovery in treatment” (Simpson, 2004, p. 106), and reports that this factor is measured by considering amount of participation in the program and the quality of the therapeutic relationship that is developed. The association of therapeutic relationship with outcomes is consistently reported across drug use groups and treatment settings, including alcohol outpatient and aftercare programs (Connors, Carroll, DiClemente, Longabaugh, & Donovan, 1997), family-based treatment for adolescents (Diamond, Diamond, & Liddle, 2000), and drug free as well as residential treatment settings (Kasarabada, Hser, Boles, & Huang, 2002). This lends significant support to the concept that a stronger alliance leads to more beneficial outcomes for those in substance-abuse treatment.

Several researchers have demonstrated that preparational materials have benefited clients seeking substance abuse treatment. One researcher found that providing alcohol-dependent clients with a videotaped orientation at intake demonstrated better program retention and increased attendance in the program as compared to a standard care group (Verinis, 1996). Additionally, Katz et al. (2004) found that an uncomplicated version of a role induction encouraged better client retention in the treatment program as compared to
clients who received standard care. The role induction used in this study consisted of a 30-45 minute initial individual interview with the client’s counselor. The counselor used this time to focus on misconceptions about therapy and discussed both client and counselor roles and responsibilities. The authors hoped to create a greater alliance between therapist and client, therefore resulting in increased retention, which is associated with positive treatment outcomes (Katz et al., 2004).

Even more encouraging, a recent study found that clients with low motivation to change respond better to treatment when there is evidence of a stronger therapeutic alliance (Ilgen, McKellar, Moos & Finney, 2006). In this study, the authors examined the influence of motivation, therapeutic alliance, and alcohol use after 6 and 12 months from the Project MATCH database, a multi-site clinical trial designed to test a series of a priori hypotheses on how patient-treatment interactions relate to outcome. Based on Miller and Rollnick’s (2002) statement that clients who demonstrate low motivation are more responsive to the relationship between themselves and their therapist, these authors hypothesized that the alliance could influence the relationship between patient motivation and outcome (Ilgen et al, 2002). These authors found that stronger therapeutic relationships were associated with a reduction in alcohol use among low-motivation clients, as compared to clients with high levels of motivation (Ilgen et al, 2006).

Interestingly, it was the therapist’s perception of the therapeutic alliance that was the most predictive in this study. The authors theorize that, since clients with low motivation tend to be more ambivalent about treatment (Miller & Rollnick, 2002), they may be more attuned to the process of therapy, including the quality of the relationship between client
and counselor (Ilgen et al, 2006). Limitations of this study include that the selection criteria for and close monitoring of these participants, who were part of Project MATCH, may have increased their level of motivation and enhances therapeutic alliance. In spite of this, the authors suggest that if the therapeutic alliance is truly more predictive than treatment orientation or specific therapeutic techniques, then providers working with clients with low motivation should focus on building a stronger therapeutic alliance (Ilgen et al, 2006).

In sum, clients in treatment for substance abuse problems appear to have similar types of expectations and fears about therapy as a general clinical population. Additionally, the therapeutic alliance has been proven to be an important component of substance abuse treatment. Based on all this evidence, it seems that this client population would be a good target for a preparation program intervention.

Current Study

As mentioned previously, one concern is that potential clients are not utilizing the preparational methods that are already available to them (i.e., brochures, information available on certain websites, such as APA). This raises the question of identifying exactly how clients are exposed to information and opinions of therapy. One must consider the common portrayal of psychologists in the entertainment media which is not often accurate or positive (Schneider, 1987). Many of these films (i.e. movies such as Analyze This and Prince of Tides) depict therapists with inappropriate boundaries, demonstrate unrealistic therapy outcomes, and poke fun at mental health services in
general. Every therapist should be concerned that their clients may form their own opinions of therapy from these unreliable sources.

The models used in these studies (Ilgen et al, 2006, Katz et al., 2004, Simpson, 2004) are very similar to the model that we propose, namely that by addressing early expectations and fears about therapy, a better alliance may be developed which will lead to improved outcomes. We wish to acknowledge the large body of literature that describes specific techniques identified as efficacious for those seeking treatment for substance abuse, such as the stages of change model developed by Prochaska (1979) and motivational interviewing, developed by Miller and Rollnick (1991). While these studies highlight important treatments for this population, we wish to focus on pantheoretical factors for this particular study. For this reason we have decided to stick closely to our original model and continue to monitor more common factors such as expectations, fears, alliance, and outcome. As we believe that these factors are present in all types of therapy, we posit that measuring these factors will be relevant and beneficial for this particular population as well.

Hypotheses

Literature supports the theory that pre-therapy education that includes role induction and vicarious therapy pretraining is helpful for those who are seeking mental health services. In providing this education, the client’s expectations about therapy are altered to become more realistic, and any fears about therapy are minimized. Therefore, the client enters therapy with an idea of his or her role as a client, and a clearer picture of what he or she may expect to happen. It is hypothesized that this foundation will result in
increased participation from the client, as he or she feels like an equal participant in the process. It is also hoped that more realistic expectations will result in increased participation, which will be a catalyst for increased therapeutic alliance, lower dropout rates, and more successful outcomes. The specific hypotheses are:

1. Clients who view the multimedia presentation will report more accurate expectations about therapy relative to the standard care group, after viewing the intervention.

2. Clients who view the multimedia presentation will report fewer fears about therapy relative to the standard care group, after viewing the intervention.

3. Clients who view the multimedia presentation will report a better alliance with their therapist relative to the standard care group, after viewing the intervention.

4. Clients who view the multimedia presentation will report better outcomes relative to the standard care group, after viewing the intervention.

Method

Study Design

An experimental design was created to test the multimedia program with a clinical sample. Two conditions were created, the multimedia intervention group and the treatment-as-usual (TAU) group. Participants receiving substance abuse TAU were compared with participants who viewed the multimedia program and also received TAU. Baseline fearfulness, expectation and symptom level (outcome) scores were collected from all participants upon joining the study, and condition assignment was made. At the end of the first week in the program (approximately 2-3 days after recruitment into the
study), all participants completed questionnaires about expectations and fears about therapy, alliance, and outcomes (Time 1). The same questionnaires were repeated at the end of the second week (Time 2) and the end of the third week (Time 3).

Participants

Eighty subjects were recruited from veterans attending the 21-day lodger substance abuse treatment program (SATP) at the Harry S. Truman Memorial VA and clients entering a women’s residential treatment center at McCambridge Center. All subjects were 18 years of age or older and met all physical and mental health criteria necessary for admission to these programs. Potential subjects were subjected to the following exclusionary criteria: 1) Those who are unable to give informed consent through legal means (i.e. guardianship, etc); 2) Those who demonstrate a reading level below the 8th grade, and thus would not be able to fill out questionnaires; 3) Those who are court-ordered to attend the program; and 4) Those who have previously gone through the program and have already established a relationship with their current assigned counselor. Subjects who had previously attended the program but were being assigned to a new counselor were still eligible for the study.

Participants included seventy-two (90%) males and eight females. The average age was 47.25 years and ranged from 24 to 68 years ($SD = 10.74$). The majority of the sample self-identified as Caucasian (79%), fourteen as African American (18%), two as American Indian (2%) and one as Hispanic (1%). All participants were diagnosed with an alcohol or substance dependent disorder, fifty-four (68%) were diagnosed with alcohol dependence, and twenty (25%) participants had a mental health diagnosis in addition to
their alcohol or substance dependence diagnosis. The majority of the sample had prior treatment experience, only five (6%) reported having no prior mental health or drug and alcohol treatment prior to this admission. Twenty-five (31%) reported no prior mental health treatment, and twelve (15%) reported no prior drug and alcohol treatment. According to discharge summaries, sixty-one (76%) of the participants were considered to have a successful discharge from the treatment program.

**Treatment**

Treatment consisted of weekly individual and group therapy sessions lasting a minimum of 21 days. Group treatment was scheduled from 8am to 5pm during the weekdays, with some optional groups available during the weekends. Clients met with their therapist a minimum of once per week. Those providing treatment were either licensed social workers or licensed professional counselors. The same therapists provided group as well as individual treatment. Group topics included: community meeting, process group, self-harm, relapse prevention, stages of change, addiction plus, dual diagnosis, conflict resolution, spirituality (optional), tobacco education, early recovery, and community re-entry group. Treatment was a milieu format, and clients were encouraged to follow the 12-step model by attending AA and/or NA groups during the evenings and weekends, and by finding a sponsor and working the 12 steps.

