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Role induction, perseverance in therapy and psychotherapy outcome

Carla Gayle Strassle
University of Tennessee

To the Graduate Council:

I am submitting herewith a dissertation written by Carla Gayle Strassle entitled "Role induction, perseverance in therapy and psychotherapy outcome." I have examined the final electronic copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Psychology.

Leonard Handler, Major Professor

We have read this dissertation and recommend its acceptance:

Michael Nash, Richard Saudargas, Lawrence James

Accepted for the Council:

Carolyn R. Hodges

Vice Provost and Dean of the Graduate School

(Original signatures are on file with official student records.)

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ROLE INDUCTION, PERSEVERANCE IN THERAPY AND PSYCHOTHERAPY OUTCOME

A Dissertation
Presented for the
Doctor of Philosophy
Degree
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ABSTRACT

Therapists and researchers alike consider premature termination to be problematic to assessing true outcomes in psychotherapy. Some feel that it is the number one problem facing both researchers and clinicians today. The role induction (RI) procedure, or educating clients about the purpose and process of therapy, is one method that has been found to lower premature termination rates as well as increase positive outcomes in psychotherapy. The current study was designed to investigate the effects of a RI on premature termination rates, outcome, and measures of therapeutic alliance. The mechanism of RI as a medium in which to influence clients to remain in therapy was also investigated. Sixty-eight clients and their therapists participated in the current research. Each client and the therapist completed outcome and alliance measures at specified points in the therapy. Half (n = 34) of the clients received a role induction and the other half acted as a control group. The role induction was in the form of a 13-minute videotape entitled "What to Expect in Psychotherapy".

The results of the current study did not provide support for the hypotheses related to the role induction's effectiveness in decreasing rates of premature termination or increasing outcome alliance measures. The most likely reason for failure to find significant results was due to low statistical power related to low sample sizes for the various analyses due to premature termination of clients from therapy. Although the hypotheses were not supported, the study provides interesting data on psychotherapy outcome and some promising areas of further research related to the effect of suggestibility on premature termination. Despite the results of the current study, the need

to find some method by which premature termination rates can be reduced that is feasible for use in both research and practice settings is still paramount. Further research is recommended with the overriding goal of designing a RI that works and is easy to administer so that a RI procedure that is both effective and efficient can be utilized and made available to the community of practicing therapists.

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Chapter I.

Introduction

Within the research literature, one of the earliest variables to be investigated in relation to psychotherapy outcome was the actual amount of time a client spent in psychotherapy. This early research paralleled that of research into basic client demographics, perhaps because the number of sessions was a relatively simple variable to compute. From the beginning of this research an interesting pattern was evident: clients do not stay in psychotherapy for long periods of time. In their 1986 meta-analysis, Howard, Kopta, Krause and Orlinsky estimated the amount of therapeutic change that would take place after a specified number of sessions using data from 15 outcome studies. General findings of the analyses indicated that after 8 sessions approximately 50% of patients would demonstrate improvement, and that after 26 sessions approximately 75% of patients would demonstrate improvement.

Although these results were intended to provide researchers with a yardstick by which to expect significant results on outcome measures, this yardstick, even in relation to the 15 studies investigated, was somewhat misleading since the median number of sessions for the fifteen studies was only 12. This was far short of the 26 sessions indicated by the research to be needed to show improvement in 75% of the patients. This example alone highlights one of the basic findings in the literature on psychotherapy outcome. The literature on the specific topic of length of stay in therapy is large and generally consistent, prompting Garfield (1994) to state "contrary to many traditional expectations concerning length of therapy, *most clients remain in therapy for a (sic)*

relatively few interviews" (p. 195, italics original). Garfield surveyed the literature and found that the median number of sessions across studies ranged anywhere from approximately 4 to 12 sessions, with a majority of studies reporting a median of 6 sessions. In a large preponderance of these studies, anywhere from approximately 60 to 80% of the clients attended less than 10 sessions.

Researchers have puzzled over the relatively low median number of sessions reported in the literature. Luborsky, Crits-Cristoph, Mintz and Auerbach (1988) put forth several possibilities which they thought might account for the relatively short length of treatment for most clients, including the possibility that clients who feel they are not getting what they need out of therapy leave sooner; that therapists may tend to assign more change to clients who have stayed in therapy longer; and the possibility that therapists incorrectly assume that there is a minimum number of sessions required before real change can occur. Although much thought and discussion has been given to such ideas, there has been little accompanying research to test their plausibility, largely due to the relative absence of research that actually follows up on clients who are thought to have terminated prematurely to determine their reasons for doing so and to measure the amount of change that can be attributed to their time in therapy. Silverman and Beech (1979) conducted one such study that did examine some of these possibilities. They found that in their sample 70% of the clients who had terminated therapy after only one session reported satisfaction with the therapy. Aside from satisfaction, Silverman and Beech also examined problem resolution as rated by the client. They found that 79% (37 respondents) reported that their problem had been resolved, but only 18 of these

respondents reported that they felt the therapy had helped in the problem resolution. Research such as this is important to our eventual understanding of how exactly to define premature termination. Unfortunately, a sample size of 47 contained in a single study cannot provide any general conclusions from which to proceed. At this point, it is largely up to either the therapist or researcher to decide who should be classified as a premature terminator, with a general rule of thumb coming from the research of Howard et al. (1986), that six to eight sessions is necessary for treatment; anything less "should be considered...as not having been effectively exposed to treatment" (p. 163).

Because of the lack of general classification, there has been much discussion (e.g., Baekeland & Lundwall, 1975; Garfield, 1994; Howard et al., 1986; Luborsky et al., 1988; Silverman & Beech, 1979) of how to define these clients who attend relatively few sessions. No consensus has been reached, however; individual studies define premature termination in a variety of ways, a practice that some researchers (e. g., Pekarik, 1985) feel contributes to the widespread inconsistencies in the literature. The rates for premature termination, in all the ways that it has been measured, range anywhere from approximately 30% for the studies compiled by Garfield, to 30 to 60% for over 350 studies reviewed by Baekeland and Lundwall (1975).

Many variables have been investigated in order to better understand the phenomenon of premature termination. These investigations range from looking at simple demographic data to more complex issues of therapeutic alliance or the client's expectations for psychotherapy. Research indicates that of all the demographic variables investigated, the client's social class is related most strongly to premature termination,

with clients of lower social class being more likely to terminate prematurely from therapy than clients from higher social classes (Baekeland & Lundwall, 1975; Pilkonis, Imber, Lewis & Rubinsky, 1984; Rosenzweig & Folman, 1974). Additionally, it has been found that clients with lower levels of initial disturbance are more likely to prematurely terminate from therapy (Baekeland & Lundwall, 1975; Hilsenroth, Handler, Toman & Padawer, 1995).

Another class of variables that has been found to relate to premature termination is the client's expectations for the therapy. In looking at expectations of length of time in therapy, Pekarik & Wierzbicki (1986) found that clients stayed in therapy for the length of time that they had estimated therapy would take (about 10 sessions), which was discrepant from the length of time that the therapists felt the clients should remain in therapy.

By far, however, most of the research on expectations has focused on some facet of the client's expectations of themselves or the therapist in relation to premature termination. Additionally, given the general finding of the relationship between lower social classes and premature termination, much of the research has focused on the expectations of this population. The research by Overall and Aronson (1963) indicates that clients of lower social classes expect a more medical approach with an active yet permissive therapist. Further, their research indicates that when these views are not met, the clients tend to terminate prematurely from the treatment. From a slightly different angle Lorion (1974) notes that clients from lower social classes know less about how therapy works, including what role they should play in the therapy. These views are

mirrored by Hollingshead and Redlich (1958) whose work *Social Class and Mental Illness* can be considered basic reading for an understanding of how social class affects all aspects of psychotherapy. Hollingshead and Redlich report that lower class clients "are unable to understand that their troubles are not physical illnesses....These patients are disappointed in not getting sufficient practical advice about how to solve their problems and how to run their lives" (p. 340), and thus prematurely terminate from therapy. Richert (1983) has also put forth ideas on the different role expectations and preferences of clients and how these expectations affect their stay in therapy. Overall, it appears that when clients hold expectations, particularly to length of therapy or the relative role that they and the therapist should play in therapy, they will be more likely to terminate if these expectations are not met.

Yet another area that has been investigated in regard to premature termination is that of therapeutic alliance. Research results are beginning to show that therapeutic alliance actually predicts premature termination rates better than it predicts outcome in general, with clients with the lowest levels of therapeutic alliance prematurely terminating from therapy (Samstag, Batchelder, Muran, Safran & Winston, 1998).

Therapists and researchers alike consider premature termination to be problematic to the assessment of true outcomes in psychotherapy, as the very nature of the problem often precludes the measurement of outcome. Indeed, Phillips (1985) has labeled premature termination as "the number one problem of psychotherapy practice and research" (p. 1). Whatever the reason for premature termination, whether it be individual client or therapist variables, or more likely, an intricate combination of these plus

psychotherapy process variables as the research on therapeutic alliance suggests, in most cases, one unilateral conclusion about premature termination that can be made is that it is disruptive to the psychotherapeutic endeavor and most likely results in incomplete resolution of the problem for which the client originally sought psychotherapy. This is not to say that clients have not benefited from their time in therapy, a point that many researchers have emphasized (e.g., Baekeland & Lundwall, 1975; Garfield, 1994; Howard et al., 1986), or that their judgment concerning the correct point of termination from psychotherapy is less valid than that of the therapist. Overall, however, premature termination from psychotherapy, at a minimum, does not allow for an integration of the therapeutic gains derived from therapy which is an important part of the termination process, and, even more damaging, may not allow any significant gains to be made. If Baekeland and Lundwall (1975) are correct in saying that "...it is the dropout rather than the remainer who in the long run seems to be the typical patient" (p. 379), it would behoove both the practitioner and the researcher to discover methods by which the rate of premature termination from psychotherapy can be reduced.

Although the research on premature termination for psychotherapy has yielded some results concerning what types of clients holding specific expectations are most likely to terminate from therapy, not all areas that exert influence on premature termination are amenable to interventions designed to mitigate against such termination. Demographic variables such as social class, for example, are relatively stable, although social class, at least more so than other more common demographic variables, can change. It is also difficult to design interventions in the area of therapeutic alliance, both

because the study of therapeutic alliance is still quite new and because, as a common factor, therapeutic alliance is thought to be an extant part of all therapies to some degree. As it stands, then, by far the area that has been most amenable to interventions related to decreasing premature termination is in the expectations that clients have for psychotherapy.

