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Margaret Zofia Cegielski

Iowa State University

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THE EFFECT OF INFORMATION ABOUT COUNSELING PROCESS OR THE COUNSELING CENTER ON MULTIPLE MEASURES OF COUNSELING OUTCOME AT A UNIVERSITY COUNSELING SERVICE

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The effect of information about counseling process or the counseling center on multiple measures of counseling outcome at a university counseling service

by

Margaret Zofia Cegielski

A Dissertation Submitted to the Graduate Faculty in Partial Fulfillment of the Requirements for the Degree of DOCTOR OF PHILOSOPHY

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1981
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INTRODUCTION

In 1952, Eysenck made the provocative assertion that the change eventuating from psychotherapy was no greater than what resulted as a consequence of naturally occurring life experiences. Since that time, research activity in the area of psychotherapy outcome has proliferated at intense rates as some investigators claim that treatment is effective and others proffer rebuttals that it is useless. Contrary to Eysenck's claim, Luborsky, Singer, and Luborsky's (1975) analysis and synthesis of 25 years of research on the efficacy of psychotherapy resulted in the conclusion that most forms of psychotherapy produce change in a meaningful number of patients, and that this change is frequently greater than that attained by control patients not receiving treatment. Comparably favorable conclusions were drawn by Smith and Glass (1977) as a result of their meta-analysis of 375 outcome studies. Their investigation revealed that the average therapy patient is better off than 75% of untreated individuals, regardless of type of treatment, client, therapist, or outcome criteria.

Stemming from the more general question of therapeutic efficacy, the topic of specific vs. nonspecific factors in psychotherapy continues to be an issue of central importance (Strupp, 1978). Typically, proponents of each therapy system credit their results to the more or less specific therapeutic techniques to which they subscribe. So far, however, it has not been demonstrated that one technique is
clearly superior to another (Bergin and Lambert, 1978; Luborsky et al., 1975; Sloane, Cristol, Pepernik, and Staples, 1970). Eysenck's often quoted figure that approximately 2/3 of all neurotic patients who enter outpatient psychotherapy, regardless of orientation, evidence marked improvement, (Garfield and Bergin, 1978; Lambert, 1976) supports a skeptical view regarding the unique potency of any particular technique.

Several reviews have summarized the research on studies comparing the effects of different modes of psychotherapy. Meltzoff and Kornreich (1970) reviewed 38 studies relevant to the issue of differential outcome and concluded that evidence is lacking that one traditional school of psychotherapy yields better outcomes than another. Luborsky et al. (1975) reviewed over 100 comparative studies, some of which overlapped with the Meltzoff and Kornreich review, and drew the similar conclusion that most studies which compare different forms of psychotherapy find insignificant differences in improved clients. More recently, Bergin and Lambert (1978) in their extensive consideration of therapeutic outcome summarized the comparative effects of different psychotherapies as follows: "psychoanalytic, insight therapies, humanistic or client-centered psychotherapy, many behavioral therapy techniques and, to a lesser degree cognitive therapies, rest on a reasonable empirical base. They do achieve results that are superior to no treatment and to various placebo treatment procedures. Generally, the above schools of therapy have been found to be about
equally effective with the broad spectrum of outpatients to whom they are typically applied" (Garfield and Bergin, 1978, p. 170).

Thus, appreciable evidence indicates that traditional therapeutic procedures, as well as many behavioral techniques yield beneficial results. Yet, with the exception of behavioral approaches to certain circumscribed disorders, the application of particular techniques fails to provide new insight into how psychotherapy works (Strupp, 1978).

Psychotherapy and the Placebo Effect

Alternative hypotheses to explain psychotherapeutic efficacy have been advanced (Shapiro and Morris, 1978; Frank, 1973). These hypotheses seek to explain treatment results by means other than the specific action of a given therapeutic method. Rather, they invoke concepts of placebo genesis or nonspecific effects to account for the effectiveness of various methods of psychotherapy.

The original definition of placebo appeared in Motherby's New Medical Dictionary (Motherby, 1795) and defined it as a "commonplace method or medicine". Currently, a placebo is defined as any therapy or component of therapy that is deliberately used for its nonspecific or psychological effect, or that is used for its presumed specific effect, but is without specific activity for the condition being treated (Shapiro and Morris, 1978). Thus, a placebo effect is defined as the psychological or psychophysiological effect produced by placebos. In contrast to nonspecific effects, specific activity is
the therapeutic influence attributable solely to the contents of process of the therapy rendered (Shapiro and Morris, 1978). This definition of specific activity does not speak to the operation of nonspecific or placebo action. However, as long as the recipient of therapy is aware that s/he is receiving treatment, even specific therapy results are likely to be the result of both placebo and nonplacebo effects.

The proponents of the nonspecific effects hypothesis call into question the commonly accepted view that psychotherapy is a treatment based on scientific principles. Shapiro and Morris (1978) view the placebo effect as an important component "and perhaps the entire basis for the existence, popularity, and effectiveness of numerous methods of psychotherapy" (p. 369). Similarly, in his classic book, Persuasion and Healing, Frank (1973) asserts that the majority of psychotherapeutic change is the result of the action of factors shared by all therapeutic approaches. According to Frank, these nonspecific factors are generated by the human relationship between therapist and client and include understanding, respect, interest, encouragement, acceptance, and forgiveness. Since the client seeking therapy is presumably experiencing demoralization and feelings of hopelessness, these nonspecific but supportive elements of the therapeutic relationship are likely to elevate his/her morale, which in turn is registered as improvement (Shapiro and Morris, 1978).
Besides the supportive elements just mentioned, Frank identifies the conceptual scheme which all psychotherapies provide as another important common factor of all therapies. The client's demoralization is defied by an explanation for hitherto unexplained feelings and behaviors. Accordingly, this new found understanding abates the mystery of the client's suffering and eventually replaces it with positive expectancy.

Nonspecific effects receive considerable empirical support from Luborsky et al.'s (1975) critical review comparing studies of psychotherapeutic effectiveness. Since a high proportion of clients receiving any of the psychotherapies tended to improve, Luborsky et al. concluded that the most telling explanation for the lack of difference between treatments was that improvement was related to the client-therapist relationship shared by all forms of psychotherapy. Indeed, a multitude of evidence, gathered from many clinical studies of diverse client problems and treatments, yields a clear conclusion: the therapist's interest and involvement in the client and the therapy is related to both success in treatment and placebo effects (Shapiro and Morris, 1978). What is not clear, however, is how the obviously complex interaction between the therapist, and his/her interest in the treatment, and the client ultimately influence psychotherapy outcome.

Attention to the placebo effect in psychotherapy is aimed at bifurcating the specific and nonspecific factors in treatment. In 1958,
Gliedman, Nash, Imber, Stone, and Frank wrote that a true understanding of the specific components of psychotherapy can only occur when the components of the placebo effect are also understood. Gliedman et al.'s view that the study of the placebo effect will help differentiate specific from nonspecific factors in psychotherapy is expanded upon by Shapiro and Morris' (1978) statement that, because both psychotherapy and the placebo effect function primarily via psychological mechanisms, the placebo effect may have greater implications for psychotherapy than any specific form of treatment.

Thus, although an appreciation of nonspecific effects has lead to the proliferation of controlled clinical studies, a perusal of the placebo effects literature reveals a disheartening wealth of conflicting findings and replication failures. These equivocal findings are largely due to the diverse subject populations, settings, methods of treatment, types of illness and/or problems, and change measurement methods which are used in research. Even when identical procedures are used in similar populations, replication is infrequent (Kellogg and Baron, 1975; Storms and Nisbett, 1970). Rather than concluding that the placebo effect is a multidetermined phenomenon influenced by the interrelationship of many factors and processes. Although explanations of the placebo effect often stem from ex-post facto theorizing rather than empirical inquiry, many processes have been advanced to explain placebo effects. To date, empirical verification to support hypotheses
about placebo action is largely lacking and the action by which placebos cause their effects remains unknown.

Concepts of Placebogenesis

Three general themes serve to group the differing placebogenic modes of action: 1) social influence effects, 2) evaluation effects, and 3) expectancy effects (Shapiro and Morris, 1978; Shapiro, 1964).

Social Influence Effects. Several mechanisms arising out of the societal perception of the therapist as a socially powerful individual, may account for placebo action. Suggestibility is most commonly cited as a mode of placebo action. Measures of suggestibility have been found to correlate positively with placebo reaction, and several investigators have assumed that the placebo effect is simply a variation of the suggestibility response (Strupp, Levenson, Manuck, Snell, Hinrichsen, and Boyd, 1974; Beecher, 1968; Frank et al., 1957).

Persuasion has also been advanced as a social influence explanation for the placebo effect (Liberman, 1961). It results from the therapist's persuasive influence, which is augmented since s/he is probably viewed as expert and trustworthy. When persuasion enables the therapist's social influence, the client is viewed as a rational individual and the power of the therapist's argument is stressed. In contrast, when suggestibility is the mode of social influence, the client is viewed as gullible and yielding.

The transference explanation of social influence effects views the placebo response as the outgrowth of the client-therapist relationship.
Social influence effects may function via transference or the unknowing displacement by the client of feelings that had been attached to significant persons in the past. Accordingly, salutary placebo effects stem from a positive transference resulting from satisfactory early experiences with significant others, or by clients who expect comfort from the therapist despite unsatisfactory early relationships. Positive transference may manifest itself via dramatic symptom reduction (Shapiro and Morris, 1978).

**Evaluation Effects.** Evaluation effects are a different class of processes influencing placebo action, and are derived from attempts to evaluate the placebo response. It is likely for example, that clients may modify their subjective reports and even change their behavior because of their awareness that they are being evaluated. Also, because so much variance exists in the methods used to assess placebo effects, the assessment itself can distort the data (Nelson, Lipinski, and Black, 1975). Similarly, stemming from the client's apprehension about being evaluated, or prompted by a desire to please the therapist, the operation of response bias may erroneously be attributed to placebo effects (Tedeschi, Schlenker, and Bonoma, 1970). Furthermore, in searching for an explanation for the arousal produced by initial aspects of therapy, clients may assign a label denoting therapeutic success to their experience (Wilkins, 1973).
**Expectancy Effects.** The third (and most pertinent to this study) mechanism of action proposed to explain placebogenesis is that of expectancy effects. Besides establishing a special relationship with their clients, therapists, both intentionally and unintentionally, communicate expectations about effects of treatment. If the therapist does not make these expectations explicit, the client may search for cues or rely on his/her own knowledge and values (Morris and O'Neal, 1975). In this way, specific attitudes or expectancies function as important nonspecific facets of therapy (Goldstein, 1962; Goldstein, 1960a; Frank et al., 1957).

Four models have been proposed to explain the contribution of expectancy to nonspecific therapy effects. First, classical conditioning is the likely determinant of the placebo effect, when expectations are produced by prior temporal association. Both human and animal subjects have evidenced classically conditioned reactions to drugs (Thornton and Jacobs, 1971; Seligman and Maier, 1967). For example, the organism's association of an injection with the subsequent physiological reaction will eventually produce the same physiological response to the mere expectation of the injection.

Second, Festinger's (1957) cognitive dissonance paradigm has been advanced as a motivational explanation for nonspecific actions in therapy. Accordingly, when a discrepancy exists between two beliefs, the individual is motivated to reduce the internal aversive state created by this discrepancy. An individual's belief in the power of
the therapist and therapy to produce positive results, will create a state of dissonance, if the person does not start to feel better. In order to reduce this state of dissonance, a placebo effect may even-tuate. Thus, the expectation that therapy will produce a certain effect, can lead to its occurrence.

Hope, defined as the combination of expectations with desire (Frank, 1961) is the third way that expectancy may contribute to non-specific actions in therapy. Hope involves the integration of physiological arousal with thoughts that envision positive changes in one's life situation, and is a necessary element for the motivation of goals (Stotland, 1969). According to Frank (1961), hope has a direct influencing effect on the reduction of anxiety, depression, and other symptoms of psychological malaise.

The fourth way that expectation may contribute to placebogenesis is by influencing the internal standard by which the client evaluates the effects of treatment. The evaluation of therapy is a subjective process, since similar results could be assessed as a success or a failure, depending on the criterion used to make the judgment. Expectations play an important role in determining the nature and strength of this internal standard. Thus, for example, if a client's expectations about treatment are negatively discrepant with his/her therapeutic experience, clinical worsening or premature termination may result (Garfield, 1978).
Expectancy Effect and Premature Termination in Psychotherapy

Early in the history of expectancy effects research efforts emerged which attempted to utilize these effects to solve the age old problem plaguing physicians and psychotherapists alike: getting patients to stay in treatment. The problem of patients leaving psychotherapy prematurely was addressed by one group of researchers more than two decades ago (Frank, Gliedman, Imber, Nash, and Stone, 1957). They wrote as follows: "The responsiveness of a patient to a given form of psychotherapy involves two components: his staying in treatment and his improvement under it. The first is a necessary but not sufficient, condition for the second—a patient cannot improve under psychotherapy unless he remains in treatment" (p. 284, 1957). Although this observation of Frank et al. may not seem remarkable, their 1957 report that 30% to 65% of patients leave treatment after extensive and time consuming initial examinations, attests to the historically significant problem of premature termination.

More recently, in their critical review of the literature on dropping out of treatment, Baekeland and Lundwall (1975) wrote that one of the most vexing problems facing the healer, is that far too many clients leave therapy before they have completed it to the therapist's satisfaction. These researchers critically analyzed the literature on dropping out of treatment and identified 15 factors that were predictive of early terminations. One conclusion drawn by Baekeland and Lundwall was that discrepant expectations about treat-
ment promote premature termination. This conclusion was later questioned by Garfield (1977), since it had been based on a minimal sample of studies which were not cross-validated.

Garfield (1978) addressed the issue of continuation in treatment, in his review of the research pertaining to client variables in psychotherapy. According to Garfield's review of 14 representative studies, premature terminators (clients who end treatment before mutuality of agreement that therapy has been completed) constitute a large percentage of those who begin therapy. Specifically, Garfield found that most clinics lose one-half of their clients after five or six interviews. In all studies reviewed, this pattern was seen as a problem and not the result of an agreement between therapist and client that therapy should be terminated.

Two approaches for dealing with the problem of premature termination are evident from the existing literature (Garfield, 1978). One approach regards the provision of treatment to those who are likely to terminate prematurely as a waste of professional effort. This approach places the blame for the problem on the "unsuitable client" and thereby implies that a more careful screening of clients should take place before they are accepted for treatment. In essence, this solution to the dropping out of treatment problem favors the YAVIS (young, attractive, verbal, intelligent, social) client as most suitable for treatment.

A second approach, and one that focuses less blame for dropping
out of treatment on the client; is one that takes cognizance of the client's expectations about therapy which may not be congruent with those of the therapist. Several studies have examined the role played by discrepant therapist and client therapy expectations (Baekeland and Lundwall, 1975) and found that discrepant therapy expectations were associated with dropping out of treatment (Fiester and Kjell, 1975; Hoehn-Saric, Frank, Imber, Nash, Stone and Battle, 1964; Heine and Trosman, 1960).

Research on the drop-out phenomenon has largely focused on client input variables such as demographic data, since investigators have tended to conceptualize dropouts as being characterized by a certain type of client. Fiester and Kjell (1975) addressed this question by conducting a principal components factor analysis on dropout and nondropout groups at a hospital based mental health center. They concluded that viewing dropouts as characterized by one single type of individual is another unfounded homogeneity myth (Kiesler, 1971). Thus, attempts to characterize the typical premature terminator have proved largely futile, and reviewers have concluded that existing relevant knowledge is clouded by a morass of confusing and contradictory findings (Garfield and Bergin, 1978; Warren and Rice, 1972; Garfield, 1971). However, one conclusion that seems warranted is that lower socioeconomic status (SES) clients contribute disproportionately to dropout rates (Fiester and Kjell, 1975; Lorion, 1974; Jacobs et al., 1972; Warren and Rice, 1972).
As Hollingshead and Redlich's (1958) landmark studies concerning social class and mental illness revealed, a substantial incongruity exists between conceptualizations of treatment held by lower socio-economic status (SES) clients and those held by their therapists. Besides misaligned expectations, research repeatedly suggests that lower class patients tend not to seek therapy until problems are urgent (Heitler, 1976; Riessman and Scribner, 1965); are most likely to terminate prematurely (Overall and Aronson, 1962); and tend to benefit least from verbal psychotherapy when they do remain in treatment (Heitler, 1973; Hunt, 1960).

Such findings have led to polemics between those who interpret them as meaning that traditional psychotherapy is inappropriate for lower SES clientele (Lorion, 1974; Hunt, 1960), and those who maintain that routine exclusion of lower class patients from psychotherapy is an inadequate solution (Heitler, 1976; Orne and Wender, 1968; Overall and Aronson, 1962). Those who take the latter position, also typically hold that the benefits of traditional psychotherapy should be extended to lower class patients through special efforts to facilitate the quality of the therapeutic relationship (Heitler, 1976; Lorion, 1974).

The New Haven studies (Hollingshead and Redlich, 1958) suggested that the boundaries of verbal psychotherapy oppose the expectations, as well as the typical methods of problem solving of lower class patients. Since that time, accumulating evidence has led to agreement among researchers that "dissymmetry of expectations not only
interferes with the therapeutic task, but can actually lead to the premature death of a therapeutic system" (Lennard and Bernstein, 1960, p. 128).