**Measures**

*Expectations About Counseling-Brief Form (EAC-B; Tinsley, Workman & Kass, 1980; Tinsley, de St. Aubin, Brown, 1982). The EAC-B (Appendix A) consists of 66 items rated on a 7-point scale with response options that range from (1) “not true” to (7)
“definitely true”. The EAC-B consists of eighteen subscales. Internal consistency of these sub-scales has been reported to range from alphas 0.69 to 0.82, with a median alpha of .77 (Tinsley et al., 1982). Test-retest reliabilities for a 2-month interval range from 0.61 to 0.87, with the exception of .47 on the Responsibility scale, and have a median of .71. Research has demonstrated that the EAC-B discriminates between client expectations about counseling and two other client constructs, perception of and preference for therapy (Tinsley and Westcot, 1990). The subscales can be combined to obtain four factor scores; Personal Commitment, Facilitative Conditions, Counselor Expertise, and Nurturance. Recently, several researchers have questioned the validity of these four factors, which were developed from analyses on the longer EAC questionnaire (Ægisdottir, Gerstein, & Gridley, 2000; Hatchett & Han, 2006). Hatchett and Han evaluated the factor structure of the EAC-B and determined that a three-factor model was the best fit for this brief questionnaire. The three factors identified by these authors are; Facilitative Conditions (27 items, Cronbach’s α = .92), Counselor Expertise (16 items, Cronbach’s α = .84), and Client Involvement (27 items, Cronbach’s α = .91) (Hatchett & Han, 2006). These factor scores can be obtained by adding the scores of the items relative to each scale, then dividing that sum by the total number of items belonging to that factor. For the purposes of this study, the three factor model will be used as it was developed specifically from the EAC-B.

Thoughts about Psychotherapy Survey (TAPS; Kushner & Sher, 1989). The TAPS (Appendix B) is used to assess the fearfulness of mental health services among persons who may or may not be in psychotherapy. Kushner and Sher (1989) derived the TAPS
from the Thought About Counseling Survey by Pipes, Schwarz and Crouch (1985). Kushner and Sher used instructions that were designed for individuals who were not currently in psychotherapy or counseling to imagine seeing a therapist for the first time. Items are scaled 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 scales are scored by adding the responses. It can be broken into three subscales, Therapist Responsiveness, Image Concerns, and Coercion Concerns. Internal consistency (Chronbach’s alpha) among the three scales ranged from 0.87 to 0.92 (Deane & Todd, 1996). For the purposes of this study, the full-scale scores will be used during data analyses.

*Working Alliance Inventory-Short Form Revised (WAI-SR; Hatcher & Gillaspy, 2006; WAI, Horvath & Greenberg, 1981, 1982)*. The WAI is most often used when empirically measuring alliance (Horvath, 1994; Horvath and Symonds, 1991; Martin, et al., 2000). The WAI is self-report measure of alliance that is completed by each client. The full scale is comprised of 36 items that are rated on a 7 point Likert scale ranging from “never” to “always.” The full-scale measure has three subscales, task, goal, and bond, which are derived from 12 items. Each of the three subscales demonstrates good reliability. The internal consistency of the bond and task subscales has been reported at .92, and the internal consistency for the goal subscale is reported at .89. A composite score may also be obtained by adding the subscale scores together. The internal consistency of this composite score is .93. The composite score was used for the purposes of this study.
Hatcher and Gillaspy (2006) recently examined the factor structures of both the WAI and the short form, the WAI-S developed by Tracy and Kokotovic (1989), and concluded that the hypothesized structures of the WAI-S were not confirmed. Hatcher and Gillaspy reported that there were interpretative and methodological issues that caused problems. They cited the sample size as being too small and expressed concern that the questionnaire was administered after the first session when the work on goals, tasks and bond had just begun (Hatcher & Gillaspy, 2006). These authors conducted their own factor structure and tested an alternative version of a short form (WAI-SR, in Appendix C) against the WAI, HAQ, and CALPAS. Hatcher and Gillaspy (2006) found coefficient alphas that ranged from .85 to .90 for the subscales and total score alphas that ranged from .91 and .92. The authors report that their scale “has stable factor structure across two quite different samples, and shows evidence of greater differentiation between Goal and Task scales” (Hatcher & Gillaspy, 2006, p. 21). In addition, the authors performed an IRT analysis of the current 7-point rating scale, and found that clients have some difficulty determining the grading between points, as well as have more difficulty with the lower five points of the scale. They worried that this lead to inconsistent use of the scale (Hatcher & Gillaspy, 2006). Based on these findings, the authors decided to reduce the scale to 5 points, and included descriptions of each rating (possible answers include: Seldom, Sometimes, Fairly Often, Very Often, and Always). For the purposes of this study, the full-scale scores will be used during data analyses.

Outcome Questionnaire (OQ; Lambert, Hansen et al., 1996). The OQ (Appendix D) is a 45-item general symptom measure. This measure was designed to assess client
progress in therapy by repeated administration during the course of treatment and at 
termination (Lambert and Hansen et al., 1996). Three aspects of the client’s progress are 
measured: subjective discomfort, interpersonal relationships, and social role performance. 
Each item is scored on a 5-point scale (0 = never; 4 = almost always). The range of 
possible scores is 0 to 180; higher values indicating pathology. The OQ (Appendix D) 
provides a total score as well as three subscale scores; for the purposes of this study, the 
total score was used. Lambert, Hansen et al. (1996) have reported the internal consistency 
of the scale to be $r = .93$. A test-retest value gathered after a three week lapse was 
reported as $r = .84$ (Lambert, Burlingame, et al., 1996).

Jacobson and Truax (1991) and Lambert, Hansen, et al. (1996) established cutoff 
scores for the Reliable Change Index (RCI) and for clinically significant change. RCI is 
estimated at 14 points, meaning that a client who endorses a minimum change of 14 
points in either a positive or negative direction has made reliable change. An OQ score of 
64 or above is indicative of a clinical need, and those with scores below 64 are 
considered to be at a functional level (Lambert, Hansen, et al., 1996). For the purposes of 
this study, the full-scale scores will be used during data analyses.

*Short Quiz Material.* A twelve-item quiz (Appendix E), previously used in a research 
study by Guajardo and Anderson (2007), was used as a manipulation check. The 
questions are multiple-choice and refer to information that was directly presented during 
the multimedia intervention.

Demographic information about participants was collected from the ASI, which is 
routinely completed by the therapist and client during the first few days of treatment as
Demographic variables included age, gender, race, amount of education completed, number of prior treatment episodes for mental health and/or drug and alcohol treatment, number of days of drug or alcohol use in the past 30 days, clients’ identified drug of choice, years of education completed, and diagnosis at admission. The Prior Treatment variable was coded as either “treatment inexperienced” (0-1 prior treatment episodes) or “treatment experienced” (2+ prior treatment episodes). When examining these variables during data analyses, results showed that the number of total prior treatments ranged from 0 to 30, the number of prior mental health treatment episodes ranged from 0 to 20, and the number of prior drug and alcohol treatment episodes ranged from 0 to 18. The frequency histogram of the number of prior treatments was positively skewed. A median split of total prior treatment yielded two relatively equal sized groups; those with no or one prior treatment experience were labeled as “treatment inexperienced” and those with two or more prior treatment episodes were labeled as “treatment experienced.”

**Procedures**

Veterans were recruited from the lodger Substance Abuse Treatment Program (SATP) at the Harry S. Truman Memorial Veterans Hospital and residential clients receiving substance abuse treatment were recruited from the McCambridge Center, a community treatment center. Clients completed questionnaires that assessed baseline scores for expectations and fears about therapy, as well as current symptoms (Baseline scores). These measures were repeated at the end of the first (Time 1), second (Time 2/Early discharge scores), and third week (Discharge) of treatment. For example, when a
client was discharged early from the program, their Time 2 questionnaire scores were used when available as their Discharge scores to account for their responses prior to leaving treatment. However, some clients left before completing Time 2 questionnaires; therefore there is no data available for analyses involving discharge information. Follow up rates were as follows; 74 clients (92%) completed Time 1 questionnaires, 65 clients (81%) completed Time 2/Early Discharge questionnaires, and 53 clients (66%) completed Discharge questionnaires. The assigned conditions (intervention vs. TAU) are the independent variables, and the TAPS, OQ, WAI-SR, and three EAC-B factor scores are the dependent variables.

