Pretherapy training and its effects on attitudes toward psychotherapy

J. Scott Hickey

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PRETHERAPY TRAINING AND ITS EFFECTS ON ATITUDES TOWARD PSYCHOTHERAPY

By
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B.A., Antioch College, 1974

Presented in partial fulfillment of the requirements for the degree of Master of Arts UNIVERSITY OF MONTANA 1979

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The present study investigated the effects of pretherapy training on analogue subjects' attitudes toward psychotherapy in general, and toward a specific psychotherapist, portrayed on videotape. On the specific attitude measure, the study employed a $2 \times 2$ factorial design with two repeated measures. The first factor represented a median split on the general attitude measure, and the second factor represented the treatment/control variable. On the second dependent measure, general attitude toward therapy, a $2 \times 2$ factorial design was employed (treatment/control $\times$ pre/post). Several hypotheses were offered, including: 1) that pretherapy training would reduce subject uncertainty about requirements of the patient role, and therefore engender more positive attitudes on both the general and specific measures; 2) that subjects initially more negative in general attitude would demonstrate the largest gains on both measures; and 3) that the general and specific measures would be significantly related to each other. Only the third hypothesis was supported. Results failed to substantiate any effect for the pretherapy training. Instead, initial attitude, as measured on the general attitude scale, was the only significant determinant of post-test scores, or pre-post differences on either of the measures. These results were discussed in the light of de-briefing data suggesting a lack of realism in the analogue employed. Additional analyses, examining the effects of awareness of the experimental hypotheses, produced a chance number of significant tests. Interpreted cautiously, they may suggest that aware subjects were more likely to change in a positive direction on the specific attitude measure.
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Chapter I

INTRODUCTION

In a broad survey of public attitudes toward mental health, Nunnally (1961) concluded that public doubt stems not from distrust of mental health professionals, but from distrust of the "methods and institutions with which they are associated." (p. 64) At that time, methods for treating cancer were rated more favorably by this sample than were methods for treating mental illness.

Public distrust of the treatment methods of the psychotherapist may be less surprising when the expectations of patients entering treatment are examined. These negative attitudes may be influenced as much by misinformation, or a lack of clear expectations, as by any other factor. As Frank (1961) has noted:

> Because of the diversity and the ambiguities of public conceptions of mental illness and psychotherapy, psychiatric patients reach the psychiatrist's office with a wide variety of attitudes and expectations. Only the most sophisticated are clear about why they are there and what they expect. (p. 128)

The unsophisticated patient may frequently arrive for therapy with a vague conception, or a strong misconception, of the treatment process. His role within the therapeutic relationship may, from his point of view, appear ambiguous at best. Unless these attitudes and expectations are clearly examined, a mutual understanding of the process, content, and goal of therapy is likely to be achieved with
difficulty, if at all. It is conceivable that many patient behaviors interpreted as unworkable resistance, poor motivation, lack of psychological-mindedness, or pathological dependency may reflect confusion about the nature of the therapeutic process or a misunderstanding of the patient role. When the attitudes and expectations of patient and therapist are widely discrepant, some conflict is likely generated. This conflict may contribute to notoriously high rates of premature termination. A recent review (Baekeland & Lundwell, 1975) estimated a 20 to 57 percent dropout rate from outpatient psychiatric clinics. It may also contribute to notoriously poor outcomes with unsophisticated patient groups, such as those from the lower socioeconomic classes (Heitler, 1974; Jones, 1974).

If vague or misguided patient conceptions of treatment are potential contributors to therapy failures, then attempts at identifying patients with false or negative attitudes toward psychotherapy may yield a group requiring special preparation before beginning treatment. Techniques aimed at socializing the patient for his role in treatment may help curtail the number of patients deemed failures and may facilitate the process of therapy for those who might otherwise succeed in therapy without the technique, after more haphazard attempts at socialization.

A review focusing on two related lines of research will be presented. First, reports of patient and therapist expectations of the therapy process, especially as related to patient and therapist role behaviors, will be examined. Second, attempts at modifying
patient role behaviors through various pretherapy training techniques will be evaluated. The review encompasses the years 1960 to 1978.

The current investigation will be an attempt to explore and clarify the effects of these pretherapy training techniques. An increased understanding of the effective components of these training procedures may prove of value in identifying those patients most likely to benefit from pretherapy socialization.

Patient Expectations

Type of preferred treatment. The patient judged by himself or others to require professional mental health services may arrive in treatment with definite opinions regarding the preferred mode of treatment. When the choice of treatment modalities is made explicit, a surprising number of patients prefer psychotherapy over other treatment modalities. Garfield and Wolpin (1963) surveyed first referrals to a psychiatric training clinic and reported that nearly ninety percent of their sample preferred psychotherapy to medication, other medical treatment, or just "rest." Other investigators have reported comparable results in similar settings. When choices were limited to medication, receiving advice, or talking about one's past life, eighty-six percent of patients in another psychiatric setting chose the talking cures over medication (Goin, Yamamoto & Silverman, 1965).

When the treatment options are not made explicit, a large number of patients are unable to state their preferences (Hornstra, Lubin, Lewis & Willis, 1972). In a study of over 600 applicants for
service at a community mental health center, Hornstra and his associates reported that over thirty percent of patients were unable to state a preference, despite the fact that nearly two-thirds had received previous psychiatric treatment within the past two years. Relatives of patients were also surveyed when possible. These relatives fared no better in stating a preferred mode of treatment for the identified patient. When treatment options were subsequently presented in a multiple choice format, about fifty percent of patients and relatives preferred "talk" to other forms of treatment. Interestingly, patients preferred "talk as needed," while their relatives suggested "regular talk."

Heine and Trosman (1960) divided their sample of referrals to a university psychiatric clinic into two groups with respect to treatment preference: those who desired medication or diagnostic information and those who desired advice or help in changing problem behaviors. All patients received psychotherapy with no medication. Not surprisingly, premature termination from therapy was associated with an unmet desire for medication or diagnostic information.

In a study of attendance patterns among depressed outpatients, a group of investigators (Dezkin, Weissman, Tanner & Pursoff, 1975) reported that a majority of subjects held positive attitudes toward psychotherapy at the onset of therapy. All patients were treated with psychotherapy and an antidepressant drug. As the chemotherapy began working, attitudes toward psychotherapy began declining. At the end of treatment only thirty-three percent maintained positive
attitudes toward psychotherapy, with over half claiming neutrality. This investigation was reported in insufficient detail to determine what constituted "attitude toward therapy." It is conceivable that those who responded favorably to treatment no longer wished to continue.

To summarize, it appears that when given clear choices, the majority of referrals to outpatient clinics prefer psychotherapy over other forms of treatment. The relatives of patients appear to concur. A large number of these patients may arrive at clinics with limited knowledge of available options and no clear preferences, despite recent exposure to these services. Their expectations regarding mode of treatment may be vague indeed.

Duration. The data on treatment dropouts and premature terminators is somewhat discouraging. As mentioned above, unselected samples of outpatients defect from treatment at rates as high as 57 percent (Baekeland & Lundwell, 1975). When the expectations of patients are taken into account, however, the terms "dropout" and "premature termination" appear largely related to perspective of the therapist.

Garfield and Wolpin (1963) have collected the most detailed data with respect to patient expectations of duration of treatment. When this sample of seventy was asked to estimate the length of the treatment sessions, the largest number (39%) chose fifty minutes. A nearly equal number, however, believed sessions would last only thirty minutes. Ten percent believed they would be seen twenty minutes or
less. One-third of these patients expected some improvement by the second interview; another third thought five sessions would produce improvement; and fully seventy percent expected a cure within ten sessions.

The results of another investigation tend to confirm the notion that a large number of patients expect to make a small number of visits with good results. Goin et al. (1965) reported that the modal number (44%) of expected visits in his sample was three to ten. One of every six patients expected to make only one or two visits. Expected duration of treatment was unrelated to preferred mode of treatment or to sex of patient in this sample.

It appears that the typical clinic outpatient expects to make ten or fewer visits and expects complete improvement of target symptoms within this period. On the basis of large surveys, the modal number of outpatient visits to mental health facilities has been estimated at four to eight (Saltzman, Luetgert, Roth, Creaser & Howard, 1976). Furthermore, the typical patient may prefer infrequent sessions as needed to regular weekly interviews (Hornstra et al., 1972). It would appear that many so-called dropouts and premature terminators would not consider themselves as such. They remain in therapy as long as they had planned. In fact, one might argue that their expectations are more realistic than those of therapists, since they more closely resemble the true state of affairs.

Patient role. Comparisons between patient expectations and reality with respect to frequency and duration of therapy are readily
made. In the area of patient role expectations, clear evaluation of veridicality is more difficult. Different forms of psychotherapy appear to place different demands on the patient. The theoretical orientation of the therapist plays a part in establishing the patient role. To date, some preliminary attempts have been made to differentiate modes of psychotherapy on the basis of required and encouraged patient behaviors (e.g., emphasis on reporting fantasy material). Sloane, Staples, Cristol, Yorkston, and Whipple (1975), for instance, attempt to differentiate dynamically oriented and behavioral psychotherapies on such a basis. As yet, such definitions appear largely descriptive and are far from establishing differentiated patient roles. Some generalization across modes of therapy appears warranted. Gomes-Schwartz, Hadley, and Strupp (1978) have commented:

> In most forms of individual therapy, the patient is expected to collaborate actively in the treatment process by forming a working alliance with the therapist and by experiencing and expressing affect. (p. 438)

Patients, however, appear to differ widely in expected roles within the treatment relationship. The amount of responsibility the patient is willing to accept in his own treatment has received a great deal of attention. The patient's preferred treatment modality may, of course, reflect his preferred role. Patients expressing a desire for chemotherapy may be expressing an unwillingness to join in active collaboration with a therapist. They may prefer treatments requiring less personal commitment. As discussed above, these patients represent a minority of clinic caseloads.
Among patients preferring talk over medication, finer discriminations can be made. Goin et al. (1965), for instance, reported that while half of their sample wanted and expected to talk about their past life, one-third expected to receive advice. When those expecting advice were divided into two groups, half receiving the desired advice and half receiving less directive treatment, no differences were apparent in attendance or in client satisfaction. A nonsignificant trend favoring "advice" patients may have reached significance in a larger sample (only 40 patients were studied).

Heine and Trosman (1960) found that patients who sought advice but did not receive it tended to leave treatment in significantly greater numbers. One-third of another sample (Garfield & Wolpin, 1963) felt that advice and guidance were the most important therapist activities. Forty-six percent expected their therapist to spend ten percent of his time (the lowest alternative) in giving advice, but 45 percent expected 30 to 50 percent of therapy hours to be devoted to advice. A full 90 percent expected some guidance by the fifth interview. Perhaps these strong expectations for advice are bolstered by the belief of 40 percent of this sample that psychiatrists can "read your mind about at least a moderate number of things." When faced with a professional one believes capable of penetrating unexpressed feelings, the need for active expression of affect may seem less pressing.

Lennard and Bernstein (1960) reported an extensive investigation of the therapy process. Although the sample size (N=11) was
very small, a great deal of detailed data was collected. In examining the role expectations of their patients, they found that all eleven expected to be more active and to talk more than their therapist. Six questions designed to tap expectations of specific therapist activities were presented:

Will the therapist:
1) suggest what to talk about next?
2) prohibit the patient from doing things he considers inadvisable?
3) counsel or advise the patient on the management of day-to-day living?
4) explain what therapy is all about?
5) reassure the patient and be sympathetic when he feels depressed or unhappy?
6) discuss politics or other issues of the day with the patient?

While therapists didn't reach full agreement on these activities, each appeared to have definite beliefs. Patients did not. The average patient-therapist pair disagreed on three of the six items. The impact of these disagreements, to be discussed more fully below, was apparent in the proportion of interview time spent socializing the patient to his role.

It appears that, as Frank (1961) has suggested, the typical psychotherapy patient arrives for treatment with vague expectations of the role he is to take in the treatment process. While clinical lore has it that many patients want their therapists to "do all the work," it is possible that many of these patients are merely uncertain about their own role in the process of therapy. Garfield and Wolpin (1963) noted that patients seem to know that they need to cooperate, but often have little sense of what that means. These
authors felt that some of their patients sensed that they might fail to fulfill the role of patients, and therefore fail to get the help they need.

**Type of therapist.** Certain expectations of therapist personality seem implicit in the beliefs discussed thus far. Patients expecting direct, active therapists tell us as much about their ideal therapist as they do about their beliefs concerning the process of psychotherapy. Clearly, some variability is present in patient expectations on this dimension.

The utility of data in differentiating among client expectations of therapist type varies with the methodology employed to obtain it. Perhaps the simplest and least useful data have been gathered via sentence completion or open-ended questions. Using this method, patients report the expectation of a sympathetic, sincere, interested, and competent person who is unlikely to criticize or be pessimistic (Garfield & Wolpin, 1963). After terminating therapy, only a small percentage of patients complain of passive, weak therapists (2%) or cold, distant, disinterested therapists (6%) (Strupp, Fox & Lessler, 1969).

In a medical setting, Ruesch (1948) found patients expected one of three types of physician: 1) nurturant, 2) authoritative, or 3) "ideal" in personality. This is merely an intuitive typing of open-ended questionnaire data.