Beutler and Clarkin (1990) discuss the importance of expectations to the therapeutic endeavor. They discuss expectations not only in terms of how they may be detrimental to psychotherapy, as in the case of premature termination, but also in terms of how expectations can be harnessed to contribute to the client's overall involvement in the treatment. They spend considerable time discussing how psychotherapy can be enhanced when the client and therapist have inherent areas of "fit" between them, but note that "the possibility of (allowing clients to select a preferred therapist or assigning a personally compatible therapist) doing this consistently does not usually exist within the constraints of clinic demands and therapist availability" (p. 187). As this is the case, they also spend time discussing how clients' expectations can be altered to better fit the therapeutic environment. They state, "To the degree that the patient's expectations are unrealistic to the problem, to the setting or to the therapist's own value system, the patient should be taught more conducive and congruent beliefs" (p. 80). They go on to suggest that preparing clients for treatment by educating them about therapy before it begins is a useful method to facilitate positive treatment response, including decreases in premature termination rates. This method of preparing clients for psychotherapy has alternately been called role induction, anticipatory socialization, and structuring interviews. For the

purposes of this study, role induction (RI) will be used to denote any procedure designed to educate the client about the process of therapy.

Orne and Wender (1968) were the first researchers to put forth a method to educate clients about psychotherapy. They asserted, "The transactions which take place in psychotherapy...can run their normal course only if the participants are familiar with certain ground rules, including the purpose of the enterprise and the roles to be played by the participants" (p. 88). They acknowledge the differences between a therapeutic relationship and other, more medical treatment, paralleling the research of Overall and Aronson (1963) and Lorion (1974) reviewed above, which clearly indicates that these mistaken notions about the therapeutic context are more likely to be held by clients of lower social classes. Because of the lower social class client's possible naiveté concerning therapy, they state that "a patient who does not understand what is expected of him is almost certain to encounter difficulties" (p. 92). Then, as a way to help facilitate clients of lower class continuing in therapy, they introduce a "method...which...is perhaps the most obvious: the patient is told what he needs to know" (p. 93).They identify the three major purposes of the RI to be : 1) help the client see that talking as the modality of psychotherapy can help with the problem 2) delineate the respective roles of the client and therapist in therapy and 3) give the client a general idea of the course and components (e. g., transference, resistance) in therapy. By doing this, Orne and Wender believed that the client, particularly clients of lower social classes although they advocated the use of RI with all clients could better understand the purpose and process of therapy which

would, in turn lead to lower premature termination rates and better psychotherapy outcomes.

The first experimental study to test Orne and Wender's (1968) RI was conducted by Hoehn-Saric et al. (1964) upon the suggestion of Orne four years before the Orne and Wender (1968) article, complete with a hypothetical RI interview, was published. In this study, Hoehn-Saric et al. employed the RI procedure of Orne and Wender on 20 clients who had never had previous psychotherapy. Twenty additional clients were treated for the same length of time but not given a RI. The stated purposes of the RI procedure in this study included the three purposes outlined by Orne and Wender, but also contained a fourth purpose, which was to give the client an expectation of improvement within four months of treatment. Results of the study indicate that clients receiving the RI procedure had more desirable therapy behavior in the third session, better attendance, less difficulty establishing and maintaining a therapeutic relationship, and better outcome on 3 of 8 outcome measurements, including therapist's rating of improvement, client's rating of mean target symptom improvement, and social ineffectiveness rating. Based on these results, Hoehn-Saric et al. concluded that RI was effective in producing "good" therapy behaviors, including attendance and outcome behaviors. They caution, however, that "Which aspects of the role induction interview are the most important; how they interact with different therapeutic approaches; how and by whom such information can best be communicated remain problems for further research" (p. 280).

Sloane, Cristol, Pepernik and Staples (1970) attempted to address such questions in their research, as well as to disentangle the RI from the expectation of improvement

within four months, which was given in the Hoehn-Saric et al. study. They found that the RI interview, both with and without a time expectation for improvement, produced better ratings of change based on a research psychiatrist's (i.e., not the treating physician) interview with the client after four months of therapy. Attendance was not significantly different between the group who received the RI and the group who received no RI. Here, then, is a study in which psychiatrist rated change is greater with RI, but attendance is not affected.

Since the publication of these two studies there have been numerous studies devoted to examining some aspect of the RI procedure and its effects on some aspects of the therapeutic process. The RI procedure has been modified for use in group settings, with pioneering research in this area conducted by Yalom, Houts, Newell and Rand (1967) and continuing at a steady pace, as attested to by the literature review for RI with groups by Mayerson (1984). In addition to its modification for use with groups, the RI procedure, whose original application was in an interview format with either a research clinician or the treating therapist, has been expanded to different mediums such as printed material, audiotapes and vidoetapes of RI procedures. Strupp and Bloxom (1973), for example, were the first researchers to adapt the RI procedure to video format; Friedlander and Kaul (1983) used an audiotaped RI procedure; Garrison (1978) contrasted written versus verbal RI procedures. Each study, regardless of the medium of the RI procedure, indicated that clients who had a RI procedure had significantly better results on the various dependent variables measured in each study compared with a control group who had received no RI procedure. Additionally, in the case of the Garrison (1978) study

where two different mediums (written versus verbal RI) were compared, there was no difference between the two mediums, but both significantly differed from the control group. The apparent lack of superiority of any one type of RI technique led Heitler (1976) to say that a "variety of preparatory techniques hold promise" (p. 350), but that "Better answers, however, concerning the effective ingredients of various preparatory techniques and their most effective combinations await further controlled research" (p. 349). Finally, from Orne and Wender's (1968) original conceptualization of the RI procedure as an instructional method to tell the client what to expect in therapy, Researchers have branched out into other methods by which clients can be prepared for therapy.

Sauber (1974) identifies three basic methods used in preparing clients for therapy. He makes a distinction between role induction, where there is direct instruction such as in the interview-based RI as originally conceptualized by Orne and Wender (1968), and non-directive RI, such as reading written material, and arguably video and audiotaped material that is presented with no direct follow up. He identifies the third approach as one of vicarious training, where the client learns about therapy by watching and modeling an identified other's behavior. The film by Strupp and Bloxom (1973) is an excellent example of this type of RI method, where group therapy clients are prepared for therapy by watching the group therapy and seeing its results for "Tom", a truck driver whose life is highlighted in the film. An additional approach to preparing clients for therapy which is not discussed by Sauber is the technique of Warren and Rice (1972), who, in contrast to all other RI procedures which apply the RI intervention before the start of therapy, designed their intervention to take place in four half-hour segments before specified

therapy sessions. This approach, like the other more traditional RI approaches, was found to lead to better outcome and also to decreased rates of premature termination.

With the advent of the various mediums and methods for preparing clients for psychotherapy, the literature on RI has flourished. Most of the research attention has focused on outcome, as indicated by several reviews of RI research. Orlinsky and Howard (1986), for example, reviewed 18 studies and found that, overall, RI procedures produce significant positive effects on 21 of 34 outcomes. Kivlighan, Corazzini and McGovern (1985), and Mayerson (1984), as noted above, have conducted reviews of group RI procedures and conclude that RI is indeed a useful tool for producing desired outcome and in-therapy behaviors. Other reviews focusing on both individual and group therapy, such as those conducted by LaTorre (1977), Heitler (1976) and Bednar, Weet, Evensen, Lanier and Melnick (1974), come to similar conclusions.

As indicated by its relative absence in the reviews listed above, less attention has been paid to premature termination as it relates to RI. Some studies (e.g., Garrison, 1978; Warren & Rice, 1972) have been conducted using premature termination as a dependent variable in general outpatient psychotherapy. The results of these studies, however, are mixed. The research of Warren and Rice (1972), for example, shows that RI reduces premature termination, while others studies, such as the study by Garrison (1978), does not. There have been several studies which have applied RI procedures to more specialized populations in order to reduce premature termination rates which have been more unilaterally favorable of RI techniques. Lambert and Lambert (1984), for example, successfully lowered premature termination rates in a sample of immigrant clients

seeking services. Stark and Kane (1985) lowered premature termination rates in substance abusing clients, a population which is addressed in more detail specifically for alcohol-dependent clients by Zweben, Bonner, Chaim and Santon (1988) in their review of strategies that decrease premature termination.

Up to this point, we have a large body of literature which appears to indicate that RI is effective in producing positive therapy outcome, and, in at least a majority of the relatively few studies which investigate it, a decrease in premature termination rates as well. What is lacking is a review that attempts to combine all these disparate findings into a definitive picture of the usefulness of RI. Monks (1995) attempts to do this in what she reports is the first meta-analysis of RI. In her study she investigated the effect of RI on therapy behavior, therapy outcome, premature termination rate and attendance for both individual and group therapy without distinguishing between the two. The largest mean effect size was found for therapy outcome, with Cohen's $\underline{d} = .34$, which Monks rated as a medium effect size. RI was found to account for 3% of the variance in the therapy outcome. The other measures of attendance, premature termination rates and therapy behavior produced small effect sizes of .32, .23, and .20, respectively. RI accounted for 2% of the variance in attendance and only 1% of the variance for both premature termination rates and therapy behavior. Although these effect sizes are quite small and contribute to very little of the variance, Monks asserts that this finding makes sense because "if it (the effect size) was large, RI would then be more like therapy itself" (p. 76). Monks concludes that RI is an effective technique and asserts that "there are many aspects of role induction that need to be explored further" (p. 83).

One would think that with the results of this meta-analysis, the research on RI would progress in light of RI's usefulness on a variety of variables ranging from outcome to premature termination. This, however, has not been the case. In fact, Monks' (1995) research indicates that of all the studies investigated, only 1 study had been published after 1989; most of the research on RI had taken place in the decade following Orne and Wender's (1968) original article on RI. This curious finding is duplicated in this current research, where, again, a literature search of RI revealed only three research articles published on the topic of RI after 1989. This trend of less research being published on RI is doubly interesting as it appears that RI research continues in the dissertation arena where a literature search geared solely to dissertation abstracts related to RI produced 24 dissertations completed on RI in the 1970's and 80's (11 and 13, respectively), and 15 dissertations completed on the topic after 1990. The reason for the disappearance of RI studies from the published literature is unknown. Its disappearance, especially given the results of Monks' meta-analysis, is especially puzzling.

One possible explanation for the lack of RI studies in the current literature could be the 'file drawer problem', where it is hypothesized that manuscripts with non-significant results are not submitted or are rejected for publication, leading to an exaggeration of the true effect of an intervention as indicated by the literature as a whole because only significant results are published. Monks addressed this problem in her research by calculating a "fail safe N" (p. 72), and concludes that each dependent variable examined would need at minimum five times the number of measurements of that dependent variable that were actually found in the literature to change the results of the

meta-analysis to reflect either no or negative effects for RI. This being the case, the relative absence of RI research in the current literature remains difficult to understand.

Hypotheses

As it stands, RI has been shown to be an effective tool for reducing rates of premature termination as well as improving specific therapy variables such as outcome. The current study was designed to investigate the effects of a RI on premature termination rates and outcome in a university-based psychological clinic that offers reduced-fee services to both university students and to the community at large. Four specific hypotheses were made. 1. First, it was hypothesized that clients who received a RI before entering therapy would have lower rates of premature termination, defined for the purposes of this study after the recommendation of Howard et al. (1986) to be attendance of fewer than 8 therapy sessions.

