The Effects of Disclosure of Comprehensive Pretherapy Information on Clients' Behaviors and Perceptions of Therapists and the Therapy Process

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THE EFFECTS OF DISCLOSURE OF COMPREHENSIVE PRETHERAPY INFORMATION ON CLIENTS' BEHAVIORS AND PERCEPTIONS OF THERAPISTS AND THE THERAPY PROCESS

by

Patricia J. Dauser

A Dissertation
Submitted to the
Faculty of The Graduate College
in partial fulfillment of the
requirements for the
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and Counseling Psychology

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THE EFFECTS OF DISCLOSURE OF COMPREHENSIVE PRETHERAPY INFORMATION ON CLIENTS' BEHAVIORS AND PERCEPTIONS OF THERAPISTS AND THE THERAPY PROCESS

Patricia J. Dauser, Ed.D.
Western Michigan University, 1993

An experimental study of the effects of comprehensive versus partial pretherapy disclosure was conducted. Sixty-three clients in a university counseling center participated. The control and treatment groups received information on four pretherapy issues. Those issues were services provided, confidentiality, length of sessions, and right to terminate therapy. The treatment group received additional information which included personalized data regarding therapists, what to expect in therapy, and risks and alternatives to therapy. The study examined the effects of the comprehensive information received by the treatment group versus the partial information received by the control group on (a) perceptions of therapists, (b) opinions and attitudes toward therapy, and (c) actual client behaviors. No statistically significant differences between groups were found in perceptions of therapists; however, females rated their therapists more positively overall on the Counselor Rating Form-Short (Corrigan & Schmidt, 1983) than did males. There was no statistically significant difference in the proportion of treatment versus control participants in requests for a change in therapist, attendance at the first session, client-initiated terminations, wish to participate in counseling, or knowing what to expect in therapy. A significantly
greater proportion of treatment than control group participants found the mailing most helpful, as compared to information received at intake. The mailing contained the personalized disclosure information for the treatment group. A significantly greater proportion of treatment than control participants stated they understood what counseling would be like. Based on the results of the present and prior studies, it seems possible to disclose comprehensive pretherapy information to potential clients without producing a negative impact on the client or the therapy relationship.
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The effects of disclosure of comprehensive pretherapy information on clients' behaviors and perceptions of therapists and the therapy process

Dauser, Patricia J., Ed.D.
Western Michigan University, 1993

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Patricia J. Dauser
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CHAPTER I

OVERVIEW/INTRODUCTION

Overview of the Dissertation

The writing of this dissertation is completed in five chapters. Each chapter begins with an overview section, explaining the contents within. Detailed below is an overview of the dissertation document, explaining the purpose and content of each chapter.

Chapter I presents in capsulated form the entire research project. Following the overview section, Chapter I is meant to "stand alone," allowing the reader to gain an abbreviated understanding of all aspects of the research. The stand-alone portion begins with the second section, background information on pretherapy disclosure. The background section includes reviews of the theoretical and research literature on disclosure of therapy information, the purposes of the present study, research questions, and a statement of the primary research hypothesis. The third section is an account of the methodology utilized in this study. A description of the selection of participants, procedures, preparation of disclosure documents, instrumentation, and data collection are presented. The fourth section describes the results of the primary research investigation. The fifth section provides a discussion of the research results, limitations of the study, and recommendations for future research.
Chapters II, III, IV, and V provide extensive detailed information, expanding upon the material presented in capsulated form in Chapter I.

Chapter II contains the review of the literature to familiarize the reader with relevant theoretical and research issues related to disclosure of therapy information. The literature review concludes with a rationale for the present study.

Chapter III describes the research methodology in great detail so that the process can be understood and replicated if desired.

Chapter IV presents all the results of this research study, including tables when appropriate.

Chapter V contains a discussion of the results, limitations of the study, and suggestions for future research.

Background of the Research Issue

The background section is composed of four parts. The first part summarizes the review of the literature on disclosure of therapy information. Included in the literature review are summaries of theoretical articles, recent surveys of practitioners, and research findings investigating the effects of therapy disclosure. The second part of this section outlines the purposes of the present study. The research questions are stated in the third part, with an emphasis on the primary research question. This section concludes with a statement of the overall research hypothesis.
Review of the Literature

In recent years, there has been a growing emphasis in the field of psychotherapy regarding client rights, particularly the importance of providing information to clients about therapy (Corey, Corey, & Callanan, 1988; Handelsman & Galvin, 1988; Jordan & Meara, 1990; Sullivan, Martin, & Handelsman, 1993). There is general agreement that clients should be given information about the therapy process, so they can be knowledgeable participants (Talbert & Pipes, 1988). A review of the literature identifies 12 such types of therapy information (Hedstrom & Ruckel, 1992). They are (1) therapy process or techniques, (2) services provided and/or type of clients served, (3) expectations and/or anticipated results, (4) possible risks, (5) alternatives to therapy, (6) qualifications of therapist, (7) rights and limits of confidentiality (including third party issues), (8) length and frequency of sessions, (9) right to terminate treatment (or description of rights if involuntary), (10) cost and method of payment, (11) identification of supervisor, and (12) identification of board of licensing. Most recently, the emphasis has been on providing these data to clients before they agree to participate in treatment (American Association for Counseling and Development [AACD], 1988; VanHoose & Kottler, 1985). By receiving pretherapy information, clients can make a more knowledgeable decision about entering therapy and choosing a particular therapist. Another emphasis is on providing the information in writing, rather than just orally (Everstine et al., 1980; Handelsman & Galvin, 1988). Written documents provide documentation that information has been shared and they can be saved by clients.
for future reference.