Overall and Aronson (1962) were among the first to examine the expectations of lower class clients about psychotherapy, as well as the effects of those expectations on early termination. Forty lower SES clients were given questionnaires both before and after their first interview, assessing such expectancies as therapist activity or passivity, emphasis on medical or psychological problems, and use of supportive therapy. These investigators found that their sample of clients tended to expect a medical psychiatric interview, with the therapist taking an active, permissive role. Discontinuation of treatment occurred most often among clients whose expectations were most misaligned. Overall and Aronson concluded that efforts should be made, during initial phases of treatment, to reduce cognitive inaccuracies by reeducating the patient about his/her own, as well as the therapist's role in treatment.

Reflecting the attitudes of other investigators (Overall and Aronson, 1962; Heine and Trosman, 1960), Lorion (1974) wrote that if clients enter treatment with negative attitudes and inappropriate expectations, the burden of responsibility rests on the mental health profession to implement procedures that will increase the probability that available services will be used by those in need. Lorion further pointed out, the frequently overlooked perspective, that
clients' expectations about treatment may validly reflect their awareness of environmental limits to possible solutions.

Expectancy Effects and Psychotherapy Process and Outcome

Theory and research in a variety of human behaviors have demonstrated expectation to be a major influencing factor on that behavior (Frank, 1973; Goldstein, 1960). Historically, the concept of expectancy emerged from the research on "placebo effect" described in the medical literature (Wilkins, 1973). In the late 1950s, placebo effect as found in medical research was conceptually translated to expectancy effect in the psychotherapy literature (Wilkins, 1973). Rosenthal and Frank (1956) were among the first investigators to suggest that expectancy or client beliefs have effects, specifically on psychotherapy outcome.

It is of historical interest to note that as far back as 1936, Breur and Freud cast a negative vote on the expectancy issue, stating: "It would be quite reasonable to suspect that one deals here with an unintentional suggestion. The patient expects to be relieved of his suffering and it is this expectation and not the discussion that is the effectual factor. But this is not so." (Breur and Freud, 1936, p. 4).

Twenty years later Cartwright and Cartwright (1958) also disparaged the import of expectancy and therapeutic outcome. They wrote "...we have no confidence in predicting any particular relationship between degree of belief...that certain effects will result, and de-
The Expectation-Reality Discrepancy. In a paper presented at APA (1963), Cartwright stated that "... how far the patient can go in using the opportunity of psychotherapy for making positive personality changes is largely predetermined by the kind of structure he brings to the experience...." Consistent with Cartwright's somewhat altered assumption, Levitt (1966) offered the hypothesis that a negative correlation exists between the effectiveness of any psychotherapeutic intervention and the discrepancy between the patient's expectation of the nature of the therapy process and the reality of that encounter. Levitt refers to this concept as the "expectation-reality discrepancy" (ERD). In his review of preparatory techniques for lower SES clients, Heitler (1976) agreed that widely discrepant role expectations make the establishment of a truly therapeutic alliance difficult.

Although data bearing directly on the relationship between ERD and therapy outcome are yet scanty, considerable evidence indicates that ERD is a widespread phenomenon. Every public opinion survey which was ever been conducted indicates that the public is misinformed about the psychotherapy process (Levitt, 1966). Although much of this evidence stems from studies of lower SES groups, some studies have found that more highly educated people are also not attuned to the realities of the psychotherapy process.
Nunnally's (1961) comprehensive survey sheds some insight into the expectation-reality discrepancy. Subjects (with a mean education level of 13.8 years) were asked to agree or disagree with a number of statements regarding performance of a psychiatrist. Seventy-two percent of the sample agreed that the main job of the psychiatrist is to explain to the patient the origin of his trouble; fifty-six percent agreed that the main job of the psychiatrist is to recommend hobbies and other ways for mental patients to occupy their minds; fifty-three percent agreed that psychiatrists teach their patients to live for the future instead of the present; thirty-five percent agreed that psychiatrists try to teach their mental patients to hold in strong emotions.

Beliefs about psychotherapy from a similarly educated sample were surveyed by Garfield and Wolpin (1963), providing further evidence of the ERD. Seventy percent of their subjects expected complete recovery within ten or less sessions, while forty-five percent believed that half of the therapist's time is spent giving advice in an active and expert role.

Lorion (1974) reviewed some of the major empirical studies in the ERD domain and concluded that misconceptions of the therapeutic process are widespread across social class and may be more those of degree than of kind in the lower social classes. These misconceptions seem to stem from the client's preconceptions of the psychotherapy process as something akin to the activity one encounters when interac-
ing with a medical practitioner (Lorion, 1974; Orne and Wender, 1968). Clients tend to expect that treatment will last 5-10 hours, with considerable symptom improvement coming in short order. Further they seem to expect the psychotherapist to be directive, actively probing and quickly determining what is wrong with the client, and then proceeding to tell him/her how to remedy the situation. Conversely the client tends to see him or her self as a relatively passive participant.

It is interesting to note further how the underlying assumptions of the psychotherapy field are dramatically different from expectations underlying medical treatment, particularly since an individual who lacks knowledge about the psychotherapy encounter may well interpret the situation as if it were a medical one. Specifically, as opposed to a psychotherapy client, a medical patient is often passive, coming to an expert who after the necessary examination and tests will tell the patient what must be done. Further, medical treatment, regardless of duration, rarely considers the patient's feelings (Orne and Wender, 1968).

These differences highlight the inherent incompatibility of patient roles within the medical and psychotherapeutic paradigms. Psychotherapy relies on the patient's active cooperation in treatment and will fail those individuals who expect to be passive recipients of the therapist's ministration.

It is not difficult to see how the popular expectations of thera-
psych behavior clash with the contemporary practice of psychotherapy, which intentionally leaves the onus of verbalization largely to the client. This inequity can do much to hinder the therapeutic alliance which ideally would consist of mutually understood roles, as well as the client's cooperation stemming from his/her understanding of how demands being made on the client can help reach personal goals of relief and change (Heitler, 1976). Orne and Wender (1968) are explicit in supporting this view. Their development of the Anticipatory Socialization Interview, was based on their contention that psychotherapy, like any other social interaction, can run its normal course only if participants are familiar with certain ground rules, including the purpose of the endeavor and the roles to be enacted by the participants. As Strupp aptly stated "psychotherapy, in the final analysis, must lead to self-help" (1978, p. 19).

Thus, it is not surprising to find that those researchers inclined to take a proactive, problem-solving approach to the widely documented drop-out phenomenon, attempt to do so by preparing clients for therapy. Based on findings suggesting that effects of psychotherapy may depend on the activation of the clients favorable expectations (Overall and Aronson, 1962), Hoehn-Saric et al. (1964) designed a pretreatment interview intended to clarify the expectations of psychiatric outpatients and to increase the congruence of their behavior with therapist's expectations as to how they should behave in therapy. Twenty outpatients, with a mean education of eleven years were exposed to the
Role Induction Interview (RII), while twenty patients served as controls. The RII covered the following areas: 1) a general explanation of psychotherapy; 2) an exposition of expected patient and therapist behavior; 3) preparation for phenomena such as resistance, which are typical in the progress of therapy; 4) the induction of a strong expectation for improvement within four months of treatment. Multiple in-therapy behavior and outcome measures were employed. Results showed first of all, that attendance rate was significantly higher for those subjects who were exposed to the RII. The experimental group also exhibited significantly better therapy behavior as assessed by the Therapy Behavior Scale and therapist ratings of the quality of the therapeutic relationship. Finally, outcome as assessed by therapist ratings of improvement, patient ratings of mean target improvement, and social effectiveness ratings also significantly favored the experimental group. The conclusion reached by Hoehn-Saric et al., that a pre-treatment interview has favorable effects on certain aspects of therapy behavior and outcome and is a potentially valuable tool in psychotherapy, has been supported by other similar attempts to shape client participation in treatment (Heitler, 1973; Warren and Rice, 1972; Doster, 1972).

The overall results of the Hoehn-Saric et al. (1964) study were encouraging. These results also highlighted potential problem areas for future investigators of the client preparation for therapy process. The difficulty inherent in defining and measuring therapy im-
provement, which generally plagues therapy outcome research, was made evident by this study, since several of the dependent measures failed to yield positive results. The experimental group exhibited better therapy behavior than the control group on five of seven measures; three of those five measures reached significance. The experimental group also showed more favorable results than the control group on five of eight outcome measures. Three of those five measures significantly favored the experimental group. Hoehn-Saric et al. were particularly impressed by the usefulness of a "target symptoms" (Hoehn-Saric et al., 1964) outcome measure. This measure asked the patient to state three complaints s/he most wanted changed by therapy. After therapy the patient was asked to rate the change in target symptoms on a five point scale for each symptom.

A major criticism of the Hoehn-Saric et al. study is that it was impossible to determine precisely which effect or combination of effects resulted in the observed differences between experimental and control groups. This difficulty arose because the information which was provided to the clients about therapy was confounded with the expectation for improvement in the Role Induction Interview.

A different confounding resulted from the finding that experimental group patients were rated by their therapists as having a greater ability to form a positive relationship than control group patients. Thus, the direct effect of the RII on the patient's capacity to profit from therapy was confounded with the indirect effect which
it may have had on the therapist's perceptions of the patients' treat-ability.

Finally, since in this study the Role Induction Interview was not conducted by the therapists, the question is raised as to whether the RII might best be carried out by therapist, thus enabling him/her to shape the patient's expectations to his/her own style of therapy and blend role induction efforts with the therapeutic process.

Sloane, Cristol, Pepernik, and Staples (1970) conducted a similar study in order to determine whether the explanation of the psychotherapy process or the firm suggestion that improvement should occur within four months was a more powerful aid to improvement. These investigators avoided the confounding of information and expectations via a 2 x 2 factorial design in which subjects did or did not receive expectations about outcome and did or did not receive therapy information. In contrast to Hoehn-Saric et al.'s findings, Sloane et al. found that attendance measures remained unaffected by either expectations or information. Patients' ratings of target symptoms and general adjustment were also unaffected by the experimental manipulations. However, therapists' ratings of target symptoms did indicate a significant decrease in severity for those patients receiving therapy information.

While the factorial design employed by Sloane et al. was an improvement over previous research, their study also evidenced problems. When patients were asked what they recalled about their pretraining "none were able to spontaneously recall what they had been told" (1970,
Thus, it was impossible to determine the extent to which the pretherapy indoctrination had actually changed the patients' understanding of the therapeutic process. This result clearly pointed to the need for assessing the strength of the experimental manipulations in therapy outcome research. Perhaps the greatest interpretive difficulties were posed by the fact that 50% of the patients in this study had previously been in therapy, which served to attenuate the strength of the therapy information manipulation.

**Expectancy: Empirical and Conceptual Considerations**

Since its inception, the concept of expectancy effects and its importance for eventual treatment outcome has been investigated via three basic paradigms. Some studies focus on the consequence of congruent versus incongruent therapist and client expectations by experimentally establishing congruent and incongruent therapeutic dyads to therapy. Comparison of clients in terms of the number of patients in each type of dyad benefiting from treatment are conducted post therapy. A variation of this approach involves the random assignment of subjects to groups, who then receive instructions designed to instill either high or low expectancy of therapeutic gain.

Wilkins (1973) in his review and critique of the expectancy effects literature has classified studies which experimentally induce expectancy under the rubric of expectancy state studies. The key feature of these studies is that the instructions serve as an independent variable, while differences between groups on measures of therapy
outcome serve as the dependent variable. Any attained differences are attributed to the conceptual intervening variable—subjects' expectancy. These studies are criticized by Wilkins on several methodological and conceptual grounds, including how the therapy instructions are given, whether the therapists were blind to the experimental conditions, and the confounding of measures of outcome with those of expectancy.

Overall, the experimental induction of congruent and incongruent therapeutic dyads indicates that no relationship exists between congruence of expectations and therapeutic outcome (Martin, Sterne, and Hunter, 1976; Mendelsohn and Geller, 1967; Goin, Yamamoto, and Silverman, 1965; Goldstein, 1960a). Those studies which consider remaining in treatment as an outcome measure, do show that congruence of expectations effect the dropout rate by encouraging clients to remain in therapy (Warren and Rice, 1972; Overall and Aronson, 1962; Heine and Trosman, 1960).

A noteworthy observation was revealed by Wilkins' review of studies which instilled high or low expectancy of therapeutic gain. In all cases, those expectancy state studies which yielded expectancy effects employed therapists who were not experimentally blind. Conversely, in studies failing to demonstrate expectancy effects, therapists were blind. Retrospective analysis of these data suggests that therapist variables may be responsible for results which had been attributed to the construct "expectancy of therapeutic gain". Wilkins'
comment that this may be a blessing in disguise for clinicians, as it suggests that therapeutic gain may be determined, of all things, by the therapist, is indicative of his sentiment in this regard.

A conceptual criticism of research attempting to instructionally induce expectancy becomes evident on the basis of the circularity of the definitions of experimentally induced expectancy. Rather than being identified by the operations employed, the presence or absence of expectancy is identified by the outcome which expectancy is said to produce. Clients are said to have improved because they held high expectancy of improvement. If expectancy is to be a valid construct and inappropriate conclusions based on circular definitions are to be avoided, it must be identified by measures independent of the outcome which it is said to produce.

A different paradigmatic approach is taken by the naturalistic studies which assess patient expectations at the outset of treatment and then perform post-hoc correlational analyses on patients who show positive and negative change in treatment outcome.

In view of existing evidence which supports the contention that conceptual disparities about therapy exist between therapists and their clients, several investigators have devised questionnaires to measure attitudes and expectations about psychotherapy. Assessment of expectancy most typically shows that clients expect improvement within a very short time span (Bent, Putman, Kiesler, and Nowicki, 1975; Garfield and Wolpin, 1963), and also want to be given advice. This
particular misalignment of therapist-client expectations is so common that Overall and Aronson (1962) termed such client expectations as Guidance Expectations, and conversely referred to therapists' preferences for client behavior as Participant Expectations. Similarly, Heine and Trosman (1960) labeled patients as either Passive Cooperators or Active Collaborators, and also found that premature terminators tend to expect the therapist to take complete responsibility for treatment. Continuers on the other hand, tend to expect shared responsibility.

Goin, Yamamoto, and Silverman (1965) also developed an attitude questionnaire intended to separate those clients who expected to be passive recipients of treatment, from those whose expectations were more closely related to those of the therapist. These investigators found no differences in terms of therapist ratings of improvement or drop-out rate between clients who sought and received advice and those who sought but did not receive advice. However, more clients did report satisfaction with treatment when it was congruent with their expectations.

The naturalistic studies have been characterized as studies of expectancy traits, or attitudes which the client brings into the therapy situation concerning therapeutic procedure, and what can potentially be gained. Although a number of these studies show positive associations between client expectancies and outcome (Garfield, 1978), they too have suffered methodological criticism. One common deficiency
noted is the fact that expectancies are often inferred rather than actually being measured. Interestingly, Wilkins (1973) noted methodological differences between studies reporting significant correlations between expectancy trait and therapy outcome, and those studies reporting nonsignificant correlations. Studies reporting positive results employed measure of expectancy outcome based strictly on subjects' self-reports (Friedman, 1963; Goldstein and Shipman, 1961; Goldstein, 1960b), or observer ratings based on subjects' perceptions as measures of outcome (Lipkin, 1954).

A further criticism of the expectancy trait studies stems from the fact that therapeutic improvement is attributed to expectancy effects, thus inappropriately concluding a cause-and-effect relationship on the basis of correlational data. As Friedman (1963) warned, cause-and-effect statements between expectancy and symptom reduction cannot be made with any degree of validity on the basis of correlational data. It is possible that both expectancy and therapeutic gain may be caused by some other factor.

A third group of studies, generally showing more favorable results in terms of reduced attrition rate and client improvement, employ client preparation programs and pretherapy information to induce congruent therapist and client expectations regarding their respective roles in therapy (Strupp and Bloxom, 1973; Jacobs, Charles, Jacobs, Weinstein, and Mann, 1972; Sloane, et al., 1970; Truax and Wargo, 1969; Hoehn-Saric et al., 1964). Many of these "patient socialization" ef-
Forts have been aimed at working class patients, in an effort to reduce the high incidence of premature termination which is characteristic of this group of patients. These studies directly assess the effects of the preparation for treatment on therapy process and outcome, and are based on the clinically intuitive assumption that client's who understand their therapist's assumptions, will be better able to function in therapy.

Orne and Wender's (1968) Anticipatory Socialization Interview has served as a model for other researchers involved in developing programs aimed at preparing clients for psychotherapy. In general terms, the socialization interview was designed to teach clients what is expected of them in the therapy situation, as well as what may legitimately be expected by them of the therapist.

More specifically, the intent of the socialization interview was three fold: 1) to provide a rational basis for the client to accept psychotherapy as a viable means for solving his/her problems; 2) to clarify the roles of therapist and client; 3) to provide a synopsis of the course of therapy and its vicissitudes (e.g., negative transference).