2. The second hypothesis represents an attempt to explain the mechanism of RI. In the first paragraph of their article Orne and Wender (1968) labeled psychotherapy as a "special form of social interaction" (p. 1202), and acknowledged that the theoretical basis for the article stemmed largely from Orne's work in hypnosis. Childress and Gillis (1977) designed a study to investigate if indeed the social influences within the RI procedure were the mechanisms underlying the effectiveness of the RI. They presented RIs to two groups of clients, with one RI clearly presenting social influence variables while the other RI minimized such variables. Results of the study indicated that clients given the RI with the maximized social influence variables improved significantly more on outcome measures than those in the low influence RI condition, leading Childress and Gillis to

suggest that "The findings, though certainly to be regarded as tentative, support the notion that role induction interviews facilitate therapy because they provide a vehicle by which the therapist can exercise influence" (p. 544). Such a view is not new. Frank, in his 1961 book *Persuasion and Healing*, notes that the susceptibility to influence, or suggestibility, is related to length of stay in treatment saying "suggestible persons tend to stay in treatment longer than non-suggestible ones" (p. 136). The power of suggestibility in relation to therapy has been demonstrated in other studies as well. Research by Imber, Frank, Gliedman, Nash, and Stone (1956), for example, shows that higher levels of suggestibility are related to acceptance of therapy; research by Nace, Warwick, Kelley and Evans (1982) demonstrates a positive relationship between outcome and suggestibility. Additionally, Bowers and Kelly (1979) assert that suggestion is inherent in all communication and further imply that suggestibility is a hidden factor in all aspects of therapy. If indeed a client's suggestibility does factor into therapy outcome and remaining in therapy, then there could be a differential effect where clients who are highly suggestible and who receive the RI will remain in therapy past eight sessions more so than even those clients who received the RI but who are less suggestible. Therefore, the second hypothesis was that when looking at rates of premature termination, the clients who received the RI and stayed for eight or more sessions would be found to be more suggestible than those who received the RI but stayed for less than eight sessions.

3. Third, it was hypothesized that clients who received a RI would produce greater improvement on outcome measurements than those who did not receive a RI before therapy. 4. The fourth and final hypothesis comes from Orne and Wender's (1968) basic

purposes of the RI. As reviewed above, the major purposes of the RI are to 1) help the client see that talking as the modality of psychotherapy can help with the problem 2) delineate the respective roles of the client and therapist and 3) give the client a general idea of the course and components in therapy. Orne and Wender then proceed to further delineate the specific points that should be achieved through RI. Establishing rapport is one such point, with the goal that the client should have an increased sense of rapport following the RI procedure as s/he becomes more confident in the therapy process and the therapist's ability to help. Rapport as it is discussed by Orne and Wender is remarkably similar to the common factor of therapeutic alliance. The terminology to refer to this phenomenon is confusing as several interchangeable terms are often used in the literature. Alliance, working alliance, helping alliance and therapeutic alliance are all terms used to describe, in general, "an expression of a patient's positive bond with the therapist who is perceived as a helpful and supportive person" (Luborsky, 1994, p. 39). For the purposes of this study, the fourth hypothesis stated that clients receiving a RI would form a better therapeutic alliance with the therapist earlier in the therapy process than clients who did not receive the RI.

Chapter II

Method

Participants

Participants were the first 68 clients presenting to the university clinic who met inclusion criteria for the study. All clients consented to the research. Four clients were dropped from the study and their spot replaced when they failed to complete their 1st scheduled paperwork and therefore could provide no post-intervention data; another client was dropped from the study and the spot was replaced because the RI video was shown after the first session instead of before; one other client was dropped from the study and the spot was replaced when the client declined to complete the RI procedure saying it was "too simplistic". Exclusion criteria included anyone under the age of 18; a diagnosis of a psychotic disorder; psychological testing completed before therapy began; and anyone who was sent to the clinic as a federal parole to receive psychotherapy. This specific criterion was established to guard against clients who were not necessarily in therapy by their own wishes. Data collection was organized by the researcher but handled by administrative staff to minimize interference with treatment. The sample included 27 males and 41 females, with the mean age of 30.75 (s.d. 9.39, range 18 to 62) and an average of 14.51 (s.d. 2.10, range 11 to 19) years of education. Twenty-nine percent were enrolled in college and 10% were enrolled in graduate school. Forty-seven percent were single, 25% married, 25% divorced or separated, and 3% were living in a committed relationship or widowed. Information regarding the client's ethnicity is not collected as part of standard clinic procedure and is therefore not available for this study. The clientele

of the clinic, however, is primarily Caucasian. In looking at socioeconomic status, 2% of the sample were rated as Class I, 28% Class II, 41% Class III, 16% Class IV, and 13% Class V according to the Two Factor Index of Social Position (Hollingshead, 1957 as cited in Myers and Bean, 1968). Sixty-six percent of the clients reported previous psychotherapy.

Two other variables reflecting stable client characteristics were obtained for the study. First, the client's level of suggestibility was measured by administering the Stanford Hypnotic Susceptibility Scale (SSHS:C, Weitzenhoffer & Hilgard, 1962). The SSHS:C is an individually administered hypnotic induction that has been found to have adequate reliability and validity (Hilgard, 1978; Weitzenhoffer & Hilgard, 1962). Administration results in a score from 0 to 12. Higher scores reflect higher levels of suggestibility. For the purposes of the current study, the age regression item, which is part of the standard SSHS:C protocol, was removed, resulting in a score range of 0 to 11. Thirty-two clients underwent this hypnotic induction and obtained a mean score of 6.06 (s.d. 2.37, range 2 to 9) and a median score of 6.5. The remaining clients (n = 36) were unable to be reached to schedule a research appointment before they terminated therapy. Every client consented separately for this procedure.

Second, the client's level of intelligence was estimated by administering the Vocabulary subscale of the Wechsler Adult Intelligence Scale, Third Edition (Vocabulary, WAIS-III, Wechsler, 1997a). The correlations of the Vocabulary subscale to the IQ estimate provided by the full scale WAIS-III range from .83 to .85 for the age ranges contained in the study (Wechsler, 1997b). The Vocabulary subscale consists of 33

words that the client is asked to orally define. A scaled score ranging from 1 to 19 is possible. Vocabulary scores were obtained from 37 clients with a mean of 12.73 (s.d. 2.78, range 5 to 18) and a median score of 13.0. If the client was administered the WAIS-III as part of a concomitant psychological testing battery, the Vocabulary score was taken from the WAIS-III protocol. Seventeen Vocabulary scores were obtained in this manner. If no testing was done the client was administered the Vocabulary section immediately before undergoing the hypnotic induction. Every client whose Vocabulary score was obtained in this manner consented separately for this procedure. Twenty Vocabulary protocols were obtained in this manner. The remaining clients (n = 31) were either unable to be reached to schedule a research appointment before they terminated therapy or terminated therapy before their concomitant psychological evaluation was completed.

Attendance was tracked in order to determine the rate of premature termination. Twenty-nine clients attended 8 or more sessions and 39 clients attended 7 or fewer sessions. Clients were randomly assigned to the RI or control condition (no RI). There were an equal number (n = 34) of clients in each condition. T-tests confirmed that there were no significant differences between the two groups on age, gender, years of education, marital status, their therapist's years of experience, level of suggestibility or estimated level of intelligence (see Table 1).

The therapists of these clients also consented to participate in the research. Twenty-six therapists participated in the study. All therapists were graduate students working at the university clinic as part of their practicum experience and were supervised by Ph.D. level supervisors in their respective discipline. Three therapists were working

Table 1 Results of T-tests comparing demographic data for the RI and no RI groups.

Demographic Variable	T-test
Age	$t(66) = 1.50, p > .05$
Gender	$t(66) = -.24, p > .05$
Education	$t(66) = .94, p > .05$
Marital Status	$t(66) = .74, p > .05$
Therapist Experience	$t(66) = .87, p > .05$
Level of Suggestibility	$t(30) = .44, p > .05$
Estimated Level of Intelligence	$t(35) = -1.21, p > .05$

toward a terminal master's degree in social work; one therapist was working toward a Ph.D. in counseling psychology; and 22 therapists were working towards a Ph.D. in clinical psychology. Three therapists saw only one client in the study; six therapists saw two clients; three therapists saw three clients; five therapists saw four clients; four therapists saw five and six clients, respectively; and one therapist saw seven clients. Years of clinical experience for each therapist was calculated based on the current year of practicum experience in their respective degree programs. Seventy-two percent of clients had a therapist in their 1st year of clinical experience; twenty-four percent of clients had a therapist in their 2nd year of clinical experience, and four percent of clients had a therapist in their 3rd year of clinical experience.

Materials

Role Induction

The RI was in the form of a 13-minute videotape entitled "What to Expect in Psychotherapy". The transcript for the videotape closely follows the hypothetical RI procedure and purposes set forth by Orne and Wender (1968), but was adapted in several places in order to increase the social desirability of remaining in treatment. A full copy of the transcript used for the videotape is located in the Appendix. The RI was performed by a faculty member in the theater department at the university. The transcript was read from a teleprompter to avoid deviations from the script. The teleprompter was positioned in such a way that it appeared the actor was looking directly into the camera at all times. The actor was dressed in business attire (coat and tie) and the video was filmed from a

constant angle, with the actor pictured from the mid-chest up. The frame of the video was large enough to capture the arm and hand movements of the actor.

Measures

Clients were administered the following outcome and therapeutic alliance measures.

The Symptom Checklist-90-Revised (SCL-90, Derogatis, 1994) is a 90 item self-report symptom inventory that instructs clients to rate, on a scale of 0 to 4, the amount of distress they have experienced from 90 symptoms. It has been shown to have adequate reliability and validity (Derogatis, 1994). The SCL-90 is designed to measure current symptomotology and is normed to an outpatient psychiatric sample. Scoring of the SCL-90 results in 9 subscales and 3 global scales including the Global Severity Index (GSI) which was used for the current study. The GSI is "the best single indicator of the current level or depth of the disorder" (Derogatis, p. 12), and is recommended for use when a summary measure is desired.

The Inventory of Interpersonal Problems-32 (IIP-32, Barkham, Hardy & Startup, 1996) is a 32 item self report instrument designed to measure the difficulties people experience in their interpersonal relationships by having them rate, on a scale of 0 to 4, the amount of distress they are experiencing from 32 items representing difficulties in interpersonal functioning. It has been found to have both adequate reliability and validity (Barkham, Hardy & Startup, 1996). Scoring of the IIP-32 results in a mean item total.

The Combined Alliance Short Form- Patient version (CASF-P, Hatcher and Barends, 1996) is a 31 item self report measure of therapeutic alliance that instructs

clients to rate, on a scale of 1 to 7, their experience in therapy. It has been found to have adequate reliability and validity (Blagys, 1999; Clemence, Hilsenroth, Strassle and Handler, 2000). The CASF-P is broken down into five subscales that measure hypothetically different aspects of therapeutic alliance. The Confident Collaboration subscale measures the client's confidence in and commitment to the therapy as a promising and helpful process. The Goals and Tasks subscale measures the client's perception of having similar goals and tasks to that of the therapist. The Bond subscale measures the client's perception of the therapist's acceptance and liking of the client, as well as the client's perception of trust in the relationship. The Idealized Therapist subscale measures disagreements with the therapist. The Help Received subscale measures the client's perception of improvement attributed to therapy. Each subscale is scored individually.

