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CLIENT PREPARATION TECHNIQUES: EDUCATING NONCLIENTS ABOUT THE PROCESS OF PERSONAL COUNSELLING

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Abstract

Past research indicates that the client preparation technique has improved clients' attitudes, attendance, and outcome in personal counselling. In the present study, this technique was adapted for 40 female and 70 male nonclient college students. Following the procedure, subjects' self-evaluated knowledge, positive attitudes, and knowledge of psychotherapy increased ($p < .0001$). Most of the gains were maintained at a one month follow-up. Lower SES subjects had significantly lower knowledge scores than middle SES subjects initially ($p < .01$), but no significant difference occurred at posttesting or follow-up. These findings suggest that the client preparation technique can be adapted for nonclient groups and may be particularly useful for lower SES groups.

Résumé

Les antécédents de recherche démontrent que la technique qui consiste à préparer le client à la consultation améliore ses attitudes, son assiduité aux séances d'entrevue et les effets positifs de l'intervention. A l'occasion de cette étude, on a appliqué la technique auprès d'étudiants de niveau collégial (40 filles et 70 garçons) ne faisant partie d'aucune clientèle. Suite à cette intervention, on a noté, chez les sujets, une augmentation significative ($p < .0001$) de leurs connaissances telles qu'ils les évaluent, du caractère positif de leurs attitudes et de leur connaissance de la psychothérapie. La plupart de ces gains se maintiennent sur une période d'un mois. Les scores de connaissance s'avèrent plus bas ($p < .01$) chez les sujets de niveau socio-économique faible que moyen. Cependant aucune différence significative n'est décelée au post-test ni à la relance. Ces résultats suggèrent que la technique de préparation des clients s'applique aussi à des sujets ne faisant partie d'aucune clientèle et peut être particulièrement utile auprès de groupes de niveau socio-économique faible.

Counsellors and researchers have expressed concern about the public's misconceptions and lack of understanding of the counselling process (Heitler, 1976; Levitt, 1966; Lorion, 1974). A substantial proportion of beginning clients and potential clients do not understand the necessity for self-initiation and self-exploration in personal counselling. They expect to receive direct advice for their problems, and they underestimate the length of time required for change. The discrepancy between clients' expectations and the realities of psychotherapy is a cause for concern, since inaccurate expectations are related to poor attendance in treatment and poor treatment outcome (Levitt, 1966; Lorion, 1974).

One solution to this problem is to prepare clients prior to their first counselling session (Hoehn-Saric, Frank, Imber, Nash, Stone, & Battle, 1964; Orne & Wender, 1968). In this initial contact, the client can be given information about the course of counselling, including a description of appropriate client and cousel-

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lor behaviors. This preparation, which has been labelled role induction, appears to have a positive effect on therapeutic process and outcome. Prepared clients have indicated greater motivation (Strupp & Bloxom, 1973), have had better attendance records (Hoehn-Saric, *et al.*, 1964; Holmes & Urie, 1975; Warren & Rice, 1972), and have had higher ratings on some outcome measures (Hoehn-Saric, *et al.*, 1964; Sloane, Cristol, Pepernik, & Staples, 1970).

In spite of these positive effects of client preparation for beginning clients, most nonclients remain misinformed about psychotherapy. One means of solving this problem may be to adapt the client preparation technique to nonclient groups. In the present study the role induction technique was adapted for groups of college students. The immediate and long-term changes in students' attitudes and knowledge of therapy were tested following exposure to a procedure adapted from the role induction interview.

An additional focus of the present study was social class differences in knowledge and attitudes toward psychotherapy. Lower socioeconomic (SES) groups are generally considered to be the least informed about therapy (Heitler, 1976; Orne & Wender, 1968; Overall & Aronson, 1963; Strupp & Bloxom, 1973). However, Lorion (1974) reviewed the empirical evidence in this area and concluded that few actual social class differences in expectations have been demonstrated. Lower and middle SES subjects were included in the present study in order to test social class differences in initial attitudes and knowledge and to test social class differences in changes following exposure to role induction procedures.