Despite recommendations made by theorists, recent surveys of practicing therapists furnished evidence that practitioners mainly provide therapy information orally, rather than in written format (Handelsman, Kemper, Kesson-Craig, McLain, & Johnsrud, 1986; Talbert & Pipes, 1988). Other survey research demonstrated that practitioners also prefer to share information during the first session, rather than prior to therapy (Hedstrom & Ruckel, 1992; Somberg, Stone, & Claiborn, 1993). An explanation for the reluctance to provide written pretherapy disclosure is that practitioners may fear that written measures will have a negative impact. Opponents of written disclosure claim that this procedure may interfere with the therapy process (Jordan & Meara, 1990), give the impression that new clients are not wanted (Hare-Mustin, Marecek, Kaplan, & Liss-Levinson, 1979), or create a negative impression of the therapist (Handelsman et al., 1986; Somberg et al., 1993). Winborn (1977) stated that written disclosure may remove some of the mystery of the therapy process, and as a result, lower the placebo effect on treatment outcome.

Several research studies on the impact of written therapy disclosure have been conducted. Most of these studies investigated only one specific aspect of information sharing, such as confidentiality (Muehleman, Pickens, & Robinson, 1985; Woods & McNamara, 1980), therapy procedures (Mardirosian, McGuire, Abbott, & Blau, 1990; Nathan, Joanning, Duckro, & Beal, 1978), and therapist values (Epperson & Lewis, 1987; Keating & Fretz, 1990; Lewis, Davis, & Lesmeister, 1983; Lewis, Epperson, & Foley, 1989; Lewis & Lewis,
A fewer number of studies investigating the effect of disclosing multiple (more than one) therapy issues have been conducted. Handelsman (1990) found that written disclosure procedures increased participants' ratings of the therapist qualities of likability, experience, and trustworthiness. Sullivan et al., (1993) found that therapists using combined written and oral disclosure methods were rated more positively on the Counselor Rating Form-Short (CRF-S) than those who used no disclosure methods. The CRF-S (Corrigan & Schmidt, 1983) measures perceptions of the therapist qualities of expertness, attractiveness, and trustworthiness. Additionally, participants in the Sullivan et al. (1993) study were more willing to recommend a therapist to a friend or say they would see the therapist themselves if that therapist used a consent procedure. Several studies demonstrated no significant effects of providing therapy information. In those studies, disclosure had no effect on counseling expectations (Studwell, 1984), willingness to see a counselor (Farley, 1987), or attitude toward counseling or perception of the therapist (Christiansen, 1986; Handelsman & Martin, in press). Participants recalled more information when documents were written at a lower readability level (Handelsman & Martin, in press). Only one study demonstrated a negative effect of disclosure of multiple therapy issues. Men who received a less readable document (combined sentences, single spaced, written at a 10th grade level) were less likely to recommend a therapist to a friend or say they would see the therapist themselves in comparison to those who received no form at all (Handelsman & Martin, in press). In summary, the majority of research
studies investigating the effects of disclosure of multiple therapy issues measured the impact on perception of the therapist, willingness to recommend a therapist to a friend or say they would see the therapist themselves, and attitudes toward counseling. The majority of the research demonstrated no negative outcomes on the measures employed.

**Purposes of the Current Study**

There were three purposes of the current study. The primary purpose was to enhance prior research by addressing several limitations of prior studies. A second purpose was to replicate aspects of prior research to facilitate comparisons of results. The final purpose was to study an area not previously researched; input from participants to improve the content of disclosure statements. Presented next is a discussion of each of these purposes.

**Improvements Over Prior Research**

The primary purpose of this study was to improve upon prior research by dealing with earlier limitations. One limitation of prior studies was their lack of comprehensiveness, in terms of both the number and content of disclosure issues shared with participants. As stated previously, a recent review of the literature identified 12 therapy issues that theorists have recommended for disclosure to clients (Hedstrom & Ruckel, 1992). Most studies that examined the effect of therapy disclosure investigated only one specific topic, such as the disclosure of therapist values. Even some studies involving the disclosure of multiple (more than one) therapy issues shared only a limited number of topics.
with participants (Christiansen, 1986; Farley, 1987). No prior studies were comprehensive in terms of the content of the material that was disclosed. The main perspective on informed consent in the theoretical literature is that disclosure should provide honest specific personalized information to clients so they can make a choice about participating (Haas, 1991). Personalized information means specific data about the particular therapist (e.g., degree, experience) and his or her distinctive beliefs and practices. Studies investigating the disclosure of multiple therapy issues did not provide personalized information. Instead, participants were given generic therapist statements meant to apply to all therapists (Farley, 1987; Studwell, 1984) or provided with a list of therapy issues about which they had "the right to know" (Handelsman, 1990; Handelsman & Martin, in press; Sullivan et al., 1993). In the latter studies, participants received a list of questions they could ask their therapist (e.g., How does your kind of therapy work?) rather than a description of personalized procedures. In the current study, comprehensive disclosure information, in terms of both number and content of items, was provided to clients. All 12 informational items (Hedstrom & Ruckel, 1992) were shared with treatment group participants and disclosure statements were specific and personalized, written by the therapists to whom clients were assigned. The control group in the current study received general information regarding agency services and procedures.