Apfelbaum (1958) employed cluster analysis of pretherapy Q-sorts of outpatients at a university clinic. Patients were instructed
to sort in a manner representing the therapist with whom they anticipated working. The cluster analysis yielded three types: 1) nurturant, 2) critical, and 3) well-adjusted listener, or model therapist. Apfelbaum believed these role-expectancy types represented stable and enduring attitudes. Furthermore, he believed them indicative of some dimensions of transference. Similar types have been reported by other investigators (Lorr, 1965; Rickers-Ovsiankina, Geller, Berzins and Rogers, 1971).

Rickers-Ovsiankina and her associates (1971) have adopted a similar three-category typology in an attempt to develop a scale to measure these expectancies. The nurturant, critical, and self-reliant types are seen as denoting the respective expectancies of "being taken care of," "being straightened out," and "being helped to help oneself." A fourth type, "cooperative," was added to represent the peer-like position of the successful patient at the end of therapy. Sample items include: "(How strongly do you expect) to be concerned with the impression you make on your therapist? (nurturant); to have your logic scrutinized? (critical); to initiate the conversation? (self-reliant); to act as though you and your therapist were equals? (cooperative)" (p. 124). Although the Patient Expectancy Inventory appeared to possess reasonably adequate homogeneity (internal consistency estimates in the .70's and .80's and good discriminant validity relative to the Marlowe-Crowne Social Desirability Scale and the Rotter Locus of Control Scale, it appeared less reliable with male subjects and displayed only modest stability coefficients (four week re-test: \( r = .56 - .76 \)). These patient
self-ratings of patient in-therapy behaviors devised to reflect these four roles. Finally, Berzins, Freedman, and Seidman (1969) have reported moderate correlations between scale items and patient A-B status. The A-B scale, a small number of items taken from the Strong Vocational Interest Blank, involves varying degrees of interest in selected activities of a manual, technical, or mechanical nature (A's dislike these activities, B's like them). In this investigation, A's showed symptoms of depression more frequently than did B's. Surprisingly, it appears that A's, despite their lack of energy, expect to take on an active, productive role in therapy. On the other hand, B's most strongly expected rational guidance and correctives. At the time of publication, the Patient Expectancy Inventory appeared to hold promise, but since that date no refinements have been reported.

In summary, patients may bring a variety of expectations of therapist type to the clinic. Research has corroborated at least three expectation types: nurturant, critical, and self-reliant. These types have been seen as indicators of transference (Apfelbaum, 1958), as patient roles created by both therapist and patient, and as rough indicators of progress in therapy (Rickers-Ovsiankina et al., 1971). Effects of these expectations on the therapy process will be considered below.

Socioeconomic status. A number of investigators have attempted to establish a relationship between therapy expectations and social class. Difficulties in applying psychotherapy to lower-income patients (e.g., Lorion, 1974) have prompted examination of expectations as
possible contributors to frequent therapy failures. Controversy continues regarding class differences in expectations.

Jones (1974) has contended that:

The only class-linked client characteristic that does seem associated with the psychotherapeutic process and outcome—that is, the relationship has substantial empirical support—is the client's expectations about psychotherapy. (p. 315)

Jones appears to have strongly overstated his case. Some support for his contention is forthcoming, but it is equivocal support. Aronson and Overall (1966) reported limited class differences in expectation. In surveying lower- and middle-class referrals to two clinics, these investigators reported essentially two areas of class-related expectation. First, middle-class patients expected to focus less on purely physical problems. Second, the lower class more often expected the therapist to be supportive, directive, and active. These findings were interpreted as showing a difference in expectation of technique but not necessarily in the content matter of therapy. Unfortunately, methodological flaws, such as the oral presentation of questionnaires without proper "blinds," make these data potentially unsound.

These authors had previously attempted to relate the presumably class-linked bias toward active, directive therapists to dropping out of therapy (Overall & Aronson, 1963). The entire sample was selected from the lower socioeconomic strata. Thus, class differences are assumed rather than demonstrated. These two reports alone constitute
Jones' (1974) "substantial empirical support."

Lorion (1974), employing Overall and Aronson's (1963) expectation scale and an additional scale intended to assess "attitude toward seeking psychological help," surveyed the expectations of patients from three social classes. He reported essentially no differences among middle-class, working-class, and unskilled or unemployed subjects. These lower-class patients did not anticipate a highly active, supportive, problem-solving therapist. Nor did they equate the roles of therapist and physician. Lorion concluded that lower-class patients do not necessarily hold more negative or misguided conceptions of psychotherapy than other classes. In addition, Kandel (1966) has shown that lower-class persons in therapy with psychiatrists from lower-class origins do not drop out of therapy prematurely.

Since Lorion (1974) has provided the only methodologically adequate survey of class-linked expectations and has reported a failure to establish any relationship between class membership and expectation, one must conclude that none has been consistently demonstrated.

Therapist Expectations

The predeliction of psychotherapists for the YAVIS, or young, attractive, verbal, intelligent, and successful patient, has become a cliche, yet preference is not the same as expectation. The typical patient may not closely resemble the therapist's preference.

Berzins, Herron, and Seidman (1971), for instance, have attempted to describe the role behaviors of patients by contrasting the
"typical" to the most "successful" patient. From factor analysis of patient descriptions, three major patient role factors emerged. The first factor, labeled "Deferent-Subordinate Patient Role," included such items as "places you on a pedestal," "asks for answers, reasons, motives," and "acts like a bug under the microscope." The second factor included "displays freedom of expressiveness," "shows good rapport," and "behaves as though you were equals." This factor was labeled the "Expressive-Egalitarian Patient Role." The final major factor, the "Self-Reliant-Dominant Patient Role," included patient behaviors such as "generally initiates the conversation" and "controls the selection and direction of topics."

Experienced and inexperienced therapists showed general agreement in selection of behaviors characteristic of patients with whom they had experienced the most success. Experienced therapists (four or more years in practice) valued patient behaviors most similar to the Expressive-Egalitarian Patient Role and devalued the Deferent-Subordinate Role.

Inexperienced therapists did not produce as clear a picture, but generally concurred with the experienced therapists. It would appear, however, that inexperienced therapists attach greater importance to patients' simply talking than do their more seasoned colleagues.

Chance (1959) assessed therapist expectations of patient behavior by asking therapists to predict the content of patient verbal productions. When predicting from the first and second to the third therapy hour, therapists consistently underrated the affective
expressiveness of their patients. They also overestimated patients' concerns with dependency needs, rejecting, bossing, and rebelling. Therapist expectations were at odds with reality. A trend was noted, especially among less experienced therapists, toward the formulation of expectations about all patients which appeared to be "personal and characteristic for that clinician." In other words, all therapists, but especially the inexperienced, tended to view their patients in a stereotyped fashion. The typical therapist typed each patient as passive and capable of movement only from "hostile to friendly dependency."

Analogues investigating bias in clinical judgement have also served as indirect indicators of therapist expectation. Abramowitz and Dokecki (1977), in a recent review, have concluded that clinical bias is much more circumscribed than critics have forecast. Race, sex, and value orientation have had little or no impact on analogue studies. Socioeconomic status is more consistently a factor, but may reflect higher levels of psychopathology in the lower strata, rather than bias. The authors warn, however, that these analogues may employ manipulations that are particularly transparent in this era of social consciousness. In other words, stereotypical expectations or biases may operate in the clinical setting even though they are not reflected in analogues.

Lennard and Bernstein (1960) have reported that therapists do have definite expectations of client behaviors. Patients displaying what Berzins and his associates have termed Expressive-Egalitarian Role behaviors are favored by therapists on prognostic ratings. Therapists
may tend to expect less favored behavior from their patients, including passivity, defensiveness, and hostile dependency (Chance, 1959). Although analogue studies have suggested that therapists are unlikely to link expectations to patient demographic variables or to value orientations, the possible transparency of analogues leaves this conclusion open to question.

Interaction of Patient and Therapist Expectations

Garfield (1971) has reviewed literature on attempts to match clients and therapists on a number of personality variables and has concluded that the field is riddled with inconsistencies. Attempts to match patient-therapist dyads on such measures as MMPI profiles or Q-sorts or self-concept have produced nearly equal numbers of reports supporting and failing to confirm a relationship between similarity or complementarity and outcome. Current research on the "A-B" variable (Betz, 1967) appears to hold more promise. Garfield, however, has emphasized mutuality of expectations as a potentially fruitful area of investigation.

Two early reports in the area spurred further research. Patients expecting diagnostic or chemotherapeutic services and anticipating taking the role of passive cooperators were more likely to drop out of treatment when these services were not forthcoming (Heine & Trosman, 1960). Goin et al. (1965) focused more specifically on the effect of meeting, or failing to meet, the patient's expectation that he would receive advice. No differences in termination were
noted. Seventy-two percent of "advice" patients and 57% receiving no advice felt at least somewhat improved after up to ten sessions of therapy.

Overall and Aronson (1963) reported that the discrepancy between patient expectations and patients' actual perceptions of the first interview was predictive of dropping out. Patients were surveyed before and after the first interview on items categorized as reflecting active, medical, supportive, passive, and psychiatric expectations. The discrepancies between expected and observed therapist behaviors were largest on the active (e.g., "tell you ways to solve your problems"), and supportive (e.g., "avoid subjects which might upset you") dimensions. Patients were then divided into two groups on the basis of their return or failure to return for a subsequent interview. Differences between expected and observed therapist behaviors were significantly larger among those who did not return.

Lennard and Bernstein (1960) have attempted to apply role theory to psychotherapy transcripts using content and process analysis. These authors argue that role expectations were defined by social norms applying to the situation. Complementarity of role expectations is typical of much of our social interaction. If one partner behaves in a particular way, a complementary behavior should follow from the other. Lennard and Bernstein argue, however, that role complementarity is not likely in psychotherapy because: 1) the average person has little detailed information about it, 2) psychotherapy is a highly structured and complex relationship, 3) the very problem
which brings many patients to treatment is an inability to grasp and function in role relationships, and 4) transference aspects aroused by the treatment cannot be satisfied in the treatment relationship itself.

The concept of "strain" is introduced to describe the conflict which results when dissymmetry of expectations occurs. Strain may be evidenced in decreased verbal productivity, in increased silences, and in various indices of the quality of the therapeutic relationship. Lennard and Bernstein selected primary system references (i.e., references by the patient or therapist to their roles during treatment, to the process of therapy, and to the goals and achievements of therapy) as an indicator of strain. In this system, primary system references include any questions, statements or directions about how therapy is to proceed or has progressed, e.g. definition of appropriate and desired patient and therapist activities, directions such as "say whatever comes to mind," or setting appointments, fees etc. These primary system references are presumed likely to reflect therapist and patient attempts to structure the therapeutic relationship.

Expectations of activeness were assessed using the 6-item questionnaire reproduced above (page 9). As noted above, the average number of patient-therapist disagreements was three. These authors used the first five questions and asked patients and therapist to rate them on a three-point scale (often=3, sometimes=2, never=1). When the absolute differences for each dyad were summed, a possible range of scores from 0–10 resulted. Actual scores ranged from 0–4. Dissimilarity ratings increased with ratings of therapist passivity.
Dissimilarity ratings were compared with the proportion of primary system references by the therapist during the first three hours of treatment. Comparing the two patients assigned to each therapist, it was found that greater dissimilarity with respect to expectations of activeness was associated with a greater number of therapist primary system references. This relationship suggests that therapists spend more time socializing patients who hold noncomplementary role expectations. These primary system references may represent attempts to structure the patient role.

Further support for this interpretation is provided by results indicating a marked decrease over time in both patient and therapist primary system references. A decrease to less than one half the original number was noted by the fourth month of treatment. Within the sessions, definite patterns were also apparent. Primary system references by the therapist decreased from the beginning to the end of the session. Patients showed a similar decrease from the beginning to the middle of the session, but showed an increase again at the end of the interview. The authors attribute this increase to discussion of fees and scheduling.

Analogue investigations of role "strain" due to discrepant expectations have produced mixed results. When strain is induced by the expectation that one will receive an informational talk and is instead questioned, some changes in interview behavior do seem to occur (Pope, Siegman, Blass & Cheek, 1972). In this case, strain was defined as no increase in verbal productivity relative to a previous
interview in which subjects' expectations and interview behavior had been congruent. Control subjects who received two congruent inter­views showed marked increases in verbal productivity in the second interview.

Klepac and Page (1974) employed a similar paradigm with a few major variations. Subjects were instructed to play the role of patients. Expectations for a directive or nondirective "therapist" were assessed via Q-sorts. Interviews with highly directive or nondirective "thera­pists" were conducted via closed-circuit television. It was reported that the congruence or incongruence of therapist behavior with sub­ject expectation had no effect on subject verbal productivity. Sub­jects who expected a nondirective therapist did talk more than those who anticipated a directive therapist. While these authors have sug­gested that the concept of "strain" should be discarded since no evi­dence of its existence has been produced, Pope (1974) has responded that differences in methodology (e.g., closed-circuit television, role­playing) make the two studies unsuitable for comparison. Klepac and Page do concede that their simple measures of verbal productivity may not have been sensitive to "strain." It is interesting to note that quicker patient verbal response time and longer responses have been found to be associated with greater change, particularly in target symptoms (Sloane et al., 1975).

