2003

The impact of written treatment plans on the effectiveness of psychotherapy in a university-based community clinic

Andrea C. Neal

The University of Montana

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The Impact of Written Treatment Plans on the Effectiveness of Psychotherapy in a University-based Community Clinic

by

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B.A., Western Washington University, 1994
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presented in partial fulfillment of the requirements for the degree of Doctor of Philosophy

THE UNIVERSITY OF MONTANA

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Date
The Impact of Written Treatment Plans on the Effectiveness of Psychotherapy in a University-based Community Clinic

Director: David Schuldberg, Ph.D.

Written treatment plans are commonly developed in various clinical settings, frequently for administrative reasons. The empirical literature on the relationship between written treatment plans and outcomes is lacking, although findings from the goal-setting literature indicate that creating goals improves task performance, and from process research indicate that variables related to collaborative treatment planning are correlated with positive outcomes in psychotherapy. This suggests that written treatment plans may improve outcomes for psychotherapy clients. Client collaboration is generally recommended in writing the treatment plan, and the client participation literature indicates that client participation in many aspects of treatment is beneficial to both client and clinician. This effectiveness study examined the impact of collaborative written treatment plans on the outcomes of psychotherapy clients at a university-based community clinic. Subjects were randomly assigned to the experimental group where written treatment plans were developed collaboratively with the client following a treatment planning protocol, or to the control group where subjects received treatment as usual, [perhaps say] generally with no written treatment plan. Subjects completed a symptom and functioning measure (OQ-45.2; Lambert, et al., 1996) pre-treatment and again at three-month intervals and termination, along with a client satisfaction measure (CSQ-8, Attkisson & Zwick, 1982) and a therapeutic relationship measure (WAI, Horvath & Greenberg, 1989). It was hypothesized that subjects within the experimental group would show greater functioning and improvement in symptom reduction at the last time period, and they would indicate a stronger therapeutic relationship and greater satisfaction. Repeated measures ANOVAs of the OQ scores, comparing the two groups at the first and last assessment, showed that both groups improved over time. There were no significant differences between the two groups in amount of improvement, except that subjects in the treatment as usual condition showed greater improvement, at post-test, in interpersonal relationships compared to experimental condition subjects. There were no significant differences between groups on the WAI or CSQ. An assessment of student therapists' attitudes toward written treatment plans found that students in both groups reported generally positive attitudes toward treatment plans, and a collaborative approach toward treatment, both prior to and after writing treatment plans for the study.
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Introduction and Literature Review

Treatment plans are a common component of current psychotherapeutic practices, although many treatment plans are developed to meet the requirements of a third-party payer or a governing body such as the Joint Commission on Accreditation of Healthcare Organizations. With this emphasis on meeting documentation requirements, the potential clinical benefits of writing treating plans for psychotherapy clients may be ignored. A treatment plan, or at least one that is created collaboratively, requires a client and therapist to define the problem and create objectives to resolve that problem. A treatment plan provides a focus and a goal for therapy, and this may be very beneficial for the client.

Treatment planning and documentation in general have become increasingly important in the delivery of psychotherapeutic services in the last several decades. This can be partially attributed to managed care's increasing involvement in the provision of psychological services (Jongsma & Peterson, 1999). An example of the importance of treatment planning can be seen in the Wiley treatment planning series (e.g., *The Complete Adult Psychotherapy Treatment Planner*, Jongsma & Peterson, 1999), which provide guidance for practitioners in developing treatment plans for clients with specific problems. Treatment plans are often required by insurance organizations for therapy sessions to be approved. Treatment planning is also utilized as part of the care of a wide range of populations such as individuals with serious psychiatric disorders or developmental disabilities, and in an array of settings as well, such as community mental health agencies and inpatient and residential facilities.

In addition to meeting documentation requirements, there are many reasons that improved documentation, and developing written treatment plans specifically, can benefit both the client and the practitioner. For example, it is thought that developing a treatment plan provides greater focus to the therapy process (Jongsma & Peterson, 1999). However, treatment plans are often viewed by practitioners as required documentation that provide limited clinical value and increase one's work load. Unfortunately, the empirical literature is lacking on this subject, and consequently the clinical value of treatment plans is unknown. It is likely, however,
for a number of reasons, that the act of creating a written treatment plan, with the client's collaboration, does benefit the treatment process. This hypothesis is based partly on the empirical findings of the effects of goal setting on task performance and the effects of goal consensus on psychotherapy outcomes. In addition, clinical intuition and experience suggest that the focused and collaborative aspects of writing a treatment plan can benefit psychotherapy clients.

The goal setting literature, when applied to treatment planning, suggests that this technique may improve therapy outcomes. Process research of psychotherapy finds that some process variables, including goal consensus between the therapist and client and the collaborative efforts of clients and therapists, are related to positive outcomes. Based on these findings in the goal-setting and psychotherapy process research, I hypothesized that the act of collaborating with the client in clarifying treatment goals and objectives for a written treatment plan would result in increased client satisfaction with psychotherapy, a stronger therapeutic alliance, and positive outcomes.

This project is an effectiveness study of the impact of collaborative written treatment plans on outcomes for psychotherapy clients. The study took place in a university training clinic where individuals, couples, and families are provided psychotherapy by psychologists-in-training. Individual psychotherapy clients were asked to participate in the study. Subjects were placed in the control or experimental groups based on the practicum group to which they were (generally) randomly assigned. Whole practicum groups were assigned to the experimental condition of writing treatment plans or the control condition of treatment as usual, without a treatment plan. Self-report outcome measures were used, which examined the areas of symptom reduction, interpersonal and role functioning, and satisfaction with services. The client's report of the therapeutic alliance was considered. The therapists' attitudes toward treatment planning prior to and after the utilization of written treatment plans in psychotherapy were also examined.
Historical Use of Treatment Plans

Treatment plans initially emerged in the medical field in the 1960's and the trend extended to the mental health sector in the next decade (Jongsma & Peterson, 1999). To qualify for third party payments like insurance companies, mental health providers (e.g., clinics, psychiatric hospitals, etc.) began to utilize treatment plans to meet accreditation requirements by organizations such as the Joint Commission on Accreditation of Healthcare Organizations. The purpose of these requirements, like the JCAHO guidelines, was to protect the client by ensuring better quality of care for the recipients of the services. Managed care has also influenced the use of treatment plans. As managed care organizations become more prominent in the delivery of mental health services, the utilization of treatment plans has increased (Jongsma & Peterson, 1999).

Potential Benefits of Treatment Plans

Some argue that treatment plans have multiple benefits that affect the client, the clinician, multi-disciplinary team, treatment agency, and the psychotherapy profession as a whole (Maruish, 2002; Jongsma & Peterson, 1999). Client and therapist benefit from the focus to the therapeutic process provided by the treatment plan. When the client has read the treatment plan, whether s/he developed the plan collaboratively with the therapist, or at the very least, reviewed the treatment plan with the therapist, this may change the client's perception of the therapy process. The process may appear to the client as more concrete and focused on the client's problem. The therapy experience may appear to be less ambiguous to clients.

In addition, the client will, ideally, have an understanding and agreement with the intended direction of the treatment. A treatment plan may delineate the expected outcome of therapy, and this may set realistic expectations for treatment. For example, a goal for a client with obsessive-compulsive disorder may be "reduced distress about bathroom germs, as measured by a SUDS rating of 25 in a public bathroom." This may assist the client in realizing that an expectation of not being at all distressed, when entering a situation that caused great
distress at the onset of therapy, may be unrealistic. In addition, I argue that the written treatment plan secures a commitment from the client about what s/he will work on and seek to achieve.

Treatment plans benefit administrative bodies, such as managed care organizations, by increasing the accountability of clinicians for the treatment that they provide. The term “managed care” refers to a form of delivering and regulating medical care that was implemented within the past several decades to control the rising costs of medical care. To achieve the goal of reducing costs, a managed care organization must decide which services are cost-effective and efficacious, and which services are unnecessary and therefore should not be reimbursed. Knight (1998) suggests that managed care “create(s) an organized system where care that is medically necessary is delivered by properly trained and educated health care professionals, in appropriate locations and facilities, and under practice guidelines that are likely to produce the best results for patients” (p. 21).

This focus on “best results” has led to the increased focus on client outcomes in psychotherapy. Treatment plans are a method of documenting the therapist’s intentions for treatment to be provided and the goals to be achieved through therapy. With regard to managed care organizations, treatment plans provide another method of ensuring accountability. A written treatment plan allows a reviewer of a managed care organization to make a determination about the quality of the care that is being proposed. A review of the treatment plan indicates whether the treatment being provided is based on the clinical signs and symptoms with which the client presents (Chambliss, 2000). In addition, the treatment plan clarifies the focus of therapy. A supposed benefit to the managed care organization is the acceleration of the therapy process resulting in fewer sessions (Chambliss, 2000). A goal of a treatment plan is to quickly develop clear-cut behavioral objectives of the therapy and therapeutic methods to achieve those goals.

By requiring written treatment plans, third party payers may also benefit from the commitment of certain treatment actions by the practitioner, which may lead to better outcomes for clients.

Written treatment plans provide some assurance that recipients of psychological services are being treated ethically. This point is particularly important with vulnerable
populations, such as individuals with a developmental disability or severe mental illness. These individuals in the past may have been “warehoused” in a custodial institution for years without any documentation of plans for treatment. By establishing a requirement of written treatment plans, institutions and other providers are held accountable for the treatment of vulnerable populations. Written treatment plans, especially when they are developed with, or at least shared with, the client, provide some assurance that the client is receiving ethical and appropriate treatment.

Providers benefit from developing a treatment plan because it requires that they outline ahead of time what interventions will best work for the client (Jongsma & Peterson, 1999). Not only must they plan ahead, but they must consider the best method to use for the particular client and particular problem. Developing a treatment plan requires a clinician to devote thought and energy to case conceptualization. In addition, the treatment plan may provide some protection in case of litigation, as it is another documentation of clinical practice, and the client’s signature indicates some agreement about the treatment and objectives of the therapy.

A treatment plan can be extremely useful when a multi-disciplinary team is treating the same individual (Jongsma & Peterson, 1999; Allen, Buskirk, & Sebask; 1992). When there are several individuals working on a single case, and especially if these service providers are from different departments, such as staff from areas of psychiatry, psychology, nursing, or social work, it may be challenging to communicate how to treat the individual, and determine who will be providing what treatment. The treatment plan provides a medium for the team to agree on the course of treatment for the individual and which member of the treatment team will be responsible for various aspects of the treatment.

It is also suggested that increased treatment plan utilization will benefit the psychotherapy field because more detailed treatment plans will allow for greater ease of collection of outcome data (Maruish, 2002; Jongsma & Peterson, 1999). A treatment plan can be useful in this way because it identifies measurable objectives for therapy. By comparing client change to these objectives, the outcome of the therapy process can be determined. Treatment
Treatment Planning 6

plans can track progress made in psychotherapy, and this may provide useful information about the effectiveness of psychotherapeutic services.

As indicated, there are numerous convincing arguments that treatment plans can have many benefits to many people. An important argument is overlooked with regard to the delivery of psychological treatment, which is this: the utilization of treatment plans may increase the effectiveness of psychological treatments. Clients may make great or more rapid improvements when a written treatment plan is a component of the therapy process. This hypothesis has not been supported with empirical evidence. Despite the lack of findings in the literature, it is a compelling argument considering the commitment that both the client and the therapist make when developing a treatment plan. In addition, as Jongsma and Peterson (1999) suggest, treatment planning likely increases the focus of therapy, and there is some evidence that efforts to focus therapy increases the treatment’s effectiveness (Horowitz, Marmar, Weiss, Dewitt, & Rosenbaum, 1984).

Problems Associated with Written Treatment Plans

Despite the widespread use of this therapeutic and administrative tool, there are several problems with treatment plans. The first relates to questions pertaining to the purpose of treatment planning. It is unclear whether treatment plans are a method of quality control as a document that details the treatment process, or whether treatment plans are required or recommended based on the assumption that treatment plans increase the effectiveness of therapy. If it is the latter, there is little research that indicates that a written treatment plan does improve the effectiveness of treatment.

It is not uncommon for clinicians to hold negative attitudes about treatment plans. Many staff view treatment plans as unnecessary paperwork, in an already documentation-heavy field, that is arbitrarily required by some third party. It seems that many clinicians believe that the process of creating a plan contains little therapeutic value. With clinicians with these attitudes, it is likely that treatment plans are written with little attention to create a document that is helpful to the client and treatment process. (And, the belief in their lack of utility can be a self-fulfilling
prophecy.) In addition, compliance to agency requirements of writing treatment plans is often an issue. Plans may be written late, and therefore provide little benefit to the therapy process, or they may not be written at all. In addition, it is possible that many clinicians receive little training on the development of treatment plans and have little idea of what is a "good" treatment plan. However, treatment plans may play a valuable role in providing effective psychological treatment, and this may be an area to employ in current practice to improve treatment.

Another issue related to treatment planning concerns client involvement. There are several arguments supporting the involvement of the client in the development and implementation of the written treatment plan. Encouraging consumer participation in treatment planning may improve outcomes for the client, or at least improve client satisfaction with services. This issue will be discussed in greater detail.

**Varieties of Treatment Plans**

The term "treatment plan" or "treatment planning" is commonly used in the mental health field and the term can refer to a number of things. In this paper, the term is used to refer specifically to written treatment plans. A treatment plan is just that, a document that entails a plan, or a "blueprint" (Wiger, 1997), for treatment. "The purpose is to specify exactly what is to be done for the patient, who (i.e., which staff members) will be responsible for the procedures, and what goals and problems are to be addressed by these procedures" (Siegel & Fischer, 1981, p. 28). Treatment plans are not limited to use in psychotherapy, for they are a JCAHO requirement that governs all hospitals, and consequently a wide-range of medical and psychological services develop treatment plans as one component of their treatment of patients. Varied treatment settings, such as mental health agencies, rehabilitation services, or inpatient psychiatric facilities, develop and implement different forms of treatment plans. As there are wide-ranging treatment settings that use treatment plans, there exist several different styles of this type of document. Despite this variety of setting and style, there are two aspects of the document that are consistent: (a) a goal or goals for the treatment and (b) the therapeutic intervention to be implemented by the clinician. Within these two components, the treatment
plan addresses patient commitment by eliciting agreement about changes the client will work to make. This also addresses provider compliance by determining and documenting ahead of time the treatment interventions the clinician proposes s/he will provide.

Components of the Treatment Plan

JCAHO and other organizations require certain components of a treatment plan and much of the sourcebook literature on mental health documentation reflect these guidelines (for example, see Jongsma & Peterson, 1999; Moline, Williams, & Austin, 1998; Wiger, 1997). These components are (1) the problems or symptoms, (2) the broad, long-term goals, (3) behavioral objectives, and finally, (4) the treatment interventions. Moline, Williams, & Austin (1998) differ slightly from the others (Jongsma & Peterson, 1999; Wiger, 1997) by referring to goals as “Concepts/skills to Develop.” These components are somewhat similar to the “SOAP” progress note format commonly used by clinicians and other service providers. SOAP is an acronym for the four parts of the note which consist of Subjective (the client's description of the presenting problem), Objective (the objective data as related to the problem), Assessment (the clinician's assessment of the problem), and Plan (the next actions to be undertaken to resolve the issue).

Maruish (2002) presents an extensive model for a treatment plan that includes numerous additional components to the document. These are as follows: Referral Source and Reason for Referral, Presenting Problem, Problem List, Diagnosis, Goals and Objectives, Treatment, Patient Strengths, Potential Barriers to Treatment, Referral for Evaluation, Criteria for Treatment Termination or Transfer, Responsible Staff, and Treatment Plan Review Date. Many of these supplementary elements of this treatment plan are included to facilitate communication about the client and treatment, whether this communication is with the client, a third-party payer, or another member of the treatment team.
The following treatment plan provides an example of three of these components. This example is based on the suggestions of Jongsma and Peterson (1999).

<table>
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<th>Long-term Goal</th>
<th>Objectives</th>
<th>Treatment Intervention</th>
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<tbody>
<tr>
<td>1. Alleviated depressed mood and return to previous level of effective functioning.</td>
<td>1. Meet with physician for assessment of need for antidepressants.</td>
<td>1. Provide referral to a physician to give a physical examination to rule out organic causes for depression, assess need for antidepressant medication.</td>
</tr>
<tr>
<td></td>
<td>2. As necessary, monitor and evaluate medication compliance and the effectiveness of the medication on level of functioning.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Express feelings of hurt, disappointment, shame that are associated with early life experiences.</td>
<td>1. Explore experiences from the patient's childhood that contribute to current depressed state.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Encourage patient to share feelings of anger regarding pain inflicted on him/her in childhood that contributes to current depressed state.</td>
</tr>
<tr>
<td></td>
<td>3. Utilize behavioral strategies to overcome depression by increasing activity. Client will participate in 2 recreational activities weekly.</td>
<td>1. Assign homework task of logging daily activities for one week.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Examine daily activities for mastery and pleasurable experiences.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. Develop a plan for participation in recreational activities.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4. Explore barriers to doing activities as they arise.</td>
</tr>
</tbody>
</table>

The JCAHO guidelines also specify how treatment plans are to be written. The objectives are to be written in language that is behavioral, objective, and measurable. These objectives or outcomes must be composed in such a way that the attainment of the outcome can be perceived by an objective observer. In addition, JCAHO requires that these objectives or
outcomes must be obtained by the client; these are not objectives for the treatment provider to achieve.

There are numerous guidebooks on the market currently to assist mental health practitioners in documentation of their treatments (e.g., Wiger, 1997; Jongsma & Peterson, 1999; Maruish, 2002), such as the guidebook created by Jongsma and Peterson (1999) specifically for this purpose. Although the authors appear to be basing their advice from clinical experience rather than empirical findings, their format appears to match the treatment plan components of JCAHO guidelines, other documentation resource books (Maruish, 2002; Moline, Williams, & Austin, 1998; Wiger, 1997), as well as the methods of many practicing clinicians. The authors (Jongsma & Peterson, 1999) suggest following these six steps in developing a treatment plan:

1) Problem Selection: The first step is to select the primary problem of the individual. There are likely several problems making up the client’s complaints, but in using this format, it is necessary to choose one problem that is primary. The primary problem may fit into a DSM-IV Axis I or Axis II diagnostic category, such as Depression or Borderline Personality Disorder, or it may not, such as “interpersonal relationship conflict” or “low self-esteem.” The authors suggest that the treatment plan may include more than one problem, and indeed many individuals seeking psychotherapy present with numerous problems. A key element of selecting the primary problem is ensuring that the problem addresses client’s greatest needs. The authors suggest that the client will be most motivated and involved in therapy that addresses his or her own needs. Clearly, clinical intuition and experience suggest that client participation is an important factor in developing treatment plans.

It is important to base the primary problem on findings from a thorough biopsychosocial assessment of the client (Wiger, 1997). Clinicians may use a variety of assessment methods to determine the client’s problem, including structured and unstructured clinical interviews, personality tests, and symptom checklists. Psychological testing may assist in identification and clarification of the problem which may be necessary for clients who have difficulty articulating what is wrong (Maruish, 2002). Psychological testing may assist in clarifying the problem by
determining the severity and complexity of the problem, as well as the impairment level of the client. Using assessment tools might provide information about important client characteristics, such as weaknesses, strengths, or other factors that impact the problem or would impact the therapy process. For example, administering the MMPI-2 or the Rorschach could provide valuable information about the client's ability to engage in the therapy process, and this understanding would assist in writing a more accurate and relevant treatment plan.

2) Problem Definition: The next step is to define the problem in an individualized manner for the client, meaning that it is a description of how this particular client manifests this problem. The definition may be related to DSM-IV diagnostic criteria with regard to the individual's expression of the problem. For example, two individuals presenting with depression can experience different symptoms and will have different problems related to their problems (e.g. interpersonal isolation or employment difficulties).

3) Goal Development: In conceptualizing a resolution of the target problem, broad goals are created to define the positive outcome to be achieved. These goals may be long-term and global. The goals are the "big picture" that the clinician and the client are seeking to achieve.

4) Objective Construction: Goals differ from objectives in that goals may be subjective, global, and somewhat vague. In contrast, objectives are specific and behaviorally measurable, as required by JCAHO guidelines. These objectives are the steps necessary to attain the broad treatment goal. Jongsmia and Peterson (1999) recommend at least two objectives for each problem and to indicate the target date for attaining that objective. New objectives must be added as necessary during the course of treatment. Wiger (1997) stresses that the success of the treatment depends upon the degree to which the goals are realistic and achievable. It is recommended that objectives are written in terms of small steps that the client can attain. These recommendations that the objective be specific, measurable, and realistic will be addressed further in another section.

5) Intervention Creation: For each objective there must be an intervention that the clinician will implement. The intervention is the technique that the therapist uses during the
therapy session to aid the client in achieving the objective. Jongsma and Peterson (1999) suggest that there is at least one intervention for each objective and that new interventions are added if the client does not accomplish the objective after the initial intervention.

6) Diagnosis Determination: The final step in the treatment planning process is determining the appropriate diagnosis for the client. This step is unnecessary for the implementation of the treatment plan since the problems and goals have already been clarified. However, the inclusion of the diagnosis is in line with good documentation practice and is required by JCAHO.

*Shortcomings of Treatment Plans*

As noted above, treatment plans appear to have many benefits to many parties involved in a person’s care, including the client; however, treatment plans can have several shortcomings. One aspect of treatment plans that can be problematic for some clinicians is the emphasis on writing objectives in observable measurable behaviors. This is a requirement of JCAHO and it also allows for ease in assessing outcomes. However, this format is limiting to those many psychotherapists who are not behaviorists. For example, behavioral terms are incongruent with a psychodynamic orientation, and psychodynamic therapists may be uninterested in using a treatment plan because they think in terms of psychodynamic constructs, such as “intrapsychic conflicts,” rather than “number of pleasurable activities an individual participated in during a week” (Allen, Buskirk, & Sebastian, 1992).

The proliferation of resource books for developing treatment plans may, in some situations, limit the benefits of treatment plans. In favor of saving time and effort, a clinician may use a resource book with disregard to the individual and the particular problem manifestation of the client. Jongsma and Peterson (1999) provide a long and varied list of problems, goals, objectives and interventions from which the therapist can select for the individual client. A clinician could choose statements from each section and place the statements directly in the treatment plan without making any alterations specific to the client. Although this may seem like an excellent time-saver for the overworked treatment provider, I believe that it is
disadvantageous to the client and the therapy process to write treatment plans that are not individualized for the client. Jongsma and Peterson (1999) repeatedly remind the clinician to consider the individual for whom they are creating the treatment plan and for the therapist to consider his or her own expertise in choosing the treatment interventions. Despite these precautions, this "pick and choose" format may encourage clinicians to disregard the therapeutic benefits of a written treatment plan and perpetuate the attitude that it is documentation that is required yet unnecessary clinically.

Other Examples of Treatment Plan Formats

Although it is common for treatment plans to consist mainly of behavioral terminology, other domains of psychotherapy have developed treatment plans to fit their orientation. For example, Allen, Buskirk, and Sebastian (1992) describe a treatment plan used at the Menninger Clinic which fits with the psychodynamic orientation that is applied in treatment. One goal of this treatment plan is to allow a multi-disciplinary team, such as one composed of psychologists, psychiatrists, and nurses, to easily contribute to the creation and modification of the plan.