According to Orne and Wender's model, the explanation of psychotherapy should include the idea that psychotherapy is a learning process which aims to provide new coping skills eventuating in enduring rather than transient improvement. Further, it might be important to consider with the client the assumption of psychotherapy that causes
of behavior are often complex and may be unconsciously motivated, and that recognition of the links among experiences, feelings, and symptoms may result in insight and eventual desired behavior change.

The clarification of roles includes the expectation that the client participates actively, verbally reporting thoughts and feelings, and particularly does not intentionally withhold or censor information. The therapist on the other hand does not give advice or make decisions, but rather listens actively and facilitates self-exploration. It may be helpful to stress that psychotherapy is done with and not to the client.

Finally, in discussing therapy process, emphasis needs to be placed on aspects of treatment which may cause its premature end. In this context, it is explained that the course of therapy may be stormy, that therapy does not progress at a steady rate, but may involve resistances and negative feelings toward the therapist and others.

The limited number of outcome studies which have employed preparation for therapy programs to induce congruence between therapist and client expectations, indicate a consistent, positive relationship between client preparation and subsequent improvement. Typically, it is the client who is subjected to the preparation program. However, an interesting departure from this "therapist knows best" attitude was taken by Jacobs et al. (1972). In their study, patients received a role induction interview. The psychiatric resident therapists also received an orientation which focused on the problems that lower in-
come patients are likely to experience in verbally exploring feelings, remaining in treatment which does not offer immediate solutions, and excepting psychological explanations for their difficulties.

Results showed a significant difference in improvement favoring therapeutic dyads where both members were prepared, as compared to those dyads where only patients were prepared. However, where only one participant was prepared, patient improvement was significantly greater than in the condition in which neither member was prepared. Thus, in terms of number of improved patients, preparation of both therapy participants resulted in substantial therapeutic gain over preparation of only one member.

Expectancy and Learning Theory Approaches to Psychotherapy

Besides traditional verbal therapies, researchers of learning theory approaches to psychotherapy have also investigated the influence of pretherapy information on outcome. The majority of the behaviorally oriented therapy studies can be characterized as the experimentally created "expectancy state" sort. Problems associated with the investigation of expectancy factors in the treatment of fears were recently reviewed by Lick and Bootzin (1975). Among the observations made, was that in most of the studies of systematic desensitization subjects were students meeting course requirements and manifesting mild fears of small animals. These researchers also pointed out the importance of the way in which expectancies are established and measured, and the significance of viable placebo conditions. Despite methodological concerns, Lick and Bootzin concluded that systematic desensitiza-
tion is particularly effective in creating therapeutic expectancies and that expectancy variables are important in this brand of behavior therapy.

An overlapping review by Perotti and Hopewell (1976) also resulted in favorable conclusions regarding expectancy effects and systematic desensitization. These reviewers differentiated between initial expectancies which clients bring to treatment regarding its probable success versus beliefs the subject has during treatment that s/he is achieving increasing competence in handling the fear provoking stimuli. Initial expectancies have been the focus of most research to date, but appear to have little effect on therapeutic goals, while the beliefs held by subjects during the systematic desensitization procedure are viewed by Perotti and Hopewell (1976, Note 1) as more important, and merit further investigation.

The Perotti and Hopewell review highlights the issue of what is meant by the term "expectancy effects". The importance of specifying what type of expectancy is under investigation is echoed by other researchers in the field (Lick and Bootzin, 1975; Bent, Putnam, Kiesler, and Nowicki, 1975; Garfield and Wolpin, 1963). Expectancy effects have been used to designate diverse client beliefs such as expectations regarding positive outcome, procedures in treatment, the role of the therapist, and the length of treatment.

A recent study by Lott and Murray (1975) provides an example of the type of research that is indicated if more light is to be
shed on the issue of expectancy and behavioral approaches to treatment. These researchers validated their expectancy manipulations on one group of subjects and then assessed its effectiveness using a different experimental population. The effects of initial expectations concerning the benefits of psychotherapy were also compared to experimentally manipulated expectancy. Subjects in the expectancy manipulated group showed substantially greater approach behavior to a snake than subjects in the neutral expectancy condition. Initial expectancy did not show a positive effect.

Parrino (1971) also showed that pretherapy information has a place in the behavioral treatment of fears. He assessed the effects of different kinds of information prior to therapy on the acquisition of an operantly learned response by subjects with snake phobias. The experimental conditions involved exposure to either theoretical information about reinforcement theory, or more direct descriptive information which induced a participant-role expectancy. Parrino found that the operant technique employed was effective in eliminating the avoidance response to snakes, and that it was significantly potentiated when combined with either type of pretherapy information.

Effects of Preparing Children for Psychotherapy

Holms and Urie (1975) used a child-age (ages 6-12) client population to assess the effects of a therapy preparation interview on both process and outcome variables. These investigators felt that children would be most likely to be naive about psychotherapy and thus provide
an optimal opportunity for the effects of preparation to emerge. An "understanding of therapy questionnaire" was employed to assess the effectiveness of the therapy preparation manipulation. Conclusions reached were: providing preparatory information to children about therapy decreased the likelihood that they would drop out of treatment prematurely, thereby increasing the therapies potential benefits. The preparation did not influence the process or outcome of therapy in this study.

An important methodological consideration became apparent as a result of the high degree of consistency attained between therapists' and parents' ratings of change in target problems, as opposed to the lack of consistency in their more global ratings of general maladjustment. The use of specific target problems to assess behavior change, rather than ratings of disturbance in general seems warranted, since global ratings may focus on behaviors which were not focused on in therapy.

Expectancy and Group Psychotherapy

Attempts at better alignment between client expectations about psychotherapy and the experiences a client is likely to face, have not been limited to the individual treatment modality. Bednar and Kaul (1978) refer to premature terminations as one of the "inefficiencies and tragedies" (1978, p. 786) of group treatment. As a result of their review of process and outcome research in the group therapy field, Bednar and Kaul concluded that the perceptions, expectations,
and beliefs that a group member holds about treatment can have an immediate influence on his/her group experience. In addition, evidence indicates that premature terminators have less favorable or misguided expectations about various aspects of group treatment (Caine, Wijesinghe, Wood, 1973; Liberman, Yalom, and Miles, 1973; Grotjahn, 1972).

Thus, by the time Bednar and Kaul (1978) recommended that therapists take time to discover and shape the expectations of group members prior to the commencement of treatment, several group therapists and researchers had already investigated the results of such attempts. Truax and Carkhuff (1965) exposed hospitalized mental patients engaged in group psychotherapy to vicarious therapy pretraining (VTP) and found that this manipulation moderately enhanced therapeutic outcome over that observed in the no VTP (NVTP) group. A later, similar attempt at VTP by Truax and Wargo (1969, Note 2) provided more encouraging findings. VTP was used to provide clients with a cognitive and experiential structuring of "how to be a good patient". A 30 minute tape recording of "good" patient in-therapy behavior was shown to mildly disturbed outpatients, as a means of engaging them in the process of group therapy. On 21 out of 23 outcome measures the VTP group showed therapeutic advantages over the NVTP group, with greatest improvement occurring on neurotic symptomatology as assessed by the MMPI. However, Truax and Wargo warned that these findings should not be generalized to other client populations, since they were clearly not supported by an earlier VTP study with institutionalized juvenile delinquents (Truax and Wargo, 1968).
The relative efficacy of modeling and instructions on interpersonal openness in a group setting was investigated by Whalen (1969). His experimental manipulations included the following four conditions: 1) film model and detailed instructions of interpersonal openness; 2) film model and minimal instructions; 3) no film model and detailed instructions; 4) no film model and minimal instructions. Whalen found that subjects exposed to the film model and detailed instructions condition engaged in significantly higher levels of interpersonal openness, whereas subjects in the remaining three conditions failed to do so.

An apparent difference in orientation toward client preparation programs is highlighted by studies which employ modeling techniques, such as vicarious therapy pretraining of film models (Heitler, 1976). In contrast to research employing role-induction procedures, modeling techniques pose the danger of restricting the client's behavior by also modeling what s/he should say or reveal. Role induction techniques, on the other hand, are unlikely to prescribe the specific content of the patient's verbalizations, but should facilitate the client's understanding of the therapeutic setting and process.

The favorable effects on treatment which resulted from Hoehn-Saric et al.'s (1964) role induction interview prompted Yalom, Houts, Newell, and Rand (1967) to investigate the effects of an explanatory session of client behavior and attitudes, in group therapy. The explanatory session was held prior to the group's commencement and was designed to increase faith in and attractiveness of group therapy.
Further, it instructed clients to engage in here and now interaction focusing on relationships among group members.

Yalom et al. report that approximately 1/3 of all clients beginning group therapy in a university outpatient clinic drop out unimproved with in the first dozen meetings. Thus, attenuation of the drop-out rate was one of the hoped for results of this study. The experimental and control groups, however, did not differ significantly in terms of attendance and drop-out data. The hypothesis that experimental subjects would evidence greater group cohesiveness was not supported. Yalom et al. also hypothesized that experimental subjects would develop greater faith in group therapy, and this hypothesis received moderate support. The greatest proportion of the preparatory session was devoted to the goal of increasing confrontive, here-and-now interaction in the group. Significantly greater interpersonal interaction occurred among experimental subjects. Yalom et al. concluded that a preparatory interview clarifying group process and role expectations can enhance the efficacy of group therapy by hastening the appearance of effective levels of group communication.

Heitler (1973) also examined the influence of therapy preparation on group therapy process, using lower class, therapy unsophisticated clients. Those clients receiving the preparation manipulation tended to speak earlier and more often in the sessions and to make more self-initiated and self-exploratory communications. Therapist's ratings indicated that they viewed prepared clients as more involved, and more
like an ideal group client, as well as having a better prognosis. Yet, clients' ratings of their interactions and feelings revealed only one weak difference: prepared clients liked the group more than nonprepared clients.

Perhaps the most favorable findings in the area of preparation for group psychotherapy were achieved by Strupp and Bloxom (1973), although their lack of control of subjects' prior therapy experience merits criticism. These investigators developed a dramatic role-induction film (Turning Point) addressed specifically to lower-class clients. Each of four experienced psychotherapists treated three groups in a 12 week program. The first groups viewed Turning Point prior to therapy; the second groups received a role-induction interview with a psychiatrist; the third groups viewed a control film. Consistent evidence from a multitude of postinduction and in-therapy measures showed that both role induction procedures facilitated a more favorable therapy experience. The role induction interview was found to be superior in conveying detailed knowledge of group therapy process. Turning point proved to be a superior manipulation on several other measures, including favorably raising patients' expectations about treatment, patient satisfaction ratings of in-therapy progress, and therapists' ratings of appropriateness of patient in-therapy behavior. It is interesting to note that outcome, assessed by therapist post therapy improvement ratings, did not show significant differences among the three treatment conditions. Furthermore, since the over all absence
rate was 10% and only seven patients terminated prematurely, attendance measures did not reflect the role-induction benefits.

**Expectancy Effects and Premature Termination in University Counseling Center Settings**

An extensive review of the literature revealed that two studies in the general domain of expectancy effects have been conducted in a university counseling center setting. Yalom et al.'s (1967) efforts at client preparation for group psychotherapy have been discussed previously. Goldstein (1960b) also investigated the suggested relationship between client and therapist expectations about change, and perceived change due to psychotherapy in a university psychological clinic. Correlations between expected and perceived change were computed for the fifth, tenth, and fifteenth counseling session. The expected positive relationship was not found. Client perceived change due to psychotherapy was not significantly related to client, therapist, or combined client and therapist expectations of client change.

The remaining studies relevant to the general issue of expectancy effects focused on premature termination in university counseling centers. Questions about university students who make appointments at a counseling center, but fail to keep them, have been addressed by three groups of researchers. Kirk and Frank (1976) compared students who made initial appointments, over a four year period. Students who completed extensive background information forms but did not appear for the arranged counseling session constituted 8.2% of the men and
6.2% of the women in this sample. Comparisons of "shows" versus "no shows" involved reasons for seeking counseling; time in the student's academic careers that contact was initiated; and psychological characteristics as assessed by the Omnibus Personality Inventory. The only significant results showed that students who "hit and run" in a counseling center setting have the distinguishing characteristic of impulsiveness (Kirk and Frank, 1976).

Mendelsohn and Geller (1967) conducted research at the University of California-Berkeley Counseling Center, which concerned itself with the failure of clients to appear for scheduled appointments. Although their research focused on counselor-client similarity as assessed by the Myers-Briggs Type Indicator, their data revealed that a "surprisingly high" (p. 212) proportion of clients who miss scheduled appointments, do so on the basis of events which take place in counseling, rather than as a result of events which are external to counseling.

Recently, a different approach to this puzzling problem was taken by Betz and Shullman (1979). These investigators examined the relationship between returning for counseling following an intake interview, and client sex, intake counselor sex and experience level, and sex of counselor to whom the client was referred. In this study, almost one-fourth of the clients interviewed by an intake counselor failed to return for a scheduled appointment. Results showed that clients of both sexes were significantly less likely to return when their intake interview was conducted by a male counselor, as opposed to a female
counselor. Also, clients referred to male counselors were significantly less likely to return than clients seen by and/or referred to female counselors (Betz and Shullman, 1979).

Epperson (1981) collected data from the records of 309 university counseling center clients, in order to replicate and extend the Betz and Shullman study, on a different student population. Both studies converged in their findings that following an initial interview, nearly 25% of clients failed to return for further counseling. However, in direct contradiction to Betz and Shullman's findings that female counselors had higher return rates than male counselors, Epperson found that male counselors had significantly higher return rates than female counselors.

The studies just cited point to what Betz and Shullman refer to as "a serious and poorly understood failure in the provision of counseling services" (1979, p. 544). The reported drop-out rates (Epperson, 1981; Betz and Shullman, 1979; Kirk and Frank, 1976) certainly pinpoint premature termination as a legitimate area of concern for university counseling center staff. Also stemming from these studies, is the necessity of improving the practical value of research efforts regarding staying in treatment. For example, the unequivocal nature of dropout rate invites its use as an outcome measure. However, comparison of research would be greatly facilitated if all studies differentiated between premature terminators and clients who never actually began counseling.
Conclusion

The equivocal nature of research findings in the client preparation for treatment domain has been brought out by this review of the literature. Accumulating evidence in the field of psychotherapy suggests however, that a key factor involved in determining the usefulness of psychotherapy is the structure which recipients bring to the experience (Garfield and Bergin, 1978; Levitt, 1966; Cartwright, 1963). This, and the widely documented phenomenon of premature termination (Garfield, 1978; Baekeland and Lundwall, 1975) from psychotherapy on the part of many clients has led to the suggestion that a cognitive orientation of prospective clients regarding the therapy process, might beneficially influence the course and results of treatment. Yalom et al. (1967) report favorably on the current trend toward a demystification of psychotherapy and support a more collaborative venture between therapists and clients. In line with this trend, Bandura (1977) recently proposed a theory of self-efficacy which suggests that the key to change in therapy is the person's expectations of his/her own efficacy in that situation. These expectations can stem from information provided by several sources, including vicarious experience, persuasion, emotion arousal, and structured learning. Finally, the examination of process variables in counseling by Gomes-Schwartz (1977) revealed that the most consistent predictor of therapy outcome was the extent of the client's active and positive involvement in that therapy.
Differing assumptions and methods guide the range of preparation techniques employed to facilitate client amenability to psychotherapy. Truax and Carkhuff (1967) stated in learning theory terms their view of the potential value of structuring the client role as follows: "If psychotherapy or counseling is indeed a process of learning and relearning, then the therapeutic process should allow for structuring what is to be learned rather than what amounts to "incidental learning", where the client does not have clearly in mind from the outset what it is he is supposed to learn" (1967, p. 363).

Levitt's (1966) urging, that those inclined to conduct psychotherapy research should investigate the "ERD-outcome hypothesis" echoes the sentiment of other investigators in the domain of psychotherapy. A review of the literature reveals that preparation for therapy programs are aimed predominantly at lower socioeconomic status groups. The literature also documents that misexpectations about counseling and premature termination is a widespread problem among diverse client populations. It is not uncommon for university students to seek counseling in times of crisis, but to leave treatment before they have had a chance to learn broader coping skills which would be useful the next time they are faced with emotional difficulties or problems in living (Zytowski, 1980, Note 3). Evidence of client preparation efforts directed at students seeking counseling at a university counseling center is lacking, with the single exception of Yalom et al.'s (1967) role induction procedure
aimed at group therapy members. Yet, it seems reasonable to hypothesize that a university student population which thrives in the auspices of learning, could profit from a cognitive orientation which would prepare them for efforts at solving their problems in living.

The Present Study

In summary, a multitude of studies have used diverse methods to prepare clients for counseling. These efforts, aimed primarily at lower socioeconomic status populations have provided equivocal results. This study was designed to investigate the effects of videotaped pre-counseling information on premature termination rates of clients at a large university counseling center. Other dependent measures were also employed to assess the effects of the preparation for counseling procedures. The dependent measures used in this study will be described extensively in the Method section. However, it is important to note that the psychotherapy literature provides dishearteningly little guidance regarding how to measure counseling process and outcome. Thus, the question of which dependent measures would best assess any experimental treatment effects was treated as an empirical one.

Since the investigations of Betz and Shullman (1979) and Epperson (1981) provided conflicting evidence regarding possible attenuating effects of counselor gender on premature termination, while Simons and Helms (1976) found that clients preferred same sex counselors, this study also examined both client and counselor gender effects.