Martin, Sterne, and Hunter (1976) have investigated the pro­blem of mutuality of expectations in another fashion. The role ex­pectations of psychiatrically hospitalized patients and their therapists
were examined via factor analysis, yielding similar nurturant and
critical factors for both groups. Patient-therapist dyads were formed
to create varying degrees of mutuality of nurturant and critical ex­
pectations. At discharge, patient satisfaction with therapy bore no
relation to mutuality of expectation. A positive effect was reported
only for dyads holding mutual high nurturant-low critical expectations.
Only twelve percent of therapists and thirty-six percent of patients
held expectations of this character.

In summary, the effect of mutuality of expectations remains
open to question. Therapists do appear to spend more time structuring
therapy when patients hold dissimilar expectations (Lennard & Bern­
stein, 1960). Patient satisfaction with therapy appears unrelated to
mutually held client and therapist expectations, except in a small
number of cases where both expect the therapist to behave in a nur­
turant, noncritical manner. In analogue studies, the effects of dis­
crepant expectations is unclear. To date, a stronger case can be made
for a relationship between patient expectations and patient interview
behavior. When patients expect a nondirective therapist, they are
more verbally productive (Klepac & Page, 1974). Patients who antici­
pate active therapists who behave more like the familiar physician
appear to leave traditional therapies in greater numbers (Heine & Tros­

Preparatory Techniques for Patients Entering Therapy

Orne and Wender (1968) have suggested that there is a strong
positive relationship between a patient's perception of psychotherapy and its ultimate success. In essence, they argue that some "problem patients" may be capable of profiting from psychotherapy if they are taught what to expect and if they understand "the rules of the game." These authors have proposed that a special pretherapy interview may be a useful method of preparing patients for traditional analytic therapy. The three major goals of the interview are to convey to the patient: 1) a rationale for accepting psychotherapy as a potentially helpful treatment, 2) a clear explication of patient and therapist roles, and 3) to anticipate the "stormy course of therapy," i.e., resistances and negative transference. The clear explication of the patient role, point two, is of primary interest here.

Orne and Wender emphasize clarification of therapist and patient roles with respect to the activeness dimension. The primary goal of the patient role socialization interview is to differentiate the psychiatric, doctor-patient relationship from the more familiar medical one. They suspect that a number of patients may anticipate operating in the role of the physically ill patient; that is, patients may expect to remain the passive recipients of treatment, allowing the doctor to take sole responsibility for the cure.

In the pretherapy role induction interview, patients are informed of the active nature of their role in the treatment process. They are told not to expect the therapist to provide advice or to make decisions for them. The patient's role is described as that of an active talker, discussing whatever comes to mind, while that of the
therapist involves helping the patient discover why he has been acting as he has and helping the patient become aware of facts which he has been keeping out of his mind. An excerpt from a sample transcript may help to illustrate the nature of the interview:

Everyone expects to tell the psychiatrist about his problem and then have him give advice which will solve everything just like that. Advice is cheap; there is no reason for paying for it. Before you came here you got advice from all kinds of people: your wife, your parents, your friends, your family doctor, your minister, and so on. Many of these people know you quite well...there is no reason to think that your doctor would be that much better at it than all of the people who have always told you what to do...If all of the advice you have received had helped, odds are that you wouldn't be here. Your doctor wants to help you to figure out what you really want to do--what the best solution is for you. (pp. 95-96)

Orne and Wender report that they have used the "anticipatory socialization interview" with good results in their own practices, but they have left the rigorous evaluation of this technique to others. They are to be credited with the concept which has spawned investigations of its utility through two methods: 1) the use of direct instruction and 2) the use of modeling procedures, either alone or in conjunction with direct instruction.

Direct instruction as preparation for therapy. Historically, the first report of the use of anticipatory socialization would be difficult to trace. Freud (1920), for instance, complains that relatives of patients never fail to express doubts that mere talk can cure anything. More recently, Martin and Shewmaker (1962) outlined a
method for preparing patients for group psychotherapy using written
instructions. The method is essentially similar to that of Orne and
Wender (1968), with instructions tailored to group process (e.g.,
emphasizing quick and uncensored affective response to other group
members). In evaluating this single case report, the authors felt
that the written instructions served two functions. First, it was
their impression that the instructions caused early termination by
a number of patients who felt unable or unwilling to fulfill the pre-
scribed role. Second, it was felt that the instructions helped
patients interpret defensiveness and acting-out.

The first to provide data on Orne and Wender's then unpublished
technique were Hoehn-Saric, Frank, Imber, Nash, Stone, and Battle
(1964). In this study, 40 patients diagnosed neurotic were assigned,
balanced on intake interview ratings of attractiveness, to experimental
or control groups. Attractiveness was a composite of ratings on sever-
al other rated patient characteristics, including prognosis, intelli-
gence, and motivation. Each of four therapists then treated equal
numbers of experimental and control, attractive and unattractive
patients. Prior to the first therapy session, experimental subjects
received role-induction interviews. These interviews were described
as informal, modified to fit the education and sophistication of the
patient, and illustrated with examples from his history.

Both process and outcome measures were employed. Of seven
process measures, five favored experimental subjects, though only three
reached significance: experimenter-rated therapy behavior in the third
session, attendance, and therapist ratings of the treatment relationship. Only one measure, experimenter-rated behavior in the last therapy session, favored control subjects.

Five of eight outcome measures favored experimental subjects. Three reached significance: therapists' ratings of improvement, patients' ratings of target symptom change, and experimenter ratings of patient social ineffectiveness. On outcome measures, control subjects fared better on self-reported discomfort scale change and on therapist ratings of interpersonal skills.

These results lend moderate support for the use of role-induction techniques. In a subsequent report devoted to further analysis of this data with respect to patient characteristics (Nash, Hoehn-Saric, Battle, Stone, Imber, and Frank, 1965), further support was offered. It was found that attractive experimental patients had the highest, and unattractive controls the lowest, average rank on outcome and in-therapy behavior. Of particular interest was the fact that unattractive experimentals were ranked above attractive controls. Thus, the role-induction was crucial to the success of unattractive patients.

From this data, the effective component(s) of the role-induction interview cannot be deduced. A number of plausible explanations are apparent. The socialization interview may induce a favorable expectancy for improvement. It may clarify the patient's role sufficiently to allow him to work more productively and to benefit more from treatment. Or, it may simply teach him "good patient" behavior, making him more attractive to his therapist.
Sloane, Cristol, Peppernik, and Staples (1970) noted that the role-induction procedure employed by Hoehn-Saric et al. (1964) had combined an explanation of psychotherapy with a suggestion for improvement within a few months. These authors replicated the earlier study with the additions of one group receiving only a strong suggestion of improvement within four months and another group receiving the standard role-induction interview without suggestion of improvement. Results indicated no enhancement of the role-induction procedure by suggestion of improvement. Although the socialization interview alone did improve outcome, results were not as impressive as in the earlier study. Attendance, for example, was unaffected. Sloane et al. note that their sample included many more sophisticated patients, some of whom had previous experience in psychotherapy. They suggest that naive patients, like those in the earlier study, may benefit more from this procedure.

The induction of expectancy for improvement within a particular length of time does not appear to be an effective ingredient in role induction, i.e., it does not lead to enhanced self-reported improvement in therapy (Imber, Pande, Frank, Hoehn-Saric, Stone, & Wargo, 1970). These investigators were unable to persuade even apparently undecided patients that they would improve in four weeks or four months. These manipulations had no effect on actual expectancies or on self-reported improvement.

In a group setting, a modified version of Orne and Wender's technique has produced moderately favorable results (Yalom, Houts, Newell, & Rand, 1967). Groups receiving role-inductions showed more
interpersonal interaction (i.e., discussed intermember relationships more frequently) than did unprepared groups. The role-inductions led to no differences on attraction to the group or on attendance.

Heitler (1973), also investigating preparation for group therapy, followed the suggestion of Sloane et al. (1970) by controlling for the prior sophistication of patients with respect to psychotherapy. His results strongly support the utility of this preparatory technique with unsophisticated patients. Prepared patients participated voluntarily earlier in treatment, spoke more frequently and for longer durations, initiated speech more often, and displayed more frequent self-exploratory efforts. Pretherapy preparation also had a favorable influence on therapists' views of patients. Prepared patients were rated as more involved, closer to one's ideal of a group therapy patient, more dependably initiating efforts at collaboration, and as having better prognoses.

These adaptations of Orne and Wender's anticipatory socialization interview, it may be argued, are particularly suited to analytically-oriented psychotherapy. The generalization of these findings to other forms of therapy does seem supported by at least one investigation. Parrino (1971) employed direct instruction as preparation for subjects receiving behavioral treatment for snake phobias. Experimental subjects received either theoretical information on operant procedures, information relating to their role in operant procedures, or both. Control subjects received either no treatment or an attention-placebo, a programmed text on relationship improvement. Unexpectedly, experimental
groups showed improvement on approach tests after the induction alone. The experimental groups also evidenced superior change scores on approach tests and on self-reported anxiety during approach tests. Measures collected outside of the fear-evoking situation and a fear survey were not differentially affected by pretherapy preparation.

In summary, direct instruction as preparation for psychotherapy has been most thoroughly investigated in the form of Orne and Wender's anticipatory socialization interview. To date, the data indicate that this technique is valuable in both individual and group settings, enhancing aspects of both process and outcome. Induced expectancy of improvement, whether within a specified or unspecified length of time, does not appear to be the effective component. This technique appears particularly effective with "unattractive" and naive patients. The majority of these findings have come from studies of analytic psychotherapy, but at least one study has shown favorable results with behavior therapy patients.

With the exception of the data reported by Parrino (1971), these conclusions are based on two types of measures: 1) scales of unknown and untested psychometric adequacy, and 2) measures of verbal behavior bearing unknown relations to therapy outcome.

Modeling procedures as preparation for therapy. The use of modeling procedures, with or without direct instruction, has been extensively evaluated as a pretherapy training technique. Truax and his colleagues have conducted a series of investigations on "vicarious
therapy pretraining." Patients treated in this fashion were exposed to about thirty minutes of several audiotaped segments of actual group therapy interactions. These segments were selected as examples of relatively deep exploration of problems and feelings.

In the first study of the series (Truax & Carkhuff, 1965), state hospital psychiatric patients were assigned to four groups. Two received vicarious therapy pretraining, while the other two served as control groups. Change on MMPI scale scores (administered before the training procedure and after 24 weekly group therapy sessions) served as the outcome measure. Vicarious therapy pretraining led to significantly better outcome on MMPI scales 7 and 8, and to marginally better outcome on scales 0 and K.

The second study in the series (Truax, Shapiro, & Wargo, 1968) involved a group of mental patients serving as a replicate of the previous study and a group of juvenile delinquents. In this case, a variety of Q sorts served as outcome measures, in addition to MMPI scale scores. Generally, group therapy led to improvement in mental patients and to regression with juvenile delinquents. Vicarious therapy pretraining gave juvenile delinquents no advantage, but mental patients receiving pretraining showed greater improvement on MMPI scales 2 and 8. Regarding Q sorts, vicarious therapy pretraining had its greatest effect on the ways in which patients described their ideal selves. These ideal sorts were more similar to experts' ratings of adjustment. Pretraining had little effect on how patients saw themselves after psychotherapy. This Q sort is interpreted as suggesting that patients
were able to learn from the tapes what was expected of them, although this learning had no significant effect upon present self-concepts.

This procedure appears even more effective with less severely disturbed patients. Truax and Wargo (1969) replicated the two previous studies, but with a mildly disturbed, neurotic outpatient group. On 21 of 23 outcome measures, including 16 MMPI measures and various Q-sorts, vicarious therapy pretraining led to superior results, although the magnitude of the differences was not sizable. Only four of the differences were statistically significant.

A final study (Truax, Wargo, & Volksdorf, 1970) replicated the failure of vicarious therapy pretraining to enhance therapy with juvenile delinquents.

Thus, vicarious therapy pretraining, a procedure in which audio-taped patients model self-exploration, does appear to enhance therapeutic outcome with hospitalized psychiatric patients and with outpatients, although the outcome with juvenile delinquents is unaffected. Q-sort data suggest that pretraining may alter patients' conceptions of their ideal selves, but does not affect current self-concepts.

Strupp and Bloxom (1971) have developed a 32-minute film intended to provide an economical and widely available means of socializing patients, especially those from the lower socioeconomic classes, to therapy. The film is a dramatic story dealing with the life of a truck driver, "Tom Siever." Tom suffers with a volatile temper, leading to open conflict with his wife, his co-workers, and his boss. After losing his job due to a violent argument, he seeks treatment at a mental
health clinic, but drops out after the intake interview. Tom becomes more despondent, drinking heavily and contemplating suicide. He returns to the clinic for group therapy. Several segments of therapy are shown. Tom regains his job and reconciles with his wife.