Method of presentation was also a focus of this study. Several methods of presentation have been employed successfully, but no study has compared methods of presentation that contained the same information about psychotherapy. In the present study, two methods of presentation were compared; subjects were exposed to either visually (printed) or orally (taped) presented information.

Method

Subjects

The subjects were 120 undergraduate students at an American Midwestern University who participated for course credit. Complete sets of data, including follow-up information, were obtained from 40 females and 70 males.

Subjects were divided into lower and middle class groups on the basis of parents' occupations. Subjects were identified as lower SES when both parents worked in "blue collar" jobs (e.g., manual labor, factory work) or if only one parent was employed and that parent held a "blue collar" job. Subjects were identified as middle SES when at least one parent held a "white collar" job (e.g., managerial positions, sales).

Instruments

Twenty-five items were developed from existing measures of knowledge and attitudes toward psychotherapy. These items were chosen because they have successfully distinguished between subjects naive to psychotherapy and subjects having experience with or preparation for psychotherapy (Overall & Aronson, 1963; Strupp & Bloxom, 1973; Yalom, Houts, Newell, & Rand, 1967). Four measures were obtained from these questions: Self-evaluated knowledge of psychotherapy, attitudes toward psychotherapy, medical model expectations, and general knowledge of the psychotherapy process. Subjects responded to the first two measures on 4-point scales ("none" to "very much" and "very unlikely" to "very likely") and to the second two measures on 2-point scales ("agree"-"disagree"). The items for each measure appear in Table 1.

Table 1

Questionnaire Items

I. *Self-evaluated knowledge:*
At this time, how much do you feel you know about the process of psychotherapy?

II. *Attitudes toward psychotherapy:*
How many people who start psychotherapy do you think are helped by it?
In your own life right now, how much do you feel you would gain from psychotherapy?
How likely is it that you will seek psychotherapy at some time in your life?
How likely is it that you would recommend psychotherapy to a friend with problems?

III. *Medical model expectation:*
During therapy a psychotherapist will want to know about any physical illnesses or operations you have had.
During therapy a psychotherapist will want to give you a physical examination.
During therapy a psychotherapist will

want to give you medicine.
During therapy a psychotherapist will not be particularly interested in your aches and pains.

IV. *Psychotherapy knowledge.*
One of the main jobs of the psychotherapist is to recommend hobbies and other ways for clients to occupy their minds.
Hypnosis is often used by psychotherapists.
Therapists try to teach their clients to hold in (to not think about or express) their strong emotions.
During the course of psychotherapy, as you leave each therapy session you will feel better than you did before your session.
During therapy a psychotherapist will:
Tell you what is wrong with you.
Want to hear your opinions regarding your problems and treatment.
Avoid subjects which might upset you.
Want you to talk about your feelings toward the therapist.
Tell you what is causing your troubles.
Tell you ways to solve your problems.
Expect you to do most of the talking.
Want to talk about your personal life, even about embarrassing matters.
Give you definite rules to follow.
Want to hear about your fantasies or wishes.
Try to cheer you up.
Want to understand your deepest thoughts and feelings.

Procedure

Subjects were tested in one of 12 groups; the groups ranged in size from 2-17 subjects. The subjects first completed the 25 items and additional questions regarding their parents' occupations. They were then given information about the psychotherapy process by either a written script or an audio tape. The information included four components: (1) a general explanation of psychotherapy, (2) a description of appropriate client and counsellor behaviors, (3) a description of some of the typical obstacles that often accompany progress (e.g., resistance and negative transference), and (4) information about possible benefits derived from psychotherapy.

The taped information was approximately 15 minutes in length. The printed information was identical to the taped information and required approximately 15 minutes of reading. Immediately following exposure to the taped and printed material, subjects again responded to the 25 items. One month following the role induction session, subjects were sent a third copy of the questions by mail. 92% of the original sample returned usable questionnaires. At no time during the procedure were subjects given feedback regarding the accuracy or appropriateness of their answers.