The questions which this study was designed to answer were exa-
mined by exposing first time university counseling center clients to one of two fourteen minute precounseling information videotapes. The format for both videotapes was identical and consisted of five students and two counselors engaged in a question and answer discussion. One videotape provided information about the counseling process, focusing on the client role and to a lesser extent the counselor role. The other videotape, which was designed to serve as a videotape control procedure, presented information about the services offered by the Counseling Center.

The following questions were specifically addressed by this study:

1) Will exposing university counseling service clients to precounseling information have an effect on premature termination rates?

2) Will counselor gender alone and/or in interaction with the experimental treatments and/or client gender, effect the premature termination rates?

3) Will precounseling information, counselor gender, and client gender, alone or in interaction, have an effect on the other dependent measures which were used to assess counseling experience and outcome.
METHOD
The Main Study

Subjects
Sixty-seven students seeking counseling at the Student Counseling Service at Iowa State University served as subjects. In all cases, the first contact with the counseling service was client initiated. Only first time clients were used as subjects, in order to avoid a confound between counseling experience and the experimental treatment. Participation in the study was strictly voluntary. Clients read a memo (Appendix A) which detailed the requirements of their participation, and indicated willingness to be subjects by signing an informed consent form. The 34 males and 33 females ranged in age from 17 to 33 years, with a mean age of 20.9 years.

Counselors
Fifteen female and ten male counselors at the Student Counseling Service participated in the study. Counselors read a statement (Appendix B) which requested their participation and briefly described the study. Although inclusion in the study was based on willingness to participate, with the exception of one staff member, all counselors consented to do so. Counselors varied on: 1) how many of their clients were subjects in the study (Table 1); 2) experience level (Table 2).

Design
A 2 x 2 x 3 completely randomized factorial design was used (Kirk, 1968). The independent variables were counselor sex, client sex, and videotape condition (VT1 - counseling process information vs VT2 - counseling center information vs NVT - no videotape). Appropriate in-
Table 1  Frequency Distribution of Counselors by Clients and Number of Clients per Treatment Condition

<table>
<thead>
<tr>
<th>Treatment Condition</th>
<th>Client N</th>
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<tbody>
<tr>
<td>VT1 Group</td>
<td>22</td>
</tr>
<tr>
<td>VT2 Group</td>
<td>25</td>
</tr>
<tr>
<td>NVT Group</td>
<td>20</td>
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</tbody>
</table>
teractions were also analyzed. Subjects were nested within experimental conditions. Subjects were assigned at random to experimental conditions, with the following exception: Due to practical constraints, approximately 80% of the subjects who made their first appointment by phone, were placed in the no videotape control condition (Table 1). Counselors were blind to the experimental conditions, although they were aware of which of their clients were subjects in the study.

**Dependent Measures**

The evaluation of psychotherapy process and/or outcome represents a complicated and perplexing issue for the psychotherapy researcher (Harty and Horowitz, 1976; Horenstein, Houston, and Holmes, 1973; Garfield, Prager, and Bergin, 1971; Fiske, 1971). Extensive and diverse criteria for research evaluation have been used, yet, consensus regarding which criteria are most suitable for assessing aspects of psychotherapy, is lacking. However, consensus does exist, that multiple and relatively independent measures need to be employed (Garfield and Bergin, 1978, Fiske, 1971). The importance of using a variety of outcome measures, which assess results from both the counselor's and the client's perspective, is further supported by the repeated finding that agreement between measures from different sources is generally low (Garfield, Prager, and Bergin, 1971). In view of this, the following measures of outcome were used: Nature of Termination Form; Client-rated Severity of Presenting Problem; the Counselor Rating Form; the Counseling Evaluation Inventory; the Counselor Perception of Client Form; the Counselor Experience of Client Form.
Premature Termination. For purposes of this study, premature termination was defined as the client leaving counseling without mutual agreement between counselor and client that counseling should terminate. The objective nature of this measure invites its use as an outcome measure. It is important to consider however, that premature termination can occur under different conditions. Four levels of termination were defined: 1) Level A occurred when the client failed to show up for a scheduled appointment without notifying the counselor or the appointment desk of his/her intent not to continue, and without rescheduling further appointments; 2) Level B occurred when the client did not discuss his/her desire to terminate with the counselor, but did notify the counselor or the appointment desk that s/he would not be coming for further sessions; 3) Level C occurred when the client talked with the counselor about the desire to terminate prior to dropping out of counseling; 4) Level D occurred when counseling terminated on the basis of mutual agreement between the counselor and the client. When counseling with a given client ended, the counselor filled out the Nature of Termination Form which specified one of the above conditions of termination (Appendix C).

Client-Rated Severity of Presenting Problem. The use of client-rated severity of the presenting problem at pre and post counseling intervals is documented as a useful and flexible index of the impact of treatment (Rosen and Zytowski, 1977). When making their first appointment, clients were asked to fill out the New Counselee Information Sheet. This form asks clients to briefly state what they would like
help with, and to indicate how much this problem bothers them, on a five point scale from "not at all" to "couldn't be worse" (Appendix D). At the end of counseling, the problem statement was transferred to the Follow-up Questionnaire (Appendix E) which asked the client to rate the severity of the initial problem based on present feelings. Therapeutic gain was thus derived from ratings describing "present" feelings at pre and post counseling intervals. The Follow-up Questionnaire also asked clients to 1) rate the extent to which their visits to the Student Counseling Service were responsible for any change and 2) indicate why they stopped going to the Student Counseling Service.

Client Perceptions of Counselor. The Counselor Rating Form (CRF; LaCrosse and Barak, 1976; Barak and LaCrosse, 1975) (Appendix F) was used to assess clients' perception of their counselors. Thirty-six adjectives, reaching interjudge agreement of 75% were selected by Barak and LaCrosse (1975) for inclusion in the CRF. Seven-point bipolar scales were constructed, using the 36 adjectives and their opposites. Factor analysis of 202 subjects' ratings of three counselors revealed three factors: Perceived Counselor Expertness (Appendix G), Perceived Counselor Trustworthiness (Appendix H), and Perceived Counselor Attractiveness (Appendix I). Twelve adjectives represented each of the three factors. Interitem reliability coefficients of .874, .850, and .908 were found for expertness, attractiveness, and trustworthiness, respectively (LaCrosse and Barak, 1976). Subsequent investigations using the CRF have shown reliable differences in perceived expertness, attractiveness, and trustworthiness as a function of appropriate ex-

Client Satisfaction with Counseling. The Counseling Evaluation Inventory (CEI; Linden, Stone, and Shertzer, 1965) was used to assess client satisfaction with counseling (Appendix J). Subjects were asked to indicate degree of agreement with 21 statements about their counseling experience on a 5-point scale ranging from "always" to "never". The CEI was developed via a factor analytic approach and refined by item analysis, allowing Linden, Stone, and Shertzer (1965) to derive a scale of 21 items to measure the client's reaction to the factors of client satisfaction, counselor comfort, and counseling climate. All three factor scales and the CEI total score demonstrated significant discriminative and congruent validity for a selected criterion. These factors appear to be important in evaluating the client's satisfaction with counseling, which in turn may have significance for counseling effectiveness (Haase and Miller, 1967). The item content of the CEI suggests a high degree of face validity. Total score test-retest reliability coefficients as high as .83 have been obtained (Linden, Stone, and Shertzer, 1965). The CEI is documented to be one of the most used measures of client's reports of satisfaction with counseling (Zytowski and Betz, 1972). The Inventory has been used extensively by researchers as a measure of client attitudes toward counselors (Ivey, Miller, and Gabbert, 1968) and of counseling effectiveness using satisfaction as a criterion (Bishop, 1971; Brown, D., and Cannaday, H., 1969). Furthermore, Haase and Miller's (1968) factor analytic studies
of data obtained from college students, revealed factor structures very similar to the factors reported in original CEI findings. These findings indicated the CEI's usefulness as a criterion measure of counselor effectiveness, based on client satisfaction, with college student populations.

Assessment of Perceived Client Attractiveness. As has been previously stated, Barak and LaCrosse (1975) devised the CRF to assess client perceptions of counselors on the dimensions of perceived counselor expertness, perceived counselor trustworthiness and perceived counselor attractiveness. The entire inventory is typically used to assess client perceptions of counselors. Besides the conventional use of the CRF in this study, the twelve CRF adjectives which load on the perceived counselor attractiveness factor, were used to assess counselors' perceived attractiveness of their clients. This questionnaire was labeled Counselor Perception of Client Form (CPCF) (Appendix K).

Assessment of Counselor Experience of Counseling. Orlinsky and Howard (1975) conducted the Psychotherapy Session Project at the Katherine Wright Mental Health Center in Chicago. The focus of their study was the psychotherapeutic experience, in light of their belief "that subjective experience is the primary locus of action and impact in psychotherapy" (1975, p. 5). Data on the experience of psychotherapy were obtained through the use of the Therapy Session Report (TSR) questionnaires. Parallel forms of the TSR were constructed for use
by patients and therapists. The questionnaires assessed the behavior and experiences of the patient, the behavior and experiences of the therapist, and aspects of the patient-therapist interaction. The therapist form of the TSR was organized under the heading of seventeen general questions. A multi-level factor analysis resulted in the empirical determination of eleven factorial dimensions of global therapist experience. For purposes of this study, global counselor experience of counseling with a given client was assessed via a 12 item form labeled Counselor Experience of Counseling Form (CECF) (Appendix L). This form was modified and adapted from the therapist form of the TSR questionnaires. Those questions which were considered relevant to the counseling process in a university counseling center were used in the modified version of the TSR. Items which pertained specifically to the more intensive therapeutic process of the community mental health center in the Howard and Orlinsky project, were omitted.

Procedure

First time clients who came to the appointment desk to make an appointment with a counselor, were asked to read a letter which described the study (Appendix A), and offered them $5.00 for their participation. Payment for participation was not instituted until difficulties with getting subjects became apparent; therefore, the first six students who agreed to be subjects were not paid. Willingness to be a subject was indicated by signing at the bottom of the letter (Appendix A), which also served as an informed consent form. Subjects
were assigned to groups on a random basis, with approximately 80% of clients whose first contact was by phone, being placed in the NVT-Group 3. Clients in the experimental groups were scheduled to see either the counseling center information videotape (VT2) or the counseling process information videotape (VT1) and were also given the first appointment with their counselor. Tapes were always viewed prior to the first counseling session, either on the same day or as close to that day as schedules permitted.

Students in all groups filled out the New Counselee Information Sheet (Appendix D) when they arrived for their first appointment. This is a standard form filled out by all Student Counseling Service clients. Subsequently, clients were taken to the videotape equipment room where one of three research assistants read a brief memo (Appendix M) out loud, while subjects read a copy themselves. The memo contained an introduction to the videotape and to the forms which subjects would be asked to fill out. Prior to the first counseling appointment a research assistant placed the forms in the client folders. Following their first counseling appointment, all subjects were given the CRF (Appendix F) and the CEI (Appendix J) by their counselor. Subjects were asked to return the forms to the appointment desk, before leaving if time allowed, or as soon as possible thereafter. Counselors completed the CPCF (Appendix K) and the CECF (Appendix L), also following the first appointment with each of their clients. However, in some cases forms were filled out at some later point in counseling due to
occasional noncompliance with procedural requests on the parts of clients as well as counselors.

Subjects who did not return the forms within two or three days of the first appointment received a phone call from a research assistant, reminding them to return the forms. If the forms were not returned before the second appointment, duplicate forms were placed in the client's folder and counselors re-distributed them to their clients. Subjects who still failed to return the forms were reminded by their counselor to do so, followed by another phone call, as a final reminder.

Following the last counseling appointment, counselors gave their clients the Follow-up Questionnaire (Appendix E), which restated their original complaint and asked them to rate how much the problem currently bothered them. Clients were asked to return the form immediately or as soon as possible. Clients who failed to return the forms within two or three days received a phone call reminding them to do so. Clients who then failed to return the form were mailed duplicate copies of the form with a follow-up letter (Appendix N) asking them to return it in the enclosed post-paid envelope. Following their last appointment with a subject, counselors completed the Nature of Termination Form (Appendix C).

Attempts were made to make phone contacts with subjects who terminated without notifying their counselors. Follow-up letters and follow-up questionnaires were mailed after two weeks without scheduled contacts with the counseling center. The other forms were also mailed when appropriate and post-paid, addressed envelopes were included.
The Videotapes

Supporting Literature. The psychotherapy literature is replete with examples which attest to the value of modeling techniques for changing cognitions and resultant behavior (Kazdin, 1974, 1976; Cautela, Flannery, and Hanley, 1974). A model can be defined as a stimulus which provides information to an observer, resulting in altered cognitions but not requiring immediate overt performance (Rosenthal and Bandura, 1978). For clinical purposes, modeling is usually performed by human actors/actresses whose display can include live, filmed or taped formats, enabling the client to relate what is exemplified to personal life situations. Several attributes are likely to make a model impactful, including if s/he compares realistically to oneself (Kanfer, Karoly, and Newman, 1974). However, research findings reveal that most modeling methods, whether covert, filmed, live or symbolic, yield comparable outcomes. This suggests in turn, that it is the functional component of the information provided as well as human mediating factors, that eventuate in client change (Rosenthal and Bandura, 1978). Perhaps, as Bandura's social learning theory claims (Bandura, 1977), one such mediating factor resulting in altered behavior, is the bolstered level of perceived self-efficacy which modeling fosters.

The modeling literature substantiates the use of filmed or video-taped actors/actresses in eliciting desired behaviors (Bandura, Ross, and Ross, 1963). This method of imparting information is often considered to be symbolic modeling. Indeed some researchers (Truax and
Carkhuff, 1967) lump together the transmitting of information via modeling and role-induction procedures, under the rubric of modeling. However, others (Heitler, 1976) caution against the restricting effect which modeling may have, by structuring, even if unintentionally, specifically what the client should say. This, in contrast to role-induction procedures, which provide information in order to aid understanding of the client mode and but may be less likely to regulate the content of what the client verbalizes. Thus, for the purposes of this study, the videotapes were conceptualized as role induction procedures, and intended to be distinct from modeling along the dimension just mentioned.

Technical and Conceptual Development

The videotape (VT1) which presents information about the counseling process, with particular attention to the client role, was intended as the main experimental manipulation of interest. It was developed as follows: Two male and three female undergraduate students were selected to "perform" in the videotape, in response to a statement describing their participation and offering extra credit towards their grade in the psychology class in which they were enrolled. Early in the development of the videotape the students were asked to think about what they would want to know about counseling, imagining that they were considering seeking counseling at the counseling center. One week later the group reconvened with one female and one male advanced counseling psychology graduate student. An impromptu group discussion of counseling was held, and videotaped by an advanced film student. This videotape served
as a model, in order to provide a realistic and spontaneous quality to the group discussion format which was used.

A script was developed (Appendix 0), using the same format, and some of the same questions, which occurred during the impromptu session. However, additional questions were added and the counselors' responses were structured, so as to include content which was deemed important for the purposes of this study. This included information about the counseling process with emphasis on the client role and to a lesser extent, the counselor role. Specifically, the videotape was scripted to provide information about the following: 1) the counseling process, including its vicissitudes, 2) the nonjudgemental, trusting and professional nature of the counseling relationship, 3) confidentiality, 4) counseling goals, including dealing more effectively with problems in living, enhancing self-direction, exploring and understanding thoughts and feelings, decision making, gaining coping and living skills, and clarifying options, 5) the need to be an open, active participant who is willing to self-explore, take responsibility for the course of counseling and one's life, and try out new behaviors, 6) the orientation of the counselors which seeks to look at the situation from the client's subjective frame of reference.

The students and counselors were provided with a script, which communicated the above information through a series of questions, asked by the students and responded to by the counselors, in a group discussion format. Each student was assigned two or three questions, and
each counselor provided approximately an equal number of answers.

The second videotape (VT2) presented information about the services which the Student Counseling Service offers. VT2 (Appendix P) maintained the same question and answer format, and was developed to serve as a videotape control manipulation. The pilot study, which was subsequently conducted, revealed that rather than being a neutral stimulus the videotape provided valid precounseling information in its own right. The information which it contained was gained from the Student Counseling Service Annual Report (Warman, 1979) and several descriptive brochures which the counseling center provides about its services.

Weekly rehearsals were held during one academic term, with the students, counselors and film student who operated the camera, until a smooth enactment of both scripts was accomplished. When videotaping was finished, the videotapes were extensively edited, in order to achieve a professional quality product.

The Pilot Study

Prior to their use as experimental manipulations in this study, the videotapes were piloted. The pilot research served as a manipulation check of the effectiveness of VT1 in communicating the intended information.

Subjects. Nineteen undergraduate students who received one extra credit point towards their psychology course grade served as subjects.

Design. A 2 x 2 completely randomized factorial design was used
The independent variables were videotape (VT1 vs VT2), and time (Pre vs Post). VT by Time interactions were also analyzed. Subjects were nested within experimental conditions.