Another method of developing a treatment plan, compared to determining the primary problem as described above, is to indicate problems that occur within specified domains. The development of the Menninger Clinic Master Treatment Plan was based on four domains of client dysfunction: thought organization, object relations, impulse control, and affective functioning. The psychodynamic influence is evident in these domains. These four domains were derived from a factor analysis of the assessment tools used at admission and discharge. From the findings of the four basic domains of severe impairment, the clinic created eight areas of potential problems: self-concept and identity, interpersonal relationships, thinking and cognition, emotional functioning, impulse regulation/addiction, adaptive skills, family and other (including medical).

Unlike the one-page treatment plans designed for psychotherapy clients, the Master Treatment Plan is a multiple page document. The first page contains a statement of the reason for admission to the facility, the strengths of the individual, and a diagnosis. The patient is
assessed in each of the eight domains described above and this assessment is included in the document. The most severe problems that relate to the need for hospitalization is the focus of the treatment plan. It would not be unusual for an individual to demonstrate problems in all eight of the domains, however, it is important to pinpoint the most severe problems to focus the treatment rather than work on all of the individual's problems at once.

Because this treatment plan is used in an inpatient facility, it includes features specific to hospitalization issues. Discharge planning is included in the treatment plan to elucidate the criteria for discharge and the anticipated treatment or placement of the individual once s/he leaves the hospital. The criteria for discharge are comparable to the long term goals of psychotherapy treatment plans, for these criteria outline what the patient will have achieved when treatment is completed. These components of reason for hospitalization, strengths, diagnosis, assessment in problem areas, and discharge planning provide the broad diagnostic assessment for the individual.

Once the assessment of the individual is outlined, then the focus of the treatment is clarified. The focus is determined by the most immediate problem confronting the treatment team during the hospitalization. This problem is generally complex and taps into several domains of impairment. In resolution of this problem, long-term goals to be attained at discharge are developed as well as short-term goals. The short-term goals are akin to the objectives of the treatment plans recommended by Jongsma and Peterson (1999). These are small graduated changes to be made by the patient that will advance him or her to the long-term goal. Because the Master Treatment Plan is utilized by a treatment team, the plan names the staff person responsible for the implementation of the treatment interventions.

An unusual feature of this treatment plan is the patient's clear contribution to the plan. The patient is asked to write, in his or her words, an assessment of his or her strengths and needs. This includes describing the problem(s), his/her goal(s), and how to achieve the goal(s). Client participation in this manner demonstrates an increased role in the treatment planning process for the client, far beyond simply asking the client to sign the treatment plan document.
Once the Master Treatment Plan is developed, further documentation occurs as treatment progresses. The plan is regularly reviewed by the treatment team and updated when necessary.

Another interesting aspect of this treatment plan model is how it was developed to meet specific needs of the Menninger Clinic. The Master Treatment Plan was developed in a manner to resolve problems of staff resistance to treatment planning and to allow for a plan with a psychodynamic orientation. The first issue was solved by ensuring staff participation and input in the development of the plan. This staff involvement seemed to reduce the staff’s sense that the treatment plan was externally imposed. The second problem reflects the need to develop short-term objectives that are described in behavioral terms despite any contrast with the psychodynamic approach of the facility. This issue was solved by creating a broad conceptual framework (i.e., the eight domains) with a psychodynamic approach. With this framework, behavioral objectives are designed to achieve goals within these domains. Also, behavioral objectives include insight-oriented behavior, such as “the patient will verbalize understanding of...”

The Menninger Clinic Master Treatment Plan is different from the treatment plans described by Jongsma and Peterson (1999) in that it addresses eight problem areas. In a similar fashion, Kennedy (1992) developed a treatment plan that is organized around level of functioning rather than diagnosis. Based on the Global Assessment of Functioning of Axis V from the DSM-IV, the seven broad categories to be considered in treatment planning consist of psychological impairment, social skills, dangerousness to others, activities of daily living/occupational skills, substance abuse, medical problems, and ancillary problems. Within these seven categories, a clinician can systematically organize all of an individual’s presenting problems.

The Kennedy (1992) treatment plan format contains many of the same components as the Master Treatment Plan of the Menninger Clinic, and these components include patient’s strengths, discharge planning, and diagnosis. Problems are described based on the seven broad
categories, and include long-term and short-term goals. Kennedy (1992) indicated that he used the term “short-term goals” rather than objective because objective is an ambiguous term.

Despite the different orientations and varying settings in which the treatment plans described above are based, all contain similar components. In developing the plan, a problem(s) is identified, and then goals are created to resolve the problem(s). Objectives, also called short-term goals, describe the gradual steps for the client to attain as s/he works toward the long-term goal. Finally, the treatment interventions to be implemented by the therapist are listed. The treatment plans described that are utilized in inpatient facilities with more severely ill populations take the approach of identifying problems in specific domains. This method organizes the numerous problems that a multi-disciplinary team will be treating with more severely and acutely ill patients. In an outpatient setting, however, this more detailed and thorough level of problem description is often unnecessary. Outpatient clients are more likely to seek therapy with fewer or less complex problems. Because the population treated in this study is individuals seeking outpatient psychotherapy, the treatment plan intervention were limited to the components of long-term goals, objectives, and treatment interventions.

*Goal Attainment Scaling*

Goal Attainment Scaling (GAS; Kiresuk & Sherman, 1968) is a method of evaluation that has many similarities to treatment planning techniques. The GAS was developed to assess the effectiveness of psychological treatments in a case-specific manner. The most common method of assessing outcomes of a treatment is to use the same measures for all clients. For example, all psychotherapy clients, regardless of the presenting problem or individual manifestation of the diagnosis, would be measured on change in symptoms and level of functioning, etc. However, this general approach does not allow for the determination of change or progress in the areas for which the client specifically sought treatment. The GAS technique was developed specifically for assessing change in individualized goal areas. Despite the predominantly evaluative purpose of the GAS technique, it has numerous similarities to treatment planning. For this reason, the GAS method will be examined in detail.
The GAS technique assesses the outcome of the treatment based on the change that the client exhibited in the areas that treatment was focused. The recommended steps of this technique are as follows (Kiresuk, Smith, & Cardillo, 1994). The first step is to identify the issues that will be the focus of treatment and that treatment is expected to change. As stated above with regard to treatment planning, the client may have a host of problems but only some will be in the realm of mental health. The client's problems that will be the focus of treatment are restated as positive goals for which the client will strive.

Again, client participation is considered an important factor in this process. Kiresuk, Smith, and Cardillo (1994) recommend that these goals be determined by both the therapist and the client. A goal is considered to be negotiated when the client participates actively in the goal-setting process, and the client has a general awareness and some agreement with the level of outcome that the client is expected to achieve.

A brief title is given to each goal, (e.g., "depression" or "self-esteem") and an "indicator" is selected for each goal. The indicator represents the achievement of the goal and is generally defined in terms of a behavior, affective state, skill or process. This indicator is used to determine the progress that the client has attained. For example, with the goal of "depression," indicators may include crying, weight loss, sleep disturbance, patient's view of own future, depressed mood.

Once the goals are determined, markers are created to indicate the degree of progress achieved by the client at the end of treatment. This is done by determining the expected level of outcome for each goal. The goal-setting therapist must make an accurate prediction of the client's status with regard to the goal at the end of treatment. Knowledge of the usual outcomes of treatment, the client's resources, the planned length of treatment time, and the therapist's own skill level is necessary to accurately define expected outcomes. Because the expected outcomes are used to determine the outcome of the treatment, they are based on the indicators and are written in measurable and quantifiable terms. This means that the symptom is defined by the frequency, percentage, or intensity of occurrence. Precision is important in deciding what will be
the most likely level of achievement for the client. An expected level of outcome that is too easy for the client to achieve will result in overly-favorable outcomes for the treatment while an expected level of outcome that is too difficult will lead to inaccurate negative results of the treatment.

After defining the expected level of outcome for the client, the therapist determines levels of outcome that are less and more favorable than the expected outcome. These levels are differentiated by "somewhat less than expected, somewhat more than expected, much less than expected, and much more than expected."

Once the goals and the range of expected outcomes have been created, the treatment can begin. At the end of treatment, a follow-up interview is conducted to determine what outcome the client achieved. If this method is being used to evaluate psychological services, this follow-up interview should be conducted by an individual other than the therapist. Another person is more likely to provide an objective judgment of the client's progress. However, if the technique is not being used for a program evaluation, the therapist or client can score the goals. The therapist can gain immediate feedback about the relevance of the goals developed and the treatment provided, and how realistically s/he predicted the expected level of outcome. This practice may also indicate to the therapist the type of clients and kinds of problems with which s/he is most and least successful. In addition, Goal Attainment can yield a number of quantitative indices reflecting both final levels of goal attainment and change scores; these can be useful in the evaluation of programs and services.

Goal Attainment Scaling and Treatment Planning

Although the GAS technique was designed for use in program evaluation, it has several features that are similar to treatment planning. As described above, the steps involved in utilizing the GAS method are similar to the initial steps of creating a treatment plan. The therapist determines the problem that will be the focus of therapy, and then this problem is translated into the goals of a positive outcome of what the therapist and client want to achieve with therapy. The "indicator" is similar to the objectives of the treatment plan in that these are the specific and
measurable changes for which the client will strive. This is also an area of contrast, since there are numerous objectives in a treatment plan, describing the step-by-step movement toward the treatment goals, but only one indicator for each goal in the GAS technique. Another area of contrast is that the GAS method does not include the treatment interventions to be utilized by the therapist.

Despite these differences, as well as the sharply contrasting purpose of each instrument, findings and conjecture based on the GAS is relevant to the treatment plan. For example, Evans (1981, as cited in Kiresuk, Smith, & Cardillo, 1994) suggests that there are numerous potential clinical benefits of using the GAS, beyond its ability to evaluate treatment outcomes. Evans (1981) asserts that the development of therapeutic goals benefits the client and therapist in many ways, such as increasing the therapist’s organization of treatment interventions and focusing the therapist’s direction, improving the clarity of the treatment objectives, and developing realistic expectations of therapy for both client and therapist. The development of goals may increase the client’s motivation to improve which may lead to improved therapy outcomes (Evans, 1981). It may be noted that the increase in focus and motivation as a result of completing the GAS method are similar to the mechanisms involved in increased performance when goals are set (Locke, Shaw, Saari, & Latham, 1981).

**Goal Setting and Behavior Change**

Although this aspect of the planning process is frequently disregarded in the treatment plan literature, developing a treatment plan is akin to creating goals for the therapy process. There is extensive literature on the effects of goal-setting, although generally this area of research is focusing on improving job performance rather than therapeutic outcomes. However, in many ways, the findings from goal-setting research are relevant to treatment planning. For this reason, the goal-setting literature will be briefly reviewed here.

**Goal Setting and Performance in Job-related Tasks**

Locke et al. (1981) provide an excellent review of the goal-setting literature from 1969 to 1980. These authors reviewed an extensive array of studies, both laboratory and field, examining
the factors affecting task performance when goals are set. These studies predominantly investigate work-related tasks, and the field studies generally take place in employment environments.

Numerous conclusions were provided based on this literature review. The first is that goal-setting improves performance. Indeed, Locke et al. (1981) state this conclusion with strong language, "the beneficial effect of goal setting on task performance is one of the most robust and replicable findings in the psychological literature" (p. 145). Goal setting appears to affect task performance through four mechanisms. Goal setting directs an individual's attention and action, mobilizes one's energy use or effort leading to persistence in attaining the goal, and motivates the individual to develop the necessary strategies for goal attainment. With regard to clinical work, it is likely that the goal-setting in the form of treatment planning focuses the attention and action of both the client and therapist. The act of creating objectives to reach the goal of the treatment plan is a concrete method of developing the strategies to reach the goals.

Research indicates that there are certain characteristics of the goals that play a significant role in improving performance on the task (Locke et al., 1981). Specific goals lead to better performance than vague goals do. Describing goals in specific and quantifiable terms has been shown to improve performance over a vague goal, such as "do your best on this task." This conclusion is based on many studies, most of which are based on occupational performance as diverse as typing or ship-loading, and also on behavior change more relevant to psychotherapy, such as dieting and "personality" change in an encounter group. This finding of the importance of specific goals fits neatly with the suggestion of the documentation guidebooks of writing objectives in specific, quantifiable terms. Although this practice may be objectionable to non-behaviorist therapists, it may lead to better therapy outcomes for the client.

The Transtheoretical Model of Change (Prochaska & DiClemente, 1983) is a framework for understanding how people come to behavior change. It consists of five stages: pre-contemplation, contemplation, preparation, action, and maintenance. This model asserts that individuals move through these stages as they begin to consider and then implement a behavior
change. Setting goals may assist individuals in progressing through these stages by developing a plan for making the behavior change. For example, the act of setting goals may move an individual in the contemplation stage to the preparation stage.

The level of difficulty of the goal is another important factor in performance. Difficult or challenging goals result in better performance by the individual than easy goals. Generally studies that compared difficult goals to easy goals resulted in better performance by individuals with difficult goals. In combining this with the specificity factor, there was a 90% success rate for individuals with difficult and specific goals leading to improved performance compared to individuals with medium, easy, "do your best," or no goals (Locke et al., 1981).

These findings of improved results with difficult goals are relevant to therapy practice and can inform clinicians when developing treatment plans. There are likely some cognitive and affective factors related to goal-setting in psychotherapy, however, that are not applicable to the employment-related studies on which these conclusions are based. Self-esteem, an individual's feelings about him- or herself, may be a moderating factor in task difficulty and performance. One study (Carroll & Tosi, 1970) found that subjects with high "self-assurance" increased their effort when they were given increasingly difficult goals. Subjects with low self-assurance worked less hard when goals became harder. A related factor to self-esteem is self-efficacy, the belief that you can affect the environment in a desirable manner (Bandura, 1982). With low self-efficacy, difficult goals may seem too challenging and the effort involved to work toward them may seem fruitless.

Psychotherapy clients may experience low self-efficacy with regard to the problem for which they are seeking help. They may be feeling hopeless about their abilities to overcome this problem and achieve the goal. Despite these feelings of low self-efficacy, that act of beginning psychotherapy may increase the client's hopefulness about the attainment of the goal. There are findings that suggest that this hopefulness about the positive effects of therapy is a factor in the positive outcomes of psychotherapy (Hubble, Duncan, & Miller, 1999). Thus, the client may feel overwhelmed and hopeless about attaining a difficult goal on his or her own, but through the
process of therapy, may feel that this challenge can be met. It may be important for the therapist to encourage the hope that the client experiences with seeking therapy, while also ensuring that the client has realistic expectations about the therapy process and the need for the client to work hard to attain those goals.

Despite these cautious statements about setting difficult goals for clients, it is likely that therapy goals ordinarily created by therapists and clients tend to be challenging and difficult for the client to achieve. Individuals seek psychological treatment often when they are feeling that they cannot resolve their problems on their own. Thus the resolution of this problem, the therapy goal, is something that is viewed by the client as difficult and challenging to attain, at least without assistance.

Another important factor to be considered based on Locke et al.'s findings (1981) about goal-setting is the individual's ability. Although difficult goals may increase performance, the goals must be within the individual's ability to bring about good performance. When developing a goal, the ability of the client must be considered. In a therapeutic setting, this means that the therapist must carefully assess the client to determine whether this therapy goal is within the client's abilities.

Knowledge of results, or feedback, is another necessary factor if goals are to improve performance (Locke et al., 1981). Because most therapy goals will be related to the client's behavior, the client him- or herself can determine whether the goals were attained. However, some client's may not reflect upon the achievement of goals, and for this reason the therapist may spend time during the session periodically to review the goals and discuss with the client the level of goal attainment.

The participation of the subject was also examined to determine its effect on performance (Locke et al., 1981). Surprisingly, participation in setting the goal did not consistently result in better task performance when compared to performance on assigned goals. Supportiveness, however, may affect performance. Supportiveness was described as the behavior of the supervisor that involved friendliness, listening to the subject's opinion about the
goal, and encouraging questions. This aspect of goal setting for clinical practice is quite different than an employment situation or a laboratory study of task performance. In a psychotherapeutic setting, the goals set are immensely personal in that they are based on aspects of the individual's behavior and emotional functioning. In addition, there is a power differential in a psychotherapy setting that must be attended to. For these reasons, participation in goal setting is likely different for therapy than the studies described. Client participation in psychotherapy and goal setting will be discussed in detail below.

These conclusions, based on an examination of the goal setting literature and the factors affecting task performance, suggest that the act of specifying treatment goals in a written document such as a treatment plan can improve the outcomes of psychotherapy. However, developing goals that are specific and challenging is likely necessary to obtain good results.

*Goal Setting in Psychotherapy*

As indicated above, goal setting is prominent in the field of business management, but it is also relevant to the therapy process and treatment planning specifically. Some early studies examined the effects of goal setting in psychotherapy; for example, Hill (1969) determined that therapist goal-setting behavior is an important factor in client satisfaction. This study examined aspects of the therapy process and its relationship to client satisfaction with outpatient psychotherapy patients. After each therapy session, both the therapist and patient completed a measure that gathered information about the session. Patients' questions focused on her purpose or wants of the session, and her satisfaction with the session. The therapist was asked about his or her goals for the session and the degree to which s/he was working toward that goal.

Cluster analyses were conducted to determine the dimensions of therapist goals, patient wants, and patient satisfactions. Among the patient satisfactions, two general clusters emerged: (1) symptom relief and (2) satisfaction with the therapeutic relationship and the increased self-awareness developed through the process of therapy. The therapist goals emerged as three clusters in the analysis: insight, support, and symptom relief. In examining the endorsement of these three goals, there was a group of therapists who endorsed low levels of working toward
these goals. Their patients reported decreased satisfaction in developing insight and self-awareness, less satisfaction with the development of the therapeutic relationship, and less satisfaction with symptom relief. In addition, compared to the other patients, these patients saw their therapists as less helpful. Further analyses of the data indicated that it is the therapist's goals that influence the patient's satisfaction, not the patient's wants.

This was not an outcome study and so does not provide any information about whether therapist's goals led to a better outcome for clients with regard to symptoms, behavior change, or what it was that they wanted to be different in their life. However, it does provide information about the client's satisfaction with therapy, which may be related to outcome. In the sense of client satisfaction, the study demonstrates that the therapist's goals are a necessary component. The importance of client satisfaction will be discussed in greater detail below.

Wilier and Miller (1976) examined how client involvement in goal setting is related to treatment outcome. Therapists in a psychiatric hospital were responsible for designing and documenting a program for individual clients which involved setting treatment goals, determining potential treatment outcomes, and evaluating the progress of the patient. The staff was "encouraged" to involve the patient in the process of setting goals but the patient could refuse participation. Considering these vague instructions regarding patient participation, there was a continuum of goal-setting involvement ranging from active involvement in goal setting, no involvement in goal setting but informed of goals, and no knowledge of goals. For a small group there were no goals developed, and this was likely due to a short length of stay at the hospital. Outcome measures at discharge included length of stay, goal attainment scaling, client satisfaction, and community functioning. In addition, patients were asked to assess their degree of involvement in goal-setting. For patients with a greater level of involvement in goal-setting, they reported a greater level of goal attainment and satisfaction, and they had longer stays in the facility. The authors interpreted this as a positive result, citing the finding that length of stay is connected with lower recidivism. Involvement in goal-setting was not related to the community adjustment measure of outcome.
The collaboration of the client in the development of goals was related to the positive outcomes of improved goal attainment and satisfaction with services. This suggests that encouraging participation in developing goals is important. However, there are a number of problems with this study. As the authors (Willer & Miller, 1976) point out, the connection of low client satisfaction and low client involvement may be related to a self-report bias of disgruntled patients. The reverse may also occur in which agreeable clients may be more likely to over-inflate their perception of their involvement in goal-setting and their satisfaction. In addition, the authors indicated that the therapists were to "encourage" goal-setting involvement. It is not clear to what lengths therapists went to encourage involvement. There may be some confounding factor that is related to the therapist's performance. For example, if the therapist who set goals also provided treatment, then therapists who were less likely to involve the client in treatment goals may have also provided less satisfactory treatment.

One conceptualization of the client's involvement in setting therapy goals is that it consists of two separate variables (Evans, 1984). One refers to the client's commitment to the goal and the other refers to the client's participation in the setting of therapy goals. Evans (1984) hypothesized that there was a relationship between these two variables such that participation in setting one's own goals would result in increased goal commitment.

To test this hypothesis, 29 veterans hospitalized in a psychiatric unit of a Veterans Administration Medical Center were assessed for goal participation and commitment (Evans, 1984). First, patients developed their treatment goals with hospital staff in individual sessions, and these sessions were tape-recorded for later analysis of the patient's level of participation. Judges rated each session for patient participation and patient influence in goal-setting. Participation was determined by ratings of the patient's efforts and activity in the development of the treatment goals. Patient influence was determined by the degree to which the goal represented the ideas, suggestions, or personal objectives that the patient communicated during the session. Subjects also rated themselves on their level of participation and influence in goal-setting.
Patients were also measured on their level of goal commitment (labeled "involvement" in this study), which was determined in an interview several days after the goal-setting session. Patients were asked about their knowledge of their goals, their efforts in planning how to achieve the goal, and the behaviors they had undertaken to achieve the goal. Lastly, they were asked about their level of commitment to the goal. Goal involvement was determined by a global rating by the interviewer and the accuracy of the patient's recall of the goals. Goal Attainment Scaling (Kiresuk & Sherman, 1968), described above, was used as an outcome measure to determine whether goals were achieved for the patients.

The author found that goal involvement (commitment) of the patient was significantly correlated with judges' ratings of the patient's influence and the patient's self-ratings of goal-setting participation. These findings support the hypothesis of the study. It should be noted that subjects' self-ratings were quite accurate, at least in comparison with the judges, and they did not under or over-rate their participation in the goal-setting process. An interesting finding, however, is that the measures of participation, influence, and involvement did not correlate with goal attainment scores. This indicates that in this study, greater participation and commitment to treatment goals did not mean that individuals were more likely to meet those goals. These findings, however, contrast with the results of Willer and Miller (1976), described above, in which goal setting participation was related to goal attainment.

Another study found that the act of collaboratively creating goals and then monitoring the goals together on a weekly basis led to greater levels of goal attainment. Hart (1978) was interested in the effect of the act of setting and scaling goals as a therapeutic procedure. Goal attainment scaling was used as a measure of treatment outcome. The experimental group used the Behavioral Monitoring Progress Record (BMPR) in which clients set goals and reported on their progress at each therapy session. A four-week goal was set for several problem areas and weekly goal approximations were created to achieve that goal. Within each problem area, a weekly goal and method of attaining the ultimate goal was specified. The method of attainment was designed as a "homework assignment" that was carefully defined and based on behavioral
actions. At each session, the therapist and client jointly determined the degree of attainment of each goal. For the control group, goals were developed in the manner described for the GAS, but the weekly monitoring and goal-setting did not occur in the therapy session.

The GAS Follow-up Interview Schedule was used to determine the functioning of the client within the problem areas for which goals were set. Clients who developed and monitored goals with their therapist weekly, using the BMPR method, were more likely than the control group clients to obtain a more desirable outcome, as determined by the GAS.

This study found that when the client and therapist created and monitored short-term goals together on a weekly basis, the client was more likely to achieve his/her goal. These findings are relevant to the discussion of treatment planning because of the similarity of the BMPR to the “Objectives” component of the treatment plan. Like the BMPR, objectives are created to be small steps that the client has the capability to achieve, and that with the gradual completion of this series of steps, the client will reach the broad, long-term goal.