In order to evaluate the effects of this film, 122 patients, largely from the lower socioeconomic strata, were recruited for group therapy and assigned to one of three conditions: film induction, interview induction, or attention control (a film on early marriage). There were no initial differences between groups on demographic variables or on a wide variety of other measures, such as social desirability, severity of disturbance, prognosis, attractiveness for therapy, or expectation for playing an active role in therapy. There was consistent evidence from postinduction, in-therapy, and outcome measures that the two role-induction procedures facilitated a more favorable therapy experience. At post-induction, therapists blind to patient group assignment rated experimental patients as more attractive, having better prognoses, having stronger motivation, and having a better understanding of patient and therapist roles. In-therapy effects included greater patient-rated satisfaction with progress in therapy and with progress in relationships with others. Outcome measures reflecting the superiority of role-induction included patient ratings of global improvement, target symptom improvement, improved self-understanding, and willingness to recommend group therapy to a friend. Therapists rated these patients more "attractive" and were more satisfied with the patients' progress.
Three types of measures did not reflect any gains by role-induction patients. Attendance was not influenced. Patient ratings of symptom discomfort uniformly plummeted immediately at the outset of treatment. Finally, therapist ratings of outcome did not diverge from group to group.

As a whole, these results would appear to support the valuability of role-induction. While both interview and film inductions led to many gains, the majority of measures slightly favored the film group.

In summary, both filmed and audiotaped training procedures seem to enhance the client's perception of therapy process and outcome. Unfortunately, methodological flaws have limited the generalizability of these findings. Truax and his associates repeatedly failed to incorporate attention controls, and in the initial investigation (Truax & Carkhuff, 1965) failed to employ appropriate blinds. The Strupp and Bloxom project (1971) utilized a wide variety of measures to investigate the effects of their film, but made major modifications of available psychometric instruments and failed to employ any additional instrument of established reliability or validity.

**Modeling vs. direct instruction.** A number of investigators have attempted to assess the relative efficacy of direct instruction as opposed to modeling in altering interview behavior. Green and Marlatt (1972) have made the following distinction between the two techniques: detailed instructions provide rules of appropriate behavior as well as
creating demand that they be followed, while modeling provides examples of desired behavior but neither demand nor explicit rules.

One might conclude, from the studies reviewed (e.g., Truax & Carkhuff, 1965; Strupp & Bloxom, 1973) and from additional investigations (e.g., Doster & McAllister, 1973; Marlatt, 1970) that modeling alone can influence interview behavior. When the results of modeling are compared with those of direct instruction, a confusing pattern of results emerges. Whalen (1969) has found a combination of modeled and instructed interpersonal openness is more effective than instruction alone. Green and Marlatt (1972) have found similar results in increasing subjects' affective and self-descriptive verbalizations. Doster (1972), however, reported that modeling did not contribute to subjects' self-exploration or personal communication above and beyond the effects of direct instruction. Differences in dependent measures as well as in interview context may have contributed to these discrepancies.

Scheiderer (1977) has conducted another such investigation, superior to others in that it is not a therapy analogue. Prior to thier initial interview at a university counseling center, self-referred male clients were exposed to one of four types of pretherapy training: modeling alone, modeling with detailed instructions, instructions alone, or control. Using dependent measures essentially similar to those employed by Whalen (1969), different results were obtained. Both detailed instructions and modeling were found to enhance personal disclosure, but detailed instructions were found to produce a stronger effect. The addition of modeling procedures provided no enhancement of these effects.
Instructed clients tended to rate their sessions as more effective and their therapists as more concerned than did noninstructed patients. Similarly, therapists rated the information provided by instructed clients as more useful in formulating a treatment strategy.

The value of pretherapy training is supported by these investigations. A number of investigators employing a variety of training techniques have reported increments in both patient and therapist satisfaction with therapy, in therapist ratings of patient in-therapy behavior, in patient ratings of outcome, and in therapist ratings of patient attractiveness. Unfortunately, as noted above, investigations have relied exclusively upon data with no psychometrically validated relationship to outcome.

A number of authors have suggested that these apparent favorable changes may be mediated by a clearer conception of the patient role. Truax, Shapiro, and Wargo (1968) noted changes in ideal-self Q-sorts toward expert sorts of the adjusted person. Strupp and Bloxom (1973) reported changes in patient expectations of activeness in therapy. Other authors (Goldstein, 1962; Heller & Marlatt, 1969; Pope, Siegman, Blass, & Cheek, 1972) have suggested that pretherapy instruction decreases role ambiguity for the patient, enabling him/her to relate more comfortably and to work more productively within the therapy relationship.

**General Attitude Toward Psychotherapy**

In light of data suggesting a substantial relationship between
patient expectations and measures of therapy process and outcome,
atttempts at developing psychometrically adequate measures of patient
attitudes could prove quite useful. Data from several sources (Heitler,
1973; Sloane et al., 1970; Stone et al., 1965; Strupp & Bloxom, 1973)
suggest that naive or unsophisticated patients are most likely to bene­
fit from pretherapy training. If this patient group could be readily
identified, corrective training could be undertaken to more adequately
prepare them for psychotherapeutic treatment.

The Fischer-Turner Attitudes Toward Seeking Professional
Psychological Help Scale. Fischer and Turner (1970) have developed a
scale which possesses adequate psychometric properties and which may
prove an aid in identifying patients likely to benefit from pretherapy
training. The Attitudes Toward Seeking Professional Psychological Help
Scale was originally developed to provide a continuously scored instru­
ment which would provide an index of willingness to seek out professional
assistance for psychological difficulties.

Items generated by psychologists from a number of clinical set­
tings were subjected to the judgments of a panel of clinical and coun­
seling psychologists and psychiatrists. Thirty-one items were retained
which were unanimously judged to be relevant and scorable as either pro
or con statements. Initial item testing led to the elimination of two
items on the basis of poor item-total correlations or excessive corre­
lation with the Marlowe-Crowne Social Desirability Scale.

The remaining 29 items (see Appendix A) yielded an internal
consistency coefficient of .86 for the original sample and .83 in an additional pool of 406 subjects. Stability coefficients ranged from \( r = .86 \) (five days) to .73 (six weeks) and back to .84 (two months). Correlations between total attitude scores and social desirability were nonsignificant, ranging from -.12 to +.04, even under conditions of anonymity.

Validity data are somewhat sparse. As stated above, attitude scores show negligible correlations with social desirability. The attitude scale readily discriminated those who had previously received professional psychological help. This group, about nine percent of the sample, held highly positive attitudes.

Due to significant sex differences (females hold more positive attitudes than males), correlation with other personality measures were analyzed separately for each sex. As predicted, attitude scores obtained from female subjects correlated moderately with Internal-External Locus of Control scores \( (r = -.43) \) with F Scale scores \( (r = -.25) \). No relationship between attitude and social desirability, interpersonal trust, or a semantic differential scale of masculinity were noted. Data from male subjects revealed moderate positive correlations between attitude and social desirability \( (r = .20) \) and trust \( (r = .26) \). Negative relationships between attitude and authoritarianism \( (r = -.37) \) and internality \( (r = -.31) \) were reported. Significant correlations were all in the predicted direction and of a reasonable magnitude.

In summary, the scale shows good internal consistency, good stability, and an ability to discriminate subjects who have previously
sought professional psychological help. The discriminant validity of this scale has not been clearly established. Moderate correlations with other paper-and-pencil personality measures are all in the predicted direction.

Mikesell and Calhoun (1971) have reported that the Fischer-Turner Scale correlates negatively with severity of disturbance as role-played by college students. The more severe the disturbance subjects were asked to role-play, the less positive were their attitudes. This result has been replicated with clinic outpatients. Calhoun, Dawes, and Lewis (1972) reported a strong negative correlation between outpatients' self-rated severity of problem and the attitude scale scores. No relationship was found between attitude scores and number of clinic visits. Sex differences in this study were less pronounced, suggesting that among actual help-seekers sex differences are not as important with respect to attitude toward help-seeking. Calhoun and Selby (1974) have also reported a negative relationship between attitude toward help-seeking and severity of psychological distress. Modest but significant correlations were reported between attitude scores and the Zung Self-Rating Depression Scale and Scale 8 of the MMPI. Two additional measures, a mood adjective checklist and the Neuroticism Scale of the Maudsley Personality Inventory, were unrelated to the attitude measure.

Fischer and Cohen (1972) have attempted to establish some demographic correlates of the Attitude Toward Seeking Professional Psychological Help Scale. In this sample of nearly one thousand subjects, social class of origin was unrelated to help-seeking attitudes.
Differences between educational levels were highly significant, although age did not contribute appreciably to the variance. Attitudes of upper-class subjects were unrelated to education, but the link between education and attitude for middle- and lower-class subjects was quite apparent. Among college students, social science majors, especially psychology students, were more in favor of seeking professional help. Jewish subjects tended to express more favorable attitudes than Catholics or Protestants, although the comparison did not quite reach significance.

Wolkon, Moriwaki, and Williams (1973) reported that race alone does not determine attitude on this measure, but social class does. Their conclusions seem unwarranted and unsupported by their data, however. Having included three groups (middle-class white, middle-class black, and lower-class black), any SES-related effects pertain only to black subjects.

Factor analysis of the attitude scale has yielded four major factors: recognition of need for psychological help, interpersonal openness regarding one's problems, stigma tolerance, and confidence in the professional. The authors failed to report the percent of variance accounted for by each of the factors, specifying only item loadings for the factors. The factors were stable across three samples, a male sample, a female sample, and a sample of both sexes. The openness dimension was found by Wolkon and associates to be positively related (r = .32) with a modified version of Jourard's self-disclosure scale.
Cash, Kehr, and Salzbach (1978) have replicated the finding that subjects reporting prior professional assistance hold more favorable attitudes toward seeking psychological help. Significantly more positive scores were noted on each of the four factor scales. When these subjects were exposed to audiotapes of sample first interviews, attitudes were related to a variety of judgments of therapists. To the degree that subjects espoused more favorable help-seeking attitudes, they were more likely to ascribe expertise, trustworthiness, regard, empathy, and genuineness to the therapist. Similarly, ratings of therapist helpfulness, expectation for improvement, and expected return for a second interview were positively related to attitude. The size of the majority of these relationships is quite small, with most correlations in the .20's. Expected helpfulness of the professional and willingness to return for a second session were more strongly related to global attitude (r=.41 and .37 respectively).

In summary, the Fischer-Turner Attitudes Toward Seeking Professional Psychological Help Scale has been shown to possess adequate internal consistency and stability. Validity data are more sparse, but the scale discriminates between those who have received previous psychological help and those who have not. A variety of demographic variables appear predictive of test scores. Females, the more highly educated, and to some extent Jews express more favorable attitudes. Those suffering more severe psychological disturbance, whether role-played or real and whether self-reported or measured on personality inventories, hold less favorable help-seeking attitudes. Finally,
persons scoring more positively are more apt to ascribe helpfulness and competence to the professional and report greater willingness to return for a hypothetical second interview. The Fischer-Turner Scale appears able to discriminate the general attitudes of individuals toward psychological services. Many specific expectations may contribute toward the development of one's general attitude toward psychotherapy. Expectancies of therapist activity, of length of treatment, of advice-giving, and of many other variables may contribute to one's general attitude toward psychotherapy. If so, then specific changes in expectations should be reflected in changes in Fischer-Turner Scale scores. That is, if pretherapy training procedures produce positive changes in expectations, these changes should in turn lead to more favorable scores on the Fischer-Turner Scale.

The Barrett-Lennard Relationship Inventory. Growing out of an attempt to investigate the outcome of client-centered therapy, Barrett-Lennard (1962) has constructed a scale which purports to assess the client-therapist relationship. The Barrett-Lennard Relationship Inventory (BRI) is aimed at measuring the client's perception of his/her therapist's behavior (and vice versa, although that is not of current concern). More specifically, it is intended to assess the extent to which the client feels the therapist has succeeded in creating the hypothesized conditions necessary for positive growth: empathic understanding, level of regard, unconditionality of regard, congruence, and willingness to be known. Later formulations (e.g., Rogers & Truax,
have modified the proposed "core conditions," but the BRI remains relatively robust.

Scale items (see Appendix C) are rationally derived from client-centered theory and are presented in a true-false format modified to permit three grades of "yes" and three grades of "no" response. In the initial sample of 40 clients, split-half reliabilities for the five subscales ranged from .82 to .93. Four-week stability coefficients obtained from a sample of equivalent size ranged from .78 to .90 with a full scale coefficient of .95. Subscale correlations indicated a great deal of overlap between empathic understanding and congruence. Further investigation, however, revealed that this overlap \( r = .70 \) held only in positive interpersonal relationships. The correlation was virtually zero among negatively rated interpersonal relationships. This latter relationship would tend to minimize the impact of the confound of the two subscales.

Validity data from the original study are promising. Among the eighteen "more disturbed" clients in this investigation, total scale scores correlated moderately with combined therapist-rated and self-reported indices of client change \( (\tau = .48, \text{Spearman's } \rho = .61) \). Expert therapists were marginally favored on the relationship ratings.

The BRI appears to have stood the test of time reasonably well. A review at the beginning of the current decade (Luborsky, Chandler, Auerbach, Cohen, & Bachrach, 1971) noted that four of six investigations of the BRI supported the relationship between scale scores and outcome. More recent reviewers (Gurman, 1977; Lambert, DeJulio, & Stein, 1978)
have concluded that client-perceived ratings of the therapy relationship (i.e., the BRI or the Truax Relationship Questionnaire) fare as well or better at predicting outcome than tape-judged ratings, therapist trait measures, or therapist ratings of the relationship.