Dependent measures. In their landmark outcome study, Volsky, Magoon, Norman, and Hoyt (1965) identified client perceptions of their own role, the counselor's role, and characteristics of the counseling process itself as three general areas of client expectations meriting assessment. As a step toward examining the hypothesis that the nature of client expectancies about counseling are an integral part of understanding the client and his/her behavior in the interview relationship, Volsky, et al., (1965) developed the Perception of Counseling Inventory. Thirty students were interviewed about various aspects of the counseling relationship. The resulting list of 379 statements was given to forty practicing counselors, to rate along a scale ranging from -5 to +5. Counselors were asked to consider the items as perceptions that clients might have that would make them ready or unready to benefit from counseling. They were instructed to give the lowest rating to perceptions that would detract from readiness to benefit from counseling, and the highest ratings to perceptions that an ideal client would have. Mean rank and variances for each item were computed resulting in 167 usable statements.

A modification of this inventory consisting of 60 items seen as particularly relevant to the needs of the pilot study, was used to assess subjects' expectations and perceptions of counseling at pre and
post videotape intervals (Appendix Q). Subjects were asked to read 60 statements about counseling and indicate their degree of agreement or disagreement on a four point scale ranging from "strongly agree" to "strongly disagree".

Procedure. Upon arriving, the nine subjects who saw VT1 responded to the 60 item version of the Perceptions of Counseling Inventory. Upon completing the Inventory subjects viewed VT1. Immediately following, a second copy of the Inventory was distributed, and subjects were again asked to respond. The ten, VT2 subjects arrived shortly after VT1 subjects had left. The same experimental procedure was followed.

Results. The analysis of variance revealed that both VT1 and VT2 changed subjects' beliefs about counseling in the desired or more informed direction (p < .05). This change in expectations was found to favor the VT1 group over the VT2 group, but the difference was not significant (p < .12).

Discussion. A shortened version of the Perception of Counseling Inventory at pre and post videotape intervals revealed that both videotapes produced significantly changed expectations about counseling. The less than significant difference between treatments indicates that VT1 and VT2 may overlap in the information which they present. This in turn suggests that the information which VT2 presents may not be neutral and thus that it may not function as a neutral videotape control procedure in the main study.
RESULTS

Overview of Analysis

Initially, the dependent measures were analyzed with a 2 (counselor gender) x 2 (client gender) x 3 (videotape condition) completely randomized analysis of variance, using a least squares solution for unequal Ns. Subsequently, a sequential and partial regression analysis was done. This procedure allowed the examination of variance due to main effects, prior to examining variance due to interactions. An overall lack of statistically significant main effects and/or interactions was demonstrated. A chi-square test of independence was used to analyze: 1) reasons for termination from the client's perspective; 2) nature of termination from the counselor's perspective. The response choices for these dependent measures were not considered to constitute an ordinal scale, and were thus collapsed to form dichotomous variables. Finally, the Pearson Product Moment Correlation Coefficient was employed to intercorrelate the dependent measures.

Subsequently, two single-classification analysis of variance procedures were employed. In the first analysis, each of the 25 individual counselors served as the treatment. Not surprisingly, significant differences between counselors were found on several dependent measures. Next, four levels of counselor experience were defined and the analysis of variance was conducted with experience level as the independent variable.

In summary, analysis of variance did not reveal significant main
effects for the videotape treatment conditions. The chi-square test of independence produced two gender effects, which will be discussed later. There were also no significant interactions.

Analysis of Variance of Dependent Measures

Descriptive Data

Analysis of client age, year in school, and presenting problem (vocational vs. personal) revealed two significant differences in subject distribution. Female counselors saw more sophomores, while male counselors saw more juniors, $F(1, 65) = 5.06, p < .03$. Group 1 and Group 2 contained more sophomores, while Group 3 contained more juniors, $F(1, 65) = 4.07, p < .02$. Analysis of kept appointments, "no shows", and cancellations failed to reveal significant differences. On the average, clients had 3.5 sessions, with .31 "no shows" and .21 cancellations.

Client Dependent Measures

Change in presenting problem. Severity ratings at pre and post counseling intervals were analyzed separately and as difference scores (difference = post minus pre). Analysis failed to yield significant main effects for videotape group, counselor gender, or client gender. Interactions were also not significant. However, when the difference scores were collapsed across the independent variables highly significant differences emerged between pre and post severity ratings, $t(1, 66) = 11.17, p < .0001$. Overall, clients' ratings showed that significant improvement in their presenting problem occurred following
counseling. Clients also responded to the item "indicate the degree to which your visits to the Student Counseling Service were responsible for any change in your problem." The response range was from 1-5, 5 being "100%". No significant differences were found on this dependent measure. Examination of cell means showed a range of values from 3.0 to 3.75, indicating that typical clients attributed at least "pretty much" but less than "very much" responsibility for their improvement to their counseling experience. Examination of raw data showed that out of 67 respondents, three responded with option 1, "Not at all" and five chose option 5, "100%". This suggests that mean values are representative statistics for this item.

Counselor Rating Form and Counseling Evaluation Inventory. CRF expertness, trustworthiness, and attractiveness measures, and client satisfaction with counseling assessed by the CEI, failed to reveal significant main effects or interactions.

Counselor Dependent Measures

CPCF and CECF. Perceived client attractiveness and global counselor experience respectively assessed by the CPCF and the CECF, did not yield significant main effects or interactions.

Chi-square Test of Independence of Dependent Measures

Client Reasons for Termination. The four client reasons for termination were collapsed into two categories: Either the client did or did not receive the help which s/he desired. Twenty-nine clients who saw female counselors and 30 clients who saw male counselors reported
receiving desired help. One client who saw a female counselor and seven clients who saw male counselors indicated that they left counseling because they did not find counseling helpful. The chi-square statistic revealed a significant main effect for counselor gender, \( \chi^2(1) = 3.827, p = .05 \). Clients who saw male counselors reported that they stopped going to the Student Counseling Service because they were not getting the help they wanted, more often than clients who saw female counselors.

**Counselor Defined Termination.** The four counselor defined levels of termination were categorized either as absence or presence of consensus between counselor and client that counseling should terminate. Thirteen female clients and 27 male clients did not terminate prematurely. Seventeen female clients and ten male clients terminated prematurely. The chi-square test revealed a significant main effect for client gender, \( \chi^2(1) = 6.05, p = .01 \). Female clients terminated prematurely more often than male clients.

**Correlations**

Substantively significant correlations between ratings used as client dependent measures, resulted between each of the CRF dimensions and the CEI. High positive correlations also occurred between two counselor dependent measures; the CPCF and the CECF. Table 2 presents the inter-item correlation matrix for these dependent measures.
Table 2

Inter-item Correlation Matrix for Dependent Measures

<table>
<thead>
<tr>
<th></th>
<th>Attractiveness</th>
<th>Expertness</th>
<th>Trustworthiness</th>
<th>CEI</th>
<th>CPCF</th>
<th>CECF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attractiveness</td>
<td>1.00</td>
<td>0.81</td>
<td>0.87</td>
<td>0.85</td>
<td>0.31</td>
<td>0.13</td>
</tr>
<tr>
<td>Expertness</td>
<td>1.00</td>
<td>0.88</td>
<td>0.84</td>
<td>0.29</td>
<td>0.13</td>
<td></td>
</tr>
<tr>
<td>Trustworthiness</td>
<td>1.00</td>
<td>0.86</td>
<td>0.30</td>
<td>0.13</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CEI</td>
<td></td>
<td>1.00</td>
<td>0.29</td>
<td>0.20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CPCF</td>
<td></td>
<td></td>
<td>1.00</td>
<td>0.65</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CECF</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1.00</td>
</tr>
</tbody>
</table>
One-way Analysis of Variance of Dependent Measures

One way analysis of variance with each of the twenty-five counselors serving as the independent variable showed significant differences between counselors on the following measures: 1) CRF expertness dimension, \( F(24, 42) = 2.70, p < .002 \); 2) CRF trustworthiness dimension, \( F(24, 42) = 2.79, p < .002 \); 3) CRF attractiveness dimension, \( F(24, 42) = 3.47, p < .0002 \); 4) CEI, \( F(24, 42), p < .004 \).

Subsequently, a one-way analysis of variance was performed with counselor experience level serving as the independent variable. For purposes of this analysis, four levels of experience were defined as follows: 1) practicum student; 2) intern; 3) M.S. level counselor - in this case averaging 10 years of experience; 4) Ph.D. level counselor.

Significance was attained on 1) the CRF expertness dimension, \( F(3, 63) = 7.51, p < .0003 \); 2) the CRF attractiveness dimension, \( F(3, 63) = 3.04, p < .03 \); 3) the CRF trustworthiness dimension, \( F(3, 63) = 2.67, p < .05 \); 4) the CEI, \( F(3, 63) = 3.28, p < .03 \); 5) difference scores for severity ratings, \( F(3, 63) = 3.25, p < .03 \); and 6) degree of responsibility attributed to Student Counseling Service visits for change in presenting problem \( F(3, 63) = 3.00, p < .04 \).

This item is termed "SCS" in Table 3.

Table 3 presents means for these dependent measures according to counselor experience level. Mean values show that on measures of counselor expertness, counselor attractiveness, and client satisfaction, practicum students and interns received comparable ratings, as did M.S.
Table 3

Means for CRF Dimensions, CEI, Difference Scores, and SCS

<table>
<thead>
<tr>
<th>Experience Level</th>
<th>N Counselors</th>
<th>N Clients</th>
<th>Expertness</th>
<th>Attractiveness</th>
<th>Trustworthiness</th>
<th>CEI</th>
<th>Difference</th>
<th>SCS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practicum Student</td>
<td>6</td>
<td>8</td>
<td>61.62</td>
<td>62.62</td>
<td>67.32</td>
<td>87.13</td>
<td>-2.12</td>
<td>3.12</td>
</tr>
<tr>
<td>Intern</td>
<td>3</td>
<td>21</td>
<td>63.76</td>
<td>62.38</td>
<td>68.05</td>
<td>90.05</td>
<td>-0.95</td>
<td>2.76</td>
</tr>
<tr>
<td>M.S. Level Counselor</td>
<td>3</td>
<td>7</td>
<td>76.14</td>
<td>72.57</td>
<td>75.96</td>
<td>98.29</td>
<td>-1.71</td>
<td>3.71</td>
</tr>
<tr>
<td>Ph.D. Level Counselor</td>
<td>13</td>
<td>31</td>
<td>74.16</td>
<td>69.32</td>
<td>73.68</td>
<td>96.04</td>
<td>-1.70</td>
<td>3.51</td>
</tr>
</tbody>
</table>

Note: - Scores for each CRF dimension range from 12-84 with higher scores representing more favorable perceptions.
- CEI scores range from 21-105, with higher scores representing greater satisfaction with counseling.
- Difference Scores = (Post severity rating - pre severity rating) with negative values representing greater improvement.
- SCS scores range from 1-"not at all" to 5-"100%".
and Ph.D. level counselors. In general, the more experienced the counselor the higher the ratings s/he received. Experienced M.S. level counselors received the highest expertness, attractiveness, and satisfaction ratings, which were slightly higher than ratings of Ph.D. level counselors. Examination of difference scores and SCS means showed that on these measures interns obtained the lowest ratings and Master's level counselors obtained the highest ratings with one exception: Clients who saw practicum students reported the most improvement in their presenting problem.

Dunn's Multiple Comparison Procedure (Kirk, 1968) was used to compute planned comparisons among means. Significant differences between means occurred only on the CRF expertness dimension. M.S. level counselor means were greater than intern means, \( t (63) = 11.69, p < .05 \), and practicum student means, \( t (63) = 13.87, p < .05 \).
DISCUSSION

This study was the first to "prepare" clients seeking individual counseling at a university counseling center for their ensuing counseling experience. Differences were not observed between groups exposed to precounseling information and the NVT (Control) group, on any of the outcome measures used. However, in general clients reported significant improvement in their presenting complaint as a result of their counseling experience. These findings essentially parallel those of Sloane et al. (1970), who also found that an explanation of the psychotherapy process failed to influence attendance and other outcome measures, while target symptom ratings decreased significantly for clients exposed to pretherapy information. Yet, it is the examination of some differences between this and Sloane et al.'s study that will perhaps shed light on factors which may have contributed to the failure to produce experimental effects in this research.

Selection Factors

One outstanding difference between the present study and other research efforts (Sloane et al.'s included) aimed at preparing clients for counseling lies in the nature of the populations and therefore the sampling methods which were used. Previous studies have directed their efforts at lower SES and less sophisticated individuals than a college student population. Lower SES clients typically receive treatment at a community mental health center or out-patient hospital clinic where entry into a study is often treated as a routine matter. Conversely,
at the counseling center under consideration it was extremely difficult to recruit an adequate sample of clients to serve as subjects. Although paying clients helped secure their participation, an entire academic year was required to obtain 67 subjects. Thus, since clients in general were unwilling to become involved, it is reasonable to assume that a considerable self-selection factor was operating. In other words, it is likely that those clients who did agree to be subjects were different from this counseling center's other clients in ways which may have influenced the outcome of this study. It is reasonable to consider that this sample of subjects contained individuals who may have been more motivated, more open to new experiences, more sure of themselves and their counseling needs/goals and thus less threatened by the prospect of being subjects in a study which scrutinized their counseling experience. If it is reasonable to consider that this sample of clients differed in any or all these ways then it is also tenable that these individuals' expectations about counseling started out in line with the goals which the preparation for counseling videotapes sought to accomplish. In being more open and more willing to take a risk, subjects in this study may have started out as "better clients" and thus attenuated the potential effects of the videotapes.

In general, clients reported significant improvement in their target complaints as a result of their counseling experience and averaged 3.5 counseling session. Also, only 8 clients (12%) reported ter-
minating because counseling was not helpful. These findings seem to lend support to the idea that due to a strong self-selection factor this subject sample contained clients who, in essence, knew what they wanted from counseling and got it. There is little doubt that client personality variables, education level, intelligence, motivation, and problem type render clients differentially receptive to various forms of therapeutic influence (Strupp, 1978). It seems tenable then that this population was quite different not only from the lower SES clients who participated in the more successful "preparation" studies (Jacobs et al., 1972; Hoehn-Saric et al., 1964), but also from clients in general at this counseling center. This difference, in turn, may have functioned in a way which rendered the experimental manipulation less potent.

The Treatment Groups

Closer scrutiny of the information that was actually communicated to clients in each of the treatment groups may provide further understanding about the outcome of this study. Group 1 subjects were provided with information about the counseling process with special emphasis on the client role. The particular modeling format which was used consisted of five university students asking questions of two counseling center counselors (who were in actuality advanced graduate students who had each had several practica at the counseling service). The students asked their questions in a way which communicated some skepticism and doubt about engaging in the counseling experience. The
counselors responded with realistic information which focused on the benefits which could be gained from counseling if the client was willing to be open, self-explore, take responsibility and in general work hard in counseling. This presentation may have had at least three different effects on its viewers. Clients, in identifying with the students in Videotape 1, may have incorporated some of the models' negative affect about counseling into their own attitudes. Secondly, since the models communicated doubt about seeing a counselor while the clients had already made the decision to enter counseling, the information provided in the videotape may have been dismissed in that it conflicted with the current beliefs of the clients. Finally, since the counselors' answers may have communicated the message: "this is what a client should be like", as well as being responses to the model's skeptical questions about counseling, clients may have perceived the videotape as coercive in nature, which would certainly serve to counter the videotapes intent.

Videotape 2 maintained the same question and answer format but provided information about the diverse services which the counseling center offers. However, models in Videotape 2 conveyed curiosity rather than doubts through their questions. Counselors were not trying to be convincing but rather enthusiastically communicated information about the expertise of the center's staff. One plausible explanation for the lack of treatment effects for Group 2 is that client's expectations about counseling may already have been aligned with the
information provided by Videotape 2. Tinsley and Harris (1976) found that the strongest expectations held by college students about counseling was the expectation of seeing an experienced and expert counselor. It is likely, therefore, that clients who made the decision to see a counselor, already expected that counselor to be an expert, who possessed the necessary skills to help the client solve problems. Thus, providing information to clients about the expertness of the counseling center's staff may at best have confirmed expectations which clients already held.

Finally, Group 3 clients were not exposed to a precounseling videotape, but did respond to the forms which served as the dependent measures. This group was intended to serve as a control group, but cannot be considered comparable to a no contact or no treatment control group. Several studies have shown that clients who consented to respond to questionnaires prior to counseling, either continued in counseling significantly longer or dropped out of treatment significantly less than clients who refused to respond to questionnaires (Koran and Costell, 1973; Dodd, 1970; Wirt, 1967). It is possible that willingness to respond to questionnaires reflects greater motivation to cooperate in therapy.

Gender Effects

Conflicting findings of Epperson (1981) and Betz and Shullman (1979) regarding counselor sex and premature termination provided evidence that gender was an important factor to examine in this study. In
general, there were no significant findings due to counselor or client gender. Two isolated gender effects were found. First, counselor reports of premature termination showed a higher incidence of premature termination for female clients. It is difficult to provide an explanation for this finding, in that the literature does not provide evidence for any obvious relationship between client sex and outcome (Garfield, 1978). Secondly, clients of male counselors reported that they did not find counseling helpful more often than clients of female counselors. Again, one can only speculate about the meaning of this finding. However, it does seem likely that these results cannot be generalized to other settings. Rather the differences may be due to individual counselors and clients involved, as well as their interaction as a counseling dyad.