An added aspect of this study, however, is the frequent client participation in treatment which occurred on a weekly basis as goals were reviewed, monitored, and created. Ideally, the client and therapist work together to create the objectives in the treatment plan. This likely does not occur to the same extent though since, for the sake of documentation management, most therapists at least formulate a draft of a treatment plan outside of the therapy session. In using the BMPR, subjects and therapist together created the objectives during the therapy session. Therefore, the typical use of the treatment plan does not replicate the extensive client participation as with this study. The more typical system in developing treatment plans is likely most efficient for therapists.

Another difference between this study and the typical use of treatment plans is the frequent monitoring of goals and the development of the next week's objectives at each session. This strategy may provide some advantages, such as the weekly review of client's progress and the maximum flexibility of developing goals at each session. However, continually reviewing goals and creating objectives at each session is time-intensive and may not fit therapeutic
orientations that rarely or never assign homework to clients. This method as outlined by Hart (1978) is likely not practical or suitable for most therapists despite the positive outcomes of the study. In addition, there are advantages to the more typical method of treatment planning in which the objectives are determined at the onset of treatment. In this latter situation, a map is created that provides a plan for the client and therapist to follow, and may result in increased continuity. Developing a treatment plan at the beginning of therapy, and then modifying as necessary during the course of therapy, may be easier for the therapist and may provide a treatment strategy that is more thoughtful and adapted to the client's problem.

Effected of Client Participation and Collaboration in Treatment and in the Planning Process

Frequently the discussion of developing written treatment plans, as noted above, include the suggestion that the client is encouraged to be involved in the development of treatment goals for the document. The importance of collaboration was indicated in some of the studies described above (Wilier & Miller, 1976; Hart, 1978). Despite the paucity of empirical literature demonstrating the positive effects of client participation, there are numerous reasons for involving the client in treatment.

As suggested above, the involvement of the client in developing treatment goals is likely to lead to greater attainment of those goals. In addition, client involvement in treatment is likely to increase client satisfaction. Finally, client involvement in many facets of treatment is a method of empowering the client and reducing the power differential that exists between client and therapist. There are numerous methods of involving clients in treatment, some of which are reviewed below, with the benefits of this involvement included when this information was available.

One method of involving clients in treatment is in the documentation of the treatment session (Badding, 1989). In this modality, the client is asked, usually at the end of the session, to provide information to be entered into the progress note. The type of information requested depends on the practitioner, but may include the client's emotional status, behavior, goals, or any other relevant information. The practitioner then incorporates the information provided by
the client into the progress note, using his or her professional judgment about how to include this information. The document may then be shared with the client if the practitioner chooses to do so.

Badding (1989) examined the effects of involving therapy clients in writing therapy notes after a session, and compared this to therapy clients who did not participate in the documentation of their case record. This study examined the relationship between client involvement in case recording and their attitudes on client recording, their familiarity with their treatment plan, and their feelings of control with the therapy process.

Somewhat surprisingly, individuals who did participate in this treatment modality did not express more positive feelings about this method than individuals who did not. In general, client involvement in case recording was viewed favorably by both groups (approximately 60% highly positive, 15% moderately, 25% low). An important point to gain from this data is that client recordings did not appear to reduce positive feelings for those who participated in it. Individuals who participated in the documentation of their treatment plans were more knowledgeable of their treatment plans, presumably from reviewing their case record after the documentation or from discussing their treatment plan in the context of the documentation. This author did not find that individuals who participated in the case record had a greater sense of “control” about the therapy process, but it may be more accurate to suggest that clients had a greater level of involvement in the therapy process. In a qualitative aspect of the study, clients in the experimental group reported that the client recording was a valuable way to express feelings, be active in therapy, to concentrate and remember sessions, and to think more about the content of the sessions. One client reported, “I like writing my own report. It helps me do my own therapy work” (p. 545).

Practitioners had concerns about using this method with certain clients, especially those who were psychotic, paranoid, or narcissistic. There was a concern that therapists would feel the need to censor their thoughts and impressions to avoid a negative reaction from clients. Clients, on the contrary, expressed more concern about having inaccuracies in their record rather than negative impressions. In this respect, the client recording assisted in creating an accurate record
of the client's experience and situation. In general, this technique resulted in benefits to both
therapists and clients.

Another method of encouraging client participation in treatment is to provide access to
the therapeutic record. Psychiatric staff of an inpatient unit examined patient and staff's
reactions to providing access to medical records to patients (Stein, Furedy, Simonton, & Neuffer,
1979). The purpose of sharing the records with the client was to allow the patient to be better
informed about his/her treatment and to increase the patient's participation in progress. Initially,
there was much disagreement among staff about the benefits or detriments to patients. This
study was conducted to test this technique and learn more about both patient's and staff's
reactions. In general, there was a positive response from most patients and staff. The majority
indicated that they were in favor of open medical records (92%), and many indicated that the
access increased their ability to understand their problems (86%) and take a more active role in
their treatment (85%). The majority of patients indicated that they felt better informed, but many
individuals found that they did not like what they read. About half said that they were upset by
some of what they read and about one-third indicated that they felt more pessimistic after
reading their record. Despite some negative reactions, a majority of the patients felt more self-
confident from reading their files (71%). Sixty-eight percent found inaccuracies in their case
record.

The staff also responded favorably to this new policy, despite initial disagreements about
the therapeutic effects of the technique. The majority of staff indicated that it was a positive
policy (90%) and thought that it was a useful therapeutic tool (89%). Seventy percent of the staff
thought that the treatment helped most patients although a quarter of the staff surveyed knew of
at least one patient who was harmed by the open record policy. The authors (Stein, et al., 1979)
thought that it was only one or two patients involved in the study who had been harmed.

In addition to improving the therapeutic treatment of the patients, the policy of opening
records to patients is likely to have increased the accuracy of the record. The authors (Stein, et
al., 1979) also conducted a chart review to discover any changes in the charts after this policy
was enacted. Recordings of disruptive behaviors doubled after records became open to patients. The number of cross-outs and erasures decreased and the number of items labeled “error” doubled. These findings were attributed to the increased thoughtfulness put into creating the records and the opportunity for patients to correct inaccuracies in their record. This is an interesting study considering that it is an uncommon practice and many clinicians avoid, when possible, sharing the documentation with the client. Despite the common view clinicians share about this practice, in this study the response to this type of involvement were generally positive by both patients and staff.

Janzen and Love (1977) found that increased client involvement in an adolescent girls’ group home led to improved behavior by the residents and better relations between staff and residents. Prior to the authors’ consultation, the token economy utilized to enforce appropriate behavior was executed in a rigid manner such that the girls were unable to negotiate any changes in the system. The token economy was unsuccessful as indicated by the increased acting out behavior of the girls, as well as the consideration of placing some of the girls in more restrictive environments. The token economy system was redesigned by involving the house-parents (who were executing the system) and the girls in a discussion of problem behaviors, negative consequences and desired privileges. The results of these discussions were made into an “individual management contract” and signed by both the house-parents and the girls. The house-parents reported that the behavior of the girls improved significantly after the implementation of the new system, and the girls indicated that they had fewer suspicions toward the house-parents and engaged in goal-oriented thinking about their behavior (i.e., “If I do X, I will get back my lost privileges.”). It also appeared that the girls internalized the details of the contract, as indicated by the statements of several girls that it wasn’t the contract that caused the change in their behavior, it was their desire to change their behavior. In this example of client involvement, the ability to collaborate in the disciplinary process made a great difference in the residents’ behavior and cooperation.
Psychosocial rehabilitation refers to a model of treating individuals with serious mental illness (SMI) that places significant emphasis on the collaboration of the client. The goal of psychosocial rehabilitation is to return the seriously mentally ill individual to normal functioning with as many aspects of a normal life as possible. This is in contrast to the treatment of SMI individuals forty years ago when long-term treatment in an institution was commonplace, and many aspects of their lives were determined by providers. This goal of treating SMI has shifted so that many individuals live in the community with the objective of living in the "least restrictive" environment, where they play an active role in making decisions about their life.

Patrick Corrigan (2002), a prominent researcher in the field of psychosocial rehabilitation, described the role of collaboration in treating seriously mentally ill individuals:

State of the art practice guidelines instruct providers to mix supportive psychotherapy, symptom monitoring, medication management, and skills training to help people obtain symptom relief. Many professionals and advocates believe that this kind of treatment package requires a mutually respectful and optimistic collaboration between consumers and their providers...consumers who are empowered in these collaborative relationships will benefit more from treatment and be more successful in controlling their symptoms (p. 218).

Collaboration and participation with seriously mentally ill consumers has unique concerns and issues. Treatment providers may be leery of involving SMI consumers in treatment planning and important treatment decisions. SMI consumers are often seen as having poor decision-making abilities, and consumers may have priorities that are different from treatment providers. In encouraging the consumer to play an active role in decision-making and treatment planning, Byalin (1993) argues that the consumer is more likely to follow the treatment plan. Byalin (1993) presents an approach to use with consumers to gain their collaboration and lead to good decision-making by consumer and treatment provider.

Byalin (1993) suggests that there are several important factors to consider in the decision-making process. A treatment provider must first consider the treatment options and then
present these to a consumer to facilitate well-informed decision-making. In addition, there are two factors that are important issues for seriously mentally ill consumers, and these should be considered in making decisions about treatment options. Therapeutic efficacy is expected positive outcomes of the intervention and environmental restrictiveness refers to issues of autonomy, separation from the community, and time away from home.

Decision-making regarding this treatment choice, then, is based on maximizing treatment efficacy and reducing environmental restrictiveness. Byalin (1993) recommends providing support and encouragement during the decision-making process, avoiding direct or indirect influence, and exploring the consumer’s fears of making a "wrong" choice. While practitioners may consider treatment efficacy to be paramount, consumers and their families may consider lowering environmental restrictiveness to be a priority. This process of involving the consumer in decision-making may be difficult for practitioners to follow, but is a step toward empowering the consumer. Consumer empowerment is an important consideration in working toward the goal of increasing the participation of the consumer.

Client involvement in developing written treatment plans is absent from the treatment interventions described above. Based on these findings of the benefits of client involvement in a variety of treatment interventions, it follows that client collaboration in the development of written treatment plans will also be beneficial. In addition, many of the experts in writing about treatment plans suggest that client involvement is extremely important. Kennedy (1992) suggests that involving clients should be part of the treatment plan method. This should include giving copies of the plan to clients and family members. In addition, the treatment plan should be viewed and presented as a contract between the client and the treatment team. For these reasons, the collaboration of the client in the development of the written treatment plan is emphasized in this study.

Goal Consensus, Therapeutic Alliance, and Outcome

Collaboration and consensus with the client in psychotherapy has been a significant area of interest in process research of psychotherapy. Orlinsky, Grawes and Park (1994) explained
the difference between process and outcomes research as follows: "process research aims to determine what psychotherapy is and outcome studies seek to evaluate what therapy does" (p. 270). Orlinsky et al. (1994) performed an extensive literature review of the process research in relationship to outcomes in psychotherapy. Process research will be examined in some detail here, with an emphasis on the relationship among collaboration, consensus, and outcomes.

The Generic Model of Psychotherapy was developed by Orlinsky and Howard (1987) as a pan-theoretical model to examine the processes of psychotherapy. There are six components of this model: therapeutic contract, therapeutic operations, therapeutic bond, self-relatedness, in-session impacts, and sequential flow. Three of these components will be discussed in greater detail as each relate to this current research. Orlinsky et al. (1994) describe the therapeutic contract as the understanding that exists between the therapist and the patient(s) about their goals and the conditions which exist for engaging each other as patient and therapist. The therapeutic events are shaped by "the efforts that participants make to negotiate, implement, enforce, or alter the therapeutic contract" (p. 279).

Bordin's theory of the therapeutic bond (Bordin, 1974), or working alliance as he named it, is slightly different from this theory of Orlinsky et al. (1994). Bordin theorized that the working alliance between client and psychotherapist is made up of the three components of tasks, bonds, and goals (Bordin, 1979). According to this theory, the working alliance is based on the collaboration that occurs between client and therapist and the sense of joint purpose. A similar construct to Bordin's working alliance is goal consensus. Orlinsky et al. consider goal consensus to be one aspect of the treatment contract and is defined as the therapist's and patient's agreement on therapy goals and expectations.

In reviewing the literature, Tryon and Winograd (2001) found that there are several aspects of the therapeutic relationship that was considered to be goal consensus. One aspect of goal consensus is the extent to which the patient and therapist agree on the goals. Another type of goal consensus is the degree to which the therapist explained the nature and expectations of therapy and the client's understanding of the explanation. Another aspect relates to the
discussion of goals and the patient's belief that the goals are clearly specified. The patient's commitment to the goals is also a dimension of goal consensus. Finally, goal consensus has been studied in terms of the patient's and therapist's agreement on the origin of the patient's problem and who or what is responsible for the resolution of this problem.

Orlinsky et al. (1994) developed a list of process factors that related to outcome, and determined some findings to be "facts" when they met the criterion of "consistently replicated empirical findings" (p. 352). In examining the three of these components of the Generic Model of Psychotherapy, few aspects of the therapeutic contract were found to have a consistent relationship to outcomes for psychotherapy clients. The dimensions of goal consensus and expectational clarity were consistently related to positive outcome. It was found that in the studies reviewed, a total of 51% of the studies found a relationship between these process variables and positive outcome. In examining studies that assessed the patient's perspective of the process variables and outcome, the percentage was 63%, and in studies that used objective indexes, the percentage of positive outcome related to goal consensus and expectational clarity was as high as 67%.

Eisenthal, Koopman, and Lazare (1983) conducted a study that contributed to these findings of the relationship between positive outcome and expectational clarity. This study examined the relationship between patient satisfaction and aspects of a negotiation approach. Subjects were patients receiving psychotherapy at a walk-in clinic of a general hospital. Measures of the process variables examined aspects of patient participation in decision-making in treatment planning and the explanations of the therapist to the client. The types of explanations examined included the clarity of the stated treatment plan, the rationale for the treatment plan, the clarity of the link between the patient's chief complaint and the treatment plan, and the explanation of how treatment works and details related to what will be entailed in treatment. Patient satisfaction was measured by the patient's response, with a six-item Likert scale, to the question, "Are you satisfied with your talk with the clinician today?" Patient satisfaction was significantly correlated with many of the explanation variables. The highest
correlation occurred with clarity of the rationale for treatment \( (r = .36, p < .01) \), and this was followed by clarity of the treatment plan \( (r = .31, p < .05) \). With regard to the decision-making variables, patient satisfaction was significantly correlated with the degree to which the therapist actively worked to get the patient to express agreement with and acknowledgement of the treatment plan \( (r = .26, p < .05) \).

Perceived agreement with goals has been found to be related to outcome for psychotherapy clients. Saffran and Wallner (1991) studied psychotherapy clients receiving short-term cognitive therapy. Using a measure of working alliance, the California Psychotherapy Alliance Scale (CALPAS; Marmar, Weiss, & Gaston, 1989), it was found that goal agreement, as perceived by the client, was significantly correlated with symptom change as measured by the MCMI Major Depression scale \( (r = .52, p < .01) \) and the Beck Depression Inventory \( (r = .66, p < .001) \). Although this study found a relationship between positive outcome and goal agreement, others studies have not found this relationship. Gaston, Marmar, Gallager, and Thompson (1991) examined the relationship between therapeutic alliance, which includes goal agreement, as measured by the CALPAS, and outcomes for clients receiving short-term psychotherapy for depression. In this study it was found that the therapeutic alliance, including goal agreement, was not substantially related to the reduction of symptoms.

Long (2001) examined differences between actual goal agreement and perceived goal agreement. Perceived goal agreement was measured by the Working Alliance Inventory (WAI, Horvath & Greenberg, 1989), a measure of the therapeutic alliance that is also used in the present study. Actual goal agreement was determined by asking the client and therapist to indicate on a list of goal areas which were the goals of therapy. In this study, another aspect of goal agreement was theorized to be causal attribution, meaning the degree of agreement between the therapist and client about the source of the problem. This study found that differences occurred between perceived goal agreement and actual goal agreement. Some therapists and clients had the perception that they share the same goals for therapy, but when
the types of goals were actually endorsed, there was a disparity between therapist and client. This study also found that it was the actual goal agreement rather than the perceived goal agreement that was related to therapeutic change for the client.

Horowitz et al. (1984) studied several process variables with outcome in a time-limited dynamic psychotherapy. One hypothesis was that increased activity by the therapist to clarify the treatment’s focus would be related to improved outcomes for patients. This type of activity was measured with therapist self-report and observer ratings for each of the 12 sessions. Improved outcome on a measure of individual change was significantly correlated with the therapist’s report of increased activity in focusing the treatment at the fourth session. A significant relationship between focusing activity and outcome was not found at any other time of the treatment or when observers rated therapists on this process measure.

Increased goal and expectational clarity was associated with positive patient outcomes in an acute day hospitals (Goldstein, Cohen, Lewis, & Struening, 1988). This study examined the relationship between several process variables and outcomes with seriously mentally ill patients treated at an acute day hospital for acute psychiatric symptoms. Patients who indicated that the rules and expectations for the facility were clear were more likely to indicate that the program was helpful and that they were satisfied with the program.

These specific studies, as well as the aggregate findings in the review of Orlinsky et al. (1994) indicate that efforts made by the therapist to focus therapy, to clarify and agree on therapy goals, and to develop accurate expectations of therapy are related to positive outcome for the client. None of these clients examined written treatment plans specifically, but the findings are related to the development of a written treatment plan. As noted above, a written plan provides a vehicle for discussing, clarifying, and agreeing upon the goals and focus of therapy. In addition, writing a treatment plan with a client is another method of discussing what the client can expect from therapy.

Another aspect of the therapeutic process, as theorized in the Generic Model of Psychotherapy, is the therapeutic operations. The therapeutic operations are a technical aspect
of the therapy process involving the specific technical procedures that patients and therapists commit themselves to perform based on the therapeutic contract. These include, in some manner, the presentation of the problem, the expert understanding of the therapist, interventions by the therapist, and finally, patient cooperation. As Orlinsky et al. (1994) write, "participation in a course of therapeutic action typically requires patients to become actively involved in some fashion (patient cooperation)." Patient cooperation is considered to be an aspect of Therapeutic Operations and is a relevant construct. The patient's cooperation with therapist intervention versus resistance to the interventions is strongly associated with positive outcomes (69% overall).

A third aspect of the therapy process, according to the Generic Model of Psychotherapy, is the therapeutic bond, which is the interpersonal relationship developed between therapist and patient, during the course of negotiating the therapeutic contract and performing the therapeutic operations. Orlinsky et al. (1994) indicate that a strong therapeutic bond usually involves rapport and effective teamwork. The participants of this relationship need to be able to understand each other and work together to be able to get work done together. The therapeutic bond (or group cohesion when group therapy was the mode of treatment) was significantly related to positive outcome (overall 66%). Orlinsky et al. (1994) emphasize the strength of these findings: "the strongest evidence linking process to outcome concerns the therapeutic bond or alliance, reflecting more than 1,000 process-outcome findings" (p. 360). An Effect Size of .25 or more was found for at least one-fourth of the studies that demonstrated positive findings. Among the various components of therapeutic bond, of interest to this current study are patient engagement and patient motivation which were both highly related to positive outcomes (65% and 50% overall, respectively).

Another aspect of the therapeutic bond is the collaborative versus directive or permissive approach of the therapist and patient. Orlinsky et al. (1994) reported that the patient's approach had a strong relationship to outcomes (overall 64%). The therapist's approach was also related to outcomes (overall 43%). These findings can be understood in that a collaborative
approach (on the part of the therapist or patient) was more likely to be related to positive outcomes. A lack of a collaborative approach or the existence of a negative or dependent approach was more likely to be related to negative outcomes. These findings are relevant to the current study in that the collaborative aspects of developing goals to create a written treatment plan may contribute to positive outcomes for clients. A measure of the client's perception of therapeutic alliance, the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989), is also included in the study to examine whether these collaborative efforts on the part of the therapist affect the client's report of therapeutic alliance.

Summary

Written treatment plans are widely-used in clinical practice, likely due to administrative requirements and possibly based on efforts to benefit the client and therapy process. Although it is suggested (e.g., Jongsma & Peterson, 1999) that written treatment plans do benefit the client and the therapist, there is a lack of empirical data to demonstrate this. However, the goal setting literature indicates that setting specific goals will improve performance, suggesting that setting goals as part of the treatment plan will improve outcomes for clients. In addition, the psychotherapy process research indicates that there are several processes that occur in therapy that improve outcomes for clients. Goal consensus between therapist and client is one of these processes. Setting goals is just one component of a written treatment plan; treatment plans also include objectives, small, attainable steps for the client to make to achieve the long-term goal, and also the interventions to be implemented by the therapist. Based on findings from the goal setting literature, it is likely that elucidating long-term goals and objectives for the clients are important factors in improving outcome for clients. By clarifying the treatment interventions, the therapist makes a commitment to a course of treatment. These components of the treatment plan provide direction and a commitment to action for both client and therapist that, I hypothesize, are instrumental factors in the improvement in client outcome.
Measuring Outcomes in Psychotherapy

In determining how a treatment intervention, like a written treatment plan, impacts psychotherapy, it is necessary to examine outcomes for the psychotherapy client, meaning the result or the effect of the treatment on the individual. Currently there is much discussion of the best method of measuring outcome. A brief review of the types of outcome measurement currently in use follows. Hunter, Higinson, and Garralda (1996) described three types of outcome measures: population, specific, and performance.

Population outcome indicators are measures of changes in the health status of an entire population. Examples include measures of rates of mental health problems, suicide and self-harm behavior, and homelessness. This type of outcome measure is exceptionally broad, however, and consequently it is impossible to determine whether a particular treatment is the cause of any changes in the population indicators.

Specific outcome measures are more focused and provide greater information about the effects of particular services and treatments. Specific measures evaluate the outcome of a specific case. The main categories of specific measures, as defined by Hunter, Higinson, and Garralda (1996), consist of clinical change, compliance and satisfaction, and met and unmet needs. The disadvantage of specific outcome measures is just that, they are too specific, focusing only on one of these areas, such as satisfaction or symptomatology. To remedy this problem, the authors recommend using a combination of several different measures to create a complete picture of clinical change.

The third type of outcome measurement consists of performance indicators, such as structure (building, equipment, staffing), processes (admission and readmission rates, length of hospital stay), and output (discharge rates, number of referrals). These performance indicators are limited in their usefulness because they provide an indirect measure of the quality of care. Also, performance indicators may be ambiguous in their effectiveness; for example, length of hospital stay may be interpreted as a positive or negative outcome.
Despite their disadvantages, both population and performance indicators are often used as measures of outcome. Although these indicators may provide information suggesting that services are achieving the desired objectives, the indicators do not provide detailed information about how consumers are affected by the services they receive. For this reason, specific outcome measures are used in this study.

There are certain factors to take into consideration when selecting a measure to examine clients' outcomes. These factors, which were considered in the selection of outcome measures for this study, are sound psychometric properties, the practicality, the suitability, and the sensitivity of the measure (Vermillion & Pfeiffer, 1993). An outcome measure is most useful when it is practical, meaning that it is brief and easy to administer, and the findings are easy to understand.