Results

The relationship of social class, role induction method (script vs. tape), and time of testing to the four measures of attitudes and knowledge was tested in a set of 2 x 2 x 3 repeated measures analyses of variance. Mean scores for the four measures appear in Table 2.

Table 2
Mean Scores of Lower and Middle Class Subjects on Pre-, Post-, and Follow-up Tests of Psychotherapy Attitudes and Knowledge

	Lower Class			Middle Class		
	Pre-test	Post-test	Follow-up	Pre-test	Post-test	Follow-up
Self-evaluated knowledge	1.44	2.37	1.98	1.27	2.20	1.88
Attitudes toward psychotherapy	5.54	6.94	5.98	5.48	6.95	6.10
Medical model expectation[1]	1.90	3.47	3.46	1.73	3.56	3.39
Psychotherapy knowledge	10.44	14.14	13.54	11.30	14.02	12.22

[1]Lower scores indicate greater expectations for medical-type treatment.

The analyses revealed no significant effects for method of role induction; hence, data for the two methods are combined in the table.

Table 3
Summary Table of the Analysis of Variance of Self-Evaluated Knowledge Scores

Source	df	MS	F
Between subjects:			
SES level (A)	1	2.42	7.00*
RI method (B)	1	.89	2.56
A x B	1	.77	2.23
Subjects (within groups)	106	.35	
Within subjects:			
Time (C)	2	22.05	89.57**
A x C	2	.14	.58
B x C	2	.18	.74
A x B x C	2	.02	.09
C x Subjects (within groups)	212	.25	

*$p < .01$.

**$p < .0001$.

The analysis of self-ratings of psychoterapy knowledge revealed a main effect for time, $F(2,212) = 89.57$, $p < .0001$. At pretesting the average self-rating was between the scale points of "very little" and "some"; at posttesting it was between the points "some" and "very much"; at follow-up it was close to the point "some". Post hoc comparisons indicated that both posttest scores and follow-up scores were significantly higher than pretest scores ($p < .01$); hence, the role induction procedure produced a change in students' evaluations of their knowledge that was partially maintained for one month following the procedure. The analysis of self-evaluated knowledge scores also revealed that lower SES students gave themselves somewhat higher evaluations than did middle SES students at each time of testing, $F(1, 106) = 7.00$, $p < .01$. No other effects were significant.

In the case of attitude scores, a main effect was found for time, $F(2,212) = 40.21$, $p = .0001$; at pretesting the mean attitude rating was just inside the negative range of the scale; at posttesting the mean rating was in the positive range of the scale; at follow-up it was at the neutral point of the scale. Post hoc comparisons indicated that posttest and follow-up scores were both significantly higher than pretest scores ($p < .05$). Students were, then, somewhat more positive about the value of psychotherapy after the role induction procedure. No other effects were significant in the analyses of attitude scores.

Table 4

Summary Table of the Analysis of Variance of Attitudes Toward Psychotherapy Scores

Source	df	MS	F
Between subjects:			
SES level (A)	1	.02	0.00
RI method (B)	1	.02	0.00
A x B	1	8.90	1.04
Subjects (within groups)	106	8.59	
Within subjects:			
Time (C)	2	49.77	40.21*
A x C	2	.47	.38
B x C	2	.71	.57
A x B x C	2	.22	.18
C x Subjects (within groups)	212	1.24	

*$p < .0001$.

The one significant effect in the analysis of the medical model expectation scores was a significant main effect for time, $F(2,212) = 229.07$, $p < .0001$. Students were less likely to view psychotherapy as a medical intervention following the role induction procedure, and this change was maintained at follow-up. Also, students' general knowledge of psychotherapy improved from pretest to posttest, and most of this gain was maintained at follow-up, $F(2,212) = 113.46$, $p < .0001$. The subjects appear, therefore, to have become more knowledgeable about the counselling process.