**Purposes and Hypotheses**

Many writers have proposed that pretherapy training techniques reduce the ambiguity of the patient role. It has also been argued that this role clarification reduces potential "strain" in the therapy relationship, since fewer misunderstandings about appropriate role behaviors are likely to arise. In short, pretherapy training should enhance patient perception of the therapeutic relationship.

A number of investigators have reported findings supporting this conclusion. None to date, however, have employed psychometrically reliable measures. Thus, while Strupp and Bloxom (1973) reported that their role-induction film increased patient ratings of therapist ability to reassure them, their conclusions were based on simple scaled responses to straightforward questions. Similarly, Hoehn-Saric et al. (1964) reported significantly more positive therapist ratings of the treatment relationship among "socialized" patients, but based these conclusions on a simple self-report question. That these training procedures may produce the effects described is plausible, yet the exclusive reliance on simple, unscaled self-report leaves the interpretation of these data open to question.

In addition, pretherapy training techniques appear to offer the
greatest gains to those patients most prone to failure in therapy. Nash et al. (1965) reported that their unattractive patients (i.e., patients with poorer prognoses, motivation, and lower rated intelligence) who were pretrained surpassed attractive controls on outcome measures. The findings of other investigations (Heitler, 1973; Sloane et al., 1970) indirectly suggest that patients unsophisticated with regard to therapy are likely to show the strongest gains following pretherapy training. Again, however, it must be noted that Nash et al. (1965) employed simple rating scales of unknown psychometric properties. Neither Sloane et al. (1970) nor Heitler (1973) directly tested the conclusion that unsophisticated clients benefit more from pretraining. Rather, the inference was drawn by contrasting the two studies.

Finally, the relationship between general attitude toward psychotherapy and client-perceived measures of the quality of the therapeutic alliance has been reported in only one previous investigation (Cash et al., 1978). This finding would be substantiated by replication.

Therefore, the primary purpose of the present investigation was to substantiate the effects of a pretherapy training package using psychometrically reliable instruments. Additionally, the linkage between general attitude toward therapy and perception of the therapy relationship was examined. Finally, the response to training of those differing in attitude was investigated.

An analogue pre-post design was employed. Subjects were assigned to positive or negative attitude groups on the basis of the Fischer-
Turner Scale. Prior to treatment, subjects instructed to place themselves in the client's role rated a videotaped therapy session (actually scripted and acted) for the presence of therapeutic conditions on the BRI. After exposure to a pretherapy training videotape, subjects were asked to repat their ratings on both of these scales.

Hypotheses. On the basis of literature reviewed above, the following hypotheses were offered:

1) Pretherapy training enhances both general attitude toward psychotherapy and perceived presence of the therapeutic conditions. Specifically, pretherapy training leads to increments in scores on both the Fischer-Turner Scale and the BRI.

2) General attitude toward psychotherapy influences the perceived presence of therapeutic conditions, i.e., a positive relationship can be demonstrated between Fischer-Turner scores and the BRI.

3) Training is differentially effective depending primarily on general attitude toward therapy prior to treatment.

   a) Post-test relationship ratings (BRI scores) should fall in the following (descending) order: i) Positive attitude, pretrained group (PP), ii) Negative attitude, pretrained group (NP), iii) Positive attitude controls (PC), and iv) Negative attitude controls (NC).

   b) Post-test scores on the general attitude scale should fall in the same pattern, reflecting
greatest positive gains among those
initially negative in attitude who were
subsequently exposed to the training package.
Chapter II

METHOD

Design

A 2 X 2 factorial design was employed with pre- and post-tests on the two dependent measures. One factor represented the attitude variable (positive or negative), while the other represented the treatment versus control procedure. Table 1 summarizes the design.

Subjects

Subjects were 48 male students from University of Montana undergraduate psychology courses, who participated in partial fulfillment of course requirements.

Procedure

During the initial session, subjects, in groups of four to ten, were administered the Fischer-Turner Attitude Toward Seeking Professional Psychological Help Scale. See Appendix A for a sample protocol. Subsequently, subjects were informed of the experimenter's interest in the process of psychotherapy as a client might perceive it. Subjects were asked to empathize as closely as possible with a client on a videotape they were about to see. They were informed that they would be asked to rate the session from the point of view of the client. The "therapy session" was actually a scripted, acted videotape simulation.
of a treatment session. The full transcript is presented in Appendix B. After viewing the tape, each subject was asked to assume the role of the client and to rate the session on the BRI (see Appendix C).

Prior to the second experimental session, subjects were assigned to either the positive attitude or the negative attitude group on the basis of their ATSPPH scores. Subjects scoring above the median (median score=49.5) were the positive and below the median the negative attitude groups. Subjects within these two groups were matched on attitude scale scores and randomly assigned to the treatment or control conditions. In this manner, four cells were constituted (positive attitude treatment, negative attitude treatment, positive attitude control, and negative attitude control). For session two, subjects were reassembled in groups of four to ten, but on this occasion groups were formed such that all group members were treatment subjects, or all were control subjects.

Experimental assistants blind to the purpose of the investigation introduced the treatment tape as follows: "As you know from our first session last week, we are interested in psychotherapy. We have prepared a taped program on therapy, and we would like you to watch it now. After the tape, you will be filling out some questionnaires again." Treatment subjects were then exposed to the treatment tape, a pretherapy training package (Appendix D). The package was designed to incorporate both instruction and modeling of the patient role. Didactic presentation was interspersed with short, scripted excerpts of therapy sessions. These excerpts served to illustrate
aspects of the patient role and potential frustrations (e.g., desire for more advice) which often accompany that role. In addition, instructions and exhortation toward active involvement in therapy were emphasized.

After the treatment tape for experimental subjects, or at the start of the second session for controls, subjects were instructed to fill out the ATSPPH a second time, since "We are still learning about these scales." Then the therapy session was shown again on the monitor, and subjects were asked to re-rate it on the BRI.

A de-briefing questionnaire was administered to all subjects. Questionnaire items were designed to assess experimental demand, realism of the psychotherapy tape, ease of role-taking for the tape ratings, and perceived attitude change. Finally, subjects were asked to leave addresses if they wished to be informed of the results of the study, and were given the opportunity to ask any question about the experimental procedure.
Chapter III

RESULTS

Demographic Data

Groups did not significantly differ on any of the demographic variables (age, education, SES, race and religion). Values for the appropriate statistical tests are presented in Table 2. Although none of the tests reached conventional levels of significance, a marginal trend was noted suggesting that subjects with positive initial attitudes tended to be older (mean difference = 1.2 years, t=-1.94, df=45, p<.10). The typical subject in this study was a twenty-year old (X=20.33), Caucasian (45 of 47) college sophomore (X=13.85 years education) from a modal middle-class background (22 of 47 Level III, Hollingshead Two-Factor Index). Most subjects had no previous experience with psychotherapy (43 of 47). The modal subject described himself as preferring Protestantism (19 of 47). A complete list of demographic and experimental data is provided in Appendix E.

Dependent Measures

Stabilities. Both of the primary dependent measures demonstrated very high test-retest correlations from pre- to post-testing, a one-week interval. A Pearson r of .87 was obtained for the attitude scale (t=11.68, p <.001). The test-retest correlation for the BRI was .92 (t=15.62, p <.001).
Test of hypothesis 1 - pretherapy training enhances both general attitude toward psychotherapy and perceived presence of the therapeutic conditions. Group means for the attitude scale (ATSPPH) are presented in Figure 1. Due to unequal cell sizes (one subject failed to return for post-testing) the post-test attitude scale scores were submitted to an unweighted means, two-way analysis of variance (Kirk, 1968). A summary of the analysis is presented in Table 3. The analysis yielded a significant main effect for the initial attitude (positive/negative) factor, $F = 38.87, p < .01$. Neither the treatment/control factor nor the two-way interaction reached significance ($p > .05$).

A presentation of rating scale (BRI) means is provided in Figure 2. As can be seen, all groups except the negative attitude controls demonstrated gains from pre- to post-tests. The negative controls actually showed a decrement in BRI scores. Rating scale scores were submitted to a split-plot factorial analysis of variance with repeated measures (see Table 4). The single missing score was estimated in order to employ this conventional analysis (Kirk, 1968). The analysis yielded a single significant effect -- the main effect for positive/negative attitude, $F = 4.31, p < .05$. Neither the treatment/control factor nor the pre/post factor yielded significant F-ratios, nor did any of the interactions.

The absence of significant treatment effects and interactions with the treatment factor is a disconfirmation of hypothesis 1. Initial attitude groupings (positive/negative) proved to be the only factor significantly related to post-test scores on the attitude scale.
Similarly, both pre- and post-test scores on the rating scale were related only to the initial attitude groupings, and were unrelated to treatment or to test occasion.

**Tests of hypothesis 2** - general attitude toward psychotherapy is positively related to perception of the therapeutic conditions. Product-moment correlations were calculated on the pairs of attitude and rating scale scores. At pre-testing, the analysis yielded an $r$ of .35 ($t=2.49$, $p<.025$). At post-testing, the relationship had increased slightly ($r=.42$, $t=5.74$, $p<.001$). The magnitude of the increase is not significant (two-tailed $r=.40$, $p=.66$).

The significant correlations between the two scales confirm hypothesis 2. Attitude toward therapy is positively related to perception of the therapeutic conditions.

**Tests of hypothesis 3** - scores on both post-test measures will fall in the pattern Positive Attitude Pretrained > Negative Attitude Pretrained > Positive Controls > Negative Controls, or that the greatest gains will be made by treatment subjects initially negative in attitude, followed by positive treatment subjects. The predicted pattern of results failed to emerge for either of the measures (see Figures 1 and 2). Since the analysis of variance for BRI scores yielded only a significant main effect and no significant interactions, multiple comparisons of means are inappropriate and were not conducted (Kirk, 1968). Analysis of variance of BRI pre-post difference scores yielded one significant main effect - that for the positive/negative attitude
This finding indicates that positive attitude subjects showed a greater increase on BRI scores (mean difference =12.22) than did negative attitude subjects (mean difference=-1.16). A summary of the analysis is presented in Table 5.

A similar analysis conducted on attitude scale scores yielded no significant effects.

Again, the pattern of results would support the view that only initial attitude exerted any effect on the results (change in the rating scale scores and the attitude scores). No support for a treatment effect is provided.

**De-briefing Questionnaire**

Two questions designed to test subjects' knowledge of the experimental hypotheses were presented in the de-briefing questionnaire (i.e., "Please explain what you think the purpose of this experiment might have been" and "What do you think the experimenter was hoping you and the other participants might do?"). Two independent raters were provided with copies of the Hypotheses section of this paper. They were asked to determine whether subjects had indicated an accurate, group-appropriate perception of the experimental hypotheses in either of these responses. An inter-rater agreement estimate of .86 was obtained (# agreements/ # agreements + disagreements), indicating satisfactory reliability for the judgments.

When tested against a prediction that none of the subjects were aware of the hypotheses, all groups (positive, negative, treatment,
control) obtained significant chi-square values (range = 22.47-28.35, probabilities all < .01). Approximately half of the subjects (25 of 47) were aware of at least one of the experimental hypotheses.

When tested against a prediction that groups did not differ in proportion of subjects having knowledge of the hypotheses, all chi-square values were nonsignificant. An additional test of this finding is provided by analysis of responses to the question, "Do you feel your attitudes toward psychotherapy have been influenced in any way by this experiment? If so, please explain." Ten subjects indicated attitude change, all in the positive direction. Groups did not differ on this measure. Probabilities for chi-square values all exceeded .50.

Several additional analyses were conducted in order to assess whether experimental artifacts affected scores on the dependent measures. First, responses to each of the four de-briefing items (demand, realism, role-taking and perceived change) were correlated with change scores on the two primary dependent measures. Since responses to the demand item were scored for group-appropriate awareness of hypotheses, separate correlations were calculated for treatment and control groups. Of the ten correlations, only one reached significance. A Pearson $r$ of .60 was obtained between demand and BRI change scores for control subjects ($p < .01$). This correlation indicates that among control subjects, awareness that the experimenter expected them not to change their tape ratings from pre to post was associated with positive gain on the BRI.

Second, analyses of variance were computed separately for aware and unaware subjects. Unweighted means analyses on attitude scale
scores (treatment/control x positive/negative) yielded no significant effects (p's all > .10). Similar analyses conducted on BRI score yielded no significant effects for aware subjects, and only a marginally significant effect for unaware subjects -- that for the treatment versus control factor, $F=3.5143; \text{df}=1,22; p < .10$. This marginally significant effect indicates a tendency for unaware treatment subjects to show greater pre-post gains on the BRI (mean gain=+6.17) than did control subjects (mean decrement=−7.70).

Third and finally, scores were collapsed across positive and negative groups and two-way analyses (treatment/control x aware/unaware) were performed on each of the primary dependent measures. The attitude scale analysis produced no significant F-ratios. The BRI analysis, however, produced one significant effect -- a main effect for the aware versus unaware factor, $F=6.1327; \text{df}=1,43; p < .05$. Aware subjects demonstrated a mean gain of 13.97 points while unaware subjects declined an average of .93 points from pre to post. A marginal interaction was also noted, $F=3.8855; \text{df}=1,43; p < .10$. Multiple comparisons of means, using the method of Least Significant Differences (Kirk, 1968) indicated that the unaware control group was significantly different (lower) than both of the aware groups (p<.05). No other comparisons reached significance.