Prior to recruitment, a list of study numbers was created, and each study number was assigned to a condition. Block randomization was used for each set of two subjects; condition assignment for the first subject was randomly chosen by flipping a coin (heads = experimental group, tails = TAU), and the second subject was assigned the remaining condition. Those assigned to the experimental condition viewed the multimedia program immediately after filling out Baseline questionnaires, and completed the short quiz after viewing the program.

*Multimedia Therapy Education Program*

The multimedia enhanced program, previously used in Guajardo and Anderson (2007) was used for this study as a role induction intervention for those who are unfamiliar with the process. This program was created using information gathered from and thorough literature review, an informal survey distributed among a small group of practicing clinicians, and information from brochures available in two university clinics.
and the APA website. Based on this investigation, several specific types of client expectations were chosen, including the roles of the client and therapist, the work the client expects to perform, anticipated results of therapy, confidentiality, establishing goals, reasons someone might seek therapy, content of the first session, and potential benefits of therapy (please see Appendix F). In addition, sections of videotape-recorded sessions from the Vanderbilt II study (Strupp, 1993) were chosen to provide participants with realistic examples of good therapeutic interactions. Several short clips were selected based on scores from the Vanderbilt Psychotherapy Process Scale (VPPS) to represent cases of good therapist-client interaction. Actors were hired to re-enact the selected therapy sessions on videotape in order to preserve confidentiality of the original session. The multimedia program itself is an integration of the printed educational text and the video clips. The program was set up so that the viewer can read the text at their own speed and view the short clips between sections of text. Length of viewing time ranged between 15-30 minutes. A detailed explanation of the creation of this intervention can be found in Guajardo and Anderson (2007).

Results

Means and Standard Deviations for EAC-B (Client Involvement, Counselor Expertise, and Facilitative Conditions), TAPS, WAI-SR, and OQ can be found in Tables 2-4.

Manipulation Check and Preliminary Analyses

Manipulation Check. The scores from the 12-item short manipulation check were examined to assess client attentiveness to the intervention. In the Multimedia group, thirty-two of thirty-nine participants missed one or no questions (82%), three missed two
questions (8%), three missed three questions (8%), and one participant missed five questions (2%). One participant refused to view the multimedia intervention; therefore he did not take the quiz. It appears that about one in five participants had trouble attending to the entire intervention.

Preliminary analyses. Demographic variables such as age, race, successful completion of the program, and symptomatic functioning were entered as covariates for the EAC-B expectations factor scales, TAPS fearfulness, and OQ symptoms. They were not significant in the analyses and therefore were removed from the models. Gender was not examined, as only 7 (9%) of the participants were women. An alpha of .05 was used for all analyses.

Main Analyses. A mixed-model 2 x 2 x 2 MANOVA was used to test hypothesis 1, that clients who view the multimedia presentation will report more accurate expectations about therapy relative to the standard care group, after viewing the intervention. The MANOVA included Conditions of Treatment Group (multimedia exposure vs. control), Prior Treatment (treatment experienced vs. inexperienced), and Time (pre- versus post-intervention). Interactions of Group X Time or Group X Prior Treatment X Time were considered supportive of the hypotheses. Hypothesis 1 was tested with a mixed-model MANOVA on the three EAC-B factors: Facilitative Conditions, Counselor Expertise, and Client Involvement and found to be non-significant for the three way interaction, $F(3, 66) = 0.32, ns$ (ES = 0.01 and also for the two way interaction $F(3, 66) = 0.73, ns$ (ES = 0.03; see Table 5 for MANOVA results). Although results did not support the hypothesis, there was a significant finding with the Time X
Prior Treatment analysis, $F (3, 66) = 4.13, p = 0.01$ (ES = 0.16). Because of this significant finding, an ANOVA was run with prior treatment broken down into two variables: prior drug and alcohol treatment and prior mental health treatment (see Table 6). A significant difference was found between clients on the EAC-B factor scale of Client Involvement when prior drug and alcohol treatment experience was taken into account, $F (1, 67) = 5.56, p = .02$ (ES = 0.07), specifically, clients with less prior drug and alcohol treatment experience reported expecting higher levels of client involvement. The same analysis was significant for Facilitative Conditions, $F (1, 67) = 5.38, p = .02$ (ES = 0.07), specifically, clients with more prior drug and alcohol treatment experience reported expecting higher levels of a good therapeutic environment. The analysis was non-significant for Counselor Expertise $F (1, 67) = 0.16, ns$. Prior treatment episodes did not account for any significant differences for any of the factors: EAC-B, Facilitative Conditions, $F (1, 67) = 2.65, ns$; Counselor Expertise, $F (1, 67) = 0.36, ns$; and Client Involvement, $F (1, 67) = 1.16, ns$. Prior mental health treatment was also not significant for Facilitative Conditions, $F (1, 67) = 0.05, ns$; Counselor Expertise, $F (1, 67) = 1.22, ns$; and Client Involvement, $F (1, 67) = 0.00, ns$.

Hypothesis 2 examined whether clients who viewed the multimedia presentation reported fewer fears about therapy relative to the standard care group, after viewing the intervention. This hypothesis was tested using a separate MANOVA in which the Group X Time and Group X Prior Treatment X Time comparisons were examined on the TAPS, was and were also found to be non-significant, $F (1, 69) = 0.27, ns$ (ES = 0.00) for the two way interaction; $F (1, 69) = 1.30, ns$ (ES = 0.02), and for the three way interaction;
(see Table 7 for MANOVA results). Additionally, no significant differences were found between clients’ TAPS scores when prior treatment experience was taken into account, $F(1, 68) = 0.07, ns$ (ES=0.00); prior drug and alcohol treatment $F(1, 68) = 0.11, ns$ (ES=0.00); and prior mental health treatment $F(1, 68) = 0.07, ns$ (ES=0.00; see Table 8).

A MANOVA was also used to test hypothesis 3, that clients who view the multimedia presentation will report a better alliance with their therapist relative to the standard care group, after viewing the intervention. As shown in Table 9, hypothesis 3 was tested using a MANOVA for the Time 1 versus Discharge scores on the WAI-SR and was found to be non-significant, $F(1, 43) = 0.19, ns$ (ES = 0.00) for the two way interaction; $F(1, 43) = 0.42, ns$ (ES = 0.01) for the three way interaction. No significant differences were found between clients’ WAI-SR scores when prior treatment experience was taken into account, $F(1, 42) = 0.13, ns$ (ES = 0.00); prior drug and alcohol treatment $F(1, 42) = 2.77, ns$ (ES=0.06); and prior mental health treatment $F(1, 42) = 0.00, ns$ (ES=0.00; see Table 10).

To examine hypothesis 4, a MANOVA was used to test whether clients who viewed the multimedia presentation reported better outcomes relative to the standard care group, after viewing the intervention. As shown in Table 11, Baseline versus Discharge scores on the OQ were compared and found to be non-significant, $F(1, 58) = 0.74, ns$ (ES = 0.00) for the two way interaction; $F(1, 58) = 1.03, ns$ (ES = 0.02) for the three way interaction. No significant difference was found between clients in OQ scores when prior mental health treatment experience was taken into account, $F(1, 57) = 3.55, p = .07$, (ES
prior drug and alcohol treatment $F(1, 57) = 0.41, ns (ES=0.01)$, and prior mental health treatment $F(1, 57) = 0.29, ns (ES=0.01)$; see Table 12).

Separate MANOVAs were also run to assess possible long-term effects (Baseline versus Discharge) of the multimedia intervention on expectations and fears about treatment, again with treatment group and prior treatment episodes as between subjects variables. Neither of these analyses were significant; EAC-B, $F(3, 56) = 0.21, ns (ES = 0.01)$, and TAPS $F(1, 53) = 0.02, ns (ES = 0.00)$.1

Discussion

The data suggest that the multimedia program had little effect on reducing fears and expectations associated with therapy with clients entering treatment for substance abuse. The intervention also did not account for any improvement in symptoms or increase in the therapeutic alliance. Our analyses did reveal some pre-treatment differences that might be related to the lack of significance found in this study. Specifically, we found that participants with lower levels of drug and alcohol treatment experience self-reported higher expectations for treatment on the Client Involvement scale than those with higher levels of drug and alcohol treatment, and participants with higher levels of drug and alcohol treatment experience self-reported higher expectations for good treatment conditions on the Facilitative Conditions scale than those with lower levels of drug and alcohol treatment. These findings will be discussed in more detail in the next section.