A second limitation of prior research was that the majority of studies on multiple disclosure were conducted by analogue design using nonclient populations (Farley, 1987; Handelsman, 1990; Handelsman &
A field study is needed to increase the relevance of findings to actual practice settings. A field study could also add another dimension to previous research by measuring effects on actual client behaviors. Prior analogue designs measured attitudes and opinions about whether participants might be willing to see a particular therapist. Relying solely on self-report provides a narrow view and may contain considerable error (Heppner & Claiborn, 1989). Recording of client behaviors would provide data on whether attitudes and opinions lead to behavioral change. The current study utilized an actual client population. Because this was a field study, the effects of pretherapy disclosure on actual client behaviors could be assessed. The behaviors measured were client requests for a change in therapist, attendance at the first therapy session, and client-initiated termination of therapy.

A third limitation of prior research was the timing of the administration of the dependent variable. Many studies of multiple disclosure (Christiansen, 1986; Studwell, 1984; Sullivan et al., 1993), measured the effects after the client had read a therapy transcript or actually met the therapist, thus exposing the client to therapist verbal and/or nonverbal behaviors. In a review of studies on social influence (Heppner & Claiborn, 1989), counselor responsive nonverbal behavior, status cues, and verbal behaviors had significant positive or negative effects on perceptions of therapists. The methodology of prior studies may, therefore, have confounded the results (Handelsman, 1992). To control for this intervening variable, studies should measure perceptions of therapists before actual contact. Since therapist contact could possibly
influence participants' opinions, attitudes, and behaviors as well, measurement of those dependent variables should also occur prior to the first session. In this study, the Pretherapy Questionnaire (which measured perceptions of therapists and opinions and attitudes toward therapy) was administered before participants had contact with their therapists. The measurement of requests for a change of therapist and attendance at the first session also took place before therapist contact. Data on client-initiated termination was collected after the first session to allow a longer-term outcome measure.

A fourth limitation of prior research was the timing of therapy disclosure itself. Several prior studies of multiple disclosure provided information to participants during the first session, rather than prior to therapy (Christiansen, 1986; Handelsman & Martin, in press; Sullivan et al., 1993). Recent trends in the theoretical literature advocate pretherapy disclosure as an ethically responsible procedure. By receiving information before a relationship with a therapist begins, the client makes a knowledgeable decision to participate in treatment, thereby upholding the true meaning of informed consent (Bray, Shepherd, & Hay, 1985; VanHoose & Kottler, 1985). Research investigating the effects of pretherapy disclosure is needed to address practitioners' concerns that such procedures might produce a negative effect on treatment (Somberg et al., 1993). Disclosure of therapy information in the current study was completed before the first therapy session.
Replication of Prior Research

A second purpose of the current study was to replicate aspects of prior research so that results could more readily be compared. Replication occurred by utilizing the same dependent and independent variables that were included in prior studies of multiple disclosure. Thus, the CRF-S (Corrigan & Schmidt, 1983) was a dependent variable in this study. Three independent variables that were found in past research to have interactive effects with disclosure were also included in this study. Those were client gender (Handelsman & Martin, in press), therapist experience (Handelsman, 1990, Sullivan et al., 1993), and readability of written documents (Handelsman & Martin, in press). Client gender and therapist experience were independent variables investigated in this study. The importance of readability was acknowledged by using procedures to improve the readability level of written documents.

New Research Area

The third purpose of this study was to include a component not previously studied. The content of disclosure statements in present and prior studies and theoretical articles was determined by theorists and practitioners. Potential clients have not been asked to identify the types of disclosure information they would like to receive. In this study, participants' opinions were obtained to gather information to improve future disclosure statements. Participants were asked which pretherapy information was most helpful, how it helped, and what additional information was needed.
Research Questions

The major research question was: What are the effects of comprehensive versus partial disclosure of pretherapy information on (a) perceptions of therapists, (b) opinions and attitudes toward therapy, and (c) actual client behaviors? The methodology and results of the major research question are presented in the remainder of Chapter I. Two other research questions were developed in this study. They were: What are the effects of therapist experience on client perceptions of the therapist when pretherapy information is given? and How can disclosure documents be improved? Details on the methodology and results of these secondary questions are presented in Chapters III, IV, and V.

Research Hypothesis

The overall research hypothesis was that a pretherapy disclosure statement would have no effect on clients' perceptions of therapists and the therapy process or on client behaviors as measured in this study.

Methodology

In this section, a description of the research setting is provided first. Next, information about the selection of participants and a description of the research sample are provided. The third part presents the research procedures. Part 4 explains the preparation of two documents needed for the study: the treatment and control group disclosure statements. Part 5 provides information on the research measures. Finally, a description of the data collection procedures is provided.
Research Setting

This study was conducted in the Counseling and Student Development Center (CSDC) at Northern Illinois University (NIU), DeKalb, during the 1992-93 school year. CSDC is the only mental health service agency on a campus of 25,000 students. The agency serves the entire university community through assessment, treatment, consultation, outreach, and referral services. The majority of clients (all of whom are students) are 18 to 30 years old, two-thirds female, and about 14% ethnic minorities (Hotelling, 1993).