Therapists were administered the following Combined Alliance Short Form-Therapist version and a measure rating their estimate of the client's improvement.

The Combined Alliance Short Form- Therapist version (CASF-T, Hatcher and Barends, 1996) is the 41 item companion self report measure of therapeutic alliance to the CASF-P. It instructs therapists to rate, on a scale of 1 to 7, their experience in therapy. It has been found to have adequate reliability and validity (Blagys, 1999; Clemence, Hilsenroth, Strassle and Handler, 2000). The CASF-T is broken down into six subscales reflecting hypothetically different aspects of the therapist's view of the therapeutic alliance. The Confident Collaboration subscale measures the therapist's confidence that s/he and the client are working toward the same goals. The Therapist Confidence subscale

measures the therapist's confidence in both the therapy and his/her ability to facilitate the desired change in the client. The Bond subscale measures the therapist's acceptance and liking of the client as well as the trust in the relationship. The Agreement subscale measures the therapist's perception of the client's level of agreement about the therapy. The Patient Working Capacity subscale measures the therapist's perception of the client's ability to use the therapy effectively. The Patient Commitment subscale measures the therapist's perception of the client's commitment to therapy. Each scale is scored individually.

The Global Assessment of Functioning Scale (GAF) from the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV, APA, 1994) is a global measure of clinical progress based on psychological, social and occupational functioning that directs the therapist to rate on a scale of 0 to 100 their client's current level of functioning.

Procedure

Before 1st Session

As part of standard clinic procedure every client is given an intake interview as their first point of contact. As part of the intake procedure every client 18 or older fills out an SCL-90 and IIP-32 and meets with an intake interviewer for the purpose of gathering pertinent information for treatment planning and initial diagnosis. As part of standard intake procedure the intake interviewer informs each client that research is currently being conducted in the clinic in which they may be asked to participate. This information is also contained in the clinic's standard consent to treatment form that every client reads and signs before the intake. After the intake procedure the case is taken to a staff meeting

where it is picked up by an available therapist. Testing, if it is indicated, is also assigned at this time. After cases were assigned, each case was reviewed by the researcher to determine if it met any of the exclusion criteria discussed above. If it did not, the case was randomly assigned to either the RI or the control group (no RI) by a computer program. Other than differences related to the presence or absence of a RI, there were no differences in the research protocol between the two groups.

If the client was assigned to the RI group s/he was called by the researcher one day prior to the first scheduled therapy appointment. Following a script the researcher identified herself as calling from the clinic, reiterated the date, day of the week and time of the appointment and requested that the client arrive 15 minutes early to "take care of some clinic business". Clients in the control group received no call prior to their first therapy appointment. When they arrived for their first therapy session, clients from both groups were given an information sheet reminding them that clients participate in research at the clinic and were asked to participate by filling out paperwork after some therapy sessions. No client declined to participate in the research. The information sheet then covered three points of information: 1) Clients were assured that their responses to the research were confidential and would not be shared with their therapist. They were informed, however, that they were free to discuss any of their responses with their therapist if they wished; 2) The information sheet directed the client to check in with the receptionist before and after every therapy session. This was done so that the receptionist could inform the client before designated paperwork sessions that s/he would need to stay after their therapy session to complete paperwork. If the receptionist did not catch the

client before that specified session, she could inform the client afterward if the client checked with her before leaving; and 3) The client was informed that within two weeks of beginning therapy s/he would receive a phone call requesting that s/he come in for one additional session for research purposes. After reading this information sheet, Clients in the control condition were informed that they would have paperwork to complete after their first therapy session and were then simply invited to take a seat and wait for their therapist.

After reading the information sheet clients in the RI condition were informed that they would have paperwork after their first session and then were taken to a TV/VCR in a section of the waiting room cordoned off by an office cubicle divider to watch the 13 minute RI video. They were told that when they finished viewing the video they could take a seat in the waiting room and wait for their therapist. Clients in the video condition were identifiable to the receptionist by a V for video in the appointment book next to their first therapy appointment. No therapist was ever informed of their client's RI group (RI or no RI) in an effort to keep them blind to this part of the study. Due to the RI condition indication in the appointment book, however, at least for those clients assigned to the RI group, therapists could have been aware of their client's RI group. This was especially likely for clients who were scheduled to see the RI video but were late to their first appointment because they watched the video before they were taken into therapy by their therapist. The therapist is these cases most likely new that the client had arrived and had been sent to watch the RI video before the therapy session. No direct measure of therapist's knowledge of their client's RI group was made.

First Session

Every therapist who was scheduled for a first session with a client in the study received an information sheet in their box on the day of their first session with the new client. The information sheet requested that the therapist remind the client during the first session of the three main points of information contained in the client's information sheet that they had read prior to coming into the session with the therapist. All therapists had individually agreed to participate in the study before data collection began, and therefore requests to participate in the research by filling out paperwork on each individual client were not made.

Paperwork

Immediately following the first session clients were asked to complete the SCL-90, IIP-32 and CASF-P. General instructions for the first session and subsequent paperwork sessions reminded the clients that the paperwork was part of the research being conducted at the clinic and that their responses would not be shared with their therapist. This process was repeated after the 4^{th} and 8^{th} therapy sessions. If clients were unable to complete the paperwork after the specified session, they completed it before they saw their therapist for the next session.

Immediately following the first session therapists were asked to complete the CASF-T and GAF. This process was repeated after the 4^{th} and 8^{th} therapy session. If therapists did not complete the paperwork after the specified session they were reminded to complete the paperwork before they saw the client for the next session.

Additional Research Session

Immediately upon receipt of first session paperwork the researcher collected the demographic data. All demographic data were taken from material contained in the client's therapy application. In calculating social class level, two changes were made to each of the scales (education and occupation) which make up the Two Factor Index of Social Position to reflect levels not contained in the original index (Hollingshead, 1957 as cited in Myers and Bean, 1968). The changes to the education scale were made to reflect the educational levels of clients currently in graduate school and clients who had received a GED instead of a high school diploma. Changes to the occupational scale were made to reflect the occupational levels of clients who were graduate students and clients who were undergraduate students.

The researcher then determined whether the client would need to be administered the Vocabulary section of the WAIS-III or if this data was available from a psychological assessment. The researcher then gave this information to a colleague who coordinated obtaining the suggestibility and, if necessary, the Vocabulary scores. This colleague collaborated with seven graduate students who had been trained in hypnotic induction by a psychologist well versed in this area. Using a telephone script, these collaborators contacted the clients and identified the call as the one that the client had been told to expect in order to set up an additional research session. The client was told that this session would take approximately one hour to an hour and a half (depending on whether the Vocabulary subtest would be administered), and could be scheduled at their convenience. Due to the expectation that some clients might have misguided notions of

hypnosis, the client was simply told that they were being asked to come in for an additional testing, which would be explained in full detail when they arrived. Since the research collaborator was not the client's therapist and the collaborator's name would therefore be unfamiliar to the client, they were instructed not to leave a message with a family member or an answering machine and to simply continue trying to contact the client until actual verbal contact was made. As noted above, this proved to be detrimental to the data collection as some clients terminated before contact was ever made. All clients who were contacted agreed to participate in the additional research sessions.

When clients arrived for their research session they were told that they would be taking part in some standard psychological testing (if the Vocabulary subtest was to be administered) and in a standardized hypnotic procedure in order to "understand more about the process of therapy", and "understand more about the process of hypnosis", respectively. Clients provided additional informed consent for each specific procedure of the Vocabulary subtest and hypnosis. All clients who actually scheduled a research session agreed to participate in either the hypnosis, or the Vocabulary subtest and hypnosis procedures.

Chapter III

Results

Data were analyzed using the Statistical Package for the Social Sciences (SPSS). An alpha level of .05 was established as the point of significance for all analyses.

To begin, the GSI (from the SCL-90) and the IIP-32 protocols obtained from the intake interview were compared between the RI and no RI group in order to determine if there were pre-existing group differences on either of the outcome measures that might influence other analyses. Neither the GSI nor the IIP-32 for the two groups were significantly different from each other [$t(60) = .29$, $p > .05$; $t(64) = -.50$, $p > .05$, respectively].

Next, analyses were conducted to determine if the premature termination rate was lower in the RI group than in the no RI group. Orne and Wender (1968) suggest that a RI is useful for all clients. Others (e. g., Heitler, 1976; LaTorre, 1977; Strupp & Bloxom, 1973; Warren & Rice, 1972) have suggested that RI works best with clients who have never had previous therapy or who are from lower social classes. To accommodate both viewpoints, an analysis was run to determine if there was a pure effect for RI, and a separate analysis was run to test the effect of RI with these specific variables taken into account. First, a chi-square was conducted to test for a pure effect for RI. The data were dichotomized to reflect a group that attended 7 or fewer sessions and a group that attended 8 or more; eighteen clients from the no RI group attended 7 or fewer sessions and 16 attended 8 or more; twenty-one clients from the RI group attended 7 or fewer

sessions and 13 attended 8 or more. This was not a significant difference, χ^2 (1, $\underline{N}$ = 68) = .54, $\underline{p}$ > .05, therefore the first hypothesis was rejected.

A logistic regression was performed to determine if social class or previous therapy exerted influence on the RI's effectiveness. The RI, social class level and previous therapy were entered into the model. None of the variables predicted the rate of premature termination (r^2 = .006) and the accompanying chi-square indicated that none of the variables exerted a significant effect on premature termination χ^2 (2, N = 69) = .38, $\underline{p}$ > .05.

Next, an analysis was run to determine if the client's level of suggestibility influenced the effectiveness of the RI. This analysis was particularly hindered as discussed above by the low number of clients (32 of 68) for whom the measure of suggestibility was available. An analysis of variance (ANOVA) was performed in which suggestibility was the dependent variable and RI group and premature termination status (7 or fewer versus 8 or more sessions) were the independent variables. The analysis indicated that suggestibility was not a significant factor influencing premature termination rates, F (3, 28) = 1.88, $\underline{p}$ > .05, therefore the second hypothesis was also rejected.

Analyses were then run to determine the effect of the RI on the GSI and IIP-32 outcome measures as rated by the client and the GAF outcome measure as rated by the therapist. As with the analysis of the client's level of suggestibility, these analyses were hindered by the low number of clients who had completed at least eight sessions of therapy. Twenty-five, 28, and 25 clients and their therapists completed session eight SCl-90, IIP-32 and GAF measures, respectively.