A measure with sound psychometric properties has known and acceptable reliability and validity. There are several types of reliability and validity, and Burlingame and Lambert (1995) suggest the following. Internal consistency reliability is not always useful when a scale taps a content that is broad. For example, general social functioning would assess an individual's functioning in several different contexts, and the functioning could vary greatly among contexts. With some measures, therefore, test-retest reliability may be a better test of reliability since it is examining the temporal stability of the measure.

Another factor is the measure's suitability to the patient population being assessed. Measures that best evaluate services for the seriously mentally ill population will be very different than for services that provide psychotherapy in an outpatient clinic. Psychotherapy clients treated in community clinics are more likely to be seeking resolution of adjustment problems, depression and anxiety, and problems of everyday living. In contrast, a seriously mentally ill client of a community mental health agency may seek assistance in areas of daily living, such as stable housing, supported employment, and recreational activities. These two populations have different needs and therefore require different methods of outcome assessment.
The fourth criterion for selecting an outcome measure is sensitivity to change in the client. The measure must be able to tap into the changes the client has made during the intervention period. The change being assessed may need to be more sophisticated than simply change in symptoms or change in functioning. Herron et al. (1994) suggest that these two types of change need to be measured distinctly. A client may improve symptomatically before s/he improves in functioning.

*Use of Client Satisfaction as an Outcome Measure*

Client satisfaction differs from the type of measures discussed above, such as measures of psychiatric symptoms and functioning, because the focus is not on client change. Client satisfaction is a measure of the individual's evaluation of the services that he or she has received. It has become increasingly prominent as an outcome measure for mental health services in the last several decades (Lebow, 1982). This greater concern with client satisfaction is related to the increasing importance of service evaluation as third party payment has become a common method of payment of services, and as society has become more consumer-oriented. A related trend is the transition to using the term "consumer" as opposed to patient or client. This paper follows this trend in sometimes using the term "consumer."

One theory of client satisfaction is that it relates to the degree of discrepancy between expectations and experience. A problem with assessing satisfaction with services relates to the degree that the individual is realistic about his or her expectations of the services they are to receive (Stallard, 1996). Lebow (1982) defined satisfaction as the "extent to which treatment gratifies the wants, wishes, and desires of clients" (p. 244). Satisfaction may consist of one factor, as shown by Larsen et al. (1979), or it may be multi-dimensional with several factors.

Stallard (1996) outlines several concerns related to evaluating client satisfaction. One consideration is that those who are called "consumers" are not necessarily the only or direct consumer of the services. Some third party payer, such as an employer or the federal government, is likely purchasing the services. Furthermore, there may be more than one direct client with therapies such as family, couple or group work. There may be numerous indirect
clients also, such as relatives, referrers, and other agencies. Studies of satisfaction with mental
health services most often assess the individual receiving the services rather than the indirect
recipients.

There are numerous concerns relating to a client's ability to evaluate his/her services. Some argue that because of the very nature of their need for services (some psychological
impairment), mental health consumers are unable to judge the interventions they receive. A
similar concern is that clients do not have the ability to assess interventions that are complicated
or highly technical. The rather common trend of high levels of satisfaction reported by
respondents (Larson, Attkisson, Hargreaves, & Nguyen, 1979; Lebow, 1982; Stallard, 1996)
highlights the issue of clients responding in a socially desirable manner to client satisfaction
measures. There are several ways of interpreting these findings, however, and it may be that
favorable results are an indication that the client is responding to demand characteristics. The
client may have concerns that any negative responses would affect their services in the future.
These responses could be taken at face value, however, as an affirmation of the success of the
services (Larsen et al., 1979; Lebow, 1982). Despite these concerns, the assessment of a
client's satisfaction is important, for without satisfaction, the client will not attend sessions and
treatment would end (Lebow, 1982). Evaluating a client's satisfaction with services is important
from a consumer-oriented viewpoint and for therapeutic reasons. Consequently, a client
satisfaction measure, the Client Satisfaction Questionnaire-8, (CSQ-8; Attkisson & Zwick, 1982)
was included in this study as an indicator of outcome.

In addition to assessing client satisfaction, a measure of symptom change and a
measure of the therapeutic relationship were used. For this study, outcomes were assessed with
the Outcome Questionnaire (OQ-45.2; Lambert, Hansen, Um press, Lunnen, Okiishi, Burlingame,
& Reisinger, 1996), an instrument that assesses change in psychological symptoms, role
functioning, and interpersonal relationships. A measure of the therapeutic relationship was also
included, and this instrument, the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989)
was developed based on Borden's (1979) theory that the therapeutic relationship consists of the bond, tasks, and agreement.

The Present Study

This project is an examination of the impact that written treatment plans have on the outcome of psychotherapy clients. This effectiveness outcome study was conducted in a university training clinic that serves adult individuals, couples, families, and children from the community and the university population. The experimental conditions were determined by practicum groups, such that all of the students in a practicum group administered the experimental condition of writing treatment plans for their clients while the other practicum group administered the control condition of providing treatment as usual. (Note that as a method of shorthand, these two conditions are referred to as WTP and TAU to represent written treatment plans and treatment as usual, respectively. In this paper, "treatment as usual" is used to refer to not using this type of written treatment plan. As often occurs in many settings, all therapists were expected to write treatment plans for each client, but this did not occur in a consistent or routine way. It may be that the treatment as usual therapists were performing some form of treatment planning, but they were not doing so in the specific manner that the written treatment plan therapists were doing.) Clients were then -- as much as possible -- randomly assigned to practicum groups. Psychotherapy clients completed outcome measures that assessed psychological symptoms, interpersonal functioning, and role functioning at the beginning of treatment. At three month intervals and at termination, clients again completed this measure, as well as measures of client satisfaction and therapeutic alliance. In addition, therapists completed a measure of their attitudes toward written treatment plans prior to and upon completion of their involvement in the study.

I hypothesized the following:

(1) Clients who participated in treatment planning with their therapists would produce better outcomes as measured by the Outcome Questionnaire than the control group.
(2) Clients who participated in developing written treatment plans with their therapists would report a greater sense of collaboration with the therapist in the therapy process compared to the control group. This was measured by the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989).

(3) Clients who participate in treatment planning with their therapists would report a greater level of satisfaction with therapy than the control group.

(4) Therapists would indicate that their attitudes toward written treatment plans became more positive during the time of this study.
Methods

Participants

Two groups of subjects were used for the study: psychotherapy clients and graduate student therapists. All subjects -- both psychotherapy clients and the trainee therapists -- signed an informed consent to participate in the study. The client and student consent forms are presented in Appendix 1 and Appendix 2, respectively.

Psychotherapy Clients

There were a total of 51 psychotherapy clients who agreed to be involved in the study. Twenty-eight subjects were randomly assigned to the experimental group and 23 were randomly assigned to the control group. There were some limits to the randomization, which will be discussed in greater detail below. Of those in the experimental group, ten abruptly terminated therapy, without returning for a final session with the therapist. Six subjects in the control group abruptly terminated therapy, and two of these subjects did complete and return the outcome measures when they received them in the mail. Pre- and post-treatment data was collected for 18 subjects in the experimental group and 17 subjects in the control group. The mean length of treatment for subjects was 6.63 months ($SD = 4.59$). The demographic information for the psychotherapy clients is presented in Table 1. There were no subjects in Year 1 who refused involvement in the study, although there was one subject who objected to the outcome measures and asked to terminate involvement. This subject did agree to the inclusion of the data that had been completed. Two subjects from Year 2 refused to be in the study.

To determine whether there were any differences between the WTP and TAU groups prior to treatment, independent samples $t$-test and chi-square statistics were used to compare demographic variables. An independent samples $t$-test was used to compare differences between age, income, the years of experience of the treating therapist. There were significant differences in age with older subjects in the written treatment plan group ($p = .02$). The therapists implementing the Treatment as Usual condition had a trend toward significantly more years of
experience ($p = .07$). There was not a significant difference in income. Chi-square tests were used to compare the WTP and TAU groups with the other demographic variables of marital status, gender, ethnicity, and education. There were no significant differences between groups on any of these variables. This information is also presented in Table 1.

These subjects were adults seeking individual psychotherapy after August 2001 at the Clinical Psychology Center (CPC) of the University of Montana. The CPC is operated by the Psychology department and is the training facility for clinical psychology graduate students. All of the therapists in this study were clinical psychology graduate students. Clients of the CPC consist of members of the community and university students. The university students are referred to the CPC by the university counseling and psychological services, which is a free service to students, when they have exhausted the brief number of sessions available to them, or it is clear during screening that they are in need of more long-term therapy. Generally the clientele treated in the CPC show slight impairment in psychosocial functioning with mild psychological problems, with very few clients falling within the category of severely mentally ill. However, due to external factors involving public mental health services, the CPC clientele has become steadily more disturbed over the last few years, and this may be a factor in this study. The CPC offers a sliding fee scale for clients based on income. Consequently, this clientele represents individuals typically in a low income bracket primarily without medical insurance that reimburses mental health services. Clients serviced at the CPC include individual adults, individual children and adolescents, families and couples. The CPC has become a clinic “of last resort” in the community.

A one-way ANOVA at Time 1 was used to compare the OQ Total scales and the subscales of the two groups prior to treatment. There were no significant differences between the WTP and TAU groups on the Total scale or the subscales of Symptom Distress, Interpersonal Relations, and Social Role. The Interpersonal Relations subscale approached significance ($p = .13$), however, with the TAU group having lower scores, indicating better interpersonal relationships at baseline. These results are presented in Table 2.
Statistical analyses were conducted to determine any significant differences between subjects who abruptly dropped out of therapy and those who remained in therapy until at least the three-month data point. Independent samples t-tests were used to compare age, income, the years of experience of the treating therapist, and OQ Total score and subscales. There were no significant differences in age, income, therapist’s experience, or the OQ Total score and subscales between subjects who abruptly terminated therapy and subjects who remained for three months. Chi-square tests were used to compare these two groups with the other demographic variables of marital status, gender, ethnicity, and education, and the variables of experimental condition and practicum group. There were no significant differences between groups on any of these variables. The demographic variables are presented in Table 3 and the OQ Total score and subscales are presented in Table 4.

The therapists providing treatment of these clients are graduate student in clinical psychology receiving training and credit in a clinical practicum. There were a total of 18 student therapists who implemented the treatment conditions in this study. There were two students who treated as many as six clients in the study. It was more common for student therapists to treat a small number of subjects; eight of the 18 student therapists had only one of their clients as a subject in the present study. As noted above, the treatment conditions were determined by the practicum group. Students are assigned to one of three separate practicum classes. Each practicum class is supervised by a member of the clinical psychology faculty and sometimes an affiliate faculty member who is a licensed clinical psychologist from the community. The number of subjects treated by students in each practicum class varied, with a maximum of 13 subjects treated by students from one WTP class in Year 1 to a minimum of 2 subjects treated by students in a TAU class in Year 2.

Practicum instructors vary in their theoretical backgrounds and supervision styles. The practicum instructor of Group 1, which was in the control condition, supervised students based on cognitive-behavioral therapy. The demographic information of the Group 1 therapists is presented in Table 5. The Group 2 practicum was based in the cognitive-behavioral framework,
and these students were assigned to read *Cognitive Therapy: Basics and Beyond* (Beck, 1995). The supervisor of Group 3 had an eclectic supervision approach, and used Motivational Interviewing, cognitive behavior therapy, interpersonal therapy, and attachment theories in supervision, as appropriate. The demographic information of the therapists in Groups 2 and 3 is presented in Table 6. Group 4 was supervised with a behavioral orientation with the assigned reading of *Functional Analytic Psychotherapy* (Kohlenberg & Tsai, 1991). In addition, students were required to read *The Miracle of Mindfulness* (Nhat Hanh, 1999), and they practiced mindfulness exercises at each practicum meeting. The instructor of Group 5 is an affiliate faculty member who is a psychotherapist in a community-based private practice. The supervision style of this instructor was primarily psychodynamic, although the supervisor also drew from theoretical orientations of family systems, gestalt, cognitive-behavioral, and trauma work in supervision. Students in the practicum group were required to read the psychodynamic text *Deepening the Treatment* (Hall, 1998). The demographic information of the therapists of Group 4 and Group 5 is presented in Table 7. The theoretical orientation of Group 6 was based on *Time-limited Dynamic Psychotherapy* (Levenson, 1995), which students were required to read, and interpersonal therapy. The demographic information of Group 6 is presented in Table 8. Students are placed in practicum groups based on the preference that they submit to the clinical faculty but this decision is ultimately determined by the clinical faculty based on students' training needs, faculty workload, practicum composition issues, and other factors.

Subjects were randomly assigned, based on a random number chart, to one of the three practicum groups. Students in each practicum group chose clients from the pool assigned to their practicum group. There were certain situations in which this random assignment could be altered: (a) assignment of the client to the practicum group would result in a potentially harmful dual relationship for the supervisor and client, (b) a client requested a specific student therapist, and (c) the practicum group had (sometimes temporarily) exhausted their pool of potential clients. Also, (d) all student therapists in a practicum were full and other practica were allowed to
“browse.” There were times that student therapists chose clients from outside of their pool of potential clients because the pool for their own practicum was exhausted, and this happened more frequently at the beginning of each year.

Each practicum group was assigned to either the treatment group or the treatment-as-usual group, and this assignment was in part based on the supervisor’s desire to have their students write treatment plans for their clients. All student therapists followed the protocol related to treatment planning based on their practicum assignment for each client with whom they initiated treatment after the date of August 2001. Because the study spanned two years, and the treatment condition was based on practicum group, there were therapists who implemented the WTP or TAU condition in Year 1, and then implemented the other condition in Year 2. There were six therapists who implemented both treatment conditions to subjects over the two years of the study. Independent sample t-tests were used to show any differences related to these changes in experimental conditions for some therapists. A variable was created that represented this issue, with a coding system that represented (1) a therapist who was, and always had been, in the TAU condition, (2) a therapist who had been in the TAU condition in Year 1 but was in WTP in Year 2, (3) a therapist who was in, and had always been in the WTP condition, and (4) a therapist who had been in the WTP condition in Year 1, but was in the TAU condition in Year 2. The code was determined for each subject depending on which circumstance was true for his or her therapist at the beginning of that subject’s treatment. In the t-tests, the comparisons were made between the two WTP groups (circumstance 2 and 3 from above) and the two TAU conditions (circumstance 1 and 4 from above). The t-tests found no significant differences between these two groups of therapists for the WTP condition or the TAU condition on the Total scales and subscales of the OQ, WAI, and CSQ at Time 2.

**Graduate Student Therapists**

There were a total of fifteen student therapists from Year 1 of the study who also participated as subjects of the study. Five subjects were students in the practicum that implemented the control condition. Ten subjects were students in the two practicum groups that
implemented the experimental condition. Subjects completed measures at the beginning of Year 1 and again at the end of Year 1. Data was missing for two subjects in the experimental condition from the end of the year.

**Measures**

*Outcome Questionnaire 45.2 (OQ-45.2)*

The Outcome Questionnaire (OQ-45.2; Lambert, Hansen, Umpress, Lunnen, Okiishi, Burlingame, et al., 1996) is a brief self-report instrument designed as an outcome instrument for psychological treatments. The three subscale of the OQ are Symptom Distress, with 25 items, Interpersonal Relations, with 11 items, and Social Role, with 9 items. Responses are rated by a five-point scale ranging from "Almost Always" to "Never." It is ideal for use in this study based on its good psychometric properties, the ease of administration, and the dimensions that it measures. As the importance of measuring outcomes has become more prominent in psychological interventions, hundreds of measures have been developed to accomplish this task. The majority of these measures, however, are "homemade" instruments with unknown psychometric properties. The OQ-45.2 was designed to meet the necessary criteria of an outcome measure with well-researched psychometric properties. The creators based the development of the OQ-45.2 on the four criteria in selecting outcome measures (Vermillion & Pfeiffer, 1993) that were reviewed above.

The OQ-45.2 consists of three dimensions of Symptom Distress (SD), Interpersonal Relations (IR), and Social Role Performance (SR) (Lambert, et al., 1996). The decision regarding the types of items chosen for the symptom distress scale was based on numerous findings that the most common intrapsychic symptoms are related to depression and anxiety. For this reason, the Symptom Distress scale contains more items related to depressive and anxiety symptoms (e.g., "I feel no interest in things."). There are also items assessing substance abuse (e.g., "I have trouble at work/school because of drinking or drug use.").

The Interpersonal Relations scale measures problems and satisfaction with interpersonal relationships. The inclusion of this dimension is based on findings that many people consider
positive relationships essential to happiness, and this is a frequent reason that clients give for seeking therapy. Items investigate a number of relationships including friendships (e.g., "I have trouble getting along with friends and close relationships"), family (e.g., "I am concerned about family troubles."), and marriage (e.g., "I feel my love relationships are full and complete.") and the conflict, friction, inadequacy, and isolation experienced by the client in these relationships.

Social Role Performance examines the client's performance in the roles of employment, school, family roles, and leisure life. The scale taps into the client's dissatisfaction in these areas (e.g., "I find my work/school satisfying" and "I enjoy my spare time."), as well as conflict, distress and inadequacy in tasks related to these areas.

The combination of these scales provides a measurement of the client's subjective experience and functioning in his or her daily life. A unique aspect of this instrument is that is investigates the presence or absence of symptoms as well as the presence of positive feelings.

The OQ-45.2 is scored by adding the items for a total item score. Higher total scores indicate the client is reporting the experience of a large number of symptoms of distress, interpersonal difficulties, and social role difficulties. Lower total scores indicate that the client is no more disturbed than the general population. The three dimensions are determined by adding particular items. Higher scores on these particular dimensions indicate greater distress in these areas.

The psychometric data on the OQ-45.2 suggest that the measure is reliable and valid. The internal consistency estimates range from .70 to .93 (Burlingame & Lambert, 1995). The internal consistency of the OQ was analyzed with the data of this study, and the correlations ranged from .94 for the Total Scale to .66 for the Social Role Subscale. The complete results are presented in Table 9. The three week test-retest reliability estimates range from .78 to .84. These findings indicate that the OQ 45.2 has good to very good reliability.

There have been numerous studies of the validity of the OQ 45.2. Convergent validity occurs when the measure shows good correlations with an independent measure of the same construct. The convergent validity was examined by comparing the OQ-45.2, both the total score
and the subscale scores, with existing tests of anxiety, depression, interpersonal functioning, and social adjustment. The strongest relationships for the total score, as well as the symptom distress subscale, were found when compared to the depression measures, the anxiety measures, and the symptom distress measure. With regard to the depression measures, both the OQ total score and the OQ Symptom Distress subscale demonstrated good convergent validity with the Zung Self-Rating Depression Scale ($r = .88$, $r = .89$, respectively) and the Beck Depression Inventory ($r = .80$, $r = .63$, respectively). Both the OQ total score and the OQ Symptom Distress subscale demonstrated good convergent validity with the Zung Self-Rating Anxiety Scale ($r = .80$, $r = .81$, respectively) and the Taylor Manifest Anxiety Scale ($r = .86$, $r = .88$, respectively). The Global Severity Index of the Symptom Checklist-90-R provides an assessment of overall symptom distress. The OQ-45.2 demonstrated good convergent validity when compared to this scale (OQ total score, $r = .78$, Symptom distress, $r = .61$). The Interpersonal Relations and Social Role subscales demonstrated moderate convergent validity when compared with a measure of social role functioning, the Social Adjustment Scale ($r = .65$ and $r = .44$, respectively), and a measure of interpersonal relations, the Inventory of Interpersonal Problems, ($r = .50$ and $r = .60$, respectively).

Tests of construct validity suggest that the measure is sensitive to change over time. Clients at a university training clinic completed the measure at the start of therapy and again after seven sessions (Burlingame & Lambert, 1995). Pre-test/post-test differences were highly significant on all of the scales of the OQ. This provides evidence that the OQ is sensitive to change occurring in the context of psychotherapy.

The OQ has also demonstrated discriminant validity by demonstrating differences between populations of varying severity of mental health problems. This was evidenced by the increasing means of OQ scores as the severity of psychological problems increased (Lambert, et al., 1996). Undergraduate and community normals demonstrated significantly lower scores than
clients of university outpatient clinics, and these clients demonstrated significantly lower scores than community mental health center outpatients. The OQ-45.2 is presented in Appendix 3.

**Client Satisfaction Questionnaire-8**

The Client Satisfaction Questionnaire (CSQ-18; Attkisson & Zwick, 1982) is an 18-item self-report measure of client satisfaction with psychological services. An eight-item version was created as a shorter measure and includes items such as "how would you rate the quality of the service you received?" and "have the services you received helped you to deal more effectively with your problems?" Responses are rated on a four-point scale. The CSQ-18 and CSQ-8 were found to have excellent internal consistency, with Cronbach's \( \alpha \) values of .91 and .93 respectively. The internal consistency of the CSQ-8 was replicated in another study with Cronbach's \( \alpha \) of .93 (Neal, 2000). In the present study the internal consistency was determined to be .90. Cronbach's \( \alpha \)s based in the current sample's data are presented in Table 9 for each measure used in this study.

The CSQ was compared to several service utilization measures of clients at an urban community mental health center receiving therapy (Attkisson & Zwick, 1982). Remainder-terminator status, referring to whether the client continued to be in therapy one month later, was significantly correlated with the CSQ-18 and the CSQ-8. Similarly, the number of therapy sessions attended in one month was significantly correlated with the two measures. The client rated services as more satisfactory if they were still receiving therapy and with more sessions of therapy they received. The two measures were compared to therapist ratings of change in symptom level and global functioning but there were no relationships found. However, the CSQ-18 and CSQ-8 were correlated with change in symptoms as reported by the clients. The CSQ-8 was correlated with client and therapist ratings of improvement. The authors (Attkisson & Zwick, 1982) recommend the CSQ-8 as a brief global measure of client satisfaction. The CSQ-8 is presented in Appendix 4.
Working Alliance Inventory

The Working Alliance Inventory (WAI; Horvath & Greenberg, 1989) is a 36-item self-report measure of therapeutic alliance. It consists of three subscales of 12 items each. These subscales are Task Agreement (e.g. "my therapist and I agree about the things I will need to do in therapy to help improve my situation."), Goal Agreement (e.g., "my therapist perceives accurately what my goals are."), and Bond Development (e.g., "I feel comfortable with my therapist."). Responses are rated by a seven-point scale ranging from 1 (never) to 7 (always). This measure is based on Bordin's (1979) theory that the working alliance between client and psychotherapist is made up of the three components of tasks, bonds, and goals. According to this theory the working alliance is based on the collaboration that occurs between client and therapist and the sense of joint purpose. The measure can be completed by the client, therapist, or an observer.

Reliability of the WAI has been determined to be adequate; the internal consistency was determined for the total score ($\alpha = .93$), and the subscales of Bond ($\alpha = .92$) and Task ($\alpha = .92$) (Horvath & Greenberg, 1989). An independent investigator also found the WAI to have good internal consistency for the total score ($\alpha = .96$) (Tichenor & Hill, 1989). The WAI showed good internal consistency in the present study for the total score ($\alpha = .97$) and the subscales (Goal, $\alpha = .91$, Bond, $\alpha = .95$, Task $\alpha = .90$). These results are presented in Table 9.