While most research studies focusing on preparing clients for substance abuse treatment do record prior treatment experiences; most authors do not use this variable
during data analyses. Information about prior treatment is not always reported in a similar fashion; some authors report the average number of prior treatment episodes, some indicate the percentage of participants with prior experience, and even fewer attempt to categorize participants by amount of prior treatment. Only one reviewed article demonstrated an attempt to control for prior treatment experiences in their inclusion/exclusion criteria; Connors, Walitzer and Derman (2002) excluded participants who had participated in formal treatment during the previous year. Potential participants were pre-screened, and the authors do not report how many were ineligible due to this specific exclusion factor. These authors tested the effect of two preparation programs, a role induction interview versus motivational interviewing techniques against a control group, and found similar results as this study. Clients in their study who received a role induction preparatory intervention did not demonstrate significant differences from those who did not receive a preparatory intervention for alcohol treatment, while those in the motivational interviewing condition attended more therapy sessions and had fewer days of heavy drinking than the control group (Connors et al., 2002). The authors posited that the role induction, which consisted of rational for the preparatory session, description of program components, alcohol-specific treatment information, identification and encouragement of positive client behaviors, and forewarning of possible negative reactions to treatment, was not more successful possibly because their study participants had already been exposed to the information contained in their preparatory intervention (Connors et al., 2002).
Pretreatment Differences

Analyses revealed that clients considered to be “treatment inexperienced” for drug and alcohol treatment indicated that they had higher expectations on the Client Involvement scale for treatment than those considered “treatment experienced.” This indicates that clients new to treatment expect to be more involved with their treatment than those who have prior drug and alcohol treatment experience. Since client participation has been linked to outcomes in several studies, it is discouraging to think that clients returning to treatment do not expect to have a higher level of personal involvement with their treatment. This may indicate that therapists need to work harder to engage those who have previous drug and alcohol treatment experience, and may need to explore their clients’ potentially pessimistic views about or reluctance to engage in treatment. Those considered “treatment experienced” for drug and alcohol treatment also reported higher expectations for good therapeutic conditions on the Facilitative conditions scale. This seems to contradict the previous finding, or perhaps more experienced clients are simply indicating that they expect to find a supportive environment that requires less personal commitment from them as a client.

Expectations and Fearfulness

It may be that, while clients seeking substance abuse treatment tend to have similar expectations as general psychotherapy clients, they also have specific expectations that are related to substance abuse. Crits-Christoph et al. (2007) suggested that dysfunctional beliefs about addiction may interfere with recovery because clients’ beliefs do not change until their behavior does. As an example, Crits-Christoph et al.
(2003) cite the idea that “life is boring without using.” Clients may be unaware that this belief is dysfunctional until they actually stop using long enough to have a positive sober experience. Crits-Christoph et al. (2003) completed a study demonstrating that changing these beliefs results in a decline in drug use; however, they were unsure of the actual method of change necessary for this. The authors also note that baseline dysfunctional beliefs have not been studied to examine their effects on outcome.

One concern about this study was that, due to the large number of clients with prior treatment experience, perhaps many of the expectations and fears about therapy reviewed for this study did not apply to this population. It may be the case that expectations and fears related to client roles and responsibilities, therapist roles and responsibilities, and outcomes are more applicable to first-time clients, and it may also be that those who’ve had prior treatment have a unique set of expectations or viewpoints about therapy that are based on their experience. If the experience was negative for that client, then they may have developed negative beliefs about therapy that no longer qualify as expectations, since the client is framing their viewpoints based on personal experience rather than conjecture or popular opinion. Benbenishty (1987) theorizes that if differences between hopes and expectations are substantial enough, they can result in the client developing negative views about treatment, which in turn affects the therapeutic process. He argues that while some discrepancy may be unavoidable as first-time clients form theories about therapy, it may not always indicate a problem with treatment (Benbenishty, 1987). It may be that some of our participants had so much discrepancy between hopes and expectations that they developed negative viewpoints
about therapy that persisted throughout their treatment, whether they were developed
during this treatment episode or during prior treatment episodes.

Stigma about drug and alcohol treatment may be a factor, some studies have
found that clients entering treatment for alcohol abuse cite social stigma as a barrier for
treatment (Takeuchi, Leaf & Kuo, 1988), or indicate that they are least willing to seek
services for an alcohol-related problem (Meissen, Warren & Kendall, 1996). A study
focusing on the help-seeking behaviors of those meeting criteria for alcohol dependence
supports this idea and expands on other potential barriers. The authors found three major
barriers to treatment seeking; privacy concerns (i.e. labeling, confidentiality), beliefs that
treatment was unnecessary or not beneficial, and practical/economic concerns (i.e. the
time and money that must be invested in treatment) (Tucker, Vuchinich & Rippens,
2004). Therefore, clients’ concerns about stigma, privacy issues, belief of need for
treatment, and level of commitment to treatment may be interfering with their motivation
to seek treatment, or may cause them to engage only superficially in the therapeutic
process when they are involved with treatment. A different approach may be necessary to
identify and alter these viewpoints to assist with treatment delivery for substance abuse.
Although preparatory interventions in general have demonstrated some positive results,
there is not a list of specific guidelines regarding which interventions should be used with
certain populations. Simpson (2004) recognizes this as a problem specifically for those
entering drug treatment facilities. While those seeking services for drug abuse problems
may benefit from general preparation for treatment, it is not known which aspects of
preparatory interventions are useful for these clients to maximize potential benefits.
An important question to consider is if the questionnaires used in this study account for expectations or beliefs developed after exposure to actual therapy. A closer review of the literature suggests that expectations and fears developed based on prior experience were considered by the developers of the TAPS and EAC-B when designing the questionnaires used for this study. Kushner and Sher (1991) acknowledge the importance of negative prior mental health treatment experiences, noting that these encounters have the potential to elicit fearful responses to the idea of continued or future treatment. They state their belief that fearfulness can develop in response to “actual or imagined aspects of mental health service seeking and consumption,” thus including prior experience in their working hypothesis (Kushner & Sher, 1989).

The developers of the EAC-B expectations questionnaire also seemed to consider the effects of previous treatment. In total, Tinsley, Bowman, and Ray (1988) considered three ways that expectations might influence therapy; a person’s preference for talking with someone other than a counselor (i.e., friend, pastor, family member, etc), the importance of how the initial interview with the counselor matches the persons expectations for that event, and how those involved with continued services might have expectations that would influence the process and outcome of treatment. This theory clearly includes expectations prior to beginning treatment as well as those that may develop after treatment begins. Both questionnaires regarding expectations and fears about therapy should be comprehensive enough to include expectations and fears about treatment that reflect those based on supposition and those based on actual encounters. It is always possible however, that while the authors considered these details during
questionnaire design, that these constructs are not reflected in the actual questionnaire. Careful analysis of these tools might reveal that they capture only the expectations and fears that develop before treatment experience is gained, and somehow miss a similar or related construct that relates to expectations and fears that develop in response to treatment experience.

**Alliance and Outcome**

The multimedia program did not account for any increases in therapeutic alliance or any differences in outcomes in this study. It may be the case that, although alliance is an important determinant for good outcomes, that it is not the most important component for this particular population. Other factors, when combined with a good alliance, may have a more substantial impact on outcomes. Other studies have found inconclusive evidence that alliance scores, measured early in treatment, are predictive of outcomes. Meier, Barrowclough, and Donmell (2005) reviewed the role of the therapeutic alliance in the treatment of substance abuse, and theorized that although alliance did not appear to be a good predictor of outcomes, it may influence the course of early treatment by increasing engagement and retention in drug treatment, with moderate correlations that ranged between $r = 0.15$ and $r = 0.30$. The authors noted that reviewed studies showed that alliance measured over the first month of treatment, and alliance scores averaged across treatment, did show some relationship with reduced drug use (Meier et al., 2005). Connors et al. (1997) found that the therapeutic alliance was a consistent predictor of positive participation and outcomes, and the strength of this relationship was equal to the predictive value of alliance in the general treatment population. This finding was backed
up by a review of substance abuse literature by Meier et al. (2005). Both sets of researchers did note that while the alliance was a good predictor of outcome, it did not account for a significant portion of variance, indicating that one or more moderators influence the strength of the alliance in substance abuse treatment (Connors et al., 1997; Meier et al., 2005). It is possible that the alliance is a moderator for, or is moderated by, a more influential variable that was not identified in the present studies or in previous research. This possibility should be explored in future studies. Meier et al. (2005) suggest that the quality of social relationships, attachment style, and client-therapist matching factors should be further investigated. For our sample, the outcome measure was not significantly correlated with alliance at any of the three data collection points, WAI Time 1 Pearson correlation = -0.19, WAI Time 2 Pearson correlation = -0.02, WAI Time 3 Pearson correlation = -0.28.