Repeated measures ANOVAs were conducted for these analyses. Looking at the ANOVA of the intake session plus sessions 1, 4 and 8 for the GSI, a main effect for time $F(3, 21) = 4.94$, $p < .01$ was found. Post hoc comparisons with a Bonferroni correction to account for multiple comparisons indicated a significant decrease in GSI from intake to session 4 ($p < .05$) and from session 1 to session 4 ($p < .05$). No effect for the RI [$F(1, 23) = 2.85$, $p > .05$] or an interaction between time and the RI [$F(3, 21) = 1.59$, $p > .05$] was found.

The ANOVA for the IIP-32 yielded no significant main effects or interactions [$F(3, 24) = 1.52$; $F(1, 26) = .13$; and $F(3, 24) = 1.81$, respectively for time and RI main effects and a time by RI interaction, $ps > .05$]. Finally, the ANOVA for the GAF yielded a main effect for time $F(2, 22) = 5.55$, $p < .01$. Post hoc comparisons with a Bonferroni correction to account for multiple comparisons indicated a significant increase in GAF from session 1 to session 8($p < .01$). No main effect for the RI [$F(1, 23) = .17$, $p > .05$], and no interaction between time and the RI [$F(2, 22) = 1.25$, $p > .05$] were found. Therefore, the third hypothesis was also rejected.

Repeated measures analyses were then conducted to determine the effect of the RI on the therapeutic alliance as rated by the clients on the CASF-P and the therapists on the CASF-T. Here too, the analyses were hindered by the low number of clients and therapists who completed at least eight sessions of therapy. Twenty-nine clients and 27 therapists completed session eight CASF-P and CASF-T measures.

Table 2 displays results of the analyses for the subscales of the CASF-P and CASF-T. Significant results for the Confident Collaboration subscale of the CASF-P

Table 2 Results of Repeated Measures ANOVA for CASF-P and CASF-T for sessions 1, 4 and 8.

	Main effects		Interaction effect
	Time	RI	Time by RI
CASF-P subscales			
Confident Collaboration	F (2, 26) = 6.56**	F (1, 27) = 4.00^{+}	F (2, 26) = 1.85
Goal and Tasks	F (2, 26) = 10.70***	F (1, 27) = .28	F (2, 26) = 3.45*
Bond	F (2, 26) = 10.39***	F (1, 27) = .20	F (2, 26) = 3.29$^{\pm}$
Idealized Therapist	F (2, 26) = 1.55	F (1, 27) = .73	F (2, 26) = .30
Help Received	F (2, 26) = 10.90***	F (1, 27) = .51	F (2, 26) = .74
CASF-T subscales			
Confident Collaboration	F (2, 24) = 20.14***	F (1, 25) = 2.88	F (2, 24) = .14
Therapist Confidence	F (2, 24) = 7.88**	F (1, 25) = 1.25	F (2, 24) = .20
Bond	F (2, 24) = 15.38***	F (1, 25) = .55	F (2, 24) = .09
Agreement	F (2, 24) = .47	F (1, 25) = 1.21	F (2, 24) = .14
Patient Working Capacity	F (2, 24) = 5.64*	F (1, 25) = 2.32	F (2, 24) = 1.34
Patient Commitment	F (2, 24) = 7.31**	F (1, 25) = 1.15	F (2, 24) = .77

Notes: * $p < .05$ level, ** $p < .01$, *** $p < .001$.

$^{+}$ $p = .056$, $^{\pm}$ $p = .053$.

included a significant main effect for time, F (2, 26) = 6.56, $p < .01$. Post hoc comparisons with a Bonferroni correction indicated a significant increase in ratings of Confident Collaboration from session 1 to session 8 ($p < .01$), and a main effect approaching significance for the RI, F (1, 27) = 4.00, $p = .056$, where ratings of Confident Collaboration were higher for the no RI group than for the RI group. The observed power for this main effect was low (.487), however, indicating only a 49% chance of finding a difference that was truly there.

Significant results for the Goals and Tasks subscale included a main effect for time, F (2, 26) = 10.70, $p < .001$, and an interaction for time and the RI, [F (2, 26) = 3.45, $p < .05$]. Separate repeated measures ANOVAs were run for the RI and no RI groups and indicated a significant difference for the no RI group F (2, 14) = 11.00, $p < .01$, but no significant change for the RI group F (2, 11) = 2.04, $p > .05$. Post hoc comparisons with a Bonferroni correction indicated a significant increase in Goals and Tasks scores for the no RI from session 1 to session 8 ($p < .01$). Figure 1 demonstrates this interaction. The observed power for this interaction, however, was low (.594), indicating only a 60% chance of finding a difference that was truly there.

Significant results for the Bond subscale included a main effect for time, F (2, 26) = 10.39, $p < .001$, and an interaction approaching significance between time and the RI, [F (2, 26) = 3.30, $p = .053$]. Separate repeated measures ANOVAs were run for the RI and no RI groups and indicated a significant difference for the no RI group F (2, 14) = 8.38,$p < .01$ and for the RI group F (2, 11) = 4.62, $p < .05$. Post hoc comparisons with a Bonferroni correction indicated a significant increase in Bond scores for the no RI group

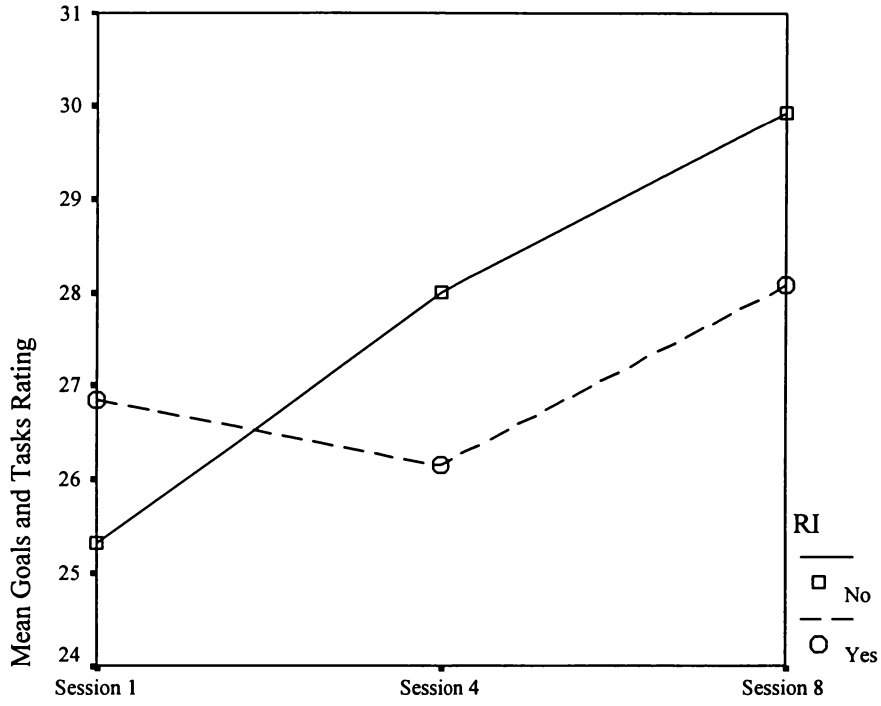
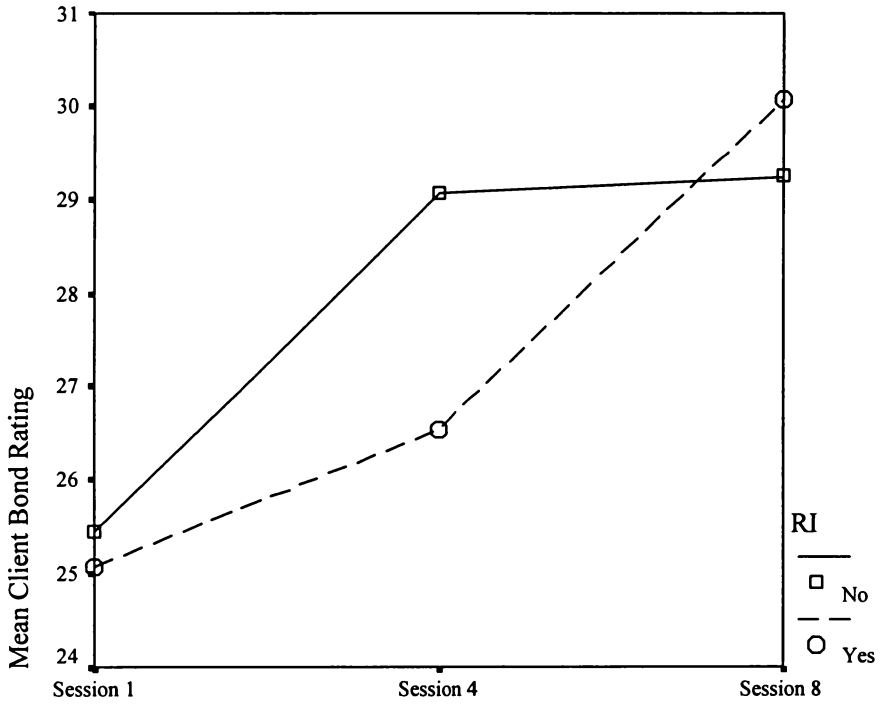


Figure 1. Interaction on the Goals and Tasks subscale of the CASF-P

from session 1 to session 4 ($p < .05$) and from session 1 to session 8 ($p < .01$), and a significant increase in Bond scores for the RI group from session 4 to session 8 ($p < .05$) with a trend for session 1 to session 8 ($p = .054$). Figure 2 demonstrates this interaction. The observed power for this interaction was also low (.573), however, indicating only a 57% chance of finding a difference that was truly there.

Finally, a main effect for time was found for the Help Received subscale, $F(2, 26) = 10.90$, $p < .001$. Post hoc comparisons with a Bonferroni correction indicated that the clients' perception of Help Received significantly increased from session 1 to session 4 ($p < .001$) and from session 1 to session 8 ($p < .01$).

Significant results for the CASF-T included main effects for time for the therapist Confident Collaboration subscale, $F(2, 24) = 20.14$, $p < .001$. Post hoc comparisons with a Bonferroni correction indicated that therapist ratings of Confident Collaboration significantly increased from session 1 to session 8 ($p < .001$) and from session 4 to session 8 ($p < .05$); for the Therapist Confidence subscale, $F(2, 24) = 7.88$, $p < .01$. Post hoc comparisons with a Bonferroni correction indicated that Therapist Confidence ratings significantly increased from session 1 to session 8 ($p < .01$); for the Bond subscale, $F(2, 24) = 15.38$, $p < .001$). Post hoc comparisons with a Bonferroni correction indicated that therapist rated Bond scores significantly increased from session 1 to session 8 ($p < .001$) and from session 4 to session 8 ($p < .05$); for the Patient Working Capacity subscale, $F(2, 24) = 5.64$, $p < .05$. Post hoc comparisons with a Bonferroni correction indicate that therapist rated levels of the patient's capacity to work on their problems significantly increased from session 1 to session 8 ($p < .01$); and for the Patient Commitment subscale,



Figures 2. Interaction on the Bond subscale of the CASF-P

$F(2, 24) = 7.31$, $p < .01$. Post hoc comparisons with a Bonferroni correction indicate that the Patient Commitment scores significantly increased from session 1 to session 8 ($p < .01$) and from session 4 to session 8 ($p < .05$). The results of these analyses indicate no support for the fourth hypothesis.