Concurrent validity was determined to be acceptable based upon the comparison of the WAI subscales with the Empathy scale of the Relationship Inventory (RI; Barrett-Lennard, 1962), which is considered to be closely related to the working alliance (Goal: $r = .70$, Task: $r = .70$, Bond: $r = .83$) (Horvath & Greenberg, 1989). Safran and Wallner (1991) found the WAI to be highly correlated with another measure of therapeutic alliance, the California Therapeutic Alliance Rating Scales (CALPAS; Marmar, Gaston, Gallagher, & Thomson, 1989). There was a high correlation between total WAI and CALPAS scores ($r = .87$).
The WAI also appears to have good predictive validity of outcome (Safran & Wallner, 1991). The WAI was completed at the third session by both clients and therapists, partaking in short-term cognitive therapy treatment. There was a significant correlation between the WAI and rating on a 100-point scale of global success completed at termination, as rated by the patient ($r = .64$) and the therapist ($r = .50$).

Tracey and Kokotovic (1989) examined the factor structure of the WAI. Using a confirmatory factor analysis, it was determined that a bilevel model fit best, with a structure of three first-order unique aspects of the alliance (which correspond with the subscales of Task, Goal, and Bond) and a second-order general dimension of Alliance. The authors (Tracey & Kokotovic, 1989) suggest from these findings that it is this one general alliance factor that is the most prominent dimension of the WAI. The WAI is presented in Appendix 5.

**Therapist Attitudes**

A measure assessing therapists’ attitudes toward written treatment plans was completed only by therapists who participated in the study in Year 1. This measure assessed students’ attitudes toward treatment plans (e.g., “What is your general attitude toward written treatment plans?”) and using a collaborative approach with their clients (e.g., “To what extent do you agree with this statement: ‘How therapy progresses should always be determined jointly by client and therapist.’”). Psychometric properties of reliability and validity were not analyzed due to the nature of the measure. Its construction was similar to an opinion survey. It was administered prior to the onset of the study (Time 1) and again at the end of Year 1 (Time 2). Five students implementing the control treatment completed the measures at Time 1 and Time 2, and ten students implementing the experimental condition completed the measure at Time 1. Time 2 data was available for eight students. Students who entered the study in Year Two did not complete the measure. This measure was created specifically for this study, and a sample is presented in Appendix 6.
Procedures

Therapist Training

Each student therapist received a short training at the beginning of each academic year prior to initiating treatment planning with any clients. At Year 1, each practicum group received this training by the principle investigator in person during the practicum class at the first week of the semester. This training format was altered somewhat for Year 2 due to limitations in the principle investigator's schedule. At the first practicum class of the semester, one student in each class read a statement as an introduction to the study. This statement instructed students in the method of explaining the study to a new client, and it informed students that the study examines differences in treatment planning. The statements were slightly different for the practica in the different experimental conditions. The statement read to the WTP practicum is presented in Appendix 7. The statement read to the TAU practica is presented in Appendix 8. The training that was conducted on the first day of class in Year 1 was conducted via conference call by the principle investigator on the second week of practicum. This was followed by in-person individual meetings during the third week of practicum with specific student therapists. The therapists who received the individual training were all students in practicum for the first time, a student who had not been in practicum the year before, and students who had been in the TAU practicum the year before and were now in the experimental group. This second training involved a brief review of the pertinent points about the structure and qualities of a good written treatment plan (for those students who were in the WTP group), further explanation of the data collection system, and an opportunity to ask questions.

Each practicum group was provided a brief explanation of the study, and the study was described as an examination of differences in treatment planning. The practicum groups were informed that there were differences between practicum groups, but they were not provided an explanation of the difference. Each practicum group received an explanation of the procedures for administering the measures. The experimental practicum groups were instructed on the four parts of the treatment plan (Problem, Long-term Goal, Objectives, Interventions), the important
aspects of developing a treatment plan (difficult but attainable, specific, self-efficacy, and commitment). Students were encouraged to use as a resource the treatment plan guidebook by Jongsma and Peterson (1999) and a copy was available for them. They also received instruction on the timeline of the development of the treatment plan. Students in the TAU group were instructed in the process of basic case conceptualization. The protocols that students received a copy of during this training are presented in Appendices 9 and 10 for the experimental and control groups, respectively. The training conducted by the principal investigator at the beginning of each year consisted of a review of the points detailed in the protocols. The students also received a handout of the expected timeline of activities for each subject. The “Chain of Events” is presented in Appendix 11 for the experimental condition and Appendix 12 for the control condition.

Administration of Measures

At the initial therapy session, clients received an explanation of the research study by their student therapist as part of the informed consent process. Each therapist had a script to use as a guideline in providing this explanation, and the scripts were slightly different for the WTP and TAU groups. The explanations are presented in Appendix 13 (WTP) and Appendix 14 (TAU). Further explanation of the study was provided in an informed consent document signed by each client who agreed to be in the study. This explanation indicated that some clients would work with their therapist on a worksheet in the beginning of therapy. The subject then completed the OQ 45.2. Student therapists were instructed to examine the two items of the OQ 45.2 that measure suicidal and homicidal intent to determine whether a risk assessment was necessary at that time based on the subject’s endorsement of that item.

Subjects completed the measures at three month intervals and at termination. These measures were the outcome measure, the client satisfaction measure, and the therapeutic alliance measure. Subjects were instructed to seal the CSQ and WAI measures in a manila envelope and these responses were never revealed to their therapists. The subjects were instructed to give the OQ 45.2 separately, and this was to allow the therapist to examine items
that related to suicidal and homicidal behavior. Therapists assessed the subject's risk of
dangerous behavior if these items were endorsed. Often clients terminate therapy without
attending a final therapy session. These "drop-out" clients were sent a packet of the measures, a
stamped and addressed envelope, and a letter requesting that they complete the measures.
Subjects were sent these measures again after an interval in which no response was received.

Treatment Plan Formulation
The therapists were instructed to initiate discussion of treatment goals at the first session
with the subject, with the purpose of eliciting the subject's ideas and goals for treatment. The
therapist initially developed a draft of a written treatment plan, based on the client's stated
treatment goals, with his or her supervisor, before discussing the particulars of the plan with the
client in the session. The therapist then presented a written draft of the treatment plan to the
client for discussion, ideally by the third session. An example of the treatment plan is presented
in Appendix 15. The therapist was instructed to present the draft of the written treatment plan to
the client to discuss any potential changes or additions. When the treatment plan was agreed
upon by both the therapist and the client, both signed the document. Although the therapist's
guidelines encouraged the treatment plan to be completed by or at the third session, more
frequently it was completed after the fourth session.

Evaluation of Therapist Compliance with Treatment Planning and Administration of
Measures
Steps were taken to ensure and monitor therapist compliance to the project's
procedures. Therapist compliance was encouraged through reminders that the data collection
process, which was new to the clinic, would be used as standard measures by the clinic as well
as the principle investigator. In addition, the students received complimentary meals each
semester as thanks for their assistance in collecting data and writing treatment plans. Therapists
submitted a copy of the treatment plan to the investigator. The principal investigator provided
electronic mail reminders for therapists when no treatment plan had yet been developed.
Therapists were also e-mailed when the three month period had elapsed requesting that they
give the next packet of measures to the client. No confidential client information was transmitted via email.

Analyses

Analyses are presented according to the hypotheses they test, and the numbers presented refer to the hypotheses.

1) A 2 x 2 mixed model repeated measures analysis of variance was used to compare the scores of the experimental and control group at pre- and post-treatment for the Total score of the OQ. A 2 x 2 mixed model repeated measure multiple analyses of variance (MANOVA) was used to compare the OQ subscales of the experimental and control groups at pre- and post-treatment. These repeated measures analyses were followed by one-way analyses of variance comparing groups at Time 1 and again at Time 2. It is the Group X Time interaction that is of primary interest, as this illustrates the differences between groups at Time 2.

The Time 2 data is the last time for which data were available for the subject, and this was often times not the data from the termination session. For some subjects it was the data collected at the last three-month interval before the subject abruptly terminated therapy. For other subjects it was the last data collected at a three-month interval from when the data collection for the study ended. Time 2 ranged from data from the three-month interval to the 18 month interval. The frequencies of Time 2 data from each of the data points is presented in Table 10.

2 and 3) A series of multiple analyses of variance were conducted to compare the WTP and TAU groups with the CSQ-8 and the Total scales and subscales of the WAI and OQ at Time 2. One MANOVA compared the WAI Total scale, the OQ Total scale, and the CSQ for the two groups. Another MANOVA compared the OQ subscales of Symptom Distress, Interpersonal Relations, and Social Role, and the WAI subscales of Goal, Task, and Bond, and the CSQ-8 score. These analyses were followed by a univariate analysis of variance comparing the WTP and TAU groups for each Total scale and subscale. In addition, an extra set of analyses were conducted to examine whether therapeutic relationship moderates the effects of the intervention
on outcome (Baron & Kenny, 1986). Pearson Product-moment correlations were used to
determine the intercorrelations of the OQ-45.2, the CSQ, and the WAI.

4) Means and frequencies of the items of the therapist measure were computed at pre-
and post-treatment for the therapists in each group.

Single participant analysis techniques were used to examine differences between single
subjects in the WTP and TAU groups over time. This was included as a supplemental analysis to
compensate for the smaller final $n$ than initially proposed.

**Power Analysis and Sample Size**

Power analyses were conducted for the tests of differences between the experimental
and control group at pre- and post-treatment with $alpha$ set at $p = .05$ and a minimum power
required of .67. The Sample Power software (Borenstein, Rothstein, & Cohen, 1997) was used.
Effect sizes were estimated for the power analysis, due to the absence of prior studies of this
nature with relevant information regarding the measures in this study. A range of effect sizes was
used and this range will be reported here. A small effect size with a power of .80 determined that
a total sample size of 390 would be adequate. A small effect size with a power of .65 determined
that a total sample size of 280 would be adequate. A medium effect size with a power of .83
determined that a total sample size of 70 would be adequate. A medium effect size with a power
of .69 determined that a total sample size of 50 would be adequate. Based on these findings, a
total sample size of 50 from 150 was considered.

The final sample size was 35, and thus the power analysis was computed again with this
sample size with $alpha$ set at $p = .05$. The Sample Power software (Borenstein, Rothstein, &
Cohen, 1997) was used. A range of effect sizes was considered and will be reported here. With a
large effect size, the power would be .63. A medium effect size resulted in a power of .30. A
small effect size resulted in a power of .09. Thus, the study ended up being under-powered.
Results

Results are presented according to the hypothesis that they test, and the numbers referring to the hypotheses will be used to aid interpretation. It should be noted that high scores of the OQ indicate poorer psychological health, whereas higher scores of the WAI and CSQ are positive indications of better therapeutic relationships and greater levels of satisfaction.

1) When a 2 x 2 mixed model repeated measures analysis of variance was used to compare the scores of the TAU and WTP groups at pre- and post-treatment for the Total score of the OQ, there were no significant differences overall between groups, $F(1, 31) = 1.25, p = .27$. Both groups improved significantly with time, $F(1, 31) = 13.19, p = .001$. There was no significant Group X Time interaction, $F(1, 31) = 1.27, p = .27$. These findings are presented in Table 2. The mean scores for both groups at Time 1 and Time 2 of the OQ Total scale, Symptom Distress, Interpersonal Relations, and Social Role subscales are illustrated in Figure 1, Figure 2, Figure 3, and Figure 4, respectively.

An additional analysis was done using Analysis of Covariance, with Time 1 OQ scores entered as a covariate to introduce some statistical control for subjects' initial level of adjustment. The results were substantially identical. Both groups improved significantly with time, $F(1, 32) = 13.27, p = .001$. There was not a significant Group X Time interaction, $F(1, 32) = 1.13, p = .30$.

The repeated measure MANOVA analysis of the OQ subscales showed a significant difference for the groups with the OQ subscales, $F(3, 27) = 3.71, p = .02$. The univariate analyses revealed significant differences between groups for the Interpersonal Relations subscale, $F(1, 29) = 7.56, p = .01$. The analyses of variance conducted for Time 1 and Time 2 showed a significant difference between groups for Interpersonal Relations at Time 2, $F(1, 32) = 6.61, p = .02$, such that subjects in the TAU group reporting better interpersonal relationships at Time 2 than subjects in the WTP group. The ANOVA is presented in Table 2.
Additional analyses of effect sizes were determined for the OQ scores at Time 1 and Time 2 (Cohen, 1988). The Effect Size (Difference in $M = 12.19$, Pooled $SD = 21.93$) is 0.56, a medium-sized effect. This indicates that the OQ was well able to detect changes in the CPC client population due to treatment and/or time.

2 and 3) MANOVA analyses were conducted examining the differences between groups at Time 2 with the three measures. The first MANOVA included the total scales of the OQ and WAI, and the CSQ. There were no significant differences, $F (3, 30) = 0.63$, $p = .60$. The univariate analyses revealed no significant differences for the OQ Total scale, $F (1, 32) = 1.95$, $p = .17$, the WAI Total scale, $F (1, 32) = 0.77$, $p = .39$, or the CSQ $F (1, 32) = 0.03$, $p = .87$. The second MANOVA consisted of the OQ subscales of Symptom Distress, Interpersonal Relations, and Social Role, the WAI subscales of Goal, Bond, and Task, and the CSQ. The multivariate analysis revealed no significant differences, $F (7, 25) = 0.92$, $p = .51$. The univariate analyses revealed significant differences between groups for the Interpersonal Relations subscale, $F (1, 31) = 6.65$, $p = .02$. There were no significant differences for the other subscales of the WAI and OQ, or the CSQ. The univariate analyses are presented in Table 11.

2B) A regression analysis was used to test the hypothesis of the therapeutic relationship as a moderator of outcome. The therapeutic relationship and group variables were centered around their means and used to create a multiplicative interaction term. Then each individual IV and the interaction variable were entered into separate linear regression analyses. While there was a direct effect for therapeutic alliance on outcome ($R^2 = .32$, $p < .001$, $B = .56$), there was no evidence for a moderating effect ($R^2 = .06$, $p = .17$, $B = .24$) for the interaction term.

4) Frequencies and means were computed for the items of the Therapist Attitude Measure at Time 1 and Time 2 for graduate student therapists in the WTP and TAU groups. Student therapists reported that their general attitude toward treatment plans was neutral to positive (Item 6, $M = 3.89$, $SD = .80$, on a 1 to 5 scale). Students indicated that they favored a collaborative approach to the therapy process (Item 9, $M = 3.41$, $SD = .57$, on a 1 to 4 scale).
Students in both groups reported that they discussed the plan or goal for treatment on a rare to frequent basis (Item 4, $M = 2.67, SD = .62$, on a 1 to 4 scale). The great majority of students in both groups endorsed the effects of written treatment plans as helping the therapist develop a plan for therapy. The means and frequencies of item responses are reported in Tables 12 through 14.

Pearson Product-moment correlations were conducted with each of the total scales and subscales of the three measures to determine the intercorrelations. Data from Time 2 was used for these analyses. This provided information about the intercorrelations of the measures with each other, as well as the intercorrelations among the subscales of a measure. Note that high scores of the OQ indicate worse psychological health while high scores of the WAI and CSQ indicate better therapeutic relationship and satisfaction, respectively. The correlations reported were significant at the .05 level except when noted otherwise. The correlations are presented in Table 15.

All of the subscales of the OQ 45.2 are highly correlated with the Total score of that measure, with the highest correlation occurring with the Symptom Distress scale (.95) and the lowest correlation occurring with the Social Role scale (.85). In comparing the OQ subscales with each other, the correlations were moderate, ranging from the high correlation between Social Role and Symptom Distress (.73) to the lowest correlation between Interpersonal Relations and Symptom Distress (.62).

The WAI subscales were highly correlated with the Total score, with the highest total score occurring with the Task subscale (.97) and the lowest correlation occurring with the Bond subscale (.95). The WAI subscales were also highly correlated with each other. The Goal and Task subscales demonstrated the highest correlation (.93) while the Goal and Bond subscales demonstrated the lowest correlation (.87).

The comparison of the OQ Total scale and subscales to the WAI Total scale and subscales produced moderate negative correlations for all comparisons. The highest correlation among the Total scales and subscales of the WAI and the OQ occurred between the WAI Total
subscale and OQ Total score (-.57). The lowest correlation occurred between the OQ Interpersonal Relations subscale and the WAI Goal (-.44).

The CSQ was also compared to the Total scales and subscales of the WAI and OQ. The CSQ was moderately correlated with each scale and subscale of the WAI with the highest correlation occurring with the WAI Total scale (.56) and the lowest correlation occurring with the WAI Bond subscale (.50). In comparing the CSQ with the OQ Total scale and subscales, there were no significant correlations.

Post-hoc Analyses

Randomly Selected Single Participant Analyses

Single participant analyses were conducted post-hoc in an effort to further explore previous analyses. These were conducted to examine subjects’ progress on an individual subject level to, ideally, determine any differences between the two groups that were reflected in the “trajectories” of subjects across sessions and that might not emerge in the large-n pre-post analyses. The single n analyses were not initially proposed but added post-hoc as a supplement to the originally proposed analyses, because it was recognized that the study is rather underpowered. Consequently these analyses are not true experimental single participant analyses, with, for example, multiple baseline measures of functioning and symptoms prior to the intervention (Kratochwill, 1992). Subjects from both groups who had at least completed data at three time points were considered, which consisted of ten subjects in the experimental group and 3 subjects in the control group. Two subjects from each group were randomly chosen for the single n analysis with the aid of the “select random sample of cases” function of SPSS.

Four subjects are reviewed below with the accompanying graphs of change over time in Figures 5 through 12. These findings are then tied to the hypotheses of the study. To assist in understanding individual subject’s scores, the cutoff scores for the OQ Total score and subscale scores were considered here. The cutoff scores were determined by Lambert et al. (1996) based on comparisons of community nonclinical samples and clinical samples, suggesting that an
individual with a score below cutoff is not reporting clinically significant psychological symptoms or problems. Cutoffs for the OQ Total score and subscales are as follows: Total: 63; Symptom Distress: 36; Interpersonal Relations: 15; and Social Role; 12.

Subject 1 is a psychotherapy client in the WTP condition who continued to receive treatment at the end of the study. This subject had completed data at each three month interval, up to the last interval of 18 months. Pretreatment OQ Total scale and subscales were above the cutoff scores and each decreased to below cutoff by three months, and continued to decrease. The OQ Total scores and subscales showed variability throughout the treatment with steady decreases in scores, indicating improvement, followed by increased scores, indicating increased symptoms and reduced functioning in relationships and social roles. The WAI Total score and subscales followed a similar pattern to the OQ, in the opposite direction. As the OQ Total score and subscales decreased, the WAI Total score and subscales increased, indicating more positive perceptions of the therapeutic relationship. Similarly, there was a similar pattern of some decrease in the WAI scales as the OQ scales increased. Satisfaction remained stable throughout the course of treatment. Figure 5 presents the Total scores of the OQ, CSQ, and the WAI for Subject 1. Figure 6 presents the subscales of each measure for Subject 1.

Subject 2 is a psychotherapy client in the WTP condition, who completed data at each three month interval up to 12 months, and then completed the data at the termination of therapy, which was approximately 15 months from the onset of therapy. This subject was above the cutoff score for the OQ Total score and each of the OQ subscales at the beginning of therapy. The OQ score and subscale scores remained stable throughout treatment, although Interpersonal Relations showed a decrease at six months and dropped below cutoff at this time, and then returned to baseline for the rest of the treatment. The WAI Total score and subscales remained stable at three months but decreased slightly at each consecutive data collection period. There was some variability in the CSQ score. Figure 7 presents the Total scores of the OQ, CSQ, and the WAI for Subject 2. Figure 8 presents the subscales of each measure for Subject 2.
Subject 3 is a psychotherapy client in the TAU condition who continued to be in treatment at the study's end. This client completed the data at three months, 12 months and 15 months. The missing data points occurred because this subject had a break in treatment during the summer. Pre-treatment OQ scores were above cutoff for the Total score and subscales scores except for the Social Role score which was below cutoff. The Social Role scale remained stable throughout treatment, as the other OQ scales dropped to below cutoff at three months. OQ scores increased at 12 months and decreased again at 15 months; simultaneously, the WAI subscales of Goal and Task decreased and then increased. WAI Bond and the CSQ remained stable throughout treatment. Figure 9 presents the Total scores of the OQ, CSQ, and the WAI for Subject 3. Figure 10 presents the subscales of each measure for Subject 3.

Subject 4 is a psychotherapy client in the TAU condition who remained in treatment at the end of the study. This client completed data at the three and six month intervals. The OQ Total scale and subscales were below cutoff at pre-treatment and remained stable until six months when the Symptom Distress and the Total scores decreased. As OQ scores decreased at six months, the WAI Total score and subscales increased. Figure 11 presents the Total scores of the OQ, CSQ, and the WAI for Subject 4. Figure 12 presents the subscales of each measure for Subject 4.

Hypothesis 1) In examining these individual subjects' OQ scores, which demonstrate change in symptomatology and functioning from pre-treatment to post-treatment, three of the four subjects generally improved over time. These three subjects, Subjects 1, 3, and 4, showed an improvement on most or all aspects of the OQ by the final datapoint. With these subjects, the WTP subjects did not appear to improve at a rate faster or greater than the TAU group subjects, as indexed by the overall slope of the graphs. In fact, the one selected subject (Subject 2) that showed little improvement in symptoms and functioning over time was in the WTP group. The single participant analyses do not add support to the hypothesis that the WTP subjects would show greater improvement on the OQ scores.
In relation to hypotheses 2) and 3), visual inspection of the single participant graphs indicates little difference between the WTP and TAU group on the WAI Total scale and subscales and CSQ. Subjects generally showed positive reports of the therapeutic relationship and satisfaction with services. Again, Subject 2, from the WTP group, was an exception. At the second datapoint, Month 3, the WAI Total score and subscales were generally comparable with the other three subjects at Month 3. The WAI Total score and subscales, however, showed steady declines at subsequent datapoints. At the last datapoint, which was termination for the subject and occurred some time between 12 and 15 months into the treatment, each component of the WAI was generally lower for this subject when compared to the other subjects.

With regard to the hypotheses of this study, these single-subject analyses show mixed results with no consistent findings indicating that one group showed greater improvement than the other group. The graphs illustrate a pattern of general improvement over time in symptomatology and functioning for these CPC clients. These single participant analyses also illustrate the widely different trajectories of subjects’ change over time. There is significant variability over time for some subjects, with indications of improvement followed by worsening in symptoms, functioning, and therapeutic alliance. The analyses demonstrate that a psychotherapy client does not necessarily make steady and increasingly positive progress toward better psychological health. The results of psychotherapy do not define a monotonically increasing function.

The single participant analyses also illustrate, on an individual level, the associations among the measures as shown statistically with the Pearson product-moment correlations in the full sample at Time 2. The moderate correlations of the OQ and WAI Total scales and subscales, were observed in the generally corresponding rise and fall of OQ and WAI. For most of the subjects, a decrease in OQ scores was accompanied simultaneously by an increase in WAI scores.
Exemplary Treatment Plans: Further Single Participant Analyses

An additional post-hoc analysis was conducted to examine further the effects of written treatment plans on subjects’ outcomes. As noted earlier, the quality of many treatment plans created by the graduate student therapists were rather poor. Every student received training on the characteristics of a good treatment plan, but there were many treatment plans developed that did not fit these guidelines. This raised the question of whether different findings would emerge (with a stronger effect for treatment planning) for those cases with high quality treatment plans. It was hypothesized that subjects whose treatment plans fit the criteria of an exemplary treatment plan would exhibit improved outcomes compared to subjects with poor treatment plans. To address this question, "exemplary" treatment plans were chosen to examine the outcomes of subjects using single participant analysis.