Additionally, it is possible that substance abuse treatment is different enough from general psychotherapy that research is not generalizable across these populations. While conducting a meta-analysis of alliance and outcome Horvath and Bedi (2002) found that when they separated out six studies related to substance abuse, they had a combined effect size of only .14 as opposed to the .21 effect size found or all the studies. This suggests that, although the alliance is an important determining factor in substance abuse treatment, it may not be as generalizable as it is across other types of treatment. Additionally, although previous research suggests that those seeking services for drug and alcohol treatment share many of the same qualities and expectations as those in general therapy, the similarities may not be enough for a general-purpose preparational
program. Many substance abuse treatment programs rely heavily on group therapy in addition to individual, which may have substantial impact on the importance of the therapeutic alliance and its ability to affect outcomes. It seems possible that the addition of group therapy would add extra variables that would reduce the importance of the alliance with the individual therapist. Anecdotally, several participants reported that they felt the questionnaires helped them to consider placing more importance on individual treatment for achieving successful outcome.

Perhaps the most parsimonious explanation for the results of the current study may be that the multimedia intervention was unsuccessful because it was unnecessary. The clients involved with this study appear to have good access to treatment and most indicate having sought treatment in the past for either substance abuse or mental health problems. Other researchers working with participants with varied levels of prior treatment experience have also found no long-term outcome effects of preparatory programs (Deane et al., 1992). It may simply be that clients with prior treatment experience are not in need of a preparatory intervention, or that the beneficial effects of a preparatory intervention are not as salient to those with prior experience.

Limitations and Future Directions

Perhaps the greatest limitation of the present study is the small number of participants with no prior treatment experience. The multimedia program was developed specifically for those with no prior treatment experience; therefore this study does not address its usefulness with first-time clients only. Surprisingly, a previous study done by
these authors did not detect any differences regarding participants’ expectations about treatment regardless of prior treatment experience (Guajardo & Anderson, 2007).

It is also possible that the scope of this study was not broad enough to include negative types of expectations held by those with prior treatment experience. The program does not specifically address expectations held by those who may have had negative experiences with therapy, such as those who may feel dissatisfied, disillusioned, or even angry about previous experiences. Clients with previous treatment experiences may have developed beliefs about treatment that are not addressed in either our expectations or fears about treatment questionnaires. Those with previous treatment experience are unlikely to have fears associated with therapy as much as they are to have negative feelings or expectations. Future studies with participants with varied levels of treatment experience should included direct information about expectations and beliefs based on previous therapy experience.

Data collection points may explain the lack of findings for the alliance. Typically, alliance ratings are assessed immediately following a session. For this study, since therapists sometimes met with their clients spontaneously during the week, it was decided to collect alliance information at the end of each week of treatment instead of trying to track alliance after each therapy session. It is possible that alliance ratings are affect by the timing of the assessment, and that clients might rate their alliance differently if asked immediately after a session, instead of at the end of each week of treatment.

This study focused exclusively on the effects of the preparatory intervention on alliance and outcome with individual therapy; however, in this sample the clients spent
the majority of their treatment time in group therapy. Data reflecting the clients’ group therapy experiences was not collected; therefore it remains an unknown factor in this study. Our preparatory intervention was specific to individual therapy experiences, such as concerns about confidentiality and task agreement, but did not provide information or address expectations and fears about group therapy. Including this information in the intervention may have resulted in some significant effects.

The results of this study suggest that we should focus future efforts on those with no prior treatment experience. Definitions for expectations and fears about therapy may not be as relevant as already-developed beliefs about treatment for a population that appears to have good access to treatment. For substance abuse populations, it would seem that revising the program to address more specific substance-abuse treatment issues may be beneficial. Possible areas of focus might be the stigma of drug and alcohol treatment, concerns about privacy issues, the benefits of formal treatment for substance abuse issues, and discussing concerns about finances or time requirements for successful treatment options as suggested by previous authors (Meissen et al., 1996; Takeuchi et al., 1988).

In future research, we hope to test this program with other groups, such as using it as an educational intervention for clients who have a propensity for early drop-out, as well as an outreach intervention for persons who experience distress but would normally not seek out professional help for their problems. It may be necessary to tailor the program to the specific concerns and needs relevant to that population. The alliance is a significant predictor of outcome; however, there seems to be a great possibility that other,
unidentified moderator variables also have a powerful influence over treatment outcomes. Researchers interested in the alliance and/or treatment outcomes may wish to focus their efforts on identifying these important and influential variables.

In conclusion, this study highlights the differences between those both with and without prior treatment experience in expectations and outcome research with those seeking treatment for substance abuse. It is important to note that these differences may account for significant variance when determining potential treatment outcomes and clinicians may need to take markedly different approaches to treat these two groups in terms of treatment and outcome expectations. Researchers may wish to continue to tease out the differences between these two groups to assist with substance abuse treatment planning.
REFERENCES


### Table 1

**Relationship between Literature and Multimedia Program**

<table>
<thead>
<tr>
<th>Expectation Category</th>
<th>Literature Support</th>
<th>Previous Studies</th>
<th>Multimedia Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Counselor expertise, helpfulness, attractiveness, and trustworthiness</td>
<td>-Therapists are viewed as problem-solving experts (Schulman, 1979).</td>
<td>-Katz et al., 2004</td>
<td>Client and Therapist Roles / Expectations</td>
</tr>
<tr>
<td></td>
<td>-Some clients believe that the therapist is an “expert” that should not be questioned (Glass and Arnkoff, 2000).</td>
<td>-Glass and Arnkoff, 2000</td>
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<td></td>
<td>-The general public is wary of therapists engaging in forms of unethical behavior (Bram, 1997).</td>
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<tr>
<td>2. Prognosis for therapy</td>
<td>-Some clients believe a lifetime of psychiatric drugs is essential for the treatment of mental illnesses for symptom control and management (Glass &amp; Arnkoff, 2000).</td>
<td>-Corder et al., 1980</td>
<td>Establishing Goals</td>
</tr>
<tr>
<td></td>
<td>-Identified differences between the degree of expected change and expected duration of psychotherapy (Schulman, 1979).</td>
<td>-Douglas et al., 1999</td>
<td>Talking Openly</td>
</tr>
<tr>
<td></td>
<td>-Identified a correlation between higher rates of attrition and less accurate expectations (Heine &amp; Trosman, 1960)</td>
<td>-Webster, 1992</td>
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<tr>
<td></td>
<td>-Identified a weaker therapeutic alliance and less problem exploration in therapy correlated with attrition (Piper et al, 1999).</td>
<td></td>
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<tr>
<td>3. Therapist behavior and / or type of therapy</td>
<td>-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 (Glass &amp; Arnkoff, 2000).</td>
<td>-Douglas et al., 1999</td>
<td>Client and Therapist Roles / Expectations</td>
</tr>
<tr>
<td></td>
<td>-Identified correlation between therapist exploratory interventions and client ratings of a positive alliance (Bachelor, 1991).</td>
<td>-Garrison, 1978</td>
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<tr>
<td></td>
<td></td>
<td>-Katz et al., 2004</td>
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<tr>
<td></td>
<td></td>
<td>-Lambert &amp; Lambert, 1984</td>
<td></td>
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<tr>
<td></td>
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<td>-Walitzer et al., 1999</td>
<td></td>
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Table 1: continued

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>5. General counseling process and procedures</td>
<td>-Clients tend to feel that there is no hope of changing the mental health system (Glass &amp; Arnkoff, 2000). -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). -Clients are uneasy 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 &amp; Arnkoff, 2000).</td>
<td>-Corder et al, 1980 -Douglas et al., 1999 -Katz et al., 2004 -Webster, 1992 -Zwick &amp; Attkisson, 1985</td>
<td>Privacy First Session Diagnosis and Labeling</td>
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Table 2