Chapter IV

Discussion

The results of the study provide no support for the first hypothesis, since receiving a RI before beginning therapy did not significantly reduce the rate of premature termination. The rate of premature termination for the RI group was 62%; the rate for the no RI group was 53%. This difference did no reach statistical significance. Overall, the sample had a premature termination rate of 57%. Although these rates are quite high, they are consistent with other reported rates of premature termination contained in reviews of the premature termination literature (e. g., Baekeland & Lundwall, 1975). Additionally, neither the client's socioeconomic level nor having had previous therapy experience differentially affected the RI's usefulness.

The second hypothesis was also not supported as level of suggestibility did not differentially affect rates of premature termination for clients who received the RI. This lack of support for the hypothesis is not surprising given that suggestibility data were available for only 32 of the 68 clients. Additionally, the third hypothesis was not supported as there were no main effects for the RI for any of the outcome measures. As stated above, the lack of power significantly hindered the analyses.

Finally, the fourth hypothesis was also not supported as there were no main effects for the RI for any of the alliance subscales. One subscale (Confident Collaboration as rated by the client) approached significance ($p = .056$) with the RI group having lower Confident Collaboration scores than the no RI group. Additionally, an interaction between time and the RI was found for the Goals and Tasks subscale of the CASF-P and

approached significance for the Bond subscale of the CASF-P. For the Goals and Tasks subscale, the RI group's Goals and Tasks scores did not change, while the no RI group's scores on Goals and Tasks increased from session 1 to session 8. For the Bond subscale of the CASF-P, the RI group's Bond scores increased from session 4 to session 8 with a trend from session 1 to session 8, and the no RI group's Bond scores increased from session 1 to session 4 and from session 1 to session 8. As with the analyses for suggestibility and the outcome measures, the lack of power associated with these analyses significantly hindered the ability to detect small differences in the data between the RI and no RI groups. Both the main effect that approached significance for the RI as well as both interactions should be viewed with caution given the low power and consequently high probability of Type II error.

By far the most important limitation of this study was the lack of power associated with the small sample sizes available for analyses due to the high premature termination rate in the total sample. This more than any other factor has the potential to account for the lack of significant findings. A power analysis was conducted prior to data collection to determine how many clients would be needed to show significant differences for the RI at the .05 level. The power analysis was conducted with the assumption of a continuous sample of sessions attended instead of the artificially dichotomized sample of seven of fewer or greater than eight sessions which were analyzed for the present study. The analysis indicated that 68 clients were needed. Data collection progressed with this number in mind. This methodological flaw was no doubt very instrumental in the failure to find results of any kind for the present study.

Given the general lack of results for the RI, it is questionable how far any discussion should proceed in drawing conclusions about the study or in comparing this study to other research on RI. A simple comparison of effect sizes obtained by this study and by Monks (1995) in her meta-analysis is provided to give some perspective as to the relative effectiveness of the RI in this study as compared to other studies.

The RI produced an effect size of $\eta^2 = .11$ for GSI, $\eta^2 = .01$ for the IIP-32, and $\eta^2 = .01$ for the GAF, for an average effect size on the outcome measures of .04. This effect size is much lower than the effect size of $\underline{d} = .34$ for outcome measures reported by Monks (1995). The concept of alliance could loosely be compared to Monk's category of therapy behavior, which includes the client's attitudes toward the therapist. The RI produced a mean effect size of $\eta^2 = .04$ (range from .13 for Confident Collaboration to .01 for Bond) for combined scales of the CASF-P in this study. This effect size is also much lower than the effect size of $\underline{d} = .20$ for therapy behavior reported by Monks.

It was not possible to calculate effect size on the chi-square analysis performed to determine the RI's effectiveness on premature termination. Given the lack of results for this analysis, however, the effect size for the RI on premature termination in this study can be assumed to be lower than the effect size of $\underline{d} = .23$ reported by Monks (1995).

Given the recent meta-analysis findings of Monks (1995), as well as the numerous published studies which demonstrate that RI contributes to decreased rates of premature termination, the failing of this study to find similar results is surprising. There are several possibilities that might explain these findings. First, as noted in the introduction, few studies on RI have been published in the past decade, with the majority of RI studies

published in the decade following Orne and Wender's (1968) article. Perhaps other researchers have obtained similar non-significant results and have not published them. This harkens back to the 'file drawer problem', which appears to have been adequately addressed and dismissed as a non-threatening factor to the obtained effect sizes in Monks' (1995) meta-analysis of RI.

Another possibility is that the RI had no effect because the clients currently seeking therapy are different from the clients for whom the RI was originally created. Orne and Wender (1968) created the RI to inform clients about therapy. As such, and prompted at least minimally by the Orne and Wender article, many researchers (e. g., Heitler, 1976; LaTorre, 1977; Strupp & Bloxom, 1973; Warren & Rice, 1972) came to view the RI as a tool for clients who had never been in therapy or who had fewer opportunities to learn about therapy from other sources, such as clients from lower social classes. Both of these things, while certainly still possible, are probably much less likely in today's society than in the late 1960's when the RI procedure was first introduced. The availability of mental health services to clients from all social classes has increased dramatically with the advent of community mental health centers. Data from the current study indicates this increasing trend, with 66.2% of clients reporting previous therapy. In addition, the introduction of psychology to the mass media through books, radio and television has had quite an impact on our society so that more clients have had some type of exposure to the therapeutic endeavor. Perhaps the greater availability of therapy services and information about therapy negates the need to inform clients about therapy. Some confirmation of this may come from the client who was removed from the study

after she declined to finish viewing the RI saying it was "too simplistic" for her. This logic, however, does not appear to hold. Although neither social class nor previous therapy experience were found to effect the rates of premature termination, 60% of clients who reported previous therapy experience prematurely terminated from the current study. This being the case, it would appear that educating clients about therapy in order to decrease premature termination rates still has merit.

Yet another possibility to be considered is that the clients who were rated as prematurely terminating from therapy in fact achieved the goals for which they entered therapy and therefore found further therapy unnecessary. No follow-up data on clients who prematurely terminated from therapy was available to test this hypothesis, but this possibility does not seem highly likely, especially in light of the fact that 23% of the sample that prematurely terminated did so after only 1 session. This argument seems more likely for clients who have been in therapy for a greater period of time and decide that they have completed their therapy goals independently of their therapist's agreement. It was for this very reason that premature termination was defined as fewer than 8 sessions to reflect those who had not "been effectively exposed to treatment" (Howard et al., 1986).

One large prospect that must not be overlooked is the role that the RI itself might have played in failing to find differential rates for premature termination, outcome or alliance between the two groups. The presentation of the RI in video format, for example, could have been perceived as impersonal, which, in turn, could have caused it to fail to have the desired effect. Other studies (e. g., Strupp and Bloxom, 1973), however, have

utilized a videotaped RI procedure with favorable results, so while this is a possibility, it does not necessarily account for the lack of results in the present study.

Another possibility related to the RI itself is that it might have had no educational effect because the clients did not understand it or see its relevance to their understanding of therapy. As no manipulation check was conducted to see if the clients understood the material presented by the RI, it is difficult to know if this was the case. Yet another possibility is that the RI was ineffective because its message was not strong enough, and therefore a stronger, more meaningful RI should be employed. This possibility, however, would not explain how other researchers have demonstrated positive results using the same Orne and Wender (1968) RI procedure.

There are, of course, limitations to this study that also adversely affected the results. As discussed above, the most important of these was the lack of power associated with the small sample sizes available for analyses due to the high premature termination rate in the total sample. Other, less important limitations to the overall results, although no less important to the methodological quality of the study include the possible bias inherent in the non-random assignment of clients to therapists, the inability to ensure that the therapists remained blind to their client's RI group, and the absence of a manipulation check to determine if the RI was achieving its targeted educational purpose.

Although the hypotheses were not supported, the study provides interesting data on psychotherapy outcome. The clients' ratings of symptoms significantly decreased from intake to session 4 as well as from session 1 to session 4. This indicates that in the first few weeks of therapy clients report less symptomotology, which is maintained through

eight therapy sessions. Additionally, therapists' ratings of their clients' functioning significantly increased from session 1 to session 8, indicating that within the first few weeks of therapy therapists rate their clients as functioning better in psychological, social and occupational arenas, and that this increase in functioning is maintained through 8 therapy sessions. These findings are encouraging as they show a general effect for therapy as well as indicate that even though the RI procedure did not differentially create more positive outcomes for clients who saw the video, it did not obstruct the ability of the therapy itself to produce positive outcomes.

When looking at analyses of the client-rated measure of alliance, alliance scores increased as therapy progressed for the Confident Collaboration, Goals and Tasks, Bond and Help Received subscales. In addition to the seeming positive effect of therapy on alliance, the fact that different subscales of the alliance measure increased at different points within the therapy argues for continuing to research the concept of therapeutic alliance as consisting of several separate components as opposed to being one unitary construct.

When looking at the analyses of the therapist-rated alliance measures, alliance scores increased over time for the Confident Collaboration, Therapist Confidence, Bond, Patient Working Capacity, and Patient Commitment subscales. Again, in addition to the basic outcome findings, the fact that different subscales of the companion therapist alliance measure increased at different points within the therapy argues for continuing to conceptualize therapeutic alliance as a multi-faceted construct.

The study also provided some promising areas of further research related to the effect of suggestibility on premature termination. Suggestibility did not differentially affect rates of premature termination in clients who received a RI. Post hoc analyses looking at the effect of suggestibility on premature termination status itself, however, indicated a trend, $t(32) = -1.769$, $p = .087$, (Figure 3) whereby clients who prematurely terminated from therapy had lower levels of suggestibility than clients who remained in therapy for 8 or more sessions. Because this was only a trend and did not reach significance, any interpretation of this result should be regarded as extremely tentative. This trend seems to lend support to Bowers and Kelly's (1970) assertion that suggestibility is a hidden factor inherent in all aspects of therapy. The fact that this trend was evident for premature termination rates in general but not when examined for a differential effect on RI's effectiveness on premature termination suggests that the more opportunities the therapist has to exercise influence with more highly suggestible clients, as would be possible in the first few sessions of therapy as opposed to a single 13 minute videotape, the better the results. The low number of subsets for analysis of the suggestibility data inhibits the ability to make firmer conclusions. More research utilizing larger samples of suggestibility data is required in order to better determine the effect of suggestibility on premature termination.