The selection of exemplary treatment plans were based on the criteria of a good treatment plan as outlined in the Treatment Plan Protocol (see Appendix 9) that was provided and reviewed for students in the WTP group. For a treatment plan to be considered exemplary, each section (Problem, Long-term Goal, Objective, and Intervention) needed to be complete and accurate. For example, some treatment plans created by the graduate student therapists did not include some of these components. Common inaccuracies were in the Objective and Intervention components such that the Objectives described in the treatment plan were not activities that the client would undertake, or the Interventions were not activities that the therapist would undertake. These treatment plans were eliminated from consideration as an exemplary treatment plan. The other criteria considered were the specificity of the Objectives and Interventions, and the degree to which the Objectives and Interventions were potentially operationalizable or measurable. A treatment plan was eliminated if the Problems and Long-term Goals did not mirror each other or if the Objectives did not fit with the Long-term Goal. In addition, the extent to which the Objectives built upon each other was considered, to reflect the criteria that Objectives are “step-by-step” short-term goals to achieve the long-term goal.
The exemplary treatment plans were determined by two raters who worked independently to choose treatment plans based on these criteria, with the goal of finding three to five "good" treatment plans. One rater was the principal investigator. The other rater was a Licensed Clinical Professional Counselor who had been in practice at a community mental health center with a Master's Degree in Counseling for two years. This clinician was instructed on the above criteria and also reviewed the Treatment Plan Protocol.

Each rater independently chose three treatment plans (their objective was to choose three to five) that they determined to be exemplary, with several alternative treatment plans that each considered nearly to meet criteria. These treatment plans were compared and discussed until agreement on the exemplary treatment plans was reached.

Based on their initial decisions about exemplary treatment plans, both raters agreed on one treatment plan, which was Subject E. Each rater had two treatment plans that the other rater had not chosen as the "best" treatment plans. These four treatment plans, however, were considered by the other rater as an alternative to the exemplary treatment plans that the rater had chosen. The raters discussed their choices, reviewed the choices of the other rater, and each agreed to include the choice of the other rater. The final result was that all of the treatment plans determined to be exemplary by the two raters were included.

The differences between the two raters in selecting exemplary treatment plans are noteworthy. The clinician favored treatment plans that were more realistic and accessible to the client, with the treatment plan written in language that was more straightforward and free of psychological jargon. In addition, this clinician considered how realistic the treatment plans appeared to be. Some treatment plans contained goals that seemed very difficult to attain, although this was difficult to determine because there was no other clinical information available about the client.

In contrast, the principal investigator favored treatment plans that were highly specific in the Objectives and Interventions. Each one of these aspects (realistic, client-accessible, and specific) represents an important criterion in developing treatment plans, and was addressed in
the Treatment Plan Protocol. The client-friendly characteristic of the treatment plan was a subtle requirement, as it fits with the objective of gaining the client’s collaboration and commitment to the treatment plan. These criteria were weighed when considering the quality of the exemplary treatment plans presented here. Each of these subjects is reviewed and discussed briefly here.

Subject A was in therapy for 15 months and continued to be in therapy at the end of the study’s data collection period. The OQ Total score and Symptom Distress (SD) scores were above the clinical cut-off at pre-treatment and dropped below cut-off by three months. The SD subscale increased steadily at six and nine months as WAI Task and Goal decreased. At the final data point, 15 months, Symptom Distress decreased and Task and Goal Increased. The WAI Bond score remained high and stable with time, despite the changes with the other subscales. The Social Role scale was quite low at Time 1 and made little change throughout treatment. The Interpersonal Relations subscale of the OQ was above the clinical cutoff prior to treatment and moved to the cutoff period by the end of treatment. Figure 13 presents the Total scores of the OQ, CSQ, and the WAI for Subject A. Figure 14 presents the subscales of each measure for Subject A.

Subject B received treatment at the CPC for 18 months and continued to be in therapy when data collection ended. This is the same subject as “Subject 1” who was examined in the single participant analyses. The description of this subject can be found on page 66. Figure 5 and 6 present the Total scores and subscales of each measure, respectively, for Subject B.

Subject C was receiving therapy for over six months until termination. This subject reported greater symptomatology than many of the other subjects, as indicated by the OQ Total score and subscales, and were above cut-off at Time 1 and all of the time of treatment. The OQ subscales of Symptom Distress and Social Role increased at three months, but decreased at 6 months to just above the cut-off scores. The WAI Total score and subscales remained stable and the scores were somewhat low relative to other subjects. Figure 15 presents the Total scores of the OQ, CSQ, and the WAI for Subject C. Figure 16 presents the subscales of each measure for Subject C.
Subject D was in treatment at the CPC for 12 months and remained in treatment as data collection ended. This subject completed the three measures at each of the three-month intervals, but did not respond to a significant number of items of the WAI at the ninth month. Consequently, the WAI Total scores and the WAI subscales of Bond and Goal were not available for the nine-month point. This subject showed variability over time in the OQ subscales and the one WAI subscale (Goal) available for each datapoint. The OQ Total scores and Symptom Distress scale was above cut-off at Time 1, then dropped below cut-off at three and six months, returned to nearly pre-treatment symptomatology at month nine, and then dropped below cut-off at month twelve. The OQ subscales of Social Role and Interpersonal Relations followed a similar pattern as the Total score and Symptom Distress scale, although Social Role remained below cut-off and Interpersonal Relations remained above cut-off throughout treatment. The WAI Task subscale showed similar increases and decreases, although in an inverse direction. Satisfaction remained constant throughout treatment. Figure 17 presents the Total scores of the OQ, CSQ, and the WAI for Subject D. Figure 18 presents the subscales of each measure for Subject D.

Subject E completed data at the three month datapoint and remained in therapy when data collection ended. This subject’s treatment plan was initially chosen by both treatment plan raters as an exemplary treatment plan. The subject’s OQ Total score and the Symptom Distress and Interpersonal Relations subscales were well above cut-off at pre-treatment and these scores made little change at three months. The OQ Social Role scale dropped from above cut-off to below cut-off at three months. The WAI Total score and Subscales were quite similar to the scores of other subjects. Figure 19 presents the Total scores of the OQ, CSQ, and the WAI for Subject E. Figure 20 presents the subscales of each measure for Subject E.

These single-subject analyses are now discussed in relation to the hypotheses of the study.

Hypothesis 1) In comparing these exemplary treatment plan subjects to the TAU subjects analyzed graphically (see Figures 9 through 12), there does not appear to be any differences in the OQ Total score and subscales. The majority of subjects in both the TAU group
and this exceptional WTP group improved with time. There appears to be little difference among these three groups: the exceptional WTP group and the subjects from the single participant analyses in the WTP and TAU groups. In examining the overall slope of the graphs, the exemplary WTP subjects did not appear to improve at a faster or greater rate than either of the single participant analyses groups. The exemplary treatment plan analysis does not add support to the hypothesis that the WTP subjects, even those subjects with the best treatment plans, would show greater improvement on the OQ scores.

In relation to hypotheses 2) and 3), which suggested that the subjects in the WTP group would report a better therapeutic relationship and greater satisfaction with services, visual inspection of the exemplary treatment plans subjects demonstrates little difference when they are compared to the TAU group of the single participant analyses (see Figures 9 through 12) WAI Total scale and subscales and CSQ. Subjects generally showed positive reports of the therapeutic relationship and satisfaction with services.

When comparing the graphs of the subjects with exemplary treatment plans to the TAU single participant analyses, little differences are apparent between groups. This exemplary treatment plan analysis does not serve to support the hypotheses. There were no consistent findings, even when the subjects with the very best treatment plans were examined, illustrating that the treatment plan group showed greater improvement than the no treatment plan group. As with the large-n analysis, all of these single participant analyses illustrate the general improvement over time in symptomatology and functioning for subjects but no differences between groups. Thus, they do not support the possible explanation for this study's negative results, that poor quality treatment planning accounted for the lack of effects attributable to this procedure. It appears that even those clients whose treatment was accompanied with an exemplary treatment plan did not show differentially better outcome in comparison to the TAU subjects.
Discussion

The primary hypothesis of this study was that the development of a written treatment plan, in collaboration with the client, would result in improved outcomes, therapeutic alliance, and satisfaction with services for the psychotherapy client. This study found one significant difference between the two groups at Time 2. Subjects in the TAU group reported significantly better functioning in interpersonal relationships than subjects in the WTP group. Besides this finding, there were no significant differences between clients who developed treatment plans with their psychotherapist compared to clients who did not develop a treatment plan. Psychotherapy clients in both groups endorsed reduced psychiatric symptoms, improved interpersonal relationships, and improved role functioning in areas such as work, school, and leisure activities. Except for the area of interpersonal relationships, there were no differences between groups in the amount of positive change over treatment. In addition, clients across both conditions reported moderately high satisfaction with services and moderately strong therapeutic relationships.

Supplementary analyses were conducted to examine any differences among single participants from both groups. There did not appear to be any differences between groups in symptom report, functioning, satisfaction, and therapeutic relationship between subjects randomly chosen for the single participant analyses in the WTP group and the TAU group. The subjects with exceptional treatment plans, as determined by two independent raters, also demonstrated no differences when compared to the single participant TAU subjects. When examining the data at the single participant level, subjects improved over time, with both groups improving at about the same rate. This additional post-hoc analysis was conducted to compensate for the many poorly-written (based on the characteristics of a good treatment plan, as defined in this study) treatment plans developed in the study. The single-case analysis produced the same findings of no differences between groups, however, suggesting that it was not the poor quality of the treatment plans that was responsible for this lack of differences. These post-hoc analyses showed an interesting pattern of an ebb and flow throughout the course of
therapy for several of the subjects. The single case analyses showed fluctuations in improvement in symptoms and functioning and the clients' reports of satisfaction and the therapeutic relationship as well. These analyses illustrate that psychotherapy clients' do not necessarily progress in a linear fashion, as demonstrated by others (Tschacher, Scheier, & Grawe, 1998; Orlinsky, Grawe, & Parks, 1994)

The TAU group did show greater improvement in one subscale of the OQ, the Interpersonal Relations subscale. Visual inspection of the OQ Total score and subscales suggest a trend toward improved symptomatology and functioning for subjects in the group with no treatment plans. This suggestion that treatment plans may potentially even lead to worse outcomes may be a result of several factors. Students may have experienced negative emotions about writing treatment plans, which in turn affected the treatment that they provided to their clients. The students' responses to the Therapist Attitude Questionnaire did suggest that most students had positive attitudes toward treatment plans, but the validity of this measure is unknown.

There may have been other factors that could affect worse outcomes for subjects in the WTP condition. Students may have reviewed the treatment plan during the course of therapy, and it is unknown to what extent, if any, student therapists did this. If the treatment plan was developed but never, or very rarely, revisited, the experience may have been somewhat disempowering to clients. If the treatment plan was not reviewed, clients may have felt that their knowledge and understanding of their progress on the treatment plan was not important, and that this document was for the therapist's use and benefit only. If the treatment plan was not reviewed and updated, this may have resulted in the therapist and client working on interventions and objectives that were no longer relevant to the client's problem. The writing of a treatment plan may negatively affect the therapeutic relationship, adding an unnatural and disruptive structure to the session. There were no differences found between groups in the therapeutic relationship, however, which disputes this last explanation.
These findings suggest that the act of writing a treatment plan with a client does not affect outcomes for the individual. The sample size in this study was quite small, however, and a power analysis suggests that an n of this size may not be adequate to show significant differences. A power analysis with this study's actual sample size of 18 and 17, estimating a medium effect size, the power is .30, indicating that the study is considerably under-powered. This is an important consideration when examining the findings of this study. It may be that a larger sample size would result in significant improvement in outcomes for the written treatment group compared to the treatment as usual group. Furthermore, there are several aspects of the study that may have reduced the ability to find significant results. This research was conducted in a university-based clinic by clinical psychology graduate student therapists. This was an effectiveness study conducted “in the field,” rather than a laboratory-type setting where extraneous variables could be carefully controlled. The exclusion criteria were limited: any individual adult seeking psychotherapy was asked to be involved in the study. Consequently, subjects had a diverse set of presenting problems and diagnoses. In addition, there is great heterogeneity in the level of functioning and complexity of the problems for clients. These differences, among other factors, result in varying trajectories for clients through treatment. These issues, however, are precisely what give this study external validity, and makes it a study of effectiveness rather than of efficacy (Nathan & Gorman, 2002).

Another factor that resulted in great heterogeneity in the implementation of the treatment is the various theoretical orientations of the supervising clinical psychologists. The treatment conditions were implemented by student therapists who were in five different practicum groups. Each practicum group was supervised by different supervisors with varying theoretical orientation that included psychodynamic, eclectic, cognitive-behavioral, and behavioral approaches. While analyses were not conducted to explore practicum or specific therapist effects, it is possible that these factors contributed to the client outcomes. In addition, there was a wide range of clinical experience among the therapists, with some therapists having no clinical experience and others having four or more years of experience. This study found no significant
difference in therapist experience between the two groups. Studies of therapist experience as a variable affecting client outcomes, however, show that graduate students that are more advanced in training show better outcomes than students earlier in their training (Driscoll, Cukrowicz, Reitzel, Hernandez, Petty, & Joiner, 2003; Stein & Lambert, 1995). This great heterogeneity in the implementation of the treatment conditions may have resulted in the lack of differences found.

Compliance of implementation of the treatment condition was determined by the production of a written treatment plan. There was no indication about the extent to which students discussed the treatment plans with the client and involved the client in determining the plan, although clients and supervisors did sign the treatment plan. There may have been great diversity in the degree of collaboration and discussion about the treatment plan among the student therapists. Such process variables were not investigated in this study. In addition, student therapists did not receive feedback about the treatment plans that they developed. Indeed, the quality of treatment plans varied greatly, such that it appeared that not all students recognized what would be an accurate and appropriate entry for the different components of the treatment plan. Examples of “poor” treatment plans included incomplete sections, such as nothing listed for “Interventions.” Other treatment plans had incorrect entries in the sections of “Interventions” and “Objectives.” Student therapists were instructed to write objectives and interventions that were specific and measurable, and this was based on findings from goal-setting research that found that specific and measurable goals improved a person’s performance on a task (Locke et al., 1981). An examination of the treatment plans developed by therapists in this study revealed that some objectives and interventions were not specific, and very few were measurable. As observed by the practicing clinician rater of treatment plans, many treatment plans contained psychologically sophisticated language. This “jargon” may have impeded the collaborate process in the development of the treatment plan. Therapists appear to need more training than a one-time 30-minute presentation of the components and features of an effective treatment plan. Compliance also lapsed for some in the timeliness of completing the treatment
plans. There were a small number of instances in which treatment plans were completed at three months from the first session. In these situations, data for the three-month point was collected soon after the treatment plan was finished. When treatment plans were completed much later than the suggested third session, the benefits of the treatment plan may not have taken affect when the outcome measures were completed by the subject. However, examination of outcomes from the clients' with "exemplary" treatment plans did not support the possibility that quality of the implementation of the treatment planning was responsible for this study's negative findings.

Student therapists were also not asked or required to review and monitor the goals with their clients on a regular basis. It is likely that this monitoring activity plays an important role in achieving improved outcomes for clients. The goal-setting literature (Locke et al., 1981) indicates that gaining knowledge of results or progress toward goals is an important factor in improving performance. For this reason, developing measurable goals is most effective because the individual can determine the progress s/he has made toward the goal, and when s/he has reached the goal. Frequent review of the treatment plan may be necessary to remind the client of the goals s/he is working toward. This act of measuring the distance between one's current status to achievement of the goal shows an individual how far s/he has come, and how much farther s/he needs to go. Furthermore, a review of the goals may indicate that these goals and objectives were not realistic, applicable, or appropriate, and therefore need to be revised. The goal-setting research indicates that having knowledge of progress toward goals is an important factor, and this suggests that frequent reviewing of goals is an important component of writing treatment plans.

Prior to the study, students in both groups indicated that they discussed treatment goals and plans at times during the therapy process. It may be that students in the treatment as usual group discussed the goals and direction of therapy at about the same rate as students in the written treatment plan group. The therapists in the TAU group did not conduct a discussion and review of goals in the more prescribed manner that the WTP therapists were instructed to conduct. The student therapists in the WTP were not restricted, however, from discussing and...
reviewing treatment goals and potential therapy interventions with their clients. This may have resulted in little actual difference in amount of discussion and monitoring of goals between the two groups, except for the one-time creation of the written treatment plan by the WTP group. Some type of treatment planning, although likely not conducted in a formal manner, may have occurred in the other practicum groups or in individual sessions. Thus, diffusion of treatment may have occurred across the practa, between the two groups in this study. It may be that writing the treatment plan is not enough to acquire the benefits of goal-setting, and that the therapist and client need to frequently review, monitor, and reassess the client's progress toward the goals.

The TAU group therapists may have been naturally conducting informal treatment planning which affected the results of the study. Another factor may have related to the difficulty in keeping the study's hypotheses and conditions blind to the student therapists. This particular graduate student community is small and close-knit, and it is likely that some students talked with each other about issues related to the study. Some comments were made to the experimenter that indicated some knowledge by a few students of the study. In addition, supervisors were not explicitly instructed to avoid discussion of the different conditions, and they may have revealed some aspects of the two conditions to the students.

The hypothesis that written treatment plans would improve outcomes for psychotherapy clients was based on empirical findings, as referenced above, on goal-setting as well as research of the relationship between specific process variables and therapy outcomes. This process research indicates that factors such as goal consensus between therapist and client, clarity of expectations about the process and progress of therapy, and the collaborative approach of the therapist are related to positive outcomes for psychotherapy clients. These process variables were not measured directly in this study, so it is unknown whether subjects in the two groups differed in their experience of goal consensus, expectational clarity, or collaboration with the therapist. The lack of difference in the WAI, especially the Goal subscale, hints that there may be no differences between groups in the area of goal consensus. Again, these process variables were not directly measured, but these findings bring into question whether the presence of
written treatment plans improves client's perception of goal conception, expectational clarity, and collaboration.

There were some differences that occurred with the training for the treatment conditions received by the student therapists. Students in Year 1 received group training at the first practicum meeting by the principal investigator present in class. Students in Year 2 received the same training at the 2nd practicum meeting by the principal investigator via tele-conference. The tele-conference training was followed by in-person individual meetings by the principal investigator. These differences in training may have affected the consistency of the implementation of the treatment condition, thus weakening the treatment.

Finally, in completing the measures, the subjects may have been responding to demand characteristics inherent in the study. Subjects may have attempted to appear increasingly healthy in symptoms and satisfaction when completing the OQ over time. There would be several reasons why subjects may underreport symptomatology as treatment progressed. Subjects may have wished to provide assistance in supporting the hypotheses of the study. Subjects may have wanted to show improvement in therapy for their own sake, to avoid feeling that they had not wasted their time in therapy. Subjects were also instructed that their therapist would review the OQ, and subjects may have wished to appear to have improved to their therapist. With regard to the WAI and CSQ, great efforts were made to shield the data from the student therapists and supervisors, and subjects were informed of this. Despite these efforts, subjects may have felt hesitant to report the therapeutic relationship as poor or endorse dissatisfaction with services.

One finding of this study is that the psychotherapy clients experienced improved psychological health over time, and in fact this study does provide strong evidence for the effectiveness of psychotherapy in this student-staffed clinic. Clients reported improvement in all aspects of the Outcome Questionnaire 45.2 of symptom distress, interpersonal relationships, and role functioning. In addition, clients reported that the therapeutic relationship with their therapist was quite strong. Clients also indicated that they were generally satisfied with the services that
they received. This is a notable finding, considering that the study was conducted in a university-based clinic with psychologists-in-training. There were numerous beginning therapists with little to no clinical experience who treated their first psychotherapy clients during the study.

A subhypothesis was that the act of writing a treatment plan collaboratively would result in increased reports of the therapeutic relationship. It appeared that both groups developed a relatively strong relationship between therapist and client. Again, the differences between the practicum groups may have affected this lack of findings. Two of the practicum groups were rather process-oriented in their approaches, such that there was more focus on using this relationship to affect change in the client. Indeed, the therapy manual used by one of the control groups is subtitled "Creating Intense and Curative Therapeutic Relationships" (Kohlenberg & Tsai, 1991). A related finding is that student therapists in both groups indicated that they favored a collaborative approach in treating psychotherapy clients. It may be that students in the TAU group engaged in collaborative techniques or behaviors at a similar rate to students therapists in the WTP groups.

Another subhypothesis of the study related to the relationship between client satisfaction and the therapeutic relationship. It was hypothesized that increased client participation in the WTP group would lead to a stronger therapeutic relationship, which would lead to increased satisfaction with services by the client. There were no differences between groups in the therapeutic relationship or satisfaction with services; there was, however, a moderately high positive correlation between therapeutic relationship and satisfaction with services.

The final hypothesis was that student therapists in the WTP group would develop more positive attitudes toward written treatment plans over the course of this study. The majority of therapists held positive attitudes toward treatment plans and the effects of treatment plans on clients prior to the onset of the study. Positive attitudes toward treatment plans and their effects remained positive at the end of Year 1. The psychometric properties of this survey-style measure were not determined, thus its reliability and validity is unknown. It may be, however, that most clinicians do not hold negative attitudes toward treatment plans, or it may be that, specifically,
psychologists-in-training do not hold negative attitudes toward treatment plans. It an important point for administrative staff of mental health facilities to understand that therapists may not hold negative attitudes toward treatment plans.

The Pearson Product Moment correlations among the scales and subscales of the three measures indicate that there is a moderate correlation between therapeutic relationship and outcome. The WAI subscales are highly correlated with each other, and this supports the factor structure analysis (Tracey & Kokotovic, 1989) that suggests that the WAI may consist of one general alliance factor. In addition, there is a relationship between the therapeutic relationship and satisfaction with services, and the two scales may be measuring some of the same things. Individuals who report a better therapeutic relationship reported greater satisfaction with services. This relationship appears to be an important component in satisfaction. Satisfaction with services, however, is independent of psychological distress. Clients may experience great symptom distress or difficulties with interpersonal relationships but this does not appear to affect their level of satisfaction with the services that they received.

Although there were no significant differences found between the written treatment plan and treatment as usual group, there are additional factors that limited the ability of this study to find differences. Suggested future research would involve conducting a similar study with a larger sample size (such that it meets requirements of the power analysis). In an ideal study, greater control over the therapy modalities and client presenting problem and/or diagnosis would result in greater homogeneity in the treatment, something that may allow findings to emerge. This, of course, would move this research in the direction of an efficacy rather than an effectiveness study (Nathan & Gorman, 2002). In addition, this level of control over client characteristics and treatment conditions would be difficult to obtain in this particular clinical facility because a broad range of clients are treated with a broad range of theoretical orientations. There are changes that could be made to this study within the limitations of the clinical facility. For example, it is apparent that therapists need more extensive training in writing effective treatment plans, and they may need repeated feedback to improve their treatment
plans to meet the characteristics of effective goal-setting (Locke et al., 1981). In addition, therapists need greater monitoring to ensure that they are implementing the treatment condition properly. This would involve ensuring that therapists were developing the treatment plan in a timely and collaborative manner, and this may involve reviewing therapy notes, observing videotapes of the session, or asking client and therapist to each write summaries of the session. Finally, future research on the effects of written treatment plans should include a regular review, monitoring, and, if necessary, revision component of the client’s goals and progress toward goals.