*Means and Standard Deviations at Baseline*

<table>
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<tr>
<th>Variable</th>
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<th>TAU Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><em>M</em></td>
<td><em>SD</em></td>
</tr>
<tr>
<td>Facilitative Conditions (EAC-B)</td>
<td>5.53</td>
<td>1.06</td>
</tr>
<tr>
<td>Counselor Expertise (EAC-B)</td>
<td>2.94</td>
<td>1.08</td>
</tr>
<tr>
<td>Client Involvement (EAC-B)</td>
<td>5.82</td>
<td>0.85</td>
</tr>
<tr>
<td>Fears (TAPS)</td>
<td>70.91</td>
<td>23.62</td>
</tr>
<tr>
<td>Outcome (OQ)</td>
<td>79.62</td>
<td>28.42</td>
</tr>
</tbody>
</table>

*M* = Mean  
*SD* = Standard deviation
Table 3

Means and Standard Deviations at Time 1

<table>
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<tr>
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<th>Multimedia Group</th>
<th>TAU Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>Facilitative Conditions (EAC-B)</td>
<td>5.51</td>
<td>1.00</td>
</tr>
<tr>
<td>Counselor Expertise (EAC-B)</td>
<td>2.90</td>
<td>1.03</td>
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<td>Client Involvement (EAC-B)</td>
<td>5.75</td>
<td>0.73</td>
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<tr>
<td>Fears (TAPS)</td>
<td>70.17</td>
<td>27.78</td>
</tr>
<tr>
<td>Outcome (OQ)</td>
<td>88.93</td>
<td>20.49</td>
</tr>
<tr>
<td>Alliance (WAI-SR)</td>
<td>42.52</td>
<td>9.05</td>
</tr>
</tbody>
</table>

M = Mean
SD = Standard deviation
Table 4

*Means and Standard Deviations at Discharge*

<table>
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<th>Multimedia Group</th>
<th>TAU Group</th>
</tr>
</thead>
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<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>Facilitative Conditions (EAC-B)</td>
<td>5.36</td>
<td>0.91</td>
</tr>
<tr>
<td>Counselor Expertise (EAC-B)</td>
<td>2.68</td>
<td>1.07</td>
</tr>
<tr>
<td>Client Involvement (EAC-B)</td>
<td>5.82</td>
<td>0.84</td>
</tr>
<tr>
<td>Fears (TAPS)</td>
<td>65.30</td>
<td>27.09</td>
</tr>
<tr>
<td>Outcome (OQ)</td>
<td>69.00</td>
<td>26.46</td>
</tr>
<tr>
<td>Alliance (WAI-SR)</td>
<td>44.16</td>
<td>8.21</td>
</tr>
</tbody>
</table>

M = Mean
SD = Standard deviation
Table 5

*Three-way Analysis of Variance for EAC-B Scores*

<table>
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<tr>
<th>Source</th>
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<th>$\eta^2$</th>
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</tr>
</thead>
<tbody>
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<td></td>
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<tr>
<td>Time</td>
<td>3</td>
<td>3.20</td>
<td>0.13</td>
<td>0.03</td>
</tr>
<tr>
<td>Time x Group</td>
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<td>0.73</td>
<td>0.03</td>
<td>0.54</td>
</tr>
<tr>
<td>Time x Prior Treatment</td>
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<td>4.13</td>
<td>0.16</td>
<td>0.01</td>
</tr>
<tr>
<td>Time x Group x Prior Treatment</td>
<td>3</td>
<td>0.32</td>
<td>0.01</td>
<td>0.81</td>
</tr>
<tr>
<td>Error</td>
<td>66</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td><strong>Within Subjects Contrasts</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EAC-B: Facilitative Conditions</td>
<td>1</td>
<td>1.18</td>
<td>0.17</td>
<td>0.28</td>
</tr>
<tr>
<td>EAC-B: Counselor Expertise</td>
<td>1</td>
<td>5.80</td>
<td>0.79</td>
<td>0.02</td>
</tr>
<tr>
<td>EAC-B: Client Involvement</td>
<td>1</td>
<td>4.57</td>
<td>0.63</td>
<td>0.04</td>
</tr>
<tr>
<td>Time x Group</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EAC-B: Facilitative Conditions</td>
<td>1</td>
<td>0.00</td>
<td>0.00</td>
<td>0.96</td>
</tr>
<tr>
<td>EAC-B: Counselor Expertise</td>
<td>1</td>
<td>0.16</td>
<td>0.00</td>
<td>0.69</td>
</tr>
<tr>
<td>EAC-B: Client Involvement</td>
<td>1</td>
<td>1.82</td>
<td>0.03</td>
<td>0.18</td>
</tr>
<tr>
<td>Time x Prior Treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EAC-B: Facilitative Conditions</td>
<td>1</td>
<td>3.30</td>
<td>0.05</td>
<td>0.07</td>
</tr>
<tr>
<td>EAC-B: Counselor Expertise</td>
<td>1</td>
<td>1.67</td>
<td>0.02</td>
<td>0.20</td>
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<tr>
<td>EAC-B: Client Involvement</td>
<td>1</td>
<td>1.10</td>
<td>0.02</td>
<td>0.30</td>
</tr>
<tr>
<td>Time x Group x Prior Treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EAC-B: Facilitative Conditions</td>
<td>1</td>
<td>0.42</td>
<td>0.01</td>
<td>0.52</td>
</tr>
<tr>
<td>EAC-B: Counselor Expertise</td>
<td>1</td>
<td>0.07</td>
<td>0.00</td>
<td>0.80</td>
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<tr>
<td>EAC-B: Client Involvement</td>
<td>1</td>
<td>0.56</td>
<td>0.01</td>
<td>0.46</td>
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<td>Error</td>
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<td>68</td>
<td>(0.31)</td>
<td></td>
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<tr>
<td>EAC-B: Facilitative Conditions</td>
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<td>68</td>
<td>(0.45)</td>
<td></td>
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<tr>
<td>EAC-B: Client Involvement</td>
<td></td>
<td>68</td>
<td>(0.51)</td>
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</table>

Note. Values enclosed in parentheses represent mean square errors.
Table 6

*Analysis of Variance for EAC-B Factors and Prior Treatment (between subjects)*

<table>
<thead>
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<th>Source</th>
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<th>F</th>
<th>η²</th>
<th>p</th>
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</thead>
<tbody>
<tr>
<td><strong>Mental Health Treatment</strong></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>EAC-B: Facilitative Conditions</td>
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<td>0.05</td>
<td>0.00</td>
<td>0.83</td>
</tr>
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<td>1.22</td>
<td>0.02</td>
<td>0.27</td>
</tr>
<tr>
<td>EAC-B: Client Involvement</td>
<td>1</td>
<td>0.00</td>
<td>0.00</td>
<td>0.99</td>
</tr>
<tr>
<td><strong>Drug Abuse Treatment</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EAC-B: Facilitative Conditions</td>
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<td>5.38</td>
<td>0.02</td>
<td>0.07</td>
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<td>0.16</td>
<td>0.02</td>
<td>0.69</td>
</tr>
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<td>EAC-B: Client Involvement</td>
<td>1</td>
<td>5.56</td>
<td>0.08</td>
<td>0.02</td>
</tr>
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<td><strong>Total Treatment</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>EAC-B: Facilitative Conditions</td>
<td>1</td>
<td>1.67</td>
<td>0.02</td>
<td>0.20</td>
</tr>
<tr>
<td>EAC-B: Counselor Expertise</td>
<td>1</td>
<td>0.34</td>
<td>0.01</td>
<td>0.55</td>
</tr>
<tr>
<td>EAC-B: Client Involvement</td>
<td>1</td>
<td>1.16</td>
<td>0.02</td>
<td>0.29</td>
</tr>
<tr>
<td><strong>Error</strong></td>
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<td></td>
<td></td>
<td></td>
</tr>
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<td>EAC-B: Facilitative Conditions</td>
<td>67</td>
<td>(1.6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EAC-B: Counselor Expertise</td>
<td>67</td>
<td>(1.9)</td>
<td></td>
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<tr>
<td>EAC-B: Client Involvement</td>
<td>67</td>
<td>(1.1)</td>
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</table>

Note. Values enclosed in parentheses represent mean square errors.
### Table 7

*Three-way Analysis of Variance for TAPS Scores (within subjects)*

<table>
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<tr>
<td>Time</td>
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<td>0.02</td>
<td>0.00</td>
<td>0.89</td>
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<td>Time x Group</td>
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<td>0.27</td>
<td>0.00</td>
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<tr>
<td>Time x Prior Treatment</td>
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<td>0.37</td>
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<td>0.55</td>
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<td>Time x Group x Prior Treatment</td>
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<td>1.30</td>
<td>0.02</td>
<td>0.26</td>
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<tr>
<td>Error</td>
<td>69</td>
<td>(223.27)</td>
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</tbody>
</table>

Note. Values enclosed in parentheses represent mean square errors.