A question designed to test the realism of the simulated psychotherapy session was also presented (i.e., "How realistic did you find the simulated psychotherapy session?"). The mean rating across all subjects on this 7-point scale (1=very unrealistic, 7=very realistic) was 3.67, a value slightly below the mid-point. This apparent
lack of realism may have reduced subject involvement with the experimental procedure, thereby limiting the external validity of the study. Groups did not differ in their ratings (positive-negative $t=1.23$, $p > .20$; treatment-control $t=1.14$, $p > .20$).

Subjects were also asked to rate the case with which they were able to empathize with the client simulator on a 7-point scale. Again, higher numbers reflect more positive ratings. Although groups did not differ in their ratings (positive-negative $t=0.98$, $p > .20$; treatment-control $t=0.05$, $p > .50$), the mean rating across subjects was 3.58, a value also below the mid-point.
Groups in this investigation did not differ on any of the background or demographic variables, although a marginal tendency was noted for positive attitude subjects to be older than their counterparts in the negative attitude group. These findings stand in contrast to earlier reported results. Previous investigators have reported significant demographic correlates of attitude scale scores including education, religion (Fischer & Cohen, 1972), social class (Wolkon, Moriwaki & Williams, 1973), and prior history of psychological treatment (Cash et al., 1978). Two factors may have contributed to this failure to replicate. First, the present sample was relatively homogeneous. Even the marginally significant age difference was of a very small magnitude - 1.2 years. Second, the sample was relatively small. Fischer and Cohen (1972) for instance, employed a sample of 1,000 subjects. The small, homogeneous sample may well have reduced the probability of detecting group differences.

The primary dependent measures (ATSPPH & BRI) displayed robust psychometric properties. The obtained stability coefficients are quite adequate and are comparable to previously reported results (Barrett-Lennard, 1959; Fischer & Turner, 1970). The relationship between the attitude and rating scales were moderate and similar to the .58 correlation reported by Cash, Kehr, and Salzbach (1978).

These results also provide some evidence contributing toward
the construct validation of the Fischer-Turner ATSPPH scale. The moderate convergence of the two measures confirms the logical relationship between attitude toward therapy and perceived presence of the therapeutic conditions. Additionally, the results provide encouragement to researchers attempting to establish some predictive validity for the scale. The BRI is considered by recent reviewers (Gurman, 1977; Lambert et al., 1978) to be as strong a predictor of therapy outcome as any other relationship measure, and in fact, proved a significant correlate of outcome in a majority of studies (Luborsky et al., 1971). Since the ATSPPH scale correlates moderately with the BRI, a link between ATSPPH scores and therapy outcome may also exist.

Attitude toward psychotherapy, as measured by the ATSPPH, might eventually serve as a moderator variable in therapy outcome research. Since scores on this scale were predictive of ratings of therapist relationship skill, they may also predict receptiveness to therapeutic intervention. Should this relationship be confirmed, researchers might match treatment groups on ATSPPH scores in order to minimize the confounding of attitude toward therapy with treatment outcome. For similar reasons, this scale may also prove useful in identifying patients in need of special pretherapy intervention, or modified treatment techniques. Reliance on subjective global ratings of variables such as "patient attractiveness" (Hoehn-Saric et al., 1965) could be abandoned in favor of this more objective technique.

Predictions of the magnitude and ordering of treatment effects (hypotheses 1 & 3) were not supported. Instead, initial attitude toward
therapy was the only significant determinant of the primary dependent variables. On the rating scale (BRI), positive attitude subjects made greater gains than did the negative attitude groups.

The failure of treatment effects to reach significance may be due to a number of possible weaknesses in the treatment itself, or in the therapy analogue. First it should be noted that no treatment effects were demonstrated despite perceived experimental demand. Significant number of subjects were aware of the experimental hypotheses. Yet the sample, as a whole, failed to change in the direction of perceived demand. Only when analyses included a factor separating aware and unaware subjects did a significant effect emerge, and then only on the BRI. Subjects aware of the experimental hypotheses (positive change for treatment subjects, no change for controls) showed gains on BRI ratings at post-testing while unaware subjects actually showed a decrement. The marginally significant interaction between the awareness factor and the treatment factor, taken with the significant correlation between perceived demand and BRI gain for control subjects, suggest that control subjects were primarily responsible for the significant aware versus unaware F-ratio. Unaware control subjects lost ground at post-testing while aware subjects showed the greatest gains. Control subjects, aware they were expected to show no change, tended to show the greatest gains. These results, however, must be interpreted with caution, since only 1 of 10 correlations and 1 of 12 F-ratios reached significance, numbers expected by chance alone. A possible reactance motive (Brehm & Cole, 1966) may have played a role, with subjects
changing in the direction opposite to the perceived demand. Alternatively, the combination of demand not to change and simple exposure to therapy tapes may have produced the desired effect.

Since positive attitude subjects showed greater gains on the BRI from pre- to post-testing than did the negative attitude groups, it could be argued that attitude is related to social desirability. During construction of the ATSPPH, however, Fischer and Turner (1970) found near-zero correlations with a measure of social desirability in a sample of 400. When only male subjects were considered, the correlation reached .20.

De-briefing questionnaire responses suggest another plausible explanation for the failure to obtain treatment effects. Two weaknesses in the analogue are suggested. First, subjects rated the ease of client role-taking for tape ratings below the mid-point of a Likert-type scale. Second, the simulated therapy session was considered unrealistic by the average subject. It would be difficult to take the role of a client one considered "phony." One intent of the therapy session was to enable subjects with no previous therapy experience to vividly imagine themselves confronted with a first therapy session. Questionnaire responses seem to indicate that subjects rejected the view of therapy offered. Subjects with no previous therapy experience, and no alternative view of therapy to replace the one offered would also have a difficult time imagining themselves as clients. The analogue is weakened since the pretherapy training tape, intended to ease socialization to the patient role, probably had little relevance to the
typical subject in this study.

No questionnaire items directly assessed the interest aroused by the training tape itself. The lack of treatment effects attests to the weakness of the manipulation. An indirect measure, subject report of perceived attitude change, was endorsed by only one-fourth of the treatment group subjects. A few comments critical of the quality of the videotapes were noted in questionnaire responses. The technical quality of the videotapes does not compare with typical television fare. For instance, only one camera angle and very few edits were employed. Previous investigators (e.g., Strupp & Bloxom, 1971) have developed films of high technical quality which were rated as interesting and entertaining by viewers. Other investigators (e.g., Orne & Wnder, 1968; Yalom et al., 1971) have relied on personalized individual interviews to increase impact on clients. Truax and his colleagues reported significant changes in personality measures for patients exposed to brief audiotaped therapy excerpts. In the Truax series of investigations, however, excerpts from actual therapy sessions were presented to actual patients.

The analogue employed in this investigation may not provide a valid test of the technique. Pretherapy training would presumably be most salient and powerful when role ambiguity and attendant anxieties were strongest – at the start of psychotherapy. Pretherapy training effects have been demonstrated in previous analogue investigations (e.g., Doster, 1972; Whalen, 1969). In these studies, however, training was limited to narrow, specific behaviors such as verbal productiveness,
rather than aimed at correcting misconceptions and providing an overall cognitive structure for therapy. Furthermore, these subjects were trained with knowledge that these specific skills would be tested, a situation likely to increase involvement with training.

In the current investigation, it is unlikely that subjects were experiencing serious role ambiguity or anxiety. The structure provided by pretherapy training had little direct relevance to their participation as experimental subjects. Under these circumstances, it is probable that pretherapy training would produce minimal change relative to that expected from its use in a clinical setting. While this conservative test of the technique produced no significant results, a more reasonable test of the technique would involve its application with clinical populations, especially those with no previous therapy experience.

Although pretherapy training is not the only option available to therapists hoping to improve treatment outcome with unsophisticated clients, or those negative in attitude toward treatment (see Lorion, 1978), its cost-efficiency in terms of therapist time and patient expense make it an attractive alternative worthy of further investigation.

In summary, although the present study failed to demonstrate significant effects for pretherapy training, it is recommended that future investigators test the technique in the clinical setting. Previous research suggests positive effects for similar training packages, although support comes largely from self-report data obtained via scales of unknown psychometric properties. The scales employed in the current
investigation proved reliable and moderately related to one another. The ATSPPH may provide a brief, efficient means of identifying potential "problem patients" in need of special types of intervention, and may eventually prove useful as a moderator variable in psychotherapy outcome research.
BIBLIOGRAPHY


APPENDIX A
Fischer-Turner Attitude Toward Seeking Professional Psychological Help Scale

Instructions: Below are a number of statements pertaining to psychology and mental health issues. Read each statement carefully and indicate your agreement, probable agreement, probable disagreement, or disagreement. Please express your frank opinion in rating the statements. There are no "wrong" answers, and the only right ones are whatever you honestly feel or believe.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Disagree</th>
<th>Probably disagree</th>
<th>Probably agree</th>
<th>Agree</th>
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<tbody>
<tr>
<td>1. Although there are clinics for people with mental troubles, I would not have much faith in them.</td>
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<tr>
<td>2. If a good friend asked my advice about a mental problem, I might recommend that he see a psychiatrist.</td>
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<tr>
<td>3. I would feel uneasy going to a psychiatrist because of what some people might think.</td>
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<td>4. A person with a strong character can get over mental conflicts by himself, and would have little need of a psychiatrist.</td>
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<tr>
<td>5. There have been times when I have felt completely lost and would have welcomed professional advice for a personal or emotional problem.</td>
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<tr>
<td>6. Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.</td>
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<td>7. I would willingly confide intimate matters to an appropriate person if I thought it might help me or a member of my family.</td>
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<td>8. I would rather live with certain mental conflicts than go through the ordeal of getting psychiatric treatment.</td>
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<td>9. Emotional difficulties, like many things, tend to work out by themselves.</td>
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<td>10. There are certain problems which should not be discussed outside of one's immediate family.</td>
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<tr>
<td>11. A person with serious emotional disturbance would probably feel most secure in a good mental hospital.</td>
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<td>12. If I believed I was having a mental breakdown, my first inclination would be to get professional attention.</td>
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<td>13. Keeping one's mind on a job is a good solution for avoiding personal worries and concerns.</td>
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<td>14. Having been a psychiatric patient is a blot on a person's life.</td>
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<td>15. I would rather be advised by a close friend than by a psychologist, even for an emotional problem.</td>
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<tr>
<td>16. A person with an emotional problem is not likely to solve it alone; he is likely to solve it with professional help.</td>
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<tr>
<td>17. I resent a person -professionally trained or not- who wants to know about my personal difficulties.</td>
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18. I would want to get psychiatric attention if I was worried or upset for a long period of time.
19. The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.
20. Having been mentally ill carries with it a burden of shame.
21. There are experiences in my life I would not discuss with anyone.
22. It is probably best not to know everything about oneself.
23. If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy.
24. There is something admirable in the attitude of a person who is willing to cope with his conflicts and fears without resorting to professional help.
25. At some future time I might want to have psychological counseling.
26. A person should work out his own problems; getting psychological counseling would be a last resort.
27. Had I received treatment in a mental hospital, I would not feel that it ought to be "covered up."
28. If I thought I needed psychiatric help, I would get it no matter who knew about it.
29. It is difficult to talk about personal affairs with highly educated people such as doctors, teachers, and clergymen.
Therapy Role Play

T: Well, glad you made it in today, John. I was hoping we could start by your telling me a little bit about the kind of things you're wanting to work on, the kind of things that are bothering you right now. I know just that you're having some problems concentrating in school and I'd like you to tell me a little bit more about that.

C: It's uh...I'm uh... I'm having problems studying like I said when I came in. I was here last year for a quarter, but I just couldn't cut it, so I left... and went back home, and...I... this is kinda hard for me because I've never really done this before.

T: Never had to talk to somebody about this before?

C: No. Let's see. It's my studying. I can't concentrate when I'm doing stuff and yet I know I could do it if I could concentrate. So I just end up getting lousy grades. That first time I was here, that first quarter, I just bombed and went back home. I decided to give it another try and I made it through the first two quarters here because I took easy classes. I took the lower intro classes, and now I'm in my third quarter and the classes are getting more difficult because I've taken all the easy ones. And now I'm finding the problem's coming back. I'm just, you know,...I know I can do the stuff, yet I can't...do it.

T: You're really feeling frustrated about that. It's not like you don't trust being able to do it. It's just that when you sit down and try, you can't stick with it; you can't concentrate.

C: Yeah, sometimes I just drift off and think about something else. Or sometimes I kind of start getting tired. That happens a lot.

T: Uh hunh.

C: I just get other things on my mind or something. I just find it real difficult. Yeah, it's really frustrating.

T: Kind of confusing, too, trying to figure out why it is when you're so able to do it, it comes so hard for you.

C: Yeah, it's like, I don't know, I just feel like I'm able to do it but it's just those things are in the way. So all I see is the lousy grades I get, which say that I'm not able to do it. But yet I know I'm able to do it.

T: It's really important to you, too, to be able to make it in school. After having had one bad quarter, here you are to try it again.

C: Yeah, if I don't cut it this time, I'm kind of out for good. That's just really upsetting because I can't... well I can't get a hold on it.

T: Uh hunh... What did you do in the time between leaving after your first quarter and coming back now?
C: You mean from when I left after that first quarter?