Rumenik, Capasso, and Hendrick (1977) reviewed experimenter sex effects in behavioral research and recommended that psychological research should routinely incorporate sex of experimenter and sex of subject variables. Thus, although it is important to be aware of various confounding variables, gender included, it may prove more fruitful, for example, to examine the differences between counselors who are and are not seen as helpful, regardless of their sex.

The Dependent Measures

Perhaps the most perplexing issue confronting the psychotherapy researchers is the measurement of client change, the counseling experience and/or psychotherapy outcome. A vast array of studies have led
to the conclusion that measured change of the average client is quite limited and the correlations of separate measures are generally low (Harty & Horowitz, 1976; Horenstein, Houston, & Holmes, 1973; Fiske, 1971). An overall lack of consensus exists regarding what criteria are suitable for appropriate outcome measurement. Stemming from these facts, there is general agreement that multiple measures of outcome need to be used and that the measures should be relatively independent. Also, in an attempt to prevent systematic bias, both counselor and client perceptions should be tapped. This study employed several dependent measures in an effort to avoid the major pitfalls which plague the assessment of psychotherapy. Not surprisingly, the dependent measures used were not without problems, some of which will be discussed below.

The CRF was used to measure perceived counselor expertness, trustworthiness and attractiveness. Intercorrelation of dependent measures revealed high positive correlations between the three CRF dimensions. In fact, the three scales of the CRF have consistently been shown to be significantly and positively correlated (Corrigan, 1978; Barak & LaCrosse, 1975). Although evidence also exists that the three scales are independent (LaCrosse & Barak, 1976), thus far research employing the CRF has been limited to laboratory and counseling analogue settings. In this study, the experimental treatment variables failed to produce a differential effect on the CRF, between client perceptions of counselors in different treatment groups. Surprisingly,
the CRF expertness dimension failed to show differences between perceptions of clients in Group 2 (exposed to information about the expertness of the counseling center staff) and perceptions of counselor expertness in the remaining two groups.

The CEI was used to assess client attitudes toward counselors using satisfaction as a criterion. This scale showed positive, significant correlations with each of the CRF dimensions, comparable to the intercorrelations among the CRF measures themselves. These findings suggest that rather than measuring separate dimensions perhaps the CEI and each CRF dimension tap a signal factor - such as counselor credibility or effectiveness.

Two "homemade" devices, the CPCF and CECF were used to provide a gross measure of counselor perceptions of their clients. The CPCF consisted of the 12 adjectives which comprise the CRF attractiveness dimension. This scale resulted in highly significant correlations with each of the CRF dimensions. The CECF, a modified version of Orlinsky and Howard's (1975) Therapy Session Report, was intended to assess the counselors' global, subjective experience of counseling with a given client. This measure was highly correlated with the CPCF, but did not correlate significantly with the CRF. These findings suggest that the factors obtained may be associated with the method of measurement, or what Cartwright, Kirtner, and Fiske (1963) termed "observer-instrument combinations" (1963, p. 175), rather than with substantive factors coming from that which the measures were intended to assess.
The examination of means for each of the measures just discussed revealed that both counselors and clients tended to respond to items in an overall favorable manner. That the generally favorable ratings may in part be the result of response artifacts, is worthy of consideration. The very assessment of therapeutic effects can distort data (Nelson, Lipinski, and Black, 1975). Self-rating scales are particularly subject to a variety of response biases. In responding to questionnaires, both clients and counselors may consistently rate the stimulus as "good" or may tend to respond in the socially desirable manner. In further research with measures such as the CRF, it might be useful to ask clients to rate their counselors as they imagine the counselor would compare to the ideal counselor (Epperson, 1981, Note 4). Otherwise, it is likely that counselors are being compared to people in general and this may result in artificially high ratings. Furthermore, response bias can be prompted by the client's need to validate for her/himself that s/he is being helped by a credible counselor. Similarly, since the counselor's perceptions of progress with a client reflect his/her own functioning as a helper, therapists' self or client ratings may be generally higher than would be obtained from an outside observer. Indeed, research has shown that clients and therapists share a tendency to overrate their success and that this tendency is greater in therapists than in clients (Harty and Horowitz, 1976; Garfield, et al., 1971a). According to Harty and Horowitz, those most involved in the counseling process (clients and counselors) in contrast to outside observers and
judges, tend to overrate their success and to present a rosy view of their perceptions of each other. Furthermore, a significant number of therapists failed to perceive clients' feelings of dissatisfaction when the treatment team found that such feelings were warranted by treatment outcome.

Based on the target-complaint technique (Rosen and Zytowski, 1977; Battle, Imber, Hoehn-Saric, Stone, Nash, and Frank, 1966) severity ratings at pre and post counseling intervals were used. This measure allows the degree of change in rated severity of presenting problem to be taken as an index of the impact of treatment. Some researchers view this measure of improvement as superior to direct improvement ratings in that they are less subject to distortion and are potentially more objective (Garfield, Prager, and Bergin). Hoehn-Saric et al. (1964) were particularly impressed with the target symptom outcome technique, perhaps because it was one of the few measures which reached significance in their "preparation" study. However, this measure, which uses raw change scores has been criticized in that difference scores can be expected to correlate highly with precounseling scores, so that clients with low pretreatment scores will obtain high change scores. Also, true change may be difficult to isolate in that the change score shares measurement error with both pre and post ratings.

The final measure to be discussed is the assessment of premature termination. This study was initially conceptualized in an attempt to decrease the rate of premature termination which has been documented
at university counseling centers. (Epperson, 1981; Betz and Shullman, 1979; Kirk and Frank, 1976; Yalom et al., 1967). In the Epperson, and Betz and Shullman studies, premature termination occurred when clients failed to continue in counseling after their first appointment. Both studies found a 25% premature termination rate. Using the failure to return after the first appointment criterion, Group 1, Group 2, and Group 3 clients evidenced premature termination at 23%, 20% and 25%, respectively. These differences were not significant.

This study employed a more stringent definition: Premature termination was judged to have occurred when client and counselor were not in agreement that counseling should terminate. Examining premature termination as defined in this study brings up an issue of considerable interest. Counselors reported that 27 (42%) clients terminated prematurely. However, only 8 (12%) clients reported leaving counseling because they did not find counseling helpful. Thus, it is not unreasonable to say that from clients' perspectives, only 12% of the clients terminated prematurely. The issue that is raised is not a new one, but worthy of consideration nonetheless. Who is the best judge of progress/success in counseling and thereby when it is time to terminate?

Many assume that the counselor is in the best position to judge therapeutic progress (Berg, 1952) in that s/he is the expert, while the client's judgement may be distorted by resistance or "flights into health." This view takes the position that the counselor "knows best." On the other hand, and especially in the case of self-referred clients,
the client knows why s/he came to counseling and may therefore be in
the best position to decide if that problem still exists. This view
is supported by studies which have found that while clients' ratings
of therapeutic progress differed from those of their therapists, they
were consistent with ratings of independent judges (Harty and Horowitz,
1976; Horenstein, Houston, and Holmes, 1973). Anecdotal data from this
study lend further support to the idea that the client may be in the
best position to judge whether his/her counseling goals are being met.
One client wrote "my counselor seemed willing to help but the ideas were
not what I was looking for." Thus, even though the counselor may have
identified a problem which the client is not attending to, its resolu-
tion becomes the counselor's goal. Achievement of this goal may inap-
propriately influence the counselor into thinking that the client needs
to remain in treatment. Of course, there is still much to be said for
extending counseling beyond brief work in crisis situations. Working
toward increased self-understanding or learning better overall coping
skills, are worthwhile goals in any counseling situation. Yet, per-
haps, at least in some cases, the 25% rate of "premature termination"
is a reflection of self-referred university counseling center clients
who have made the subjective though valid judgement that continued
counseling is not something in which they want to invest more time.
After all, the client is a partner in the counseling process and may be
exercising his/her autonomy by leaving counseling when s/he decides to
do so.
Counselor Experience Level

Although this study was not designed specifically to study the effects of counselor experience level, this factor was included in the analysis, in an effort to seek explanations for the general lack of treatment effects. Indeed, in their chapter in the *Handbook of Psychotherapy and Behavior Change* Parloff, Waskow and Wolfe (1978) report that most researchers conduct post-hoc analyses on effects of therapist level of experience, in order to understand their results. Nonetheless, counselor experience level was the only factor that was found to have consistent effects on the dependent measures.

The literature supports this study's finding that counselor experience was positively related to favorable ratings on the measurement methods used. In a review of 13 studies, Luborsky, Chandler, Auerbach, Cohen, and Bachrach (1971) found that 8 studies showed a significant positive relationship between therapist experience and client improvement. These researchers concluded that experience level is one of a very limited number of therapist factors that has a significant relationship to therapy outcome.

For purposes of this analysis, experience was defined initially by highest degree attained - from students in training to Ph.D. level counselors. However, several of the Ph.D. level counselors were relatively recent graduates, while each of the M.S. level counselors had at least 10 years of counseling experience. As a group, the Ph.D. level counselors were less experienced than the M.S. level counselors. In-
formation on experience level of practicum students as compared to interns was not available, although it is conceivable that a practicum student could have more counseling experience than an intern. Indeed, on two measures practicum students received more favorable ratings than interns.

This study found a significant, positive relationship between experience level and each of the CRF dimensions: expertness, trustworthiness, and attractiveness (refer back to Table 3). The highest level of significance occurred on the expertness scale, with the most experienced counselors being perceived as most expert. This finding seems to make logical sense, in that experience is likely to increase the expertness with which the counselor applies her/his skills. Furthermore, a significant positive relationship was found between counselor experience and client satisfaction with counseling as assessed by the CEI.

On difference score measures of presenting complaints it was surprising to find that clients who saw practicum students reported the greatest improvement in their presenting problem (although none of the pairwise comparisons of means for this measure reached significance). A plausible explanation for this is that perhaps the less experienced counselors were more invested in pleasing their clients and therefore were more likely to meet clients' expectations by giving advice or otherwise providing solutions to the clients' problems. The more experienced counselors were perhaps less likely to fall into this advice giving trap, which usually plagues beginning counselors. Finally,
client's ratings of the single item which assessed degree of responsibility attributed to the counseling experience for improvement in the targeted problem, favored M.S. level counselors, followed by Ph.D. level counselors, practicum students, and interns. It is important to remember that although each measure discussed reached overall significance, significant differences between means occurred only on the expertness measure: M.S. level counselors were perceived as more expert than interns and practicum students.

The finding that experience level had significant effects while the precounseling information manipulation was not reflected by the dependent measures used, has noteworthy implications for future outcome research. It seems reasonable that rather than employing post hoc analyses of experience level studies should consider this factor in their original design. In such cases, experience level should be explicitly defined and differentiated. It is possible that studies may fail to produce effects due to counselor experience level because groups of experienced and inexperienced counselors may overlap. Finally, as in this study, when staff members are compared to practicum students and interns, a confounding between experience level and other factors may occur. Ideally, studies which examine experience level, will compare groups of counselors who have completed their formal education.
Conclusion

The findings of this study point out the plethora of difficulties which plague the psychotherapy researcher. The measurement of outcome continues to present problems, as does the control of diverse variables such as individual differences of counselors and clients. Many authors support the position that "therapists cannot be regarded as interchangeable units that deliver a standard treatment in uniform quantity or quality" (Strupp, 1978, p. 8). The same statement applies equally to clients. The quality of research will be improved if investigators take into consideration such variables as the nature of the counselor and the client, and what type of change is expected. This study proved counselor experience level to be another variable requiring consideration in any study designed to assess counseling outcome. In retrospect, it is not surprising that experience turned out to be a key variable in terms of its effects on the dependent measures. Certainly with experience, comes a relaxed manner, confidence, and greater flexibility in dealing with diverse client needs. Similarly, it is likely that an experienced male or female counselor will work more effectively with clients of either gender.

This study originated in an effort to make counseling more useful and effective for its recipients. This was attempted by preparing clients for counseling by increasing their understanding of how counseling works and instructing them in appropriate client behavior. It was hoped that success could be gauged by a decrease in the perplexing
rate of premature termination which occurs at university counseling centers. Such efforts at socializing clients have met with some success, when recipients were of lower socioeconomic and educational status. Replication efforts with college students need to consider the importance of appropriate modeling techniques and the assessment of expectations which clients bring with them to counseling. Yet, perhaps a more useful approach then attempts at tailoring the client to the counseling, would be one which tailors the counseling to the needs of the client.

Finally, it is noteworthy that recruiting clients to participate in research has been a problem at this center for the last three or four years. The requirements that people be informed of research procedures and that they give their consent prior to being a participant has resulted in a high rate of refusal. The counseling service, is, of course, committed to providing service regardless of the clients willingness to participate in research and thus has no means by which to require or coerce participation. This unwillingness of clients to give something in return for the services they expect to receive may well be a critical and perhaps unrecognized factor in studies throughout the country which use college students as subjects. However, to date no review of these phenomena has been made.
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APPENDIX A

AGREEMENT FOR CLIENT PARTICIPATION IN STUDENT COUNSELING SERVICE PROJECT
To our new clients

The attached material describes a project that is of considerable importance to us. We are examining a change in the way we provide services to students but need some help from our new clients to evaluate this change.

We are offering you $5.00 for participating in this project. It will require that you spend a few minutes filling out some forms, in addition to time spent in appointments. Call the $5.00 what you will: an incentive, a lure, a payment for time spent in research activity, or perhaps even a bribe to get you to participate. We intend it to be a recognition that your time is valuable and is one way for us to say "thank you." It probably is a little bit of all of these!

As soon as you complete your part of the project, we will mail you a check as quickly as we can process the paperwork -- probably within 10 days.

Roy E. Warman, Ph.D.
Director
Fall Quarter 1980

To Students Who Request Counseling:

The Student Counseling Service is introducing a new procedure this fall which we think will improve our services to students. This involves having some of you view a brief (14 minute) videotape prior to your first appointment with your counselor. The purpose of this videotape is to orient you to us and, therefore, make it easier to work with your counselor.

To insure that this new procedure is as helpful as we expect it to be we are evaluating it by requesting that all students who make appointments to talk with a counselor, help us by filling out some brief forms about their counseling experience. Some people will view the videotape; others will not. In this way we can determine the usefulness of the videotape and make a final decision about continuing its use.

All aspects of your participation in this evaluation will be held in confidence. Your counselor will not know whether or not you saw the tape and will not see the forms you fill out. Although everyone on our staff knows that this evaluation project is being conducted, we do request that you not mention to your counselor whether or not you saw the tape.

If for any reason you feel you can not participate in this evaluation project, you will, of course, still receive the counseling you are requesting. However, the time you spend in helping us evaluate this innovative procedure will be greatly appreciated! It will assist us in our continued effort to improve the quality of counseling we provide for all ISU students.

If you are willing to participate, please sign below and return this request sheet to the receptionist. (If you are not willing to participate, return this sheet unsigned).

Thank you,

Margaret Cegielski, Project Coordinator

Roy Warman, Director, SCS

Yes, I will participate

Student's signature ____________________________

Date ____________________

Address: ________________________________
APPENDIX B

AGREEMENT FOR COUNSELOR PARTICIPATION IN

DISSERTATION RESEARCH
AGREEMENT FOR COUNSELOR PARTICIPATION IN DISSERTATION RESEARCH

I will be collecting data for my dissertation at the Student Counseling Service during the 1980-81 academic year. The purpose of the study is to assess the effects of precounseling information about the counseling process as the counseling center on counseling outcome. Two thirds of the subjects (your clients) will be viewing one of two 14 minute videotapes which I have developed before their first appointment, while the other one-third of the subjects will not be exposed to this experimental manipulation. Subjects will be asked not to reveal whether or not they have viewed the videotape, in order to maintain counselor blindness to the treatment conditions. When counseling with a given client, is ended you will be asked to indicate the conditions under which termination occurred, as well as to fill out two brief questionnaires which assess your perceptions of the client, and your experience of counseling with that person. Your participation in this study is needed and appreciated. If you are willing to participate, please indicate by signing below. For those of you who are willing, thank you in advance for your help.

Margaret Cegielski

Counselor's Signature ______________
APPENDIX C

NATURE OF TERMINATION FORM
NATURE OF TERMINATION FORM

Counselor's Name ______________________

Client's Name ______________________

Number of Kept appointments ______________________

Number of cancellations _____________

Number of No Shows _________________

Please indicate, by checking the appropriate blank below, the conditions under which counseling with this client was terminated.

_____ A. The client stopped coming for counseling without notifying the counselor or the appointment desk.

_____ B. The client did not discuss his/her intent to terminate with the counselor, but did notify the appointment desk or the counselor that s/he would not be continuing.

_____ C. The client verbalized his/her intent to terminate to the counselor prior to discontinuing counseling. The counselor felt that the client could benefit by continuing.

_____ D. The counselor and client were in agreement that counseling should terminate.
APPENDIX D

STUDENT COUNSELING SERVICE -

NEW COUNSELEE INFORMATION SHEET
Today's Date ______________________
Your Name (Please Print) ______________________ Local Phone ____________
Last First MI
Local Address ___________________________________________________________________
City if other than Ames ______________________

What is your ISU college? ____________________________________________

- Agriculture
- Education
- Engineering
- Home Ec
- S & H
- Vet Med
- Grad
- Design

What is your academic level? ____________________________________________

- Freshman
- Sophomore
- Junior
- Senior
- Special
- Graduate
- not a student

Major ______________________ Age ____ Sex ____

Year first entered ISU: 19____

Referred by ______________________ Are you applying for readmission to ISU? Yes ____ No ____

In the box below, please write a sentence or two which describes what it is that you would like the Student Counseling Service to help you with.