Selection of Participants

Participants for this study were selected from students who requested and were assigned to personal therapy at CSDC. Stringent participant selection procedures were utilized in this study and are described next. A signed consent form to participate in a research study (see Consent to Participate in Research Study, Appendix A) was required. Of 617 students requesting personal therapy at CSDC, the form was offered to 448 students. (Students who identified themselves as "in crisis" were not asked to take part.) A total of 403 persons (90%) volunteered to participate. After volunteering, potential participants had an intake appointment. Following intake, 249 persons were deemed ineligible for inclusion in this study because they were assigned to group or career counseling (15%) or were not assigned at all (46%). Reasons for nonassignment were that their issues were resolved, they were referred elsewhere, or were placed on a waiting list.
Of the 154 research volunteers assigned to individual therapy, several additional exclusions were made. Three clients under age 18 were eliminated. To control for the possible effect of prior knowledge of the therapist, 70 clients who met with their assigned therapist for intake or prior therapy were excluded. To assure objectivity, 18 students assigned to the researcher were eliminated. Therefore, 63 (41%) of the 154 research volunteers assigned to individual therapy made up the sample. The participants in this study were 21 male and 42 female students. Their ages ranged from 18 to 41 years old, with a mean age of 22.

Procedures

The customary procedure at CSDC was to schedule an intake session for students who requested personal therapy. Prior to the session, students were asked to fill out several forms and read information about CSDC (see CSDC Intake Materials, Appendix B). Written information given to students before intake included (a) services provided and/or type of clients, (b) rights and limits of confidentiality, (c) length and frequency of sessions, and (d) right to terminate treatment. All students, therefore, received data on 4 of 12 possible disclosure issues (Hedstrom & Ruckel, 1992). Following the intake session, students assigned to individual personal therapy were notified by mail or telephone of the CSDC policy on missed appointments, name of their therapist, and appointment date and time.

During the 1992-93 school year when this study was conducted, a consent form to participate in a research study (see Consent to
Participate in Research, Appendix A) was included in the packet of materials given to students before intake. Following intake, students who volunteered for the study and met the selection procedures described above were randomly placed in a control or treatment situation (see Random Assignment Form, Appendix C). The control group followed the usual procedure at the center, except appointment notification was always received through the mail, not by telephone (see Control Group Statement, Appendix D). The treatment group also followed the usual CSDC procedure except they received additional pretherapy information in the mail along with the appointment notification. The treatment group information described their particular therapist and his or her therapy process (see Sample Treatment Statement, Appendix E). Information provided by mail to the treatment group included (a) therapist experience, (b) typical procedures used by their therapist, (c) expectations and/or anticipated results, (d) risks, (e) alternatives to therapy, (f) fees, (g) identification of the therapist's supervisor if applicable, and (h) the name and telephone number of the licensing board that governs the therapy practice. The control and treatment groups, therefore, received four pieces of pretherapy information in the CSDC packet before intake, as do all clients in the center. Both groups were notified by mail of the CSDC policy on missed appointments, name of therapist, and appointment date and time. The treatment group, however, received additional data on eight more disclosure issues in the appointment mailing. Thus, the treatment group was informed of all 12 issues of pretherapy disclosure (Hedstrom & Ruckel, 1992), while the control group received information on only four. Due to ethical considerations, it was deemed
inappropriate to have a control group that received no pretherapy information.

Participants were given the Pretherapy Questionnaire (see Appendix F) to complete when they arrived for their first therapy session, but before they met with their therapist. The Pretherapy Questionnaire consisted of the CRF-S, four multiple choice questions of opinions and attitudes toward therapy, and three open-ended questions about improving disclosure documents. Demographic information was also collected on the form.

**Preparation of Treatment and Control Statements**

The control group statement was written by the researcher and contained a standardized statement of appointment notification. The control group statement (Appendix D) consisted of information regarding the name of the assigned therapist, date of appointment, and CSDC procedure for missed appointments.

The treatment group statement consisted of the appointment notification data (i.e., the control group statement) plus personalized information about the therapist and therapy process. Seventeen treatment group disclosure statements were developed, one for each of the therapists who volunteered to participate in this study. Each disclosure statement consisted of personalized data written by the therapist and standardized data written by the researcher. Therapists wrote information describing their education, experience, therapy methods or techniques, areas of specialization, and whether they were supervised and/or licensed. (See Sample Therapist Statement, Appendix G.) The
researcher developed standardized statements describing expectations or anticipated results of therapy, possible risks and alternatives to therapy, and cost. The above information was combined (see Sample Treatment Statement, Appendix E) and included eight issues of pretherapy data (Hedstrom & Ruckel, 1992).

The readability level of the documents were controlled in this study. The researcher altered documents by shortening sentences, using words containing fewer syllables, and avoiding technical jargon. The readability of the final treatment group statements were Grades 8-9 and the control group statement was Grade 8. Readability levels were calculated by the Grammatik Max computer software program (Reference Software, 1990). CSDC therapists approved the final documents for inclusion in the study.