T: Uh hunh.

C: I uh went back home, uh, I worked on a ranch outside of Harlow... lived at home with my parents...

T: Yeah

C: And worked on a ranch, kind of a field hand. That kind of work - decent paying. It was really pleasant and I enjoyed being at home. I just felt it was time to come back. I wanna be here. I know I can do it and I...

T: Yeah

C: It really gets...oh...

T: It's hard when you've got your mind set on accomplishing something to have something get in your way like this. It's important just not only to you, but it sounds like to your family as well, your going to college.

C: That, well, I'm the only son and I have two younger sisters. No one else in the family has gone to college. So here I am the only guy in the family and I'm going to college. The first one to try. So everyone's kinda looking to see how I'm doing. They want me to do well..."Hey watch John. He's gonna do all right."

T: They've got a lot of hopes riding on you.

C: It's not like pressure, but it's just that they're hoping the best for me. And that means that I can do OK. And I want to do OK, too.

T: You don't really feel that it's pressure from them...

C: Well...

T: ...it's just that they're behind something that they know you want to do.

C: They're behind it. But I'll feel pretty bad if I have to go back and tell them I couldn't handle it. Cause that'll be a disappointment to them... about as much as it will be to me.

T: Was that something you did after you left school the first time? Going back and telling them that you messed up?

C: That was something else. I went back and was kind of...oh...sometimes it's kind of hard to talk to my parents. They're really good people and I really love 'em, but trying to explain that is, you know... I wasn't used to being away from home - being out of Harlow. Harlow's kind of close knit, you know, and being away was kind of hard. I tried to explain that as being part of it and they seem to understand, but I kind of wonder what they thought of me. Maybe, "the kid just doesn't have what it takes." They didn't say that but I still feel maybe that's what
they thought. Cause I know I can do it.

T: The idea that you've disappointed them is pretty worrisome to you. But also that you're disappointing yourself by not doing better than the work you're doing now.

C: Yeah.

Scene fades to later in session.

T: So sometimes you're just sitting there with that book and you just doze off; you can't concentrate on it at all.

C: Yeah.

T: What do you do?

C: You mean when I...

T: When you wake up?

C: Well, I look down at the book (laughs) and go, I'm supposed to have read this by now, and hell, I'm not going to make it through college by doing that. It just gets me upset.

T: How do you start feeling when you get upset about that?

C: Uhm... I just really wonder why, you know. It's like... it's not like I can't do the material, because it doesn't come across like "where am I." It's just it really bothers me that I fall asleep. I guess it just goes back to... oh... I don't sleep well at night and I'm sure that's got a lot to do with it. I don't know what that's all about. I feel I can do this stuff... do what I need to do to make it through college, but these things get in the way and keep me from being able to do that.

T: It's not like you doubt that you're smart enough to do all that, it's just that you're not doing it as efficiently as you'd like to. You start worrying about whether you can make it.

C: It's like the grades I get aren't saying what I can do. They're not saying I can study without falling asleep or daydreaming or being able to concentrate on the material. I don't want that kind of thing following me around.

T: Uh hunh. You don't like getting those C's.

C: No, I know I can do better.

T: You said you have trouble sleeping at night. How many hours sleep do you think you get a night?

C: Oh well, real sleep, maybe four or six. Between four and six, but I toss and turn a lot. It just takes an awful long time for me to get to sleep.

T: An hour?
C: Oh, anywhere from an hour to two hours. Sometimes maybe even 2½ hours. I sometimes don't even like to look, it gets me so upset.

T: Yeah. You just lie there trying to go to sleep for all that time.

C: Uh hunh. I just...oh it's such a mess.

T: Do you feel pretty worried during the days, too? Upset and worried about things?

C: Well mostly, just being able to do the work. Being able to get over what's in the way so I can show, I can prove that I can do it.

T: You have any ideas on what it is that's in your way?

C: Yeah. It's my not being able to concentrate on the material, the falling asleep or daydreaming.

T: If you could only get past those things, everything else would fall into place, at least as far as school things.

C: Yeah. I think so. Those are the things I see now and I can't think of anything else that's keeping me from doing it. I don't know, I'm just kind of mixed up about the whole thing. I don't understand why that is and I'm hoping that you can do something for me so that I can get over that.

T: It really confuses you. If you could only figure out what it is that makes it so hard for you to concentrate, you could try to start doing something about it.

C: Yeah. That's why I came in here because, you know, I've been trying. I've been able to get through the last two quarters, but now I'm confronted with courses where I can't get around that. I'm hoping you can help me find that. Cause it's like if I can figure it out, I can at least work on it.

T: Yeah. I think we can work on that together. We can try to figure out what's happening with that. I wanted to ask you too if there are any other areas of your life that are causing you concern on top of the schoolwork? Uhm...or is it the main thing that you're worried about now?

C: Oh, well I guess, it's kind of hard to admit it, but I grew up in a small town. I was really close with my family. Sometimes I miss 'em. I don't say that to a lot of people because, you know, a guy's not supposed to admit that he's homesick or whatever it is. Sometimes that's on my mind.

C: Having those good times with them for the time in between being in school was pretty important to you.

C: Yeah. It was kind of nice when I went back after the first quarter. I think about that every once in a while now. I wonder, like I said, I wonder what my parents are doing now and what my two sisters are doing, too.

T: Are they having any problems that you feel you should be home for? Or is it more the caring for them?

C: It's more the, you know, I could be a big help around the place. They
still want me to go to college and be able to do well. But it's kind of like I could see a role for me there, something to do.

T: Do you have any friends, you know, good friends or acquaintances here, who seem to help you when you're feeling kind of lonesome for your family, or your home town?

C: I kinda... I've got friends, but it's not something where they help me if I'm homesick. Sometimes if I'm feeling kind of down about that or it's on my mind, I'll go out and do something. It kind of helps, but I'll do that in place of the studying I was supposed to be doing, and it gets all mixed up in there.

T: It all keeps piling up on you then. The more you stay away from it the more you start worrying about being behind.

C: Yeah, kind of. If I do put it off, then when I really need to be able to do the work, well, of course that's when I can't concentrate, you know. Then I start dozing off in the book and it screws everything up.

T: When the pressure's on you have a lot harder time with it?

C: Yeah, sure.

T: You said you've tried some things the last couple of quarters to help you concentrate better. What kind of things did you try?

C: Uh...oh... let me think. I tried sitting in the library. I figured maybe if I tried sitting around everyone else who was studying, maybe that'd help me to study. But I just started watching everyone else study (laughs).

T: That didn't quite work.

C: No. Then I tried studying in, what do they call 'em, a carousel. That didn't work. I just felt I was surrounded, nice and cozy, and I could start drifting off. Uh... really nothing definite else that I tried to do to concentrate. Maybe oh, maybe force myself or prepare myself and say "Hey, I gotta study. I gotta do this. Just sit down and start cracking. Bang, bang bang. That's something I tried.

T: You tried to work yourself up but that didn't always work either.

C: No. Sometimes it did, but not a lot.
APPENDIX C

Barrett-Lennard Relationship Inventory

Instructions: Below are listed a variety of ways that one person could feel or behave in relation to another person. Please consider each statement with respect to whether you think it is true or not true of the relationship shown in the videotape between the client and his therapist. Imagine you are the client and rate these items from his point of view. Mark each statement in the left margin according to how strongly you feel it is true or not true. Please mark every one. Write in +1, +2, +3; or -1, -2, -3, to stand for the following answers:

+1: I feel that it is probably true, or more true than untrue.
+2: I feel it is true.
+3: I strongly feel that it is true.

-1: I feel that it is probably untrue, or more untrue than true.
-2: I feel it is not true.
-3: I strongly feel it is not true.

Please remember to rate these items from the point of view of the client in the videotapes.

1. She respects me.
2. She tries to see things through my eyes.
3. She pretends that she likes me or understands me more than she really does.
4. Her interest in me depends partly on what I am talking to her about.
5. She is willing to tell me her own thoughts and feelings when she is sure that I really want to know them.
6. She disapproves of me.
7. She understands my words, but not the way I feel.
8. What she says to me never conflicts with what she thinks or feels.
9. She always responds to me with warmth and interest – or always with coldness and disinterest.
10. She tells me her opinions or feelings more than I really want to know them.
11. She is curious about "the way I tick," but not really interested in me as a person.
12. She is interested in knowing what my experiences mean to me.
13. She is disturbed whenever I talk about or ask about certain things.
14. Her feeling towards me does not depend on how I am feeling towards her.
15. She prefers to talk only about me and not at all about her.
16. She likes seeing me.
17. She nearly always knows exactly what I mean.
18. I feel that she has unspoken feelings or concerns that are getting in the way of our relationship.
19. Her attitude toward me depends partly on how I am feeling about myself.
20. She will freely tell me her own thoughts and feelings, when I want to know them.
21. She is indifferent to me.
22. At times she jumps to the conclusion that I feel more strongly or more concerned about something than I actually do.
23. She behaves just the way that she is, in our relationship.
24. She says more about herself than I am really interested to hear.
25. She appreciates me.
26. Sometimes she thinks I feel a certain way because she feels that way.
27. I do not think she hides anything from herself that she feels with me.
+1: I feel that it is probably true, or more true than untrue.
+2: I feel it is true.
+3: I strongly feel that it is true.

-1: I feel that it is probably untrue, or more untrue than true.
-2: I feel it is untrue.
-3: I strongly feel that it is untrue.

29. She likes me in some ways, dislikes me in others.
30. She adopts a professional role that makes it hard for me to know what
she is like as a person.
31. She is friendly and warm toward me.
32. She understands me.
33. If I feel negatively toward her she responds negatively to me.
34. She tells me what she thinks about me whether I want to know it or not.
35. She cares about me.
36. Her attitudes toward some of the things I say or do stop her from
really understanding me.
37. She does not avoid anything that is important for our relationship.
38. Whether I am expressing "good" feelings or "bad" ones seems to make no
difference to how positively - or how negatively - she feels toward me.
39. She is uncomfortable when I ask her something about herself.
40. She feels that I am dull and uninteresting.
41. She understands what I say from a detached, objective point of view.
42. I feel that I can trust her to be honest with me.
43. Sometimes she is warmly responsive to me, at other times cold or disapproving.
44. She expresses ideas or feelings of her own that I am not really interested in.
45. She is interested in me.
46. She appreciates what my experiences feel like to me.
47. She is secure and comfortable in our relationship.
48. Depending on her mood, she sometimes responds to me with quite a lot
more warmth and interest than she does at other times.
49. She wants to say as little as possible about her own thoughts and feelings.
50. She just tolerates me.
51. She is playing a role with me.
52. She is equally appreciative - or equally unappreciative - of me, whatever
I am telling her about myself.
53. Her own feelings and thoughts are always available to me, but never
imposed on me.
54. She does not really care what happens to me.
55. She does not realize how strongly I feel about some of the things we discuss.
56. There are times when I feel her outward response is quite different
from her inner reaction to me.
57. Her general feeling toward me varies considerably.
58. She is willing for me to use our times for me to get to know her better,
if or when I want to.
59. She seems to really value me.
60. She responds to me mechanically.
61. I don't think that she is being honest with herself about the way
she feels toward me.
62. Whether I like or dislike myself makes no difference to the way she
feels about me.
63. She is more interested in expressing and communicating herself than
in knowing and understanding me.
64. She dislikes me.
65. I feel that she is being genuine with me.
+1: I feel that it is probably true, or more true than untrue.
+2: I feel it is true.
+3: I strongly feel that it is true.

-1: I feel that it is probably untrue, or more untrue than true.
-2: I feel it is untrue.
-3: I strongly feel that it is untrue.

69. Sometimes she responds quite positively to me, at other times she seems indifferent.
70. She is unwilling to tell me how she feels about me.
71. She is impatient with me.
72. Sometimes she is not at all comfortable, but we go on, outwardly ignoring it.
74. She likes me better when I behave in some ways than when I behave in other ways.
75. She is willing to tell me her actual response to anything I say or do.
76. She feels deep affection for me.
77. She usually understands all of what I say to her.
78. She does not try to mislead me about her own thoughts or feelings.
79. Whether I feel fine or feel awful makes no difference to how warmly and appreciatively or how coldly or unappreciatively she feels toward me.
80. She tends to evade any attempt that I make to get to know her better.
81. She regards me as a disagreeable person.
83. What she says gives a false impression of her total reaction to me.
84. I can be very critical of her or very appreciative of her without it changing her feeling toward me.
86. At times she feels contempt for me.
87. When I do not say what I mean at all clearly she still understands me.
88. She tries to avoid telling me anything that might upset me.
89. Her general feeling toward me (of liking, respect, dislike, trust, criticism, anger, etc.) reflects the way that I am feeling toward her.
91. She tries to understand me from her own point of view.
92. She can be deeply and fully aware of my most painful feelings without being distressed or burdened by them herself.
APPENDIX D

PRETHERAPY TRAINING TAPE

As I'm sure you've been told by now, the experiment you're taking part in is about aspects of psychotherapy. We're interested in teaching you some things about how psychotherapy works. You may already know quite a bit about psychological treatment. In fact, many of you may have been to see a therapist or counselor at one time or another. Even if you've never received this kind of help, you probably have some ideas about it.