Although the current study did not add to the established literature on the effectiveness of RI, the utility of such a procedure remains apparent if it indeed, as the results of Monks' (1995) meta-analysis seem to indicate, manages to reduce rates of premature termination and increase both positive outcome and positive therapy behaviors

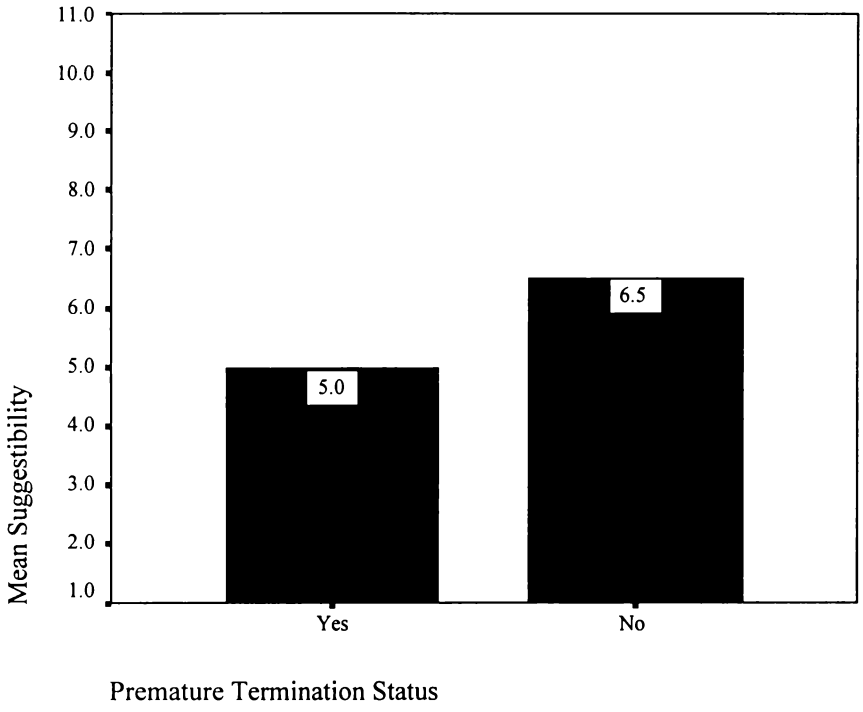


Figure 3. Mean suggestibility scores premature termination

in clients. Premature termination is a problematic phenomenon that impairs both the therapist's ability to facilitate symptom reduction or deeper change and the client's ability to address the difficulties for which they initially sought therapy. Phillips (1985) certainly reflects the views of many researchers and therapists alike when he labels premature termination as the number one problem that both clinicians and researchers face. The current study failed to reduce the rate of premature termination or create more positive outcome and quicker alliance in clients who received a RI prior to beginning therapy. Despite the results of the current study, the need to find some method by which premature termination rates can be reduced that is feasible for use in both research and practice settings is still paramount. Furthermore, it appears that RI may meet both the qualification of effectiveness, based on Monks' meta-analysis, and utility across varied settings, as indicated by its successful adaptation into various methods of representation in numerous studies reported in the literature. Research in this area, as with the general area of psychotherapy outcome, however, is costly and time-consuming. Further research is recommended with the overriding goal of designing a RI that works and is easy to administer. Specific recommendations for continued research using a protocol such as the one used in this study would be to take the limitations, most notably that of low sample sizes that have been discussed in the context of the current study, into account. By doing this, perhaps a RI procedure that is both effective and easy to administer can be utilized and made available to the community of practicing therapists in order to reduce premature termination.

References

References

American Psychiatric Association. (1994). Diagnostic and statistical manual of mental disorders (4th ed.). Washington, DC: Author.

Baekeland, F., & Lundwall, L. (1975). Dropping out of treatment: A critical review. Psychological Bulletin, 82, 738-783.

Barkham, M., Hardy, G. E., & Startup, M. (1996). The IIP-32: A short version of the Inventory of Interpersonal Problems. British Journal of Clinical Psychology, 35, 21-35.

Bednar, R. L., Weet, C., Evensen, P., Lanier, D., & Melnick, J. (1974). Empirical guidelines for group therapy: Pretraining, cohesion, and modeling. Journal of Applied Behavioral Sciences, 10, 149-165.

Beutler, L. E., & Clarkin, J. F. (1990). Systematic treatment selection: Toward targeted therapeutic interventions. New York: Brunner/Mazel.

Blagys, M. D. (1999). Reliability of psychotherapy alliance and process scales utilized during psychological assessment. Paper presented at the meeting of the Society for Personality Assessment, New Orleans, LA.

Bowers, K. S., & Kelly, P. (1979). Stress, disease, psychotherapy, and hypnosis. Journal of Abnormal Psychology, 88, 490-505.

Childress, R., & Gillis, J. S. (1977). A study of pretherapy role induction as an influence process. Journal of Clinical Psychology, 33, 540-544.

Clemence, A. J., Hilsenroth, M. J., Strassle, C. & Handler, L. (2000). Therapeutic alliance and the Combined Alliance Short Form. Paper presented at the meeting of the Society for Psychotherapy Research, Chicago, IL..

Derogatis, L. R. (1994). Symptom Checklist-90-R: Administration, scoring and procedures manual. Minneapolis, MN: National Computer Systems.

Frank, J. D. (1961). Persuasion and Healing. Baltimore, MD: Johns Hopkins Press.

Friedlander, M. L., & Kaul, T. J. (1983). Preparing clients for counseling: Effects of role induction on counseling process and outcome. Journal of College Student Personnel, 24, 207-214.

Garfield, S. A. (1994). Research on client variables in psychotherapy. In A. E. Bergin & S. L. Garfield (Eds.), Handbook of psychotherapy and behavior change (4th ed., pp. 143-189). New York: Wiley.

Garrison, J. E. (1978). Written vs. verbal preparation of patients for group psychotherapy. Psychotherapy: Theory, Research and Practice, 15, 130-134.

Hatcher, R. L., & Barends, A. W. (1996). Patient's view of the alliance in psychotherapy: Exploratory factor analysis of three alliance measures. Journal of Consulting and Clinical Psychology, 64, 1326-1336.

Heitler, J. B. (1976). Preparatory techniques in initiating expressive psychotherapy with lower-class, unsophisticated patients. Psychological Bulletin, 83, 339-352.

Hilgard, E. R. (1978). The Stanford Hypnotic Susceptibility Scales as related to other measures of hypnotic responsiveness. The American Journal of Clinical Hypnosis, 21, 68-83.

Hilsenroth, M. J., Handler, L., Toman, K. M., & Padawer, J. R. (1995). Rorschach and MMPI-2 indices of early psychotherapy termination. Journal of Consulting and Clinical Psychology, 63, 956-965.

Hoehn-Saric, R., Frank, J. D., Imber, S. D., Nash, E. H., Stone, A. R., & Battle, C. C. (1964). Systematic preparation of patients for psychotherapy- Effects on therapy behavior and outcome. Journal of Psychiatric Research, 2, 267-281.

Hollingshead, A. B., & Redlich, F. C. (1958). Social class and mental illness: A community study. New York: Wiley.

Howard, K. I., Kopta, S. M., Krause, M. S., & Orlinsky, D. E. (1986). The dose-effect relationship in psychotherapy. American Psychologist, 41, 159-164.

Imber, S. D., Frank, J. D., Gliedman, L. H., Nash, E. H., & Stone, A. R. (1956). Suggestibility, social class and the acceptance of psychotherapy. Journal of Clinical Psychology, 12, 341-344.

Kivlighan, D. M., Corazzini, J. G., & McGovern, T. V. (1985). Pregroup training. Small Group Behavior, 16, 500-514.

LaTorre, R. A. (1977). Pretherapy role induction procedures. Canadian Psychological Review, 18, 308-321.

Lambert, R. G., & Lambert, M. J. (1984). The effects of role preparation for psychotherapy on immigrant clients seeking mental health services in Hawaii. Journal of Community Psychology, 12, 263-275.

Lorion, R. P. (1974). Patient and therapist variables in the treatment of low-income patients. Psychological Bulletin, 81, 344-354.

Luborsky, L. (1994). Therapeutic alliances as predictors of psychotherapy outcomes: Factors explaining the predictive success. In A. O. Horvath and L. S. Greenberg (Eds.), The working alliance: Theory, research, and practice (pp. 38-50). New York: Wiley.

Luborsky, L., Crits-Cristoph, P., Mintz, J., & Auerbach, A. (1988). Who will benefit from psychotherapy?: Predicting therapeutic outcomes. New York: Basic Books.

Mayerson, N. H. (1984). Preparing clients for group therapy: A critical review and theoretical formulation. Clinical Psychology Review, 4, 191-213.

Monks, G. (1995). A meta-analysis of role-induction studies (Doctoral dissertation, University of Hartford, 1995). Dissertation Abstracts International, 56, 7051.

Myers, J. K., & Bean, L. L. (1968). A decade later: a follow-up of social class and mental illness. New York: Wiley.

Nace, E. P., Warwick, A. M., Kelley, R. L., & Evans, F. J. (1982). Hypnotizability and outcome in brief psychotherapy. Journal of Clinical Psychiatry, 43, 129-133.

Orlinsky, D. E., & Howard, K. I. (1986). Process and outcome in psychotherapy. In S. L. Garfield and A. E. Bergin (Eds.), Handbook of psychotherapy and behavior change (pp. 311-381). New York: John Wiley.

Orne, M. T., & Wender, P. H. (1968). Anticipatory socialization for psychotherapy: Method and rationale. American Journal of Psychiatry, 124, 1202-1212.

Overall, B., & Aronson, H. (1963). Expectations of psychotherapy on patients of lower socioeconomic class. American Journal of Orthopsychiatry, 33, 421-430.

Pekarik, G. (1985). The effects of employing different termination classification criteria in dropout research. Psychotherapy, 22, 86-91.

Pekarik, G., & Wierzbicki, M. (1986). The relationship between clients' expected and actual treatment duration. Psychotherapy, 23, 532-534.

Phillips, E. L. (1985). Psychotherapy revised: New frontiers in research and practice. Hillsdale, NJ: Lawrence Erlbaum.

Pilkonis, P. A., Imber, S. D., Lewis, P., & Rubinsky, P. (1984). A comparative outcome study of individual, group, and conjoint psychotherapy. Archives of General Psychiatry, 41, 431-437.

Richert, A. (1983). Differential prescription for psychotherapy on the basis of client role preferences. Psychotherapy Theory, Research and Practice, 20, 321-329.

Rosenzweig, S. P., & Folman, R. (1974). Patient and therapist variables affecting premature termination in group psychotherapy. Psychotherapy: Theory, Research and Practice, 11, 76-79.

Samstag, L. W., Batchelder, S. T., Muran, J. C., Safran, J. D., & Winston, A. (1998). Early identification of treatment failures in short-term psychotherapy: An assessment of therapeutic alliance and interpersonal behavior. The Journal of Psychotherapy Practice and Research, 7, 126-143.

Sauber, S. R. (1974). Approaches to pretherapy training. Journal of Contemporary Psychotherapy, 6, 190-197.

Silverman, W. H., & Beech, R. P. (1979). Are dropouts, dropouts? Journal of Community Psychology, 7, 236-242.

Sloane, R. B., Cristol, A. H., Pepernik, M. C., & Staples, F. R. (1970). Role preparation and expectation of improvement in psychotherapy. Journal of Nervous and Mental Disease, 150, 18-26.