The intake therapists and assigned therapists in this study were unaware of which of their clients were participants in this study. They were also "blind" to the control versus treatment group assignment of participants.

Measures

Responses were collected from participants on seven measures. Four of the measures were contained in the research instrument, the Pretherapy Questionnaire (see Appendix F). Those four measures were the CRF-S (Corrigan & Schmidt, 1983), multiple choice questions regarding opinions and effects of written disclosure, open-ended questions of the helpfulness of such disclosure, and demographic questions about the respondent. The other three measures were behavioral responses:
requests for a change in therapist, attendance at the first session, and client-initiated termination. Details on each of the measures are provided next.

**CRF-S**

The CRF-S consists of 12 Likert scales which measure the counselor influence dimensions of expertness, attractiveness, and trustworthiness. It was developed to correct weaknesses in the original Counselor Rating Form (Barak & LaCrosse, 1975). The CRF has been found to assess between- and within-counselor differences and to be predictive of counseling outcome (Heppner & Claiborn, 1989). The shortened CRF-S version is considered comparable to the CRF. Validation studies of the CRF-S indicated reliability coefficients which ranged from .82 to .94 with a median of .87 (Corrigan & Schmidt, 1983) and .63 to .89 with a median of .82 (Epperson & Pecnik, 1985). Confirmatory factor analyses supported the validity of the scale by demonstrating that a theoretically interpretable three-factor oblique model best fit the data produced by the CRF-S (Grimes & Murdock, 1989). Most recently, researchers recommended the CRF-S total score be interpreted in addition to the three separate counselor attributes (Heppner & Claiborn, 1989; Tracey, Glidden, & Kokotovic, 1988). In validating the CRF-S, both nonclient and client populations were asked to rate three therapists they viewed giving treatment to the same client. This methodology provided external validity of the scale and increased the generalizability of results to a client population (Corrigan & Schmidt, 1983). The CRF-S was chosen for this study because of its validity and reliability, its
extensive use as a research instrument (Heppner & Claiborn, 1989), and its ability to facilitate direct comparison with prior studies of multiple disclosure which used this instrument.

**Impact of Therapist Disclosure**

The Pretherapy Questionnaire (see Appendix F) contained four multiple-choice questions designed to measure the impact of therapist disclosure upon clients. Participants were asked the following questions:

1. Which written information did you find most helpful? Information from first session (intake), mailing, or not sure.
2. From the written material you received, do you believe you have a good idea of what to expect in counseling? No, yes, or somewhat.
3. Did the information you read have an influence on your wish to participate in counseling? No or yes. If yes, type of influence: positive or negative.
4. Did the information you read help you better understand what counseling will be like? No, yes, or not sure.

**Suggestions for Improving Disclosure Statements**

Three open-ended questions were also asked. They were:

1. Which information was most helpful in understanding the counseling process?
2. In what way was the information helpful?
3. Is there other information that would have been helpful for you to receive about your counselor or the counseling process? Please
describe.

These questions were developed to gain information from clients on how to improve disclosure documents.

**Client Descriptive Information**

The Pretherapy Questionnaire collected the following descriptive information: gender, age, and name of assigned therapist. Client gender was an independent variable investigated in this study. Data on age were utilized to describe the sample. Therapist name data were collected to determine the experience level of the assigned therapist, an independent variable used in analyzing treatment group results.

A question on the Pretherapy Questionnaire was whether participants had prior knowledge about their therapist, in addition to that provided by CSDC. This question was asked to help isolate the effect of disclosure by assuring that participants had no previous contact with their therapist. Participants who reported on this form that they had seen their therapist for intake or prior therapy were eliminated from the study.

Finally, the Pretherapy Questionnaire itself was color-coded to identify control and treatment group participants, the main independent variable in the study.

**Request for a Change in Therapist**

Data were collected on the number of control and treatment group participants who requested a change in therapist after receiving pretherapy disclosure but before attending their first therapy session. This
outcome measure was chosen to investigate empirically the belief reported by practitioners that pretherapy disclosure will create a negative impression of the therapist (Handelsman et al., 1986; Somberg et al., 1993).

**Attendance at the First Session**

Data were collected on the number of control and treatment group participants who attended their first session after receiving pretherapy information. This outcome measure was selected to improve upon prior analogue studies that measured whether potential clients might refer a friend to a hypothetical therapist or say they would see that therapist themselves.

**Client-Initiated Terminations**

The final behavioral measure was the number of control and treatment group participants who initiated termination of treatment, as opposed to those who had therapist initiated, mutual, or other reasons for termination. This assessment was selected to provide a longer term outcome measure of the effect of pretherapy disclosure on the therapy process.

**Data Collection Procedures**

Data were collected at three points in the process of participants receiving services at CSDC. First, information regarding requests for a change of therapist was recorded after participants received pretherapy data, but before their first therapy appointment. Any client at CSDC
requesting a different therapist was asked to speak with the clinical coordinator. The coordinator filled out the Request for a Change in Counselor form (see Appendix H). The reason for the request and whether or not pretherapy information was the basis for the request were documented.