### Table 8

*Analysis of Variance for Taps Scores and Prior Treatment (between subjects)*

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<th>p</th>
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</thead>
<tbody>
<tr>
<td>Mental Health Treatment</td>
<td>1</td>
<td>0.07</td>
<td>0.00</td>
<td>0.78</td>
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<tr>
<td>Drug Abuse Treatment</td>
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<td>0.11</td>
<td>0.00</td>
<td>0.74</td>
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<td>Total Treatment</td>
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<td>0.07</td>
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<td>0.79</td>
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<td>Error</td>
<td>68</td>
<td>(1085.79)</td>
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Note. Values enclosed in parentheses represent mean square errors.

### Table 9

*Three-way Analysis of Variance for WAI-SR Scores (within subjects)*

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</tr>
</thead>
<tbody>
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<td>Time</td>
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<td>0.61</td>
<td>0.01</td>
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<td>0.00</td>
<td>0.66</td>
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<tr>
<td>Time x Prior Treatment</td>
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<td>0.95</td>
<td>0.02</td>
<td>0.34</td>
</tr>
<tr>
<td>Time x Group x Prior Treatment</td>
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<td>0.42</td>
<td>0.01</td>
<td>0.52</td>
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<tr>
<td>Error</td>
<td>43</td>
<td>(29.11)</td>
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Note. Values enclosed in parentheses represent mean square errors.
Table 10

*Analysis of Variance for WAI-R Scores and Prior Treatment (between subjects)*

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<th>$\eta^2$</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Treatment</td>
<td>1</td>
<td>0.00</td>
<td>0.00</td>
<td>0.95</td>
</tr>
<tr>
<td>Drug Abuse Treatment</td>
<td>1</td>
<td>2.77</td>
<td>0.06</td>
<td>0.10</td>
</tr>
<tr>
<td>Total Treatment</td>
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<td>0.13</td>
<td>0.00</td>
<td>0.72</td>
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<tr>
<td>Error</td>
<td>42</td>
<td>(118.11)</td>
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</table>

Note. Values enclosed in parentheses represent mean square errors.

Table 11

*Three-way Analysis of Variance for OQ Scores (within subjects)*

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<tbody>
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<td>13.90</td>
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<tr>
<td>Time x Group</td>
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<td>0.74</td>
<td>0.01</td>
<td>0.39</td>
</tr>
<tr>
<td>Time x Prior Treatment</td>
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<td>1.18</td>
<td>0.02</td>
<td>0.28</td>
</tr>
<tr>
<td>Time x Group x Prior Treatment</td>
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<td>1.03</td>
<td>0.02</td>
<td>0.32</td>
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<tr>
<td>Error</td>
<td>58</td>
<td>(356.12)</td>
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</tbody>
</table>

Note. Values enclosed in parentheses represent mean square errors.

Table 12

*Analysis of Variance for OQ Scores and Prior Treatment (between subjects)*

<table>
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<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Treatment</td>
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<td>0.29</td>
<td>0.01</td>
<td>0.59</td>
</tr>
<tr>
<td>Drug Abuse Treatment</td>
<td>1</td>
<td>0.41</td>
<td>0.01</td>
<td>0.53</td>
</tr>
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<td>3.55</td>
<td>0.06</td>
<td>0.07</td>
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<tr>
<td>Error</td>
<td>57</td>
<td>(934.07)</td>
<td></td>
<td></td>
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</tbody>
</table>

Note. Values enclosed in parentheses represent mean square errors.
APPENDIX A: EAC-B

DIRECTIONS

Pretend that you are about to see a counselor 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></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not</td>
<td>True</td>
<td>Slightly True</td>
<td>Somewhat True</td>
<td>Fairly True</td>
<td>Quite True</td>
<td>Very True</td>
<td>Definitely 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 what 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 me 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>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not True</td>
<td>Slightly True</td>
<td>Somewhat True</td>
<td>Fairly True</td>
<td>Quite True</td>
<td>Very True</td>
<td>Definitely True</td>
</tr>
</tbody>
</table>

I EXPECT TO…

26. See an experienced counselor.
27. Find that all I need to do is answer the counselor’s questions.
28. Improve my relationships with others.
29. Ask the counselor to explain what she or he 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 YOU 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.
ANSWER THE FOLLOWING QUESTIONS ON THE ANSWER SHEET

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not True</td>
<td>Slightly True</td>
<td>Somewhat True</td>
<td>Fairly True</td>
<td>Quite True</td>
<td>Very True</td>
<td>Definitely True</td>
</tr>
</tbody>
</table>

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.

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.
APPENDIX B: 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:

1  2  3  4  5
I have not been        I am very
concerned about this    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
APPENDIX C: WAI-SR

WAI-SR

**Working Alliance Inventory – Short Form – Revised**

**Instructions**: Below is a series of statements about experiences people might have with their therapy or therapist. Some items refer directly to your therapist with an underlined space -- as you read the sentences, mentally insert the name of your therapist in place of _______ in the text. For each statement, please take your time to consider your own experience and then fill in the appropriate bubble.

**Important**: The rating scale is not the same for all the statements. **PLEASE READ CAREFULLY**!

1. As a result of these sessions I am clearer as to how I might be able to change.

<table>
<thead>
<tr>
<th>Seldom</th>
<th>Sometimes</th>
<th>Fairly Often</th>
<th>Very Often</th>
<th>Always</th>
</tr>
</thead>
</table>

2. What I am doing in therapy gives me new ways of looking at my problem.

<table>
<thead>
<tr>
<th>Seldom</th>
<th>Sometimes</th>
<th>Fairly Often</th>
<th>Very Often</th>
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3. I believe_____likes me.

<table>
<thead>
<tr>
<th>Always</th>
<th>Very Often</th>
<th>Fairly Often</th>
<th>Sometimes</th>
<th>Seldom</th>
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</table>

4. _____and I collaborate on setting goals for my therapy.

<table>
<thead>
<tr>
<th>Seldom</th>
<th>Sometimes</th>
<th>Fairly Often</th>
<th>Very Often</th>
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5. _____and I respect each other.
6. _____ and I are working towards mutually agreed upon goals.

7. I feel that _____ appreciates me.

8. _____ and I agree on what is important for me to work on.

9. I feel _____ cares about me even when I do things that he/she does not approve of.

10. I feel that the things I do in therapy will help me to accomplish the changes that I want.

11. _____ and I have established a good understanding of the kind of changes that would be good for me.

12. I believe the way we are working with my problem is correct.
<table>
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<tr>
<th>Always</th>
<th>Very Often</th>
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<tr>
<td>Seldom</td>
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APPENDIX D: OUTCOME QUESTIONNAIRE

**Outcome Questionnaire**

**Instructions:** Looking back over the last week, including today, help us understand how you have been feeling. Read each item and mark the box under the category that best describes your current situation. If you are not employed, consider "housework" as "work".