Stark, M. J., & Kane, B. J. (1985). General and specific psychotherapy role induction with substance-abusing clients. The International Journal of the Addictions, 20, 1135-1141.

Strupp, H. H., & Bloxom, A. L. (1973). Preparing lower-class patients for group psychotherapy: Development and evaluation of a role-induction film. Journal of Consulting and Clinical Psychology, 41, 373-384.

Warren, N. C., & Rice, L. N. (1972). Structuring and stabilizing of psychotherapy for low-prognosis clients. Journal of Consulting and Clinical Psychology, 39, 173-181.

Wechsler, D. (1997a). Wechsler Adult Intelligence Scale: Administration and scoring manual (3rd ed.). San Antonio, TX: The Psychological Corporation.

Wechsler, D. (1997b). Wechsler Adult Intelligence Scale, Wechsler Memory Scale: Technical manual (3rd ed.). San Antonio, TX: The Psychological Corporation.

Weitzenhoffer, A. M., & Hilgard, E. (1962). Stanford hypnotic susceptibility scale: Form C. Palo Alto, CA: Consulting Psychologists Press.

Yalom, I. D., Houts, P. S., Newell, G., & Rand, K. H. (1967). Preparation of patients for group therapy. Archives of General Psychiatry, 17, 416-427.

Zweben, A., Bonner, M., Chaim, G., & Santon, P. (1988). Facilitative strategies for retaining the alcohol-dependent client in outpatient treatment. Alcoholism Treatment Quarterly, 5, 3-24.

Appendix

Role Induction script

What to Expect in Psychotherapy*

Hello. Welcome to the University of Tennessee Psychological Clinic. I wanted to take a few minutes to tell you what to expect in therapy. What's therapy about? What's going to happen? Well, for one thing, the person who worked with you earlier probably talked a lot, since they were trying to learn about what led you to ask for services at the clinic. The same is going to be true about your therapist. In the first few sessions they're going to try to get to know you and understand your current situation. But as your treatment continues your therapist won't be talking as much. The reason we're asking you to watch this now is that we want to explain these things to you. There's a good reason that the therapist doesn't say much. Everyone expects to tell the therapist about their problem and then have the therapist give advice, which will solve everything just like that. This isn't true; it just doesn't work like that. Advice is cheap; there's no reason to pay for it. Before you came here you probably got advice from all kinds of people: your husband or wife, maybe your parents, your friends, your family doctor, your minister, and so on. Many of these people know you well; some of them know you *very* well; and if it were just a question of getting advice, there's no reason to think that your therapist would be that much better at it than all of the people who have always told you what to do.

Actually, we find that most people have a pretty good idea of what's wrong and while we can give advice to someone else with a problem that's similar to our own, it usually just doesn't help them. Unfortunately, when people give advice, they usually give solutions that work for them but not for you. If all of the advice you've received had helped, odds are you wouldn't be here. Your therapist wants to help you to figure out

what you really want to do - what the best solution is for you. It's the therapist's job not to give advice but to help you find out for yourself how you're going to solve your problems.

Now what does this mean? Well, if your therapist sees you getting into some kind of trouble, they might warn you about it, but here again the final decision about what to do will have to be made by you. The big advantage you'll have with your therapist is that they have no ax to grind. The therapist doesn't think they know what is best for you, but they're going to help you try to find out what's best for you. The therapist doesn't think that they know the answers but rather, they just want to understand, with you, why you do things, or why you feel a certain way.

Now, what goes on in treatment itself? What do you talk about? What do you do? How does it work? Well for one thing, you'll talk about your wishes, your needs, and your intentions, right now and in the past. Now, why should this help? Why is it important? Well, there are many reasons. Usually, people don't talk about lots of things because they're too personal, or because they would hurt other people's feelings, or maybe for some other reasons. You'll find that with your therapist you'll be able to talk about anything that comes to your mind. Your therapist won't have already decided what's right or what's wrong for you or what the best solution would be. But talking is very important because the therapist wants to help you get at what you really want. The problem most people have in making decisions is not that they don't know enough, but instead that they've never had the chance of talking things over with someone who doesn't try to make their decisions for them. The therapist's job is to help *you* make the

decision.

Another reason is that most of us are not always honest with ourselves. Sometimes we try to kid ourselves, and it's your therapist's job to make you notice when you are kidding yourself. The therapist is not going to try to tell you what they think, but instead they'll point out to you how two things you're saying just don't fit together. You know, feelings have to add up, kind of like two and two are 4, but we like to kid ourselves sometimes that instead of 4 they're five. It's your therapist's job to remind you when this happens. For example in relationships people sometimes do things that are annoying, or even down right aggravating, but many people continue in these bad relationships even though they may be a problem or they may even be unhealthy. The job of your therapist is to help you keep in mind all the important facts and feelings so that you can come to a solution that takes all of the facts into account. It's hard, though, because sometimes these feelings conflict with each other and it's hard for anyone to sort them out.

You've probably heard that therapists are interested in something called the unconscious. What's really meant by that? The unconscious isn't such a mysterious thing when you really look at it. For example, you might have met people who seem to get you really angry with them. At other times you might have felt very positive about someone, even though you've just met them. In either case, or in both cases you can't put your finger on anything they've done to account for your feelings. It may be that this person reminds you of someone else that you know, or of a particular situation but you don't realize it. In this case, becoming aware of what's unconscious would be like remembering and recognizing the difference between these different people or situations. Sometimes,

though, that's an awful lot of work.

When we're not aware of the reason for strong feelings like this, a therapist might then say- "this is unconscious". By understanding the reasons for our feelings with someone, we can treat them on a more realistic basis. It's very possible that a very nice person might be like somebody who we have good reason to dislike. Or even more of a problem would be having a positive reaction to someone, when we first meet them, who turns out to be not such a nice person and they may wind up taking advantage of our trust. It's the therapist's job to help you recognize when the feelings you have toward someone seem not to fit, and then learn to understand the real causes.

By the way, when you start treatment, you'll find that some of the people closest to you, who are all for your getting some help now, may come to feel that it isn't helping you any. This is usually a sign that you're really changing, and these very changes are puzzling and sometimes troublesome to someone close to you. You should know that almost always in treatment some of the people around you might think you're getting worse - often just at the time when you're really improving. And you yourself might also sometimes feel worse and discouraged at some stages of treatment. You know, you might feel you're not getting anywhere, or your therapist just doesn't know what they're doing, and there's no point in this, and so on. These very feelings are usually good signs that you're doing good work, but that it's uncomfortable. It's very important that you don't give in to these temporary feelings when they come up and it's also very important to let your therapist know that you're struggling.

You know it's very funny - what may happen, as you talk about more troublesome things, is that you'll find you might even have trouble keeping your appointments. You might feel you're not able to get away from work, or suddenly it'll be necessary to work overtime, just at the time of the appointment, or your car will break down or run out of gas, or your family will need your help at home for something, and so on. All of these things will seem very separate and not related to treatment. The funny part is that they may be happening just at the time when things are getting rough for you in therapy. This may mean, of course, that you're getting to something hard and important, and these are the most important times to come to your therapy meetings. This is something that may happen sooner or later. The only way to protect yourself is not to allow yourself to judge how important any given meeting will be, but instead to decide beforehand that you're going to be there, come hell or high water. In other words, if you make an appointment, you'll keep the appointment regularly. Now this doesn't mean that you can't postpone a session for good reason, if you discuss it with your therapist first. For example, if you knew three or four weeks in advance that you've got a business trip or a vacation, and you know its something you have to do, it won't, as a rule, interfere with treatment if you miss an appointment. It's the sudden emergencies, things that come up unexpectedly, that'll be important to keep track of and discuss with your therapist.

Another thing, in treatment you'll often find yourself uncomfortable. Real lasting change doesn't come easy and it's often the case that when you're talking about the important things that brought you to therapy, you become uncomfortable. Also, talking about these issues may sometimes lead you to feel depressed or anxious. This comes with

the territory, but it's important that you remember these feelings are normal, these feelings are to be expected, and actually, these feelings are positive, because this usually means that real change or real progress is being made. Also, you may want your therapist to say more and you'll find yourself trying to make decisions about what to say. We do this all the time. If we didn't, we'd get ourselves into a lot of trouble. If you think your boss is an idiot, for example, and you told him or her that they were an idiot, you might lose your job. In general, we have to make a choice between what we think and what we say. Well in treatment this is not true. We want you to say whatever comes to mind, even if you think it's trivial or not important. It doesn't matter. It's still important to say it. And if you think it's going to bother your therapist, that doesn't matter either; you still should say it. In contrast to your boss, if you think your therapist is an idiot, you need to tell him or her about it. You'll find this is very hard to do and yet it's one of the most important things to learn in treatment - to talk about whatever comes to your mind. Often what you might think is trivial and not important is really the key to something that's very important. I'll give you an example. You might, all of a sudden, notice that the room is hot or that the therapist's clothes are funny or something like that, that seems trivial and even maybe a little rude to bring up. Yet, in treatment, if you think of it, you need to feel free to say it. Many times these things turn out to be very, very important. Say whatever is on your mind, no matter what. Another common example is that early on, some people may feel tense or uncomfortable from time to time. They may even wonder if they should come back. This is common. The important thing is to tell your therapist about these

feelings when they're happening, not later, so that you and your therapist can talk about them.

Another thing, the relationships that people have are often an important source of information, and a focus of therapy. It's very likely that problems in a relationship are a part of the reason why you originally looked for therapy. It will be important to discuss your private thoughts and feelings, the negative ones and the positive ones, about important people in your life. Also, you should feel free to discuss your personal reactions to your therapist. In fact, your therapist may even ask about your thoughts and feelings about therapy with them. So, just like talking about the important issues that brought you into treatment, exploring feelings and thoughts about your therapist or that relationship is encouraged.

Finally, your treatment here is open-ended and no limits will be placed on how long you can see your therapist. Whether you decide to leave treatment after the 16th session or the 60th session is completely up to you. Together, you and your therapist will develop a plan for reaching goals that are important to you. Every so often the two of you will review these goals to check on your progress, to add new goals, or to change other goals, and to identify areas of success. When you feel that you've accomplished what you wanted to accomplish, and don't feel like you want to add any other treatment goals, you should tell your therapist. But, it's important for you to talk about leaving treatment with your therapist before you stop coming. Like with any other relationship it's important that the two of you get a chance to say good-bye.

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* Adapted from the hypothetical role induction of Orne and Wender (1968).

Vita

Carla Gayle Strassle was born in June, 1974. She attended schools in the public school system in Sumner County, Tennessee, where she graduated as valedictorian of the White House High School's class of 1992. She graduated magna cum laude with a Bachelor of Science in Psychology from Belmont University in Nashville, Tennessee in May 1996. She entered the Doctoral Program in Clinical Psychology at the University of Tennessee, Knoxville in August 1996 and received her Master of Arts in Psychology from the University of Tennessee, Knoxville in December of 1997. This dissertation represents a requirement of the doctoral degree.