The second data collection point occurred at the time of the first therapy appointment. Data were collected on the number of treatment and control participants who appeared for their first session, after receiving pretherapy information. Data on this outcome measure were obtained from the Closing Report (see Appendix I) that was filled out by therapists when treatment was terminated. The Pretherapy Questionnaire (see Appendix F) was administered to all participants who appeared for their first session. This instrument was completed by participants before they met with their assigned therapist. This methodology was utilized to improve upon prior studies by isolating the effects of written disclosure and avoiding the confounding effects of actual therapist verbal and nonverbal behavior.

The final data collection point occurred when therapy ended. Data were tabulated from the Closing Report (see Appendix I) on the number of control and treatment group participants who initiated termination of treatment.

Results

The results of the main area of investigation are described under three separate headings. They are: the differential effects of comprehensive versus partial pretherapy disclosure on (1) perceptions of
therapists, (2) opinions and attitudes toward therapy, and (3) client behaviors. Two other research areas were investigated. They were the effects of therapist experience on perception of therapists and participants' suggestions for improving disclosure documents. The results of the secondary investigations are presented in Chapter IV.

**Perceptions of Therapists**

Data on perceptions of therapists were obtained from the Counselor Rating Form-Short (CRF-S), which was included in the Pretherapy Questionnaire (see Appendix F). This instrument was administered to participants after they received disclosure information, but before they met their therapist. Of the total sample of 63 research participants, 57 completed the Pretherapy Questionnaire. (Two participants did not appear for their first session. Pretherapy Questionnaires were mistakenly not given to four research participants, due to secretarial error.) Data from four participants were eliminated because those individuals indicated on the Pretherapy Questionnaire that they had prior knowledge of their therapist, a factor that might contaminate the research findings. Data from a fifth participant were eliminated because the CRF-S was not filled out completely. Therefore, the sample size was 26 treatment and 26 control group participants. The independent variables in this analysis were control versus treatment group and client gender (male versus female). The dependent variables were scores obtained on the CRF-S. A multivariate analysis of variance (MANOVA) was performed on the subscale scores of the CRF-S. Table 1 displays the means and standard deviations of the subscale scores on the CRF-S by treatment and gender.
### Table 1
Cell Means and Standard Deviations of CRF-S Subscale Scores by Treatment and Gender Conditions

<table>
<thead>
<tr>
<th>Subscale</th>
<th>Group</th>
<th>n</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attractiveness</td>
<td>Treatment</td>
<td>26</td>
<td>21.9</td>
<td>3.3</td>
</tr>
<tr>
<td></td>
<td>Control</td>
<td>26</td>
<td>23.1</td>
<td>4.2</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>13</td>
<td>21.3</td>
<td>4.1</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>39</td>
<td>22.9</td>
<td>3.7</td>
</tr>
<tr>
<td>Expertness</td>
<td>Treatment</td>
<td>26</td>
<td>23.5</td>
<td>3.2</td>
</tr>
<tr>
<td></td>
<td>Control</td>
<td>26</td>
<td>23.2</td>
<td>3.8</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>13</td>
<td>21.1</td>
<td>4.0</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>39</td>
<td>24.1</td>
<td>3.1</td>
</tr>
<tr>
<td>Trustworthiness</td>
<td>Treatment</td>
<td>26</td>
<td>23.0</td>
<td>3.5</td>
</tr>
<tr>
<td></td>
<td>Control</td>
<td>26</td>
<td>24.2</td>
<td>3.3</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>13</td>
<td>22.2</td>
<td>3.5</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>39</td>
<td>24.0</td>
<td>3.3</td>
</tr>
</tbody>
</table>

groups. The Statistical Package for Social Sciences (SPSS) multivariate test of significance (Norusis, 1990) was used to calculate the results. No statistically significant treatment effects ($F[3, 43] = .65, p = .59$), gender effects ($F[3, 43] = 2.10, p = .11$), or treatment by gender effects ($F[3, 46] = .05, p = .98$) were obtained. The null hypothesis of no difference between the means of treatment, control, client gender groups, or their interactions on the subscale scores of the CRF-S was
accepted, as predicted. An analysis of variance (ANOVA) was performed on the total scores of the CRF-S. The SPSS univariate F test was utilized (Norusis, 1990). Table 2 displays the means and standard deviations of the total scores on the CRF-S by treatment and gender groups. A main effect of gender was obtained, $F(1, 48) = 4.8$, $p = .03$. Females ($M = 71.0$) rated counselors significantly more positively overall than did males ($M = 64.6$). There were no significant treatment effects ($F[1, 48] = .87$, $p = .36$) or interaction of treatment by gender effects ($F[1, 48] = .07$, $p = .79$) on the total CRF-S scores, as predicted.