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Frequently</th>
<th>Almost Always</th>
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<tbody>
<tr>
<td>1. I get along well with others</td>
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<td>2. I tire quickly</td>
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<td>3. I feel no interest in things</td>
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<td>4. I feel stressed at work/school</td>
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<td>5. I blame myself for things</td>
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<td>6. I feel irritated</td>
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<td>7. I feel unhappy in my marriage (if not married “Never”)</td>
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<td>8. I have thoughts of ending my life</td>
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<td>9. I feel weak</td>
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<td>10. I feel fearful</td>
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<td>11. After heavy drinking I need a drink the next morning to get going (If you don’t drink mark “Never”)</td>
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<td>12. I find my job/school satisfying</td>
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<td>13. I am a happy person</td>
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<td>14. I work/study too much</td>
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<td>15. I feel worthless</td>
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<td>16. I am concerned about family troubles</td>
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<td>17. I have an unfulfilling sex life</td>
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<td>18. I feel lonely</td>
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<td>19. I have frequent arguments</td>
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<td>20. I feel loved and wanted</td>
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<td>21. I enjoy my spare time</td>
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<td>22. I have difficulty concentrating</td>
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<td>23. I feel hopeless about the future</td>
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<tr>
<td>24. I like myself</td>
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</table>
25. Disturbing thoughts come into my mind that I cannot get rid of.
26. I feel annoyed by people who criticize my drinking (or drug use) (If not applicable mark “Never”)
27. I have an upset stomach
28. I am not working/studying as well as I used to
29. My heart pounds too much
30. I have trouble getting along with friends and close acquaintances
31. I am satisfied with my life
32. I have trouble at work/school because of drinking or drug use (If not applicable mark “Never”)
33. I feel that something bad is going to happen
34. I have sore muscles
35. I feel afraid of open spaces, or of driving, or being on buses, subways…
36. I feel nervous
37. I feel my love relationships are full and complete
38. I feel that I am not doing well at work/school
39. I have too many disagreements at work/school
40. I feel something is wrong with my mind
41. I have trouble falling asleep or staying asleep
42. I feel blue
43. I am satisfied with my relationships with others
44. I feel angry enough at work/school to do something I might regret.
45. I have headaches
APPENDIX E: SHORT QUIZ MATERIAL

Short Quiz Material: Multimedia Intervention

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
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 let you know what you can usually expect to happen in therapy. We would also like to show you 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, they might worry about confidentiality, how to talk about their problem, or what the therapist thinks about them. Of course, not every therapy session will have the same structure, and each therapist will have their own style. However, this program will provide general information that you may find useful. This program contains informational text as well as some examples of interaction between a therapist and a client.

Some confusion about paperwork is normal when attending therapy. One of the biggest concerns may be about confidentiality. You may be confused about the extent of privacy in the session and want to be more cautious during the first few sessions. However, the relationship that exists between the client and therapist is confidential and private. There are very few situations that a therapist might legally be required to share this private information, and your therapist will explain this to you in greater detail. This also means that therapists will not discuss what you talk about later when they go home, or while they are having lunch with their colleagues.

Next, we have a short video clip that is a re-enactment of a real therapy session. In this clip, the client and therapist have a discussion about 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 set-up of initial therapy sessions. For example, the first session usually consists of a more structured interview so that the therapist can get some information about your current situation and some helpful background information. After that, the focus of the therapy sessions will be on the tasks and goals that you and the therapist create together. Some clients become discouraged by the background questions during this initial meeting, and think that they are not relevant to the current situation. However, they will help your therapist to better understand you and your concerns.

Sometimes clients may be concerned about getting a diagnosis or insurance issues. You may be wary of receiving a diagnosis that will “label” you. If insurance is paying for your therapy, the type of diagnosis you receive may also dictate the number of sessions that will be covered by insurance. Or, you may not even be aware that managed care companies control these issues. Knowing this may reduce frustration aimed at the therapist. If you are unhappy with the coverage provided by your insurance or have other payment issues, bring those to your therapist’s attention.

You may come to therapy and expect the therapist to provide all the answers to your concerns. The therapist will help you to set goals for your treatment, but this will be a collaborative, or shared, activity. Working collaboratively with the therapist to establish these goals can set the stage for good interaction between you and your therapist, and you can keep each other “in check” about the reality of the situation. Establishing goals early in the session is a key aspect of successful therapy, and research has shown that it is related to better outcomes in therapy. Simply put, statistical studies show that working with your therapist to establish realistic goals early in therapy means you are more likely to achieve your therapeutic goals.

Next, we will show a re-enacted segment from an actual therapy session giving an example of how to talk about 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, 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 you and the therapist. The relationship that develops has the potential to affect the outcome of therapy. You might not be how you are supposed to act in your role as “client” or “patient” in therapy. This is a role that will develop as you continue to interact with your therapist. If you are concerned about what you are “supposed” to be doing, tell your therapist about this. It is more beneficial for both the therapist and client to know what is expected of each of them, and talking about this openly is a great way to make sure you are on the same page.

The role of the therapist can also be confusing. You may not know what to expect from the therapist, or what kind of treatment you will receive. In general, the therapist will not judge you or to tell you what to do. A therapist’s main job is to help you sort out your thoughts and feelings, and to help guide you with any issues that may come up in therapy. Discussing these issues with the therapist can help you evaluate whether therapy is right for them. There are many different kinds of therapy, and each therapist will have their own personal style. It is important for you to choose a therapist with whom you are comfortable working. If you are not happy with your therapist’s style, let him or her know. It may be possible to change the format of the sessions, or your therapist might be able to refer you to someone who will be a better fit.

There are guidelines that all psychologists must follow when treating clients. In order to behave in an ethical or appropriate manner, a therapist should not have a romantic or any other kind of relationship with a client outside of therapy. This can be difficult in areas
with lower populations, so if you live in a small area, this guideline may not be as strict. This also means that therapists should not treat family members or close friends. Therapists 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. If something about your relationship with your counselor seems uncomfortable, it may be helpful to bring it up during a session.

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 you to remember is that therapy is structured as a safe place to talk about issues that bothersome or upsetting. You need to know that you can share personal aspects of your life without the fear of being judged by the therapist. The therapist may make suggestions, but those comments are not absolutes. If you can trust the therapist to not judge you, then you can be more relaxed in therapy, and perhaps more open to suggestions that the therapist might make. This can improve communication between you and your 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, you also need to know that you 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. You should not be afraid to interrupt the therapist to clarify feelings or situations that seem to be wrong. One of the many advantages to correcting the therapist is that it creates a better understanding between you and the therapist. It’s easier for the therapist to try and help you if they have a good understanding of what is bothering you.

You may be unsure as to how to present your problem to the therapist. Sharing different aspects of your problems can be important for meeting your goals in therapy. It is really helpful for you to give as much information as possible about the reason for your visit, including details and background information. This helps the therapist to understand what you are worried about. At the same time, it is not necessary for you to know exactly what is bothering you. Still, you should try to share any information that you 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 for you and your therapist.

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 goals that are more challenging. For example, you might be frustrated with the behavior of your significant other, and wish to change some of their behaviors. Therapists in general will prefer to focus on you and your reactions to others. Or, you may worry that fundamental aspects of your own personality will be changed. It is not necessary for you to make major changes in therapy. It is up to you to decide the level of involvement or change that is comfortable for you, and your therapist will help you set realistic goals for yourself. It may be helpful to keep in mind that in general the focus of therapy will be on you, and reassure yourself that any changes will be mutually agreed-upon between you and your 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.

You may have some concerns about therapy that are not addressed during the first session, either because the therapist does not discuss them or because you don’t feel comfortable sharing them. For instance, before coming to therapy, you may worry that only “crazy” people go to therapy or wonder if something is seriously wrong with you for seeking therapy. Therapy is useful for a variety of different problems, and they don’t all have to be serious. Some people come to therapy simply to gain a better understanding of themselves.

You might also be concerned about negative repercussions for being in therapy. You may be worried that whatever diagnostic “label” you receive will follow them throughout your life, and that people (e.g. family members, employers, etc.) will react differently to you now that they are in therapy. This is a good topic to bring up and discuss with the therapist. There is no shame in going to therapy!

You may also wonder about possible causes of psychological problems. This could include how and why problems can develop. You may not realize that some disorders have organic (biological) causes, while other disorders are actually normal reactions to stress or trauma. It may relax you to know you are not necessarily responsible for the development of your disorder, and you should feel reassured to know that it can be treated. Worries or concerns of this nature should be brought up and discussed with the therapist.
Hopefully, you have found the information contained in this program to be helpful. While it would be impossible to answer all your questions, we hope you have learned something. We would encourage you to bring up any additional questions or concerns with your therapist during your first session. Thank you!

THE END!
Footnote

1These analyses were repeated with prior treatment variables treated as a continuous covariate. When run as covariates, all analyses were non-significant: EAC-B Client Involvement factor scale (baseline vs. time 1, $F(1, 70) = 1.22, ns$, and baseline versus discharge, $F(1, 59) = 0.76, ns$) and the OQ (baseline vs. discharge, $F(1, 59) = 0.19, ns$).