This further research into the effects of treatment plans is an important aspect to the process and outcomes empirical literature of psychotherapy. Treatment plans are commonly included in the clinical services provided to psychotherapy clients by. It may be that some aspects or characteristics of the treatment planning process, such as regular monitoring of the plan, improve outcomes for psychotherapy clients. This is important research to pursue to determine whether this administrative tool can be used to the advantage of the psychotherapy client.

It may be that written treatment plans simply do not improve outcomes or satisfaction for clients of psychotherapy and do not provide direction and focus to the therapeutic process as hypothesized by Jongsma and Peterson (1999). Treatment plans are beneficial for administrative monitoring and quality control regarding treatment, but, in this study, are unrelated to actual therapeutic outcome. They may be an administrative tool, but not a clinical tool. Or, alternately, treatment plans may focus treatment but this focus may not change the outcome for clients compared to treatment without this focus. The hypothesis that written treatment plans improve outcomes for psychotherapy clients cannot be eliminated based on this study, however, and future research in this area is required to gain a better understanding of how written treatment plans may affect and benefit psychotherapy clients.
References


Table 1

Demographic Information, Psychotherapy Clients

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<tr>
<th></th>
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Table 2

**Mean Scores and One-way ANOVA for OQ Subscales at Time 1 and Time 2**

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Note: Repeated Measures MANOVA of the OQ subscales showed a significant difference for the groups $F (3, 28) = 3.86$, $p = 0.02$. 

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Mean Scores and Independent Samples t-test for OQ Scales, Completer and Dropout Subjects at Time 1

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<td>.64</td>
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Table 5

Demographic Information of Year 1 Practicum: TAU Condition

Group 1: CBT

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Years of Clinical Experience

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Demographic Information of Year 1 Practica: WTP Condition

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Group 3: Eclectic

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Demographic Information of Year 2 Practica: TAU Condition

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|                     | Years of Clinical Experience | |
|---------------------|-----------------------------|
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|                     | 1  | 2  | 29.0 |
|                     | 2  | 3  | 43.0 |
|                     | 3  | 1  | 14.0 |

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<p>|                     | Years of Clinical Experience | |
|---------------------|-----------------------------|
|                     | 0  | 2  | 33.0 |
|                     | 1  | 1  | 17.0 |
|                     | 2  | 3  | 50.0 |
|                     | 3  | 0  | 0.0  |</p>
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## Table 9

*Cronbach's Alphas of Scales and Subscales of Measures*

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*Note.* Analyses conducted with Time 2 data only.
Table 10

Frequencies of Datapoint Intervals Represented by Time 2

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<td>2</td>
<td>11.1</td>
</tr>
<tr>
<td>9 months</td>
<td>1</td>
<td>5.6</td>
</tr>
<tr>
<td>12 months</td>
<td>2</td>
<td>11.1</td>
</tr>
<tr>
<td>15 months</td>
<td>2</td>
<td>11.1</td>
</tr>
<tr>
<td>18 months</td>
<td>1</td>
<td>5.6</td>
</tr>
<tr>
<td>Termination</td>
<td>3</td>
<td>16.7</td>
</tr>
</tbody>
</table>
Table 11

Mean Scores and One-way ANOVA for WAI and CSQ Scales and Subscales at Time 2

<table>
<thead>
<tr>
<th>Measure</th>
<th>Written Treatment Plan</th>
<th>Treatment as Usual</th>
<th>F</th>
<th>Df</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M (SD)</td>
<td>M (SD)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>WAI Total</td>
<td>220.04 (20.00)</td>
<td>227.34 (27.50)</td>
<td>0.81</td>
<td>34</td>
<td>.37</td>
</tr>
<tr>
<td>WAI Bond</td>
<td>75.00 (7.63)</td>
<td>77.63 (9.45)</td>
<td>0.80</td>
<td>33</td>
<td>.38</td>
</tr>
<tr>
<td>WAI Task</td>
<td>72.03 (7.25)</td>
<td>74.58 (9.67)</td>
<td>0.83</td>
<td>34</td>
<td>.38</td>
</tr>
<tr>
<td>WAI Goals</td>
<td>73.00 (6.55)</td>
<td>75.05 (9.36)</td>
<td>0.55</td>
<td>34</td>
<td>.46</td>
</tr>
<tr>
<td>CSQ-8</td>
<td>29.33 (2.57)</td>
<td>29.65 (3.26)</td>
<td>0.03</td>
<td>34</td>
<td>.75</td>
</tr>
</tbody>
</table>

Note. MANOVA analysis of OQ, WAI and CSQ Total scales showed no significant differences, $F(3, 31) = 0.54, p = 0.66$. MANOVA analysis of the CSQ and the OQ and WAI subscales showed no significant differences, $F(7, 26) = 0.93, p = 0.50$. 

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Table 12
Frequency Data for Therapist Attitude Measure Responses, Written Treatment Plan Group

<table>
<thead>
<tr>
<th>Written Treatment Plan</th>
<th>Time 1</th>
<th>Time 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>Percent</td>
</tr>
<tr>
<td>Preferred method of developing plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Own assessment.</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Client’s goals.</td>
<td>1</td>
<td>10.0</td>
</tr>
<tr>
<td>Combination of two.</td>
<td>6</td>
<td>60.0</td>
</tr>
<tr>
<td>Write a treatment plan.</td>
<td>1</td>
<td>10.0</td>
</tr>
<tr>
<td>No clinical experience.</td>
<td>2</td>
<td>20.0</td>
</tr>
<tr>
<td>Resources used in developing plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supervisor</td>
<td>8</td>
<td>80.0</td>
</tr>
<tr>
<td>Resource books</td>
<td>1</td>
<td>10.0</td>
</tr>
<tr>
<td>Practicum</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>No clinical experience</td>
<td>2</td>
<td>20.0</td>
</tr>
<tr>
<td>Effect of written treatment plans</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unnecessary paperwork.</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Helps therapist develop ideas and plan of action.</td>
<td>9</td>
<td>90.0</td>
</tr>
<tr>
<td>No effect at all.</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Helps client think about own goals.</td>
<td>9</td>
<td>90.0</td>
</tr>
</tbody>
</table>
Table 13

Frequency Data for Therapist Attitude Measure Responses, Treatment as Usual Group

<table>
<thead>
<tr>
<th>Preferred method of developing plan</th>
<th>Time 1</th>
<th>Time 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Own assessment.</td>
<td>0 0.0</td>
<td>0 0.0</td>
</tr>
<tr>
<td>Client’s goals.</td>
<td>2 40.0</td>
<td>0 0.0</td>
</tr>
<tr>
<td>Combination of two.</td>
<td>3 60.0</td>
<td>5 100.0</td>
</tr>
<tr>
<td>Write a treatment plan.</td>
<td>0 0.0</td>
<td>0 0.0</td>
</tr>
<tr>
<td>No clinical experience.</td>
<td>0 0.0</td>
<td>0 0.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Resources used in developing plan.</th>
<th>Time 1</th>
<th>Time 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supervisor</td>
<td>5 100.0</td>
<td>5 100.0</td>
</tr>
<tr>
<td>Resource books</td>
<td>3 60.0</td>
<td>1 20.0</td>
</tr>
<tr>
<td>Practicum</td>
<td>2 40.0</td>
<td>1 0.0</td>
</tr>
<tr>
<td>No clinical experience</td>
<td>0 0.0</td>
<td>0 0.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Effect of written treatment plans</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Unnecessary paperwork.</td>
<td>0 0.0</td>
<td>0 0.0</td>
</tr>
<tr>
<td>Helps therapist develop ideas and plan of action.</td>
<td>5 100.0</td>
<td>4 80.0</td>
</tr>
<tr>
<td>No effect at all.</td>
<td>0 0.0</td>
<td>0 0.0</td>
</tr>
<tr>
<td>Helps client think about own goals.</td>
<td>2 40.0</td>
<td>5 100.0</td>
</tr>
</tbody>
</table>
Table 14
Means and Standard Deviations for Therapist Attitude Measure Responses

<table>
<thead>
<tr>
<th>Ratings</th>
<th>Written Treatment Plan</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency of discussing plan or goals with client.</td>
<td>2.56 0.88</td>
<td>2.50</td>
<td>0.53</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experience with writing treatment plans.</td>
<td>2.56 0.88</td>
<td>4.00</td>
<td>1.07</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attitude toward written treatment plans.</td>
<td>4.00 0.87</td>
<td>3.63</td>
<td>1.06</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attitude toward written treatment plans effects on clients.</td>
<td>3.89 0.33</td>
<td>3.63</td>
<td>0.52</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How therapy progresses should always be determined</td>
<td>3.22 0.67</td>
<td>3.50</td>
<td>0.53</td>
<td></td>
<td></td>
</tr>
<tr>
<td>jointly by client and therapist.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clients should rarely participate in selecting interventions.</td>
<td>3.22 0.44</td>
<td>3.00</td>
<td>0.76</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ratings</th>
<th>Treatment as Usual</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency of discussing plan or goals with client.</td>
<td>2.80 0.44</td>
<td>3.00</td>
<td>0.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experience with writing treatment plans.</td>
<td>4.00 1.07</td>
<td>4.40</td>
<td>0.55</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attitude toward written treatment plans.</td>
<td>4.20 0.45</td>
<td>3.80</td>
<td>0.45</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attitude toward effects of written treatment plans on clients.</td>
<td>3.85 0.36</td>
<td>3.85</td>
<td>0.36</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How therapy progresses should always be determined</td>
<td>3.40 0.55</td>
<td>3.77</td>
<td>0.44</td>
<td></td>
<td></td>
</tr>
<tr>
<td>jointly by client and therapist.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clients should rarely participate in selecting interventions.</td>
<td>3.40 0.47</td>
<td>3.2</td>
<td>0.84</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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Table 15

Pearson Product-Moment Correlations among Scales and Subscales

<table>
<thead>
<tr>
<th></th>
<th>OQ Total</th>
<th>OQ Symptom Distress</th>
<th>OQ Interpersonal Relations</th>
<th>OQ Social Role</th>
<th>WAI Total</th>
<th>WAI Bond</th>
<th>WAI Task</th>
<th>WAI Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>OQ Total</td>
<td>--</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OQ Symptom</td>
<td>.94**</td>
<td>--</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Distress</td>
<td>.82**</td>
<td>.62**</td>
<td>--</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OQ Social</td>
<td>.84**</td>
<td>.70**</td>
<td>.67**</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Role</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>WAI Total</td>
<td>-.56**</td>
<td>-.52**</td>
<td>-.48**</td>
<td>-.48**</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>WAI Bond</td>
<td>-.53**</td>
<td>-.49**</td>
<td>-.45**</td>
<td>-.48**</td>
<td>.95**</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>WAI Task</td>
<td>-.56**</td>
<td>-.51**</td>
<td>-.50**</td>
<td>-.46**</td>
<td>.97**</td>
<td>.86**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>WAI Goal</td>
<td>-.54**</td>
<td>-.50**</td>
<td>-.44**</td>
<td>-.46**</td>
<td>.97**</td>
<td>.86**</td>
<td>.93**</td>
<td></td>
</tr>
<tr>
<td>CSQ-8</td>
<td>-.20</td>
<td>-.29</td>
<td>-.04</td>
<td>-.07</td>
<td>.56**</td>
<td>.51**</td>
<td>.54**</td>
<td>.55**</td>
</tr>
</tbody>
</table>

Note. Analyses conducted with Time 2 data only.

** Correlation is significant at the 0.01 level (2-tailed).
* Correlation is significant at the 0.05 level (2-tailed).
Figure 1: Mean OQ Total Score by Group at Time 1 and Time 2.

Figure 2: Mean OQ Symptom Distress Subscale by Group at Time 1 and Time 2.
Figure 3: Mean OQ Interpersonal Relations Subscale by Group at Time 1 and Time 2.

**OQ Interpersonal Relations**

by Group

![Graph showing mean scores for OQ Interpersonal Relations by group over time.]

Figure 4: Mean OQ Social Role Subscale by Group at Time 1 and Time 2.

**OQ Social Role by Group**

![Graph showing mean scores for OQ Social Role by group over time.]

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Figure 5: Subject 1 Total Scores over Time

Subject 1: WTP

Total Scores

Figure 6: Subject 1 Subscale Scores over Time

Subject 1: WTP

Subscales

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Figure 7: Subject 2 Total Scores over Time

Subject 2: WTP

Total Scores

Value

TIME

Figure 8: Subject 2 Subscale Scores over Time

Subject 2: WTP

Subscales

Value

TIME
Figure 9: Subject 3 Total Scores over Time

Subject 3: TAU

Total Scores

![Graph showing total scores over time for Subject 3: TAU]

Figure 10: Subject 3 Subscale Scores over Time

Subject 3: TAU

Subscales

![Graph showing subscale scores over time for Subject 3: TAU]
Figure 11: Subject 4 Total Scores over Time

Subject 4: TAU

Total Scores

Figure 12: Subject 4 Subscale Scores over Time

Subject 4: TAU

Subscales
Figure 13: Subject A Total Scales over Time.

Subject A

Total Scores

Figure 14: Subject A Subscale Scores over Time.

Subject A

Subscales

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Figure 15: Subject C Total Scales over Time

Subject C

Total Scores

Figure 16: Subject C Subscale Scores over Time.

Subject C

Subscales

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Figure 17: Subject D Total Scales over Time.

Subject D

Total Scores

Value

TIME

Figure 18: Subject D Subscale Scores over Time.

Subject D

Subscales

Value

TIME
Figure 19: Subject E Total Scales over Time.

Subject E

Subscales

![Graph showing total scales over time for Subject E.]

Note: Bar graph format was necessary due to only one CSQ and WAI datapoint.

Figure 20: Subject E Subscale Scores over Time.

Subject E

Subscales

![Graph showing subscale scores over time for Subject E.]

Note: Bar graph format was necessary due to only one CSQ and WAI datapoint.
SUBJECT INFORMATION AND CONSENT FORM
Clinical Psychology Center Client

TITLE: Treatment Planning in Psychotherapy

INVESTIGATORS: Andrea Neal, M.A., David Schulberg, Ph.D.
Department of Psychology
University of Montana
Skaggs 143
Missoula, MT 59812
Andrea: 243-2675 (message) or 207-623-1039
John Klocek, Ph.D., CPC Director: 243-5546

The purpose of this research study is to understand how using a worksheet to help planning for therapy affects clients receiving psychotherapy.

As part of this research, you may or may not complete the planning worksheet with your therapist. At the CPC, we are gathering information from you about any symptoms that you may be experiencing and how relationships and events in your daily life are going. We will also ask you about your satisfaction with services that you received here when therapy is over for you. This is important information to get from you before you start therapy and when you are done to learn how our services are affecting you, and how we can improve our services. We would also like to use this information as part of this study, and by signing this form, you are agreeing to including your information (this will include some basic personal information like your gender and age, and the questionnaire you filled out when you started treatment) that we will already be gathering in this study.

Answering the questions may cause you to think about things or feelings that make you sad or upset. Your therapist will be available if you need to talk about these things.

This project aims to learn about the effectiveness of treatment planning for people receiving psychotherapy. Your taking part in the research aspect of the group may not directly benefit you, but it may help in the scientific understanding and practical application of treatment planning.

All the information gathered for this study will be kept confidential and secured in a locked file cabinet. Your name will not appear on any of the materials except for this form. The data from this study will be kept separate from your client file. However, we may share this information with the people responsible for your care at the CPC. Your confidentiality may be broken, however, if you indicate in any of the questionnaires that that you are considering harming yourself or others. This is in accordance with the law.

Although this research does not involve any physical contact or risk of injury, the following liability information is provided: In the event that you are injured as a result of this research you should individually seek appropriate medical treatment. If the injury is caused by the negligence of the University or any of its employees, you may be entitled to reimbursement of compensation pursuant to the Comprehensive State Insurance Plan established by the Department of Administration under the authority of M.C.A., Title 2, Chapter 9. In the event of a claim for such injury, further information may be obtained from the University’s Claims Representative or University Legal Counsel.
Your participation is voluntary. You may decide to stop participation at any time for whatever reason without penalty.

I have read the above description of this research study. I have been informed of the risks and benefits involved, and all my questions have been answered to my satisfaction. Furthermore, I have been assured that any future questions I may have will also be answered by a member of the research team. I voluntarily agree to take part in this study. I understand that I will receive a copy of this consent form.

_________________________  ___________________________  ___________
Printed Name  Signature  Date

_________________________  ___________________________
Witness  Date
SUBJECT INFORMATION AND CONSENT FORM
Graduate Student Therapist

TITLE: Treatment Planning in Psychotherapy

INVESTIGATORS: Andrea Neal, M.A., David Schuldberg, Ph.D.
Department of Psychology
University of Montana
Skaggs 143
Missoula, MT 59812
Andrea: 243-2675 (message) or 207-623-1039
John Klocek, Ph.D., CPC Director: 243-5546

The purpose of this research study is to understand how using different types of treatment planning affects outcomes for clients receiving psychotherapy and how therapists' attitudes toward treatment planning are affected by utilizing treatment planning in their work.

As part of this research, you will be using different types of treatment planning in working with your clients. In addition, you will be asked to complete a measure about your experience and attitudes toward treatment planning before you become involved in this study and at the end of the study. This measure will also include information about the extent of your clinical experience. We are not expecting you to have any negative reaction from completing this measure.

This project aims to learn about the effectiveness of treatment planning for people receiving psychotherapy. Your taking part in the research aspect of the group is likely to directly benefit you, by providing you with instruction and experience in treatment planning. In addition, your involvement in this task may help in the scientific understanding and practical application of treatment planning.

All the information gathered for this study will be kept confidential and secured in a locked file cabinet. Your name will not appear on any of the materials except for this form.

Although this research does not involve any physical contact or risk of injury, the following liability information is provided: In the event that you are injured as a result of this research you should individually seek appropriate medical treatment. If the injury is caused by the negligence of the University or any of its employees, you may be entitled to reimbursement of compensation pursuant to the Comprehensive State Insurance Plan established by the Department of Administration under the authority of M.C.A., Title 2, Chapter 9. In the event of a claim for such injury, further information may be obtained from the University's Claims Representative or University Legal Counsel.
Your participation is voluntary. You may decide to stop participation at any time for whatever reason without penalty. Your faculty supervisor will not be informed of your decision to not be involved, and consequently your grade will not be affected. You will experience the same clinical opportunities as those who partake in the research.

I have read the above description of this research study. I have been informed of the risks and benefits involved, and all my questions have been answered to my satisfaction. Furthermore, I have been assured that any future questions I may have will also be answered by a member of the research team. I voluntarily agree to take part in this study. I understand that I will receive a copy of this consent form.

Printed Name ___________________________ Signature ___________________________ Date _________

Witness ___________________________ Date _________
### Outcome Questionnaire (OQ®-45.2)

Instructions: Looking back over the last week, including today, help us understand how you have been feeling. Read each item carefully and mark the box under the category which best describes your current situation. For this questionnaire, work is defined as employment, school, housework, volunteer work, and so forth. Please do not make any marks in the shaded areas.

<table>
<thead>
<tr>
<th>Session #</th>
<th>Date / /</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Item</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Frequently</th>
<th>Always</th>
<th>SD</th>
<th>IR</th>
<th>SR</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I get along well with others.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. I tire quickly.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. I feel no interest in things.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. I feel stressed at work/school.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. I blame myself for things.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. I feel anxious.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. I feel unhappy in my marriage/significant relationship.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. I have thoughts of ending my life.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. I feel weak.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. I feel fearful.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. After heavy drinking, I need a drink the next morning to get going. (If you do not drink, mark &quot;never&quot;)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
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<td>12. I find my work/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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<td>24. I like myself.</td>
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<td>25. Disturbing thoughts come into my mind that I cannot get rid of.</td>
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<td>26. I feel annoyed by people who criticize my drinking (or drug use).</td>
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<td>27. I have an upset stomach.</td>
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<td>28. I am not working/studying as well as I used to.</td>
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<td>29. My heart pounds too much.</td>
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<td>30. I have trouble getting along with friends and close acquaintances.</td>
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<td>31. I am satisfied with my life.</td>
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<td>32. I have trouble at work/school because of drinking or drug use.</td>
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<td>33. I feel that something bad is going to happen.</td>
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<td>34. I have sore muscles.</td>
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<td>35. I feel afraid of open spaces, of driving, or being on buses, subways, and so forth.</td>
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<td>36. I feel nervous.</td>
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<td>37. I feel my love relationships are full and complete.</td>
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<td>38. I feel that I am not doing well at work/school.</td>
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<tr>
<td>39. I have too many disagreements at work/school.</td>
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<td>40. I feel something is wrong with my mind.</td>
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<td>41. I have trouble falling asleep or staying asleep.</td>
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<td>42. I feel blue.</td>
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<td>43. I am satisfied with my relationships with others.</td>
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<td>44. I feel angry enough at work/school to do something I might regret.</td>
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<td>45. I have headaches.</td>
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</table>

Developed by Michael J. Lambert, Ph.D. and Gary M. Burlingame, Ph.D.
For More Information Call: 1-888-MH Score, (1-888-647-2671)
WEB: WWW.OQFAMILY.COM
FAX/VOICE: 1-973-366-8665
E-MAIL: APCSTAFF@EONLINE.COM

Total=

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Appendix 4

Your Client Number: _____________________  Today's Date: ___________________________

Please help us by answering some questions about the services you have received at the Clinical Psychology Center. We are interested in your honest opinions, whether they are positive or negative. Please answer all the questions. Thank you very much; we appreciate your help.