________________________________________________________________________

________________________________________________________________________

In general, how much does this problem bother you? Check the box below:

[ ] Not at all [ ] A little [ ] Pretty much [ ] Very much [ ] Couldn't be worse

Counselors sometimes record interviews for purposes of review. Recordings are never made without your knowledge: your counselor will request your permission.

It is the policy of the Student Counseling Service not to release personally identifiable information concerning use of counseling services without the written permission of the person who was counseled. We shall be glad to send a report or talk with person(s) you designate, if a release form is signed by you. A copy of this form is available from our receptionist.

If there is anything else you would like to tell us about yourself, please do so on the other side of this page.

________________________________________________________________________

________________________________________________________________________

Do Not Write In This Section

Date of Appt. ______________________ HSR ____ ACT ____ MSAT ____

Counselor ______________________ Math: C1 ____ C2 ____ C3 ____ A1 ____ A2 ____

AA ____ AB ____ AC ____ Tr ____ Ca ____

Revised 6/27/79
APPENDIX E

FOLLOW-UP QUESTIONNAIRE
FOLLOW-UP QUESTIONNAIRE

As the last part of your participation in the Student Counseling Service study, please respond to this form. Remember, your counselor will not see your response. Thank-you again for your time and effort.

Immediately below is the problem which you stated when you came to the Student Counseling Service:

________________________________________________________________________
________________________________________________________________________

1. Now, at the present time, how much does this problem bother you?
   Not at all  A little  Pretty much  Very Much  Couldn't be worse

2. Indicate the degree to which your visits to the Student Counseling Service were responsible for any change in your problem:
   Not at all  A little  Pretty much  Very much  100%

3. I stopped going to the Student Counseling Service because: (Please check one)
   Both the counselor and I agreed I was finished.
   I felt I had done enough, so I stopped going.
   I wasn't getting the help I wanted, so I stopped going.
   I found counseling helpful, but stopped going because I had other priorities for my time.
   I did not find counseling helpful, and I had other priorities for my time.

Student's Name ___________________________
APPENDIX F

COUNSELOR RATING FORM
COUNSELOR RATING FORM

Please respond to this form and return it to the front desk before you leave today. If you don't have time now return the completed form as soon as possible.

Please rate your counselor on the following scale. Respond to each item by circling the number which best describes how you feel. Remember your counselor will not see this form.

Unlikeable

1......2......3......4......5......6......7

Likeable

Selfless

1......2......3......4......5......6......7

Selfish

Closed

1......2......3......4......5......6......7

Open

Distant

1......2......3......4......5......6......7

Close

Inexperienced

1......2......3......4......5......6......7

Experienced

Enthusiastic

1......2......3......4......5......6......7

Indifferent

Friendly

1......2......3......4......5......6......7

Unfriendly

Confident

1......2......3......4......5......6......7

Unsure

Unappreciative

1......2......3......4......5......6......7

Appreciative

Stupid

1......2......3......4......5......6......7

Intelligent

Disrespectful

1......2......3......4......5......6......7

Respectful
Prepared

1......2......3......4......5......6......7

Compatible

1......2......3......4......5......6......7

Honest

1......2......3......4......5......6......7

Warm

1......2......3......4......5......6......7

Responsible

1......2......3......4......5......6......7

Unsociable

1......2......3......4......5......6......7

Unreliable

1......2......3......4......5......6......7

Insincere

1......2......3......4......5......6......7

Casual

1......2......3......4......5......6......7

Logical

1......2......3......4......5......6......7

Agreeable

1......2......3......4......5......6......7

Clear

1......2......3......4......5......6......7

Unattractive

1......2......3......4......5......6......7

Analytic

1......2......3......4......5......6......7
Depressed  Cheerful
1234567
Unskillful  Skillful
1234567
Genuine  Phony
1234567
Believable  Suspicious
1234567
Untrustworthy  Trustworthy
1234567
Insightful  Insightless
1234567
Alert  Unalert
1234567
Straightforward  Deceitful
1234567
Expert  Inexpert
1234567
Informed  Ignorant
1234567
Undependable  Dependable
1234567

Student's Name _____________________________

Counselor's Name ___________________________
APPENDIX G

ADJECTIVES ON THE CRF DEFINING THE DIMENSION
OF PERCEIVED COUNSELOR EXPERTNESS
ADJECTIVES ON THE CRF DEFINING THE DIMENSION OF PERCEIVED COUNSELOR EXPERTNESS

Alert—Unalert
Analytic—Diffuse
Clear—Vague
Confident—Unsure
Experienced—Inexperienced
Expert—Inexpert
Informed—Ignorant
Insightful—Insightless
Intelligent—Stupid
Logical—Illogical
Prepared—Unprepared
Skillful—Unskillful
APPENDIX H

ADJECTIVES ON THE CRF DEFINING THE DIMENSION

OF PERCEIVED COUNSELOR TRUSTWORTHINESS
ADJECTIVES ON THE CRF DEFINING THE DIMENSION OF PERCEIVED COUNSELOR TRUSTWORTHINESS

Believable—Suspicious
Dependable—Undependable
Honest—Dishonest
Open—Closed
Reliable—Unreliable
Respectful—Disrespectful
Responsible—Irresponsible
Selfless—Selfish
Sincere—Insincere
Straightforward—Deceitful
Trustworthy—Untrustworthy
Genuine—Phony
APPENDIX I

ADJECTIVES ON THE CRF DEFINING THE DIMENSION OF PERCEIVED COUNSELOR ATTRACTIVENESS
ADJECTIVES ON THE CRF DEFINING THE DIMENSION OF PERCEIVED COUNSELOR ATTRACTIVENESS

Agreeable—Disagreeable
Appreciative—Unappreciative
Attractive—Unattractive
Casual—Formal
Cheerful—Depressed
Close—Distant
Compatible—Incompatible
Enthusiastic—Indifferent
Friendly—Unfriendly
Likeable—Unlikeable
Sociable—Unsociable
Warm—Cold
APPENDIX J

COUNSELING EVALUATION INVENTORY
COUNSELING EVALUATION INVENTORY

Please fill out this form and return it to the front desk before you leave today. If you don't have time now return the completed form as soon as possible.

Rate your counseling experience by circling the number which best describes how you feel. Remember your counselor will not see this form.

<table>
<thead>
<tr>
<th></th>
<th>Always</th>
<th>Often</th>
<th>Sometimes</th>
<th>Rarely</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I feel the counselor accepts me as an individual.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. I feel comfortable in my interviews with the counselor.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. The counselor acts as though s/he thinks my concerns and problems are important to him/her.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. The counselor acts uncertain of him/herself.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. The counselor helped me to see how taking tests would be helpful to me (Respond if you took tests).</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. The counselor acts cold and distant.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. I feel at ease with the counselor.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8. The counselor seems restless while talking to me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9. In our talks, the counselor acts as if s/he were better than I.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10. The counselor's comments help me to see more clearly what I need to do to gain my objectives in life.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>11. I believe the counselor has a genuine desire to be of service to me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>12. The counselor is awkward in starting our interviews.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>13. I feel satisfied as a result of my talks with the counselor.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
14. The counselor is very patient.  
15. Other students could be helped by talking with counselors.  
16. In opening our conversations, the counselor is relaxed and at ease.  
17. I distrust the counselor.  
18. The counselor's discussion of test results was helpful to me. (Respond if you took tests).  
19. The counselor insists on being always right.  
20. The counselor gives the impression of "feeling at ease."  
21. The counselor acts as if s/he has a job to do and doesn't care how s/he accomplishes it.  

Client's Name ______________________

Counselor's Name ____________________
APPENDIX K

COUNSELOR PERCEPTION OF CLIENT FORM
COUNSELOR PERCEPTION OF CLIENT FORM

Please rate your client on the following scale. Circle the number which best describes your feelings about the person.

<table>
<thead>
<tr>
<th>Agreeable</th>
<th>Disagreeable</th>
</tr>
</thead>
<tbody>
<tr>
<td>1...2...3...4...5...6...7</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Appreciative</th>
<th>Unappreciative</th>
</tr>
</thead>
<tbody>
<tr>
<td>1...2...3...4...5...6...7</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Attractive</th>
<th>Unattractive</th>
</tr>
</thead>
<tbody>
<tr>
<td>1...2...3...4...5...6...7</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Casual</th>
<th>Formal</th>
</tr>
</thead>
<tbody>
<tr>
<td>1...2...3...4...5...6...7</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cheerful</th>
<th>Depressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1...2...3...4...5...6...7</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Close</th>
<th>Distant</th>
</tr>
</thead>
<tbody>
<tr>
<td>1...2...3...4...5...6...7</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Compatible</th>
<th>Incompatible</th>
</tr>
</thead>
<tbody>
<tr>
<td>1...2...3...4...5...6...7</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enthusiastic</th>
<th>Indifferent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1...2...3...4...5...6...7</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Friendly</th>
<th>Unfriendly</th>
</tr>
</thead>
<tbody>
<tr>
<td>1...2...3...4...5...6...7</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Likeable</th>
<th>Unlikeable</th>
</tr>
</thead>
<tbody>
<tr>
<td>1...2...3...4...5...6...7</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sociable</th>
<th>Unsociable</th>
</tr>
</thead>
<tbody>
<tr>
<td>1...2...3...4...5...6...7</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Warm</th>
<th>Cold</th>
</tr>
</thead>
<tbody>
<tr>
<td>1...2...3...4...5...6...7</td>
<td></td>
</tr>
</tbody>
</table>

Counselor's Name ____________________________
Client's Name ____________________________
APPENDIX L

COUNSELOR EXPERIENCE OF COUNSELING FORM
COUNSELOR EXPERIENCE OF COUNSELING FORM

Please circle the letter which most closely describes your experience of counseling with this client.

1. Counseling with this client could best be described as:

   Effective Collaboration (1)   Depressive Stasis (4)
   (progress with responsive client)   (not getting anywhere)

   1........2........3........4

2. My approach to this client can best be described as:

   Involved, Pleased, Interested (1)   Detached, Bored, Displeased (4)

   1........2........3........4

3. I perceive this client as:

   Open, Enthusiastic (1)   Closed, Ambivalent

   1........2........3........4

4. This client's in-counseling behavior is characterized by:

   A search for better self-understanding (1)   Filling time to get through the hour

   1........2........3........4

5. This client can best be described as:

   Active, Initiating Action (1)   Passive, Waiting for Direction (4)

   1........2........3........4

6. My feelings about counseling with this client can best be described as:

   Success, Satisfaction (1)   Failure, Frustration (4)

   1........2........3........4

In responding to the following questions compare this client to other clients you have known.

7. In general, to what extent did you look forward to seeing this client?

   a. I was quite interested in seeing this client; I found myself looking forward to it.
b. I didn't look forward to seeing this client one way or the other; I was neutral in my feelings about it.

c. I definitely did not look forward to seeing this client; I anticipated a boring or trying experience.

8. In general how motivated for counseling was this client?
   a. My client was strongly motivated for counseling.
   b. My client's motivation for counseling was about average.
   c. My client was not motivated for counseling; seemed to come just to keep the appointment.

9. In general how freely did your client express herself/himself in counseling.
   a. For the most part, my client was unable to communicate effectively with me or had difficulty doing so.
   b. My client had occasional difficulty in expressing him/herself, but expressed him/herself adequately, for the most part.
   c. My client was free in communicating with me, for the most part.

10. To what extent did your client bring out thoughts and feelings which really seemed to concern him/her?
   a. My client was for the most part, unable to bring out thoughts and feelings which concerned him/her.
   b. My client had some difficulty in bringing out his/her thoughts and feelings, but was able to deal with them to a considerable extent.
   c. My client had little or no difficulty in bringing out his/her thoughts and feelings and dealing with them.

11. In general, how helpful do you feel counseling was to this client?
   a. Counseling seemed to be of considerable help to this client.
   b. Counseling seemed to be somewhat helpful to this client.
   c. Counseling did not seem to be of much help to this client.
12. In general, to what extent did this client seem to make progress in dealing with the problems for which s/he was in counseling?
   a. My client seemed to make considerable progress in dealing with his/her problem(s).
   b. My client seemed to make some progress in dealing with his/her problem(s).
   c. My client didn't seem to make much progress with his/her problem(s).
APPENDIX M

PREVIDEOTAPE MEMO
PREVIDEOTAPE MEMO

As you know, you are about to see a 14 minute videotape which will orient you to the Student Counseling Service. You will see two counselors and five ISU students talking about what we do here. It is very important that you pay close attention to the information which the videotape presents. You will also be responding to three brief forms which your counselor will give you and which you are asked to return to the front desk (not to your counselor). You will be given the first two forms after your first appointment. Your counselor will give you the third form after your last appointment. Please try to respond to these forms before leaving the counseling service on the day you receive them. If your schedule doesn't give you time to do so, return them to the front desk as soon as you can. Do you have any questions?
APPENDIX N

FOLLOW-UP LETTER
FOLLOW-UP LETTER

Thank you for agreeing to help us in our project to improve services for our clients. We need to have you complete the enclosed forms and return them to the Counseling Service. You may have already received copies from your counselor. Please mail them back within five days in the enclosed, postpaid envelope. When you have returned them, we will mail you a check for $5, hopefully within 10 working days.

Thanks again.

Margaret Cegielski
Project Coordinator
APPENDIX O

VIDEOTAPE 1 SCRIPT
The following is a brief orientation to the Student Counseling Service. You will see two counselors and five ISU students talking about what the counselors on the staff do and how they do it.

Question 1: One of my friends told me about this counseling service and I was kind of curious about it. I'm not sure I understand what would happen if I came here. Would I talk to a psychiatrist or a psychologist? Talking to someone like that kind of scares me. What are they going to be like? What will they do?

Answer 1: Well, the counselors who work at SCS are mental health specialists with advanced education and training in psychology and related fields. There are over 20 professional counselors, both men and women, of varying ages. You won't talk to a psychiatrist. A psychiatrist is a medical doctor and counseling is not a form of medical treatment. Now what happens the first time you come here is you're asked to fill out a face sheet which asks for some basic information. Then you meet individually with your counselor and talk to them about whatever it is that brought you here in the first place. You don't lay on a couch with the counselor sitting behind you like you see in all the cartoons. Rather you just sit and talk. During that first session, which typically lasts about 50 minutes, the counselor will spend some time getting to know you but will spend most of the time understanding your situation and clarifying it, whether it be a vocational or educational issue, like finding a major, or perhaps it might be a personal problem. But, whatever it is, the two of you are working together to clarify the situation and to understand it and to decide what steps to take next and that might include deciding if you want to come back for further appointments.

Question 2: I think I'd feel funny talking to a counselor. These counselors - I feel like they're all good and everything's right with them and they know what they're doing with their lives. If I come in here with a problem aren't they going to think I'm weird, or different or something?
Answer 2: 
(Bruce) 
Well, you've got to be a human being before you can be a counselor. A counselor is really just someone with advanced training in counseling techniques and working with people and dealing with their concerns. In the counseling relationship it's not that you're down here and the counselor's up here ... it's more an equal basis, an equal footing. There's really no connotation that one person in the relationship is better than the other one, really you're just two people working together to work on some concerns or understand some problems in your life. We realize that everyone is different and we respect those differences and may even focus on them when we think it will help, but by the same token everybody's got the same worries, the same general sorts of fears. You can look at it this way - if the counselor didn't have any problems in his or her life it would be awful difficult for them to understand what's going on in your life. We all know that living in society with people has stresses and strains and ups and downs; and we're all subject to those sorts of things, you can't get away from it.

Question 3: 
(Theresa) 
Do the counselors keep some type of record? Is there any guarantee that it's not going to come out - for example, if I have a mental problem?

Answer 3: 
(Margaret) 
Your records at the Counseling Service consist of the face sheet that you filled out when you first came here, as well as brief notes that the counselor makes after each appointment. These records are kept only at SCS in locked-up storage and they are never mixed with any of your other university records. The thing is though, that mental health professionals have ethical standards and guidelines which they follow and abide by in their work. One of our most important standards is that of confidentiality. What confidentiality means essentially is that anything that is said by you or between you and your counselor will not be repeated by the counselor to anybody else. What goes on in the counselor's office during your appointment stays in that office. The exception to this is if the counselor were convinced that a client was going to harm him/herself, that is was talking in a serious way about suicide or about harming somebody else ... the counselor would have to decide what to do even if this meant breaking confidentiality. Confidentiality is something the counseling center takes very seriously. Confidentiality is essential for the counseling relationship to progress satisfactorily and
for you to trust us, ... it is very important. You can look at it this way: How can we expect you to be open with us about your personal lives if we could not guarantee you confidentiality ... So, we do.