Psychological ideas are everywhere these days. Books, movies, and television are filled with psychological plots and themes which often include scenes from therapy sessions. These portrayals may have helped create an image in your mind of how therapy should go. You may know someone, a friend or relative, who's received psychological help. They may have told you something about it. One way or another, most people have developed some impression of psychotherapy.

Imagine what you would expect if you had some problem you felt a psychotherapist could help you with. Imagine that you've gotten up the courage to ask for help, and you're about to visit your therapist for the first time. How do you think or hope your therapist would act? What kind of person would he or she be? How would he or she expect you to act? Imagine yourself meeting this therapist for the first time. What would he or she want you to talk about? What would you want him or her to do to make you feel better?

I'm sure you've got at least some vague answers to most of these questions. Some of your ideas are probably more accurate than others.
Some may be very inaccurate, too. For instance, many people believe the therapist can read your mind about a moderate number of things. Very few, if any, therapists claim to read minds, but the majority of people think psychologists and psychiatrists are at least fairly good mind-readers. On the other hand, some of your notions may be very accurate. If you think a therapist would want to know exactly how you think and feel about your problems, you're absolutely right.

The point is that when most people come to a therapist for the first time, they've got ideas about what to expect. Some of these ideas are more accurate than others. If the person and his or her therapist expect pretty much the same things, then there'll be few surprises for either, and things will go smoothly. If they expect different things, then the person may find him or herself confused or frustrated about how to act in therapy. For most people, therapy is a very new situation, and if they have no idea how to act, they'll be a little uncomfortable. Even though the therapist will do his or her best to minimize any discomfort, the person will do better if he or she knows what to expect.

As is true of people in general, therapists have different ideas about how their work should be done. Some of these differences are theoretical, but many are practical as well. For instance, some believe that talking about your childhood or your dreams can be very helpful. Others feel this isn't very important. Other differences between therapists are more personal. Some are bigger talkers than others. Some prefer to listen more. There are some differences between what different therapists would want you to do in the first
The majority of therapists would agree on several points. Most would agree that it's not good to give their patients a lot of advice. Most would also agree that the patient should be free to do most of the talking. These two facts may surprise you. Most people come to therapy expecting that they'll tell their therapist a little about their problems and that the therapist will have some good advice that'll solve everything just like that.

This isn't true. For most kinds of problems, it just doesn't work like that. Why not? For a number of reasons. Before a person gets to therapy he or she has probably already gotten advice from all kinds of people: from his or her spouse, from parents and friends, from the family doctor, the priest or minister, and so on. Most of the people know the patient better than the therapist does. If it were just a matter of 'giving advice, there would be little reason to think that the therapist would be that much better at it than the people who've always advised the person.

Actually, therapists find that most people have a pretty good idea of what's gone wrong. The person's wife or family doctor can tell what is wrong. The problem with giving advice is that even if you give advice to a person with a problem just like your own, the advice you give may have worked for you, but it's not likely to help someone else in the same way. If all the advice the patient had received had helped, chances are he wouldn't be visiting the therapist. Usually the therapist's job is to help the person find his own solution, to discover what he or she wants and how to get it.
Many people also have ideas about how often they'd like to be able to see their therapist. If asked, the majority of people would be likely to say they'd like to see their therapist on a walk-in basis, kind of a "whenever I feel the need" arrangement. Most therapists don't work that way. They usually prefer to see their patients for an hour each week. Therapists feel that most people need to work steadily at changing whatever is causing problems in their life. Weekly appointments seem to be the best way to work steadily. Nonetheless, most people have at least a little difficulty with this arrangement. It's probably the best, but not a perfect arrangement. Most people find it a little difficult to come in for a first session, but are usually enthusiastic for a while after that. Sooner or later, though, everyone has a week or two where they'd rather do anything else but go to the therapist. Usually, these are the times when it's most important to go. Often these are the times when something very important is going on. Maybe the therapist and patient had agreed that the patient should make some change in his or her life. Imagine yourself in that situation. We've all been in spots where it was frightening to try something new, and it's hard to change old habits. It might be a lot easier just to skip the appointment with the therapist. Nearly everyone who goes to see a psychotherapist has weeks like this.

On the other hand, some people who start therapy with lots of enthusiasm become discouraged that things aren't moving fast enough. We all wish there were a magic pill or something like it that would solve our problems instantly. Therapists would be glad if they had simple cures to hand out, too, but it sometimes seems that change takes forever. This kind of feeling is not uncommon. Most therapists
would be glad to talk with you about it if you were feeling that way.

Another problem that may keep people from coming to appointments
is this: they may get upset with their therapist over something or
other. For instance, they may feel they're being pressured to do too
much before they feel ready. Many people find it difficult to tell
their therapists about these kind of things. It may seem easier to
avoid the therapist than to tell him you're upset with him or her,
but it's really important to try. Therapists are much like anyone
else. They really don't enjoy having people upset with them, but
they are trained to realize how important it is that their patients
feel free to tell them about anything that's bothering them. Most
therapists would be glad to talk about disagreements with their patients.
What's more, the therapist would likely be grateful to the patient for
being honest.

These are just some of the reasons a person might want to skip
some appointments with his or her therapist. These are the appointments
that are usually the most important to keep, because there's usually
something pretty important going on.

Self-Disclosure

Probably the most important thing you could learn about therapy
and what to expect is that a person needs to disclose a lot about
himself to the therapist. What do we mean by disclosure? Well, mostly
that a person needs to share his feelings, his fears, his hopes, and so
forth with his therapist. This is not necessarily an easy thing to do,
but it is probably the most important thing a person does in therapy.

Sharing your feelings sounds easy enough, but there are many
reasons why it's difficult. There are lots of pressures on a person
not to be fully open about the way he thinks and feels. Perhaps the
strongest one is that socially we're taught not to talk too much about ourselves. We grow up being taught to avoid being self-centered or egotistical. We're told, "Don't think of yourself so much, think of others and their feelings, only selfish people think of themselves."

It's true that there are plenty of places where putting yourself on the line like this just wouldn't be appropriate. Like at a party, you wouldn't want to spend all your time talking about your inner secrets with someone you'd met for the first time. That would probably make you both uncomfortable. "These folks are morbid," someone might say, or, "Too heavy for me." With a really good friend, on the other hand, too much small talk might seem a little strange. With a good friend, self-disclosure is definitely okay. As a general rule, people tell their feelings to others they've known the longest and trust the most.

The relationship with the therapist is different from most other relationships. Right from the start, he or she expects you to try and treat him or her as if he/she were an old friend, or, more accurately, to trust him or her with your more private feelings. From the very first interview, he/she needs to become aware of your thoughts and emotions. Keeping these feelings to yourself could turn out to be like going to a medical doctor and telling the doctor you don't feel good but not telling him where it hurts. The doctor would have a pretty hard time curing you if he or she didn't know what was wrong. Psychotherapists usually don't cure people the same way medical doctors do. They don't usually have a simple cure, like a pill, or some simple advice to fix things up, but they do need to understand a problem as
fully as possible to help people work out a good solution.

Another reason people keep feelings to themselves is "politeness." Everyone ever born has both positive feelings and negative feelings—emotions and thoughts that are pleasing and ones that are troubling. We've all been taught that certain of these feelings are best kept to yourself. For instance, most people feel angry at someone else from time to time, but most of us have to get fairly irritated before we'll say anything about it. Jealousy is another feeling like that. Anger and jealousy are both things people tend to keep to themselves if they can. Not only do we keep these feelings to ourselves for the sake of others, but also for our own sakes. Most of us would prefer friends who weren't angry all the time, but, more importantly, we like to think of ourselves as people who are basically good, as people who don't have a lot of what we might consider bad feelings. We tend not to recognize the fact that everyone has these feelings. So, many of us try to ignore these "bad" feelings, pretend they're not there. This certainly isn't a wrong thing to do, but part of therapy is attending to all of your feelings and thoughts and sorting out the important ones.

But still it might not be clear what is meant by self-disclosure. Let me give a quick example of what I mean. Self-disclosure can mean the difference between just telling what happened or what's happening and actually letting a person know how you experienced it. For instance, suppose someone asked you how your date went last Saturday night, and you answer, "Oh, pretty good. We saw the China Syndrome, then we went out for a few drinks and got in around one in the morning." Suppose you're answering again, and this time you say, "Well, it turned out
pretty good. I was kind of nervous at first. It was our first time out, but it turned out we could really get along well." Which answer would you say tells you more about the way this person felt about the date? The first answer has more factual information, but the second response tells a lot more about feelings.

Let's try another. This time, I'd like to show you a few scenes from a simulated psychotherapy session. I think you'll find them interesting, but pay attention to which segment shows greater self-disclosure.

So, imagine that what you're about to see is the fourth interview between John and his psychotherapist......

Therapist: Well, you remember how we talked last week about your trying to find more people to get to be friendly with, so that in some ways you don't feel so lonesome for your friends back home and your family back home? I asked you to try every day just going up and starting a conversation with somebody, a different person every day--just to give you a chance to get out and meet some people, giving you a chance to meet some new folks. How did that go this week?

Client: It went pretty good.

T: You were able to try that?

C: Yeah. I talked to a different person every day like you asked.

T: Uh hunh. Did you enjoy doing that? Was it a pleasant thing for you?

C: It was okay. It wasn't real difficult to do.

T: Uh hunh.

C: It wasn't real easy, but I did it every day.

T: Where did you talk to people?

C: I talked to them in my dorm room, oh, for about five minutes.
Contrast this with the same scene played a different way, paying attention to the relative levels of self-disclosure.

T: Well, you remember how we talked last week about your starting to try every day to find someone to talk to? You were to just go up and start a conversation with somebody. How did that go this week when you tried it?

C: It was...uh...I remember what you told me about how to do it, what to say to myself to get me to do it. If I hadn't remembered that and worked on it, I probably wouldn't have done it. It was kind of scary to go up to someone I didn't know and do that. So I had to really force myself to do it, and I was really nervous when I'd go up to them.

T: Uh hunh. You started having feelings of not wanting to do it, that it was something a little frightening for you.

C: Yeah. It was not the ordinary thing I'd do, and I was kind of noticeably uncomfortable and a little worried. Like I could feel a little cold in my hands. But I remembered what you said to do, and I forced myself to think that way and to do it. And just about everyone I did that with...it went pretty well, and I was pretty relieved that it did. I had a pretty good conversation with them.

It is fairly clear that the second segment shows John sharing more of his feelings, being more open with his therapist. This is the kind of openness most psychotherapists agree is helpful in therapy.

The examples and explanations I've given are intended to tell you about how people who seek psychological help can best make use of their therapy to get the things or make the changes they want. In a moment, you'll move on to the final phase of the experiment. Thanks for your assistance.
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APPENDIX E: EXPERIMENTAL DATA
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<th>Education</th>
<th>Race</th>
<th>Religion</th>
<th>SES</th>
<th>Previous Treatment</th>
<th>ATSPPH Score</th>
<th>BRI Score</th>
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Note: The table contains numerical data and categorical variables representing various subjects and their attributes. The data seems to be related to psychological or statistical analysis, with columns for different subject categories and rows for specific data points.
<table>
<thead>
<tr>
<th>Subject</th>
<th>Group</th>
<th>Age</th>
<th>Education</th>
<th>Race</th>
<th>Religion</th>
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<th>Pre</th>
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<th>Post</th>
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<th>BRI Score</th>
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Data Codes

Groups
PT=Positive Attitude Treatment
PC=Positive Attitude Controls
NT=Negative Attitude Treatment
NC=Negative Attitude Controls

Race
1=American Indian
2=Black
3=Caucasian
4=Oriental
5=Other

Religion
1=Catholic
2=Protestant
3=Jewish
4=Other
5=No Preference

SES--Hollingshead Two-Factor Index
1=Upper class - salaried positions in executive level
2=Upper middle
3=Middle
4=Working class
5=Poor

Previous Treatment
1=Yes
0=No

Demand
1=aware of at least 1 experimental hypothesis
0=not aware of experimental hypotheses

Realism & Role-taking
7-point Likert-type scales, with higher numbers reflecting more favorable ratings

Perceived Change
1=self-report of change in attitude
0=self-report of no change
TABLE 1

Experimental Design Flow Chart

<table>
<thead>
<tr>
<th>SESSION ONE</th>
<th>SESSION TWO</th>
<th>Pre-treatment</th>
<th>Treatment</th>
<th>Post-treatment</th>
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<td>Groups constituted on basis of ATSPPH scores</td>
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<td>Readminister to all subjects:</td>
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<td>PC Positive/Control</td>
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<td>MT Negative/Treatment</td>
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Table 2
Tests of Group Equivalence on Demographic Variables

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<table>
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Table 3

Unweighted Means Analysis of Variance:

Post-test Attitude Scale Scores

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<th>F</th>
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<td>2324.62</td>
<td>38.869*</td>
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* p<.01
Table 4

Analysis of Variance with Repeated Measures
of the Rating Scale (BRI)

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<td>Pre/Post</td>
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* p < .05
Table 5
Analysis of Variance of Pre-post Rating Scale (BRI) Difference Scores

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* p<.05
Figure 1. Attitude Toward Seeking Professional Psychological Help (ATSPPH) Group Means
Figure 2. Rating Scale (Barrett-Lennard Relationship Inventory) Group Means.