1. How would you rate the quality of the service you received?
   1 Poor
   2 Fair
   3 Good
   4 Excellent

2. Did you get the kind of service you wanted?
   1 No, definitely not.
   2 No, not really
   3 Yes, generally
   4 Yes, definitely

3. To what extent has our program met your needs?
   1 None of my needs have been met
   2 Only a few of my needs have been met
   3 Most of my needs have been met
   4 Almost all my needs have been met

4. If a friend were in need of similar assistance, would you recommend our program to him/her?
   1 No, definitely not
   2 No, I don't think so
   3 Yes, I think so
   4 Yes, definitely

5. How satisfied are you with the amount of help you received?
   1 Quite dissatisfied
   2 Indifferent or mildly dissatisfied
   3 Mostly satisfied
   4 Very satisfied

6. Have the services you received helped you to deal more effectively with your problems?
   1 No, they seemed to make things worse
   2 No, they really didn't help
   3 Yes, they helped somewhat
   4 Yes, they helped a great deal

7. In an overall, general sense, how satisfied are you with the service you received?
   1 Quite dissatisfied
   2 Indifferent or mildly dissatisfied
   3 Mostly satisfied
   4 Very satisfied

8. If you were to seek help again, would you come back to our program?
   1 No, definitely not
   2 No, I don't think so
   3 Yes, I think so
   4 Yes, definitely

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### Appendix 5

**WAI**

<table>
<thead>
<tr>
<th>Your Client Number: __________________________</th>
<th>Today's Date: __________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.</strong> I feel comfortable with my therapist.</td>
<td><strong>1</strong> <strong>2</strong> <strong>3</strong> <strong>4</strong> <strong>5</strong> <strong>6</strong> <strong>7</strong></td>
</tr>
<tr>
<td>Never</td>
<td>Rarely</td>
</tr>
<tr>
<td><strong>2.</strong> My therapist and I agree about the things I will need to do in therapy to help improve my situation.</td>
<td><strong>1</strong> <strong>2</strong> <strong>3</strong> <strong>4</strong> <strong>5</strong> <strong>6</strong> <strong>7</strong></td>
</tr>
<tr>
<td>Never</td>
<td>Rarely</td>
</tr>
<tr>
<td><strong>3.</strong> I am worried about the outcome of these sessions.</td>
<td><strong>1</strong> <strong>2</strong> <strong>3</strong> <strong>4</strong> <strong>5</strong> <strong>6</strong> <strong>7</strong></td>
</tr>
<tr>
<td>Never</td>
<td>Rarely</td>
</tr>
<tr>
<td><strong>4.</strong> What I am doing in therapy gives me new ways of looking at my problem.</td>
<td><strong>1</strong> <strong>2</strong> <strong>3</strong> <strong>4</strong> <strong>5</strong> <strong>6</strong> <strong>7</strong></td>
</tr>
<tr>
<td>Never</td>
<td>Rarely</td>
</tr>
<tr>
<td><strong>5.</strong> My therapist and I understand each other.</td>
<td><strong>1</strong> <strong>2</strong> <strong>3</strong> <strong>4</strong> <strong>5</strong> <strong>6</strong> <strong>7</strong></td>
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<tr>
<td>Never</td>
<td>Rarely</td>
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<tr>
<td><strong>6.</strong> My therapist perceives accurately what my goals are.</td>
<td><strong>1</strong> <strong>2</strong> <strong>3</strong> <strong>4</strong> <strong>5</strong> <strong>6</strong> <strong>7</strong></td>
</tr>
<tr>
<td>Never</td>
<td>Rarely</td>
</tr>
<tr>
<td><strong>7.</strong> I find what I am doing in therapy confusing.</td>
<td><strong>1</strong> <strong>2</strong> <strong>3</strong> <strong>4</strong> <strong>5</strong> <strong>6</strong> <strong>7</strong></td>
</tr>
<tr>
<td>Never</td>
<td>Rarely</td>
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<tr>
<td><strong>8.</strong> I believe my therapist likes me.</td>
<td><strong>1</strong> <strong>2</strong> <strong>3</strong> <strong>4</strong> <strong>5</strong> <strong>6</strong> <strong>7</strong></td>
</tr>
<tr>
<td>Never</td>
<td>Rarely</td>
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<tr>
<td><strong>9.</strong> I wish my therapist and I could clarify the purpose of our sessions.</td>
<td><strong>1</strong> <strong>2</strong> <strong>3</strong> <strong>4</strong> <strong>5</strong> <strong>6</strong> <strong>7</strong></td>
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<tr>
<td>Never</td>
<td>Rarely</td>
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<tr>
<td><strong>10.</strong> I disagree with my therapist about what I ought to get out of therapy.</td>
<td><strong>1</strong> <strong>2</strong> <strong>3</strong> <strong>4</strong> <strong>5</strong> <strong>6</strong> <strong>7</strong></td>
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<tr>
<td>Never</td>
<td>Rarely</td>
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<tr>
<td><strong>11.</strong> I believe the time my therapist and I are spending together is not spent efficiently.</td>
<td><strong>1</strong> <strong>2</strong> <strong>3</strong> <strong>4</strong> <strong>5</strong> <strong>6</strong> <strong>7</strong></td>
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<tr>
<td>Never</td>
<td>Rarely</td>
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<tr>
<td><strong>12.</strong> My therapist does not understand what I am trying to accomplish in therapy.</td>
<td><strong>1</strong> <strong>2</strong> <strong>3</strong> <strong>4</strong> <strong>5</strong> <strong>6</strong> <strong>7</strong></td>
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<td>Never</td>
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<td>13.</td>
<td>I am clear on what my responsibilities are in therapy.</td>
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<td>14.</td>
<td>The goals of these sessions are important to me.</td>
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<td>15.</td>
<td>I find what my therapist and I are doing in therapy are related to my concerns.</td>
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<td>16.</td>
<td>I feel that the things I do in therapy will help me to accomplish the changes that I want.</td>
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<td>17.</td>
<td>I believe my therapist is genuinely concerned about my welfare.</td>
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<td>18.</td>
<td>I am clear as to what my therapist wants me to do in these sessions.</td>
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<td>19.</td>
<td>My therapist and I respect each other.</td>
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<td>20.</td>
<td>I feel that my therapist is not totally honest about his/her feelings toward me.</td>
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<td>21.</td>
<td>I am confident in my therapist's ability to help me.</td>
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<td>22.</td>
<td>My therapist and I are working towards mutually agreed upon goals.</td>
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<td>23.</td>
<td>I feel that my therapist appreciates me.</td>
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<td>24.</td>
<td>We agree on what is important for me to work on.</td>
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<td>25.</td>
<td>As a result of these sessions I am clearer as to how I might be able to change.</td>
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<td>26.</td>
<td>My therapist and I trust one another.</td>
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<tr>
<td>27.</td>
<td>My therapist and I have different ideas on what my problems are.</td>
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<tr>
<td>28.</td>
<td>My relationship with my therapist is very important to me.</td>
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<td>29.</td>
<td>I have the feeling that if I say or do the wrong things, my therapist will stop working with me.</td>
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<td>30.</td>
<td>My therapist and I collaborate on setting goals for my therapy.</td>
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<td>31.</td>
<td>I am frustrated by the things I am doing in therapy.</td>
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<td>32.</td>
<td>We have established a good understanding of the kind of changes that would be good for me.</td>
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<td>33.</td>
<td>The things that my therapist is asking me to do don’t make sense.</td>
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<td>34.</td>
<td>I don’t know what to expect as the result of my therapy.</td>
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<td>35.</td>
<td>I believe the way we are working with my problem is correct.</td>
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<td>36.</td>
<td>I feel my therapist cares about me even when I do things that he/she does not approve of.</td>
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Appendix 6

Therapist Measure

Last Four Digits of Your Social Security Number ____________  Today’s Date: ____________

1. How many years have you been seeing clients in practicum, either at U of M or at a prior graduate school?
   A. 0
   B. 1
   C. 2
   D. 3
   E. 4
   F. 5

2. Which best describes your preferred method of developing a plan for treatment for your client?
   A. Developing a plan for treatment based on your assessment of client’s problems and needs.
   B. Asking your client about goals for therapy, and using client’s response to guide treatment.
   C. Asking your client about goals for therapy, and combined with your own view of client’s needs, develop a plan for treatment.
   D. Writing a treatment plan.
   E. I have never seen a client.

3. Which activities or resources do you most frequently utilize in developing a plan for treatment for your client?
   A. Discuss with supervisor
   B. Resource books
   C. Practicum
   D. I have never seen a client.

4. How frequently do you refer to or discuss your plan for treatment, or the goals of treatment, with your client in session.
   A. Nearly every session
   B. Frequently
   C. Rarely
   D. Never

5. How much have you written treatment plans for therapy clients?
   A. A lot.
   B. Some.
   C. Rarely
   D. Not at all
   E. Never, I have never seen a client.
6. What is your general attitude toward written treatment plans?
   A. Extremely positive
   B. Moderately positive
   C. Neutral
   D. Moderately negative
   E. Extremely negative

7. What is your view of the effect that written treatment plans have on your psychotherapy clients?
   A. Extremely positive effects
   B. Moderately positive effects
   C. No effects
   D. Moderately negative effects
   E. Extremely negative effects

8. Which of the following statement describes the effect of written treatment plans in your opinion? You may choose more than one, however, please rank the multiple items you choose, with 1 being the statement you agree with most, and the highest number the item you agree with least but is still an accurate statement.
   A. Adds unnecessary paperwork for the therapist.
   B. Helps the therapist develop ideas and a plan of action for treating the client.
   C. No effect at all.
   D. Helps client think about what s/he wants to get out of therapy.

9. To what extent do you agree with this statement: how therapy progresses should always be determined jointly by client and therapist.
   A. Strongly Agree
   B. Agree
   C. Disagree
   D. Strongly Disagree

10. To what extent do you agree with this statement: clients should rarely participate in the selection of therapy interventions.
    E. Strongly Agree
    F. Agree
    G. Disagree
    H. Strongly Disagree
Appendix 7

Statement Read at First Practicum: Year 2

[Written Treatment Plan]

I've been asked by Andrea Neal to read this to give you some information about data collection that's going on here at the CPC. For those of you who don't know her, Andrea is a 6th year student who is currently on internship in [other state]. What I read now will be a brief introduction to the study but you will get more information next week at practicum.

Outcome measures are being collected at the CPC to be used for Andrea's dissertation and for the CPC's use to examine client outcomes. There are only certain clients who are asked to be subjects in the study. They are adult individual clients. Couples, families, adolescents, and children are not included in the study, although these other types of clients are asked to complete some outcome measures for use by the CPC.

Here is what you need to know now. Let me just say first that all this may be a little confusing for 2nd year students new to practicum. [CPC Assistant] will explain CPC procedures in her orientation and this may help clarify things for you.

The OQ 45.2 (the Outcomes Questionnaire) is the measure to be filled out by the client at the very first session. This will be in the new file packet for you to give to your client to complete.

You will have two informed consents to review with the client. These forms will also be found in the new file packet. The first is the CPC informed consent for treatment. The second is the IRB informed consent for this research. You have a sheet titled, "Statement Made by Therapist to Client at First Session about Research" which is a protocol for you to use to explain the research and consent form. You may read this word-for-word or use it as a guide. The most important points that the client needs to know is that the research is voluntary, it is anonymous, and the client can withdraw at any time. If the client agrees to be a subject, have him/her sign consent form that first session and sign as witness.

The OQ and the consent form go to [CPC Administrative Assistant] with all the other new client paperwork. Data will be collected every three months and at the termination session. You will be notified when it is time to collect more data from your client.

Andrea's dissertation is looking at the effects of differences in treatment planning. This practicum group will be using a form to write treatment plans for your clients. Andrea will give you more information about how to write treatment plans next week. The practicum groups are different so the instructions and handouts that you receive are for your practicum group only.

Thanks to everyone for your help with this. Andrea will talk to you next week with a conference call to explain everything more thoroughly.
Appendix 8
Statement Read at First Practicum: Year 2
[Treatment as Usual]

I've been asked by Andrea Neal to read this to give you some information about data collection that's going on here at the CPC. For those of you who don't know her, Andrea is a 6th year student who is currently on internship in [other state]. What I read now will be a brief introduction to the study but you will get more information next week at practicum.

Outcome measures are being collected at the CPC to be used for Andrea's dissertation and for the CPC's use to examine client outcomes. There are only certain clients who are asked to be subjects in the study. They are adult individual clients. Couples, families, adolescents, and children are not included in the study, although these other types of clients are asked to complete some outcome measures for use by the CPC.

Here is what you need to know now. Let me just say first that all this may be a little confusing for 2nd year students new to practicum. [CPC Assistant] will explain CPC procedures in her orientation and this may help clarify things for you.

The OQ 45.2 (the Outcomes Questionnaire) is the measure to be filled out by the client at the very first session. This will be in the new file packet for you to give to your client to complete.

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The OQ and the consent form go to [CPC Administrative Assistant] with all the other new client paperwork. Data will be collected every three months and at the termination session. You will be notified when it is time to collect more data from your client.

Andrea's dissertation is looking at the effects of differences in treatment planning. This practicum group will conceptualize the client's treatment based on information that you gather from the client and using feedback from your supervisor. Some of you may have been in a practicum group last year in which you used a form as part of the treatment planning. You will not be using the form this year. The practicum groups are different so the instructions and handouts that you receive are for your practicum group only.

Thanks to everyone for your help with this. Andrea will talk to you next week with a conference call to explain everything more thoroughly.
Appendix 9  
Treatment Planning Protocol

First Session

1. Discuss with the client what s/he would like to get out of therapy. You can gather this information in a variety of ways. Here are some suggestions for probe questions:

- What are your goals for therapy?
- What do you want to be different about your life when you are done with therapy?
- How will you know when you are done with therapy?
- If, after therapy is done, you look back and say, “that was worthwhile,” how will things be different? How will things have changed?
- The Solution-Focused “Miracle Question:” Imagine that a miracle happened, and your problem was magically solved, how would you know that your problem was gone? What would be different about your life?

2. Tell the client that you will be creating a treatment plan together, and in a few sessions you will put together some ideas, based on your discussions, to talk over with the client.

3. Start forming ideas about what the person’s main problem is. Ideally, this is what the client states to be the reason for therapy. The client may have more than one main problem, and you will develop treatment goals for how many problems seem important to address. Your supervisor can help you decide what and how many problems to focus on.

After the First Two Sessions

1. Start to draft the treatment plan.

2. The components of the treatment plan are as follow. These are discussed in more detail below.

   - Problem
   - Goal
   - Objectives
   - Intervention

A. Problem

- The problem is what you and your client see as his/her area of needing change. A problem may fit a diagnostic category, such as “depression.” It may be related to life events, such as “childhood sexual abuse” or “recent death of parent.”

- Describe the problem and the behaviors by which the client manifests that particular problem. For example, the problem of depression may be described for a particular client as “depression with social isolation, inactivity, and rumination about past events.”

B. Goal

- The goal is the positive outcome as a resolution to the problem described above. These goals are broad and long term. You will get more specific about what this goal looks like with the objective.
Commitment: It is important that the client is committed to attaining this goal, so try to base the goal on the client’s ideas about the problem and resolution of the problem. If you and the client have differences in opinion about what the goal should be, you should discuss this in session to come to a compromise. This will be addressed in more detail later. Commitment is also increased when the goal is seen as attainable.

Self-Efficacy: Work to increase the client’s confidence that s/he can actually reach this goal someday.

Example of Goals:
- Relief of depression as indicated by BDI score of less than 9.
- Employed in fulfilling career.

C. Objective

The objectives are the behaviors and changes made by the client during the therapy process. Think of these as the small steps necessary for the client to take to reach that big goal of therapy. Develop at least two objectives per problem. There are some important things to remember when developing objectives:

1. **Be specific.** When appropriate, include frequency and duration.
2. **Consider the client’s ability level.** It is important that the objective is attainable; however, it is important that the objective is not too easy also. When developing the objective, it may be best to push the client a little from where s/he currently is.
3. **Ensure that the client is committed to the objective.** Just like the goal, commitment is important. This may mean that you will need to give some explanation for a particular objective.

For example, you have the following objective for your client: *Increase recreational activities to 3 activities a week.* You can, hopefully, increase commitment to the goal by explaining, *“research has shown that an important factor in improving depression may be to increase the amount of activities in your daily life that give you a sense of mastery and pleasure. By increasing pleasurable activities in your daily life, this will likely improve your depression.”*

Another example of an objective for someone with a PTSD diagnosis may be: *Maintain calm affect while imagining traumatic event.* To increase the commitment to this goal, you can explain the reasons and likely benefits of using exposure in treating PTSD.

Note: An objective does not need to be behavioral in the sense that it is a specific overt behavior or activity to be exhibited. An objective may be insight-oriented, for example, *“the client will verbalize an understanding of...”*

D. Intervention

The interventions are the activities that you will do in the therapy session to assist the client in attaining his/her goal. In determining the interventions, look to the particular treatment model used in your practicum group, and the empirical research on the treatment of the problem. Your supervisor can assist you in this.

Be specific in describing these interventions.
After Drafting Your Treatment Plan:
Discuss the treatment plan draft with your supervisor. Make changes as necessary.

Presentation of Treatment Plan:
Present the treatment plan to the client in the next session.

➢ Briefly explain the different components of the treatment plan. For example, you may say:

“This treatment plan has these different sections. The first section is what seems to be the main problem you have that you want help for. The goal is your long-term goal for therapy - basically what it would look like to have this problem solved. The objectives are your smaller goals to help you reach that long-term goal. You can think of the objectives as the steps in a staircase with the long-term goal as the top. The interventions are the things that I am going to do to help you achieve those objectives.”

➢ Talk to the client about your description of the problem. As noted above, this may be slightly different than how the client perceives it. Discuss any differences in perception with the client, work to find a compromise, and modify the plan accordingly. Review the long-term goal, the objectives, and the intervention with the client. Ask for questions, comments, any additions or changes that the client thinks should be made.

➢ You may not want to make changes to the treatment plan right there in this session. You can always say, "I would like to think more about this in the next week. Let’s be sure to talk about it and figure it out when we see each other next." Then you can talk with your supervisor about how to include your client’s ideas.
Appendix 10

Treatment Planning Protocol [Treatment as Usual]

First Session:
1. Talk with client in the first session about what s/he would like to get out of therapy.
2. Gather detailed information about the issues for which client is seeking therapy.

After the Initial Sessions:
1. Develop a conceptualization of client’s problem(s) and those factors related to the problem. Your supervisor can assist with this.
   Examples:
   a. depression exacerbated by social isolation, unemployment, inactivity
   b. anxiety problems (R/O anxiety disorder, nos) especially in social situations, with poor social skills
   c. overwhelmed by stress due to job loss, with limited support network, and poor coping skills
2. Decide what therapeutic interventions would be most appropriate to treat client's problem with assistance of supervisor
3. Implement therapeutic interventions.
First Meeting with Client:

1. Get OQ 45.2 and other intake forms from the new files that are already made up in file cabinet.
2. Have client fill out OQ 45.2 before session.
3. Talk to client about research including bulleted points on “Statement Made by Therapist to Client at First Session about Research.” [The CPC Administrative Assistant] has extra copies of this document. Each practicum group is different.
4. Have client sign research informed consent, this will be with the new client documents.
5. Put all client’s documents in “new file” hanging folder in bottom drawer of file cabinet in AV closet. [CPC Administrative Assistant] will create a new folder for you.

Treatment Planning

1. Develop treatment plan with client at the 3rd session. Get the treatment plan form from the “Treatment Plan” hanging folder. This folder is in the file drawer where all other client documents are kept (top drawer, 2nd file drawer in, computer lounge). You may disregard the part on the treatment plan that says: “Estimated Number of Sessions” and “GAF.”
2. Put copy of treatment plan in bottom drawer of file cabinet in AV closet. You can charge this copy to my account 4358, but I will get you if you charge other copies to it!
3. You will get a reminder if there is not a copy of the treatment plan in the folder after about a month after your intake session.

Note: It is totally understandable that you haven’t written a treatment plan if you have not seen your client weekly since the intake, or you and your client are working to agree about the goals and objectives of the treatment plan. The three-week goal is ideal because at that point you will likely start focusing treatment, and also this is an attempt to keep procedures uniform across subjects. However, it won’t be possible to complete the treatment plan by the 3rd session in all instances.

If Your Client Stops Attending:

Notify [Student Research Assistant] as soon as you decide to terminate this client’s file. A letter and the measures will be sent out for them to complete.

Information will be coming about what to do when your client terminates, and at the three-month intervals.

THANK YOU THANK YOU THANK YOU for your help with this! Email me if you have questions, concerns, or suggestions...[email address].
Appendix 12

Chain of Events [Treatment as Usual Condition]

First Meeting with Client:

1. Get OQ 45.2 and other intake forms from the new files that are already made up in file cabinet.
2. Have client fill out OQ 45.2 before session.
3. Talk to client about research including bulleted points on “Statement Made by Therapist to Client at First Session about Research.” [CPC Administrative Assistant] has extra copies of this document. Each practicum group is different.
4. Have client sign research informed consent, this will be with the new client documents.
5. Put all client’s documents in “new file” hanging folder in bottom drawer of file cabinet in AV closet. [CPC Administrative Assistant] will create a new folder for you.

Treatment Planning

Follow treatment planning instructions as described in the handout I gave you at practicum.

If Your Client Stops Attending:

Notify [Student Research Assistant] as soon as you decide to terminate this client’s file. A letter and the measures will be sent out for them to complete.

Information will be coming about what to do when your client terminates, and at the three-month intervals.

THANK YOU THANK YOU THANK YOU for your help with this! Email me if you have questions, concerns, or suggestions...[email address].
Appendix 13
Statement Made by Therapist to Client at First Session about Research
[Written Treatment Plan Condition]

- As you probably already know, this clinic is part of the University of Montana and all of the therapists, including myself, are graduate student therapists. That is why the sessions are videotaped so that the therapists can be supervised by psychology faculty.
- Another part of the psychology department involves studying and conducting research, and this is to learn more about how to help our clients. We are conducting a research project here at the CPC and are asking all of our clients to be part of this research.
- This is totally voluntary, and all the information that will be used for research will be totally anonymous. You may also withdraw from the research at any time.
- The purpose of the research is to study certain things that therapists can do, like talking about your goals for therapy, that may enhance the benefits that clients get from therapy.
- As part of the study, you will work on your goals, and then we will write down a plan in the first few sessions.
- There are questionnaires that we ask everyone to fill out when you first start, and then every once and a while during your treatment. That information is used to help us learn about how the clinic is running. If you agree to be part of the research project, then this information will also be used as data for the research.
- Do you have any questions? You may look over this consent form, and by signing it, you are agreeing that your information may be included in this research project.
Appendix 14
Statement Made by Therapist to Client at First Session about Research
[Treatment as Usual]

- As you probably already know, this clinic is part of the University of Montana and all of the therapists, including myself, are graduate student therapists. That is why the sessions are videotaped so that the therapists can be supervised by psychology faculty.

- Another part of the psychology department involves studying and conducting research, and this is to learn more about how to help our clients. We are conducting a research project here at the CPC and are asking all of our clients to be part of this research.

- This is totally voluntary, and all the information that will be used for research will be totally anonymous. You may also withdraw from the research at any time.

- The purpose of the research is to study certain things that therapists can do, like talking about your goals for therapy, that may enhance the benefits that clients get from therapy.

- In your treatment at the CPC we'll talk about what you want to be different about your life, and I'll also get some information about your background and history. Then we'll start to focus on the problem you came here for.

- There are questionnaires that we ask everyone to fill out when you first start, and then every once and a while during your treatment. That information is used to help us learn about how the clinic is running. If you agree to be part of the research project, then this information will also be used as data for the research.

- Do you have any questions? You may look over this consent form, and by signing it, you are agreeing that your information may be included in this research project.
## Sample Treatment Plan

**Clinical Psychology Center**

**University of Montana**
1444 Mansfield Avenue
Missoula, Montana 59812
Phone: 406-243-4523

**Estimated Sessions:** 12
**GAF**: 

### Client Name: John Doe

**Client Number:** 01-01

**Problem:** Depression with symptoms of depressed mood, decreased activities, and poor sleep.

**Objective 1:** While building strategies to overcome depression through increasing activity, John will participate in 2 recreational activities weekly.

**Intervention:**
1. Assign homework task of logging daily activities.
2. Develop plan for participation in recreational activities.
3. Explore barriers to doing activities as they come up.

**Problem:** Interpersonal isolation—few close friends and limited intimacy with friends and family.

**Objective 2:** Develop 3 new acquaintance relationships.

**Intervention:**
1. Assess social skills and provide instruction as necessary.
2. Develop list of potential situations.
3. Problem-solve difficulties when trying to meet new people.

**Problem:** Increase intimacy of current relationships as indicated by seeking support from family when under stress and sharing personal details with family.

**Intervention:**
1. Explore barriers to seeking support from family members.
2. Reinforce support-seeking efforts in session.

---

**Client Signature:** John Doe

**Date:** 9/11/01

**Therapist Signature:** Janet Doe

**Date:** 9/11/01

**Supervisor Signature:** Janet Doe

**Date:** 9/11/01

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