<table>
<thead>
<tr>
<th>Group</th>
<th>n</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment</td>
<td>26</td>
<td>68.35</td>
<td>8.75</td>
</tr>
<tr>
<td>Control</td>
<td>26</td>
<td>70.50</td>
<td>10.33</td>
</tr>
<tr>
<td>Male</td>
<td>13</td>
<td>64.61</td>
<td>10.61</td>
</tr>
<tr>
<td>Female</td>
<td>39</td>
<td>71.03</td>
<td>8.72</td>
</tr>
</tbody>
</table>

**Opinions and Attitudes Toward Therapy**

Data on client opinions and attitudes toward therapy were obtained from multiple choice questions on the Pretherapy Questionnaire (see Appendix F). Response frequencies to the multiple choice questions are presented in Table 3. Chi-square analyses of results were computed.
Table 3
Response Frequencies to Multiple Choice Questions on the Pretherapy Questionnaire

<table>
<thead>
<tr>
<th>Multiple choice questions</th>
<th>Treatment</th>
<th></th>
<th>Control</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Most helpful information</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intake</td>
<td>9</td>
<td>35</td>
<td>18</td>
<td>69</td>
</tr>
<tr>
<td>Mailing</td>
<td>12</td>
<td>46</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>Not sure</td>
<td>5</td>
<td>19</td>
<td>5</td>
<td>19</td>
</tr>
<tr>
<td>Good idea of what to expect</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No/somewhat</td>
<td>12</td>
<td>46</td>
<td>14</td>
<td>54</td>
</tr>
<tr>
<td>Yes</td>
<td>14</td>
<td>54</td>
<td>12</td>
<td>46</td>
</tr>
<tr>
<td>Influence on wish to participate</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>14</td>
<td>56</td>
<td>14</td>
<td>54</td>
</tr>
<tr>
<td>Yes</td>
<td>11</td>
<td>44</td>
<td>12</td>
<td>46</td>
</tr>
<tr>
<td>Understand what counseling will be like</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No/not sure</td>
<td>6</td>
<td>24</td>
<td>19</td>
<td>73</td>
</tr>
<tr>
<td>Yes</td>
<td>19</td>
<td>76</td>
<td>7</td>
<td>27</td>
</tr>
</tbody>
</table>

The SPSS statistical program was used with the crosstabs procedure (Norusis, 1990). There were no significant differences in the proportion of treatment versus control group participants in believing that they had a good idea of what to expect in counseling ($\chi^2[2, N = 52] = 1.51$, reproduced with permission of the copyright owner. Further reproduction prohibited without permission.
p > .05) or in wishing to participate in counseling ($\chi^2(1, N = 51) = .02, p = .88$). There was a significant difference ($p = .015$) in the proportion of treatment versus control group in which type of information they found most helpful, $\chi^2(2, N = 52) = 8.4, p = .01$. A higher percentage of the treatment group found the mailing most helpful. A significant difference was also found in the proportion of treatment versus control group in understanding of what counseling would be like, $\chi^2(1, N = 51) = 12.28, p < .001$. A higher percentage of treatment group participants felt they understood what counseling would be like.

**Actual Client Behaviors**

Data on three client behaviors were collected. Chi-square analyses were computed by hand and tables of critical values were used to determine significance (Hopkins, Glass, & Hopkins, 1987).

On the first behavioral measure, requests for a change in therapist, there was no absolute difference between groups. In this study, no treatment or control group participants requested a change in therapist.

Measurement of the second behavior, attendance at the first session, yielded frequencies of two treatment group and zero control group participants who "no-showed" for the first appointment. A chi-square analysis indicated no statistically significant difference in the proportion of treatment versus control group in attendance at the first session, $\chi^2(1, N = 63) = 2.06, p = .25$.

The third behavioral measure was client-initiated terminations. Frequencies of control and treatment group participants were similar.
The chi-square analysis found no statistically significant difference in the proportion of treatment versus control group in client-initiated terminations, $\chi^2(1, N = 61) = .50, p = .50$.

Discussion

In this section, a discussion of the research results pertaining to the main area of investigation is presented first. Next, limitations of the study are described, followed by suggestions for future research.

Research Results

The research results are discussed in terms of two independent variables investigated in this study, comprehensive versus partial pretherapy disclosure and client gender. The discussion of the results of a third independent variable, therapist experience, is presented in Chapter V. The discussion of the results of open-ended questions to elicit participant suggestions for improving disclosure statements is also addressed in Chapter V.

Comprehensive Versus Partial Pretherapy Disclosure

The overall research hypothesis in this study was that no differential effects would be found between participants who were provided comprehensive data and those who received only partial pretherapy information. Three types of effects were measured: effects on perceptions of therapists, opinions and attitudes toward therapy, and actual client behaviors. The research hypothesis was confirmed in regard to perceptions of therapists (as measured on the CRF-S) and client
behaviors (requests for a change in therapist, attendance at the first session, and client-initiated termination). There were also no significant differences in the proportion of treatment and control group participants in believing they knew what to expect in therapy or wishing to participate. Two statistically significant opinion and attitude findings were detected. One finding was that a significantly greater proportion of treatment than control group participants stated that the mailing, rather than written information received at intake, was most helpful. The treatment group received appointment notification plus eight issues of personalized pretherapy disclosure information in the mailing, while the control group received only appointment notification. Both groups received general information about agency services and procedures at intake. Therefore, the treatment group preferred the personalized information over the general information received by both groups. The second finding was that a greater proportion of treatment than control group participants believed they understood what counseling would be like.