Answer: (Margaret)

I wanted to respond to what Theresa asked earlier - is it going to come out that you have a mental problem or something. We don't look at you as having a mental problem. That is a term that's used by the public and it has a negative stigma attached to it. Hopefully, the negative stigma associated with seeing a counselor is disappearing. I think that it is based on how many clients we see like we saw over 1,800 clients last year. Other places too like the Mental Health Center downtown has a waiting list. We look at it more as helping you solve problems in living by helping you acquire the skills which will enable you to deal more effectively with the ups and downs that come with living. Counseling resembles education in that we view it as a complex learning situation where you learn to become more self-directed and how to have greater control over your life. People learn to be the way that they are and counselor's help them find different ways of looking at things and different ways of behaving. Counseling is based on the view that an exploration of yourself and your problems in living, undertaken in the context of a professional but human relationship over time, can clarify things and increase your control of your thoughts and feelings and to gain greater understanding of them, too.

Question 4: (Kevin)  
I still don't think I'd feel comfortable going to a counselor and telling him my problems. But say I make an appointment and come to talk to a counselor ... what am I going to say? What will happen?

Answer 4: (Bruce)  
There really isn't an established procedure that counselors stick to, although, often the first goal is to clarify your situation and examine the options available to you. In establishing a relationship with you and devising a plan for counseling the counselor is very aware that you are an individual and s/he wants to work with you and approach your concerns from the way that you see them - from your point of view. The counselor will first and foremost have an accepting attitude towards you. S/he accepts you and your behavior without making any type of value judgement. What is most important for you is that you be open with your counselor, that is that you speak frankly about whatever's on your mind. Whatever
is on your mind, is probably important so we don't want you to censor, we want you to speak out about what you're thinking. If you are willing to explore your feelings - attitudes - behaviors in an honest; open way with yourself and your counselor - this will probably go a long way toward accomplishing the goals you had when you came into the counseling session.

Question 5: You talk about the goals of counseling and stress things like openly exploring your feelings. I'm kind of confused - I thought you came to the counseling service to get answers to your problems. Isn't that right?

Answer 5: A lot of people come to counseling looking for a quick, pat, easy solution ... the magic pill that will make you feel better or tell you what to do. You're not going to get that in counseling - there is no one magic solution. What you will get is someone who will listen to your concerns, help you become aware of what's going on in your life and clarify your options and your thinking. You're not going to come out of counseling with a pat answer, but rather with the knowledge to take a course of action in your life ... to change your life. In counseling you can't assume a passive role. You are an active participant and need to assume an active role. The counselor is not going to make decisions for you or tell you what to do. That would be pretty short sighted on their part. What would happen the next time you had a problem? You wouldn't be any better off. The counselor wants to help you gain the skills that you need to come to your own solutions ... make your own decisions. Counseling can involve a lot of hard work. It's not physical work; it's more mental work. You're actively involved in the process of self-exploration and exploration of your world, the world around you. Hopefully, you're going to find that an interesting and exciting prospect.

Question 7: Well, I'm still not sure that I'd want to come to counseling, what with my studies and all - it seems like it would take a lot of time and a lot of thinking and I have other things to do.

Answer 7: You don't think about your counseling to the exclusion of everything else. Basically, you come into counseling because you have a concern that's taking time away from your studying, your work, or your play. The goals of counseling include learning how to be more effective in your day to day life and also that you experience greater
personal satisfaction and happiness. You can learn to change the way you react to pressures and to understand your attitudes and feelings. But this insight or understanding doesn't necessarily produce change or resolution of your concerns. You have to take responsibility for what goes on in counseling and how you apply that to your life. It's helpful if you're curious and want to gain understanding of yourself. You also have to want to change and try out new behaviors. You can look at the counselor as a helper, a tool that you use to help you explore your environment ... try out new behaviors. A likely goal is that you become more self-directed and you can talk about that and learn it by trial and error in your life. We want you to have a sense of responsibility because we think that's really important.

Question 8: I realize that if a person has a problem you can't push them to go to counseling, but if I have a friend with a problem who wouldn't do anything about it could I come to the counseling service myself, then act as the counselor or sort of a go between for that friend?

Answer 8: Well, we can't really teach you how to be a counselor, but we can work with you in a couple of different ways. We can work with you to help you deal better with the situation, as well as working with you to get that other person to come in. The situation you describe is more difficult than if somebody comes to counseling because they want to, because as we've tried to point out, motivation for counseling is very important. Studies which have asked clients what the most important factor contributing to the success of their counseling was, have said that it was their initial willingness to understand themselves ... so you can see that motivation for being there really counts a lot. It's not like going to a medical doctor where your cooperation may not go much beyond taking a pill or following some routine. Ideally counseling involves a lot of commitment and involvement on your part. Clients who come to counseling because someone else made them or someone else wanted them to are notoriously poor risks ... this means they usually don't get very good results from their counseling. Nevertheless, we would work with you and the situation in any way that we could.

Question 9: How long does counseling usually last? Is there a limit - like say after one hour we haven't solved anything or I feel the same as I did when I came in ex-
cept it's lunch time - what do I do, come back?

Answer 9:  Counseling sessions are scheduled for 50 minutes so that they stay in sync with university classes and usually meet once per week, although that's flexible and can vary. You can usually get quite a bit accomplished in that 50 minute period. It may seem like you're just sitting there and not going much, but you're actually doing the kind of work we've been talking about. As far as how many sessions that depends on the individual and the situation. For example, a vocational concern like finding a major might take 2-3 sessions. Although we can't tell you what major would be best for you or what job will make you happy later in your life, we can talk to you about what's interesting to you and what's important to you and have you take some interest tests. Sometimes counseling can take longer, weeks and even months - like say somebody has a low self-concept and is dissatisfied with the way they interact in interpersonal relationships. That type of concern could take longer to work through than say just 1 or 2 sessions. What's important is that when you decide that you've gained the understanding or made the changes you wanted or just want to quit counseling, you let the counselor know. Also, if you and your counselor have agreed on some goals that you were working towards in the first place, you'll probably both sense when it's about time to quit.

Question 10:  So if we can stop whenever we want, does that mean that the counselor won't call you up and say hey you're supposed to be here?

Answer 10:  If you don't want to come for an appointment you could call and cancel it. If you disappear suddenly without any warning, the counselor might call to see if you're ill or something like that - but otherwise and the general policy is that we won't pursue you or try to convince you to come to counseling.

Question 11:  Say, I came here to talk to a counselor and found it really hard to relate to this counselor - could I trade him in for another counselor - or do I have to keep coming to the same one?

Answer 11:  Yes, you can see another counselor if you want to - your counselor won't be personally offended - you can make an appointment or see any counselor you'd like. But, sometimes clients get discouraged and want a different coun-
selor - or stop coming because they aren't getting what they expected out of counseling. Like maybe they want to be told what to do, have the counselor be a parent figure. Well, you might not get that. Any time you come to counseling it's good to talk with your counselor about your expectations and what you can expect from him or her and how they see your role in counseling. Counseling just like living is a process. This means that there are ups and downs; it's not an all or none situation. Sometimes in counseling you deal with sad and angry feelings, and at other times you get frustrated and feel like you're not making any progress, other times you're going to gain some insights, see how to apply them to your life ... you're going to gain some understanding or make a choice you've been wanting to make or a decision, and then you're going to feel really good and feel like you're making progress. It's true that counseling demands a lot from you - the client - you can expect that, but you can also expect that if you're willing to self-explore you'll probably come to see that counseling is essentially a form of self-help and that may be the best kind, and if you stick with it, it will take you in the direction of being the master or mistress of your own fate.
APPENDIX P

VIDEOTAPE 2 SCRIPT
Counseling Center Information

The following is a brief orientation to the Student Counseling Service. You will see two counselors and five ISU students talking about what the counselors on the staff do and how they do it.

Question 1: What's the counseling center for and what's it trying to accomplish?

Answer 1: Well ... One of the overall goals of the Student Counseling Service is to provide various psychological services to students and student groups. We try generally to aid them in acquiring the skills, attitudes and knowledge that they need to deal effectively with their lives. Included here also is the provision of consultation services to various academic administrative and student groups who request those services.

Question 2: Can you be more specific? I'm not sure what all that means.

Answer 2: The counseling center wants to extend its services where they're wanted and needed by the university community. To be more specific we try to provide psychological services in a wide variety of modalities including individual, group and couples counseling ... we deal with a wide variety of concerns ... personal concerns, educational concerns and vocational career concerns. During the 1978-79 academic year we saw over 1800 individual clients and that amounts to over 6200 counseling sessions that were held that year. The direction of counseling can take a wide variety of directions, where ever you want it to go but generally we try to focus on what the client wants to do ... where the client wants to go. We generally try to follow the direction of the client.

Question 3: Sounds like the counselors are really busy with all those clients. Do you have to wait a long time to get an appointment?

Answer 3: Well, the counselors at the counseling service are busy, but we're also open from 8 a.m. to 9 p.m. Monday through
Thursday and from 8 to 5 on Friday. You can almost always get an appointment with a counselor as soon as you want. Sometimes, there may be a short wait if you have a particular counselor in mind and he or she may be booked for a few days. Also, there is a counselor on duty each day that we call an intake counselor, and that person is there for short interviews with clients who want to see a counselor immediately to talk about some emergency or crisis situation or who just want to find out some information about the kind of services that the counseling center offers.

Question 4: You said something earlier about group counseling. Can you tell me more about that?

Answer 4: Well, we offer a large variety of group experiences here at the SCS. Ah ... personal growth groups, social skills groups, career planning groups, academic skill training groups and a whole lot more. Ah ... a variety of groups are offered each quarter and are open to all students here at Iowa State. We try to make announcements generally in the Daily and also on bulletin boards at various points around the campus and here at the counseling center itself. These bulletins will tell you about the availability of the groups and also where to sign-up for them. The groups generally meet on a weekly basis for the entire quarter, for about 1 1/2 to 2 hours per session.

Question 5: What type of group programs does the counseling center have? Do we just sit around and talk about our problems or what?

Answer 5: Groups are meant to be supportive learning situations where personal development and skill improvement take place via practice, listening, giving and receiving feedback. During the 1978-79 academic year the counseling service conducted a total of 25 groups ... 236 students participated. These groups usually consist of 6-12 graduate and undergraduate students and are led or facilitated by one or two professional counselors. Now some of the groups have a general focus such as personal growth - what happens is guided by the needs and interests of the students in that group. There is also increasing focus on groups either for a specific type of student or a specific problem or situation. Some examples of the specific types of students that groups are aimed at are adult women students, gay students, mid life career changes, newly single, black awareness group, and
their's, a foreign students study group. Some of the types of groups with a specific focus include assertiveness training, test anxiety management, study skills training, relaxation and stress management, elimination of self-defeating behaviors, career exploration, dating skills and decision making and there's also groups like weight loss groups.

Question 6: Besides individual and group counseling what else does the counseling center do?

Answer 6: Another goal of the counseling service is to provide leadership and foster educational planning and career development programs and materials, that meet the needs of the students. This includes providing consultation and liaison to faculty and other university personnel that work with educational planning and career development. Last year in order to increase the student bodies knowledge of resources available at Iowa State for people that are making career decisions, the counseling center compiled and published a career resource handbook and distributed 750 copies of it to appropriate university personnel. This handbook was really popular and is in its second printing. The counseling center has had alot of request for more of this handbook. The counseling service has a career resource center located in it's waiting area. It contains extensive information describing career opportunities, academic majors, opportunities for women, adults and minorities. There's also information about graduate and professional school entry. Anybody is welcome to browse through the career resource center without seeing a counselor, but if you have some questions a paraprofessional - which is a trained resource person, is available to help you.

(Bruce) You can also take an interest inventory without seeing a counselor. We have the Kuder Occupational Interest Survey ... you can take on your own and get results back in 7-10 days. This comes with taped interpretation to explain what the results of the test mean. Of course if you want further interpretation you can always make an appointment with a counselor.

Question 7: What if ... say with school and academics ... what if I'm having problems with a class or a teacher or getting good grades ... is there some help that the counseling service could give me?
Answer 7: Yes, there is. There's what we call academic support service, which is part of SCS. The purpose of academic support service is to provide assistance to any undergraduate experiencing academic difficulty, via individual or group tutoring, short-term advisement and/or referral to other campus resources. There is a small fee for tutoring. Tutoring on an individual basis costs $2.00 per hour, tutoring on a group basis costs $1.00 per hour. If you can't afford that we have a fee waiver system, where you can get the tutoring for nothing. Tutoring is provided by trained graduate and undergraduate students and is available for most undergraduate courses at Iowa State.

(Margaret) Also, many students find that their study skills and habits are inadequate for the demands of their college programs. In this situation a student can enroll in Psychology 131 - Academic Learning Skills ... a one credit course offered jointly by SCS and the psychology department. This course provides students with information and practice in a lecture/laboratory setting for the improvement of reading and study skills. There are six sections of psychology 131 each quarter and typically the sections fill rapidly and students are turned away because it's a very popular course. Each quarter there is also an informal study skills group which meets for 5 consecutive sessions, with emphasis placed on listening, note taking and test taking skills. Of course in some situations students may have a particular study problem that can best be handled by meeting individually with a SCS counselor.

Question 8: I have a friend who stayed out of school for a few years to work and get some practical experience. Well, now she's back at ISU and she's older than most of the other students. Does the Student Counseling Service have any special things for her.

Answer 8: Yes, uh ... there's the Adult Student Information Office, the focus of this adult office is to provide individualized service to new and prospective older and returning students. The staff here at the center tries to provide information about various services that are available for the older than average student, classes that are particularly relevant and information on any other concerns they might have. There's also an adult student newsletter which is distributed to all the adult students and now they even have a suite in the union for their own purposes - this provides a place to socialize or to get
information about other services that are available.

Question 9:  
( Kevin)  
Its clear that the SCS provides a variety of services to alot of different students. Is there anything else that it does that you haven't mentioned?

Answer 9:  
(Margaret)  
Well, there's also the advanced preparation program for students who feel they would benefit from an intensive orientation to all aspects of ISU and who would like to improve their academic skills. The program lasts six weeks of the summer and includes academic skill development, workshops, lectures, can include counseling as well as social and cultural activites.

(Bruce)  
Branching out from the counseling service is the consultation and outreach service. Now, the outreach service consists of the staff from the counseling center going out to the university community and providing direct services, workshops and presentations to classes, residence halls, to the Greek system, to academic departments and also to the YM and YWCA. If you'd like to take advantage of one of these outreach services, just contact one of the staff members here at the counseling center and tell them about your needs. I might add also that the representatives of Vocational Rehabilitation and the Veteran's Administration system are also housed here at SCS.

Question 10:  
( Kevin)  
What type of people provide these services? Who are they?

Answer 10:  
(Margaret)  
The staff at SCS includes mental health specialists who have advanced education and training in psychology and related fields. There is one director and two assistant directors. One of the assistant director's is director of testing ... he organizes and implements placement testing for all entering freshmen and transfer students. He is also in charge of the National Testing Program which is for entry into professional and graduate studies. Besides this there are approximately twenty professional counselors, men and women of different ages. Some of these counselors specialize in certain types of concerns, for example relaxation training and stress management. Now, this doesn't mean that all of the counselor's can't handle those types of concerns, the entire staff at the counseling service is overall very well qualified to deal with all kinds of concerns ... but some of the counselors have more specialized knowledge in certain areas. Like the students, the counselors vary, but all of them share an interest in students and their development and they work
to accomplish the SCS goals through direct and indirect contact with students and the people who work with them.
APPENDIX Q

HUMAN SUBJECTS APPROVAL FORM
INFORMATION ON THE USE OF HUMAN SUBJECTS IN RESEARCH
IOWA STATE UNIVERSITY
(Please follow the accompanying instructions for completing this form.)

1. Title of project (please type): Investigation of the Effects of Pre-counseling

2. I agree to provide the proper surveillance of this project to insure that the rights and welfare of the human subjects are properly protected. Additions to or changes in procedures affecting the subjects after the project has been approved will be submitted to the committee for review.

Margaret Z. Cegielecki MS
Typed Name of Principal Investigator
M Deck 3A Old Botany
Campus Address
4-8480
Campus Telephone

3. Signatures of others (if any) Date Relationship to Principal Investigator

4. ATTACH an additional page(s) (A) describing your proposed research and (B) the subjects to be used, (C) indicating any risks or discomforts to the subjects, and (D) covering any topics checked below. CHECK all boxes applicable.

☐ Medical clearance necessary before subjects can participate
☐ Samples (blood, tissue, etc.) from subjects
☐ Administration of substances (foods, drugs, etc.) to subjects
☐ Physical exercise or conditioning for subjects
☐ Deception of subjects
☐ Subjects under 14 years of age and/or ☐ Subjects 14-17 years of age
☐ Subjects in institutions
☐ Research must be approved by another institution or agency

5. ATTACH an example of the material to be used to obtain informed consent and CHECK which type will be used.

☐ Signed informed consent will be obtained.
☐ Modified informed consent will be obtained.

6. Anticipated date on which subjects will be first contacted:

7. If Applicable: Anticipated date on which audio or visual tapes will be erased and/or identifiers will be removed from completed survey instruments:

8. Signature of Head of Chairperson Date Department or Administrative Unit

9. Decision of the University Committee on the Use of Human Subjects in Research:

☐ Project Approved ☐ Project not approved ☐ No action required

George F. Kardas
Name of Committee Chairperson Date Signature of Committee Chairperson