Table 5

Summary Table of the Analysis of Variance of Medical Model Expectation Scores

Source	df	MS	F
Between subjects:			
SES level (A)	1	.39	.52
RI method (B)	1	.22	.30
A x B	1	.78	1.05
Subjects (within groups)	106	.74	
Within subjects:			
Time (C)	2	102.86	229.07*
A x C	2	.97	2.17
B x C	2	.88	1.95
A x B x C	2	.16	.35
C x Subjects (within groups)	212	.45	

*$p < .0001$.

The analysis of psychotherapy knowledge scores also revealed an interaction effect between time of testing and social class, $F(2,212) = 4.66$, $p < .02$. Post hoc comparisons indicated that lower class subjects had signi-

Table 6

Summary Table of the Analysis of Variance of Psychotherapy Knowledge Scores

Source	df	MS	F
Between subjects:			
SES level (A)	1	1.42	.28
RI method (B)	1	4.96	.98
A x B	1	.12	.02
Subjects (within groups)	106	5.04	
Within subjects:			
Time (C)	2	272.26	113.46**
A x C	2	11.18	4.66*
B x C	2	1.43	.60
A x B x C	2	.61	.25
C x Subjects (within groups)	212	2.40	

*$p < .02$.

**$p < .0001$.

ficantly lower scores than middle class subjects at pretesting ($p < .01$), but nonsignificantly higher scores at posttesting and follow-up. This pattern reflects a greater increase in scores among lower class subjects.

Discussion

The main purpose of the present study was to explore the utility of the client preparation technique for educating nonclient groups about psychotherapy. The results of this study indicate that psychotherapy information did tend to have a positive effect on the knowledge and attitudes of lower and middle class college students.

Perhaps the most important of the changes tested was subjects' attitudes toward psychotherapy, since this measure is closely associated with subjects' willingness to approach psychotherapy. Although the change in attitudes from pretesting to follow-up was statistically significant, this effect represented only a slight shift in attitude from a tendency toward negative views to a tendency toward neutral views. Attitudes at posttesting were more encouraging, however, being in the positive range of the scale.

It may be that these more positive attitudes could have been maintained or even improved had subjects received additional presentations of psychotherapy information in later sessions. The problem of maintaining gains from role induction procedures has not been considered previously, as past studies have focused on clients about to enter psychotherapy. Further studies are necessary to determine the value of single and multiple sessions in improving the attitudes of nonclient groups toward psychotherapy.

In the present study, the two methods of presentation selected, audio tape and printed material, appeared to be equally effective in producing changes in sujects' attitudes and knowledge. It is possible that the two methods actually did produce differential effects that were not detected by the brief measures employed in this study. It seems more likely, however, that the two methods were equally effective, since each method included precisely the same information and neither involved direct interpersonal interaction. These methods of presentation were selected for the study because they are inexpensive and can be adapted to almost any setting. Other methods, such as personal interviews or videotape, may be more effective, although no study has adequately tested these comparisons. Further exploration of the differential effects of methods of presentation are warranted.

Two social class differences were evident among our subjects at pretesting. Lower class students gave themselves higher self-ratings of knowledge, yet scored lower on the objective measure of knowledge. Lower class students knew less, but believed they knew more. For these lower class students, expectations for psychotherapy and the experience of psychotherapy are particularly likely to be discrepant. These results are consistent with previous theory and research (e.g., Heitler, 1976; Orne & Wender, 1968) that indicate lower class subjects to be more naive about psychotherapy and more likely to be disappointed in their first therapy contacts.

The fact that lower class students increased their knowledge by posttesting to a level slightly above that of middle class subjects indicates that this role induction procedure was especially effective with the students who were defined as lower class. However, the lower class group in this study was made up of college students from an upper-lower and lower-middle class background. Further research is needed to determine whether the approaches used in this study would be effective for potential clients in the lower-lower class and for those in other classes who are educationally disadvantaged.

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