The lack of negative effects of therapy disclosure discovered in the current study concur with results obtained in prior research. Prior studies likewise found either no significant effects or positive effects of therapy disclosure on perceptions of therapists (Christiansen, 1986; Handelsman & Martin, in press; Sullivan et al., 1993) or willingness to see a therapist (Farley, 1987; Handelsman, 1990). Prior studies did not investigate behavioral outcomes.

The current findings substantially add to the research literature because of the methodology used. The current study improved upon
four prior research limitations: (1) use of analogue methodology, (2) timing of the dependent variable, (3) timing of therapy disclosure, and (4) lack of comprehensiveness (see Improvements over Prior Research, p. 6). A discussion of the implications of the findings based on each of the improvements is presented next.

The current research was a field study. The disclosure of comprehensive pretherapy information to a randomized sample of clients in this study did not result in negative perceptions, attitudes, or behaviors. The relevance of this finding may generalize to other university counseling centers and provides implications for other practice settings as well. Additionally, the use of a client sample enabled data on behaviors to be collected, an aspect that has not previously been studied. Behavioral measures in this study were consistent with attitudes and opinions. Pretherapy disclosure did not have a negative impact on clients.

The improvement in methodology of providing disclosure and measuring its impact prior to the first session helped separate the effects of disclosure of therapy information from the effects of therapist contact. The lack of negative effects obtained in the current study can more conclusively be stated because the therapist contact factor was improved upon.

Finally, the results of the current study are particularly important because negative perceptions of therapists did not occur, even though participants were provided with comprehensive therapy information. In this study, the treatment group received information on 12 therapy issues and the data were personalized, descriptive of the particular therapist and his or her procedures. The eight pretherapy issues
provided to the treatment group, but not the control group, consisted of two main categories of personalized information. They were (1) information on potentially "negative" issues, such as risks and alternatives to therapy and the name and address of the person to contact if concerns were raised about the therapist, and (2) data about the therapist's qualifications and practices. The potentially "negative" issues are often not disclosed by therapists (Hedstrom & Ruckel, 1992). One reason reported by practitioners for not disclosing therapy information was the belief that such data might have a deleterious impact on the client or the therapy relationship (Handelsman et al., 1986; Somberg et al., 1993).

Information regarding the therapist's qualifications and practices had the potential to influence client perceptions of therapists, attitudes, and behaviors in this study. Treatment group participants were provided with information on degrees earned, licensing status, and whether or not the therapist was supervised. They also received data on areas of specialization. Examples from therapist disclosure statements (see Sample Therapist Statement, Appendix G) were: "I work with gay men, focusing on 'coming out' and HIV-related concerns," "I have much experience working with ethnic minorities," and "I am a Certified Addictions Counselor and do evaluations of substance abuse problems."

Although information on ethnic and racial identity of therapists, sexual orientation, values, and other areas of diversity (such as age, marital status, physical disability) were not directly stated, they could have been inferred by treatment group participants who read the disclosure statements. If participants had strong feelings regarding race, ethnicity, values, etc., then the potential for negative perceptions or attitudes
existed because personalized information of that kind was disclosed. Even though potentially troublesome data were provided in this study to treatment group participants, negative effects on perceptions of therapists, opinions and attitudes toward therapy, and client behaviors did not occur. These results are important because they add to the growing pool of data suggesting that the disclosure of pretherapy information, even personalized therapist data, does not have a negative impact on clients.

**Client Gender**

Client gender was a second independent variable investigated in this study. There was a main effect of gender on perception of therapists. In this study, females rated therapists more positively overall on the CRF-S than did males. These results are similar to those obtained in a recent analogue study (Handelsman & Martin, in press). In that study, however, males had a more negative impression of the therapist only when disclosure documents were difficult to read, single spaced, and written at a 10th grade level. (The more readable document was in outline form and written at a 4th grade level.) In the present study, methodology was utilized to improve the readability of disclosure documents; however, they were single spaced and written at the 8-9 grade level. A question remains whether the current findings represent a gender effect or the influence of a moderately high readability level on males.
Limitations of the Study

Four potential limitations of this study were: (1) the treatment group may have been more likely to read and recall disclosure information than the control group, (2) a ceiling effect on the CRF-S may have reduced the likelihood of finding potential differences between groups, (3) clients had contact with counselors during intake and sometimes in prior therapy which may have influenced their responses and reduced differences between groups, and (4) the populations to which the results can be generalized may be limited. (A fifth potential limitation involved data from the open-ended questions and is discussed in Chapter V.) The four potential limitations of this study are each briefly discussed next.

One limitation was that the treatment group may have been more likely to read and recall disclosure information than the control group. The methodology in this study may have favored the treatment group in two respects: time span and personalization. Both groups received a mailing within one week of data collection (at therapist assignment time). However, the treatment group received disclosure information in that mailing while the control group did not. Information was provided to both groups at intake, which resulted in a time lag of up to 2 months (due to a waiting list for therapist assignment). Therefore, the treatment group had access to therapist information just before dependent variables were administered while the control group did not. A shorter time span would favor recall. Personalization was another factor that may have influenced whether disclosure information was read or remembered. The material received by both groups was impersonal, included in
a packet with other CSDC material, and sent home with clients. The material received in the mail by the treatment group was personalized with individualized information about the assigned therapist. No other potentially distracting CSDC routine data were included in the mailing. Personalized data might also favor recall. If the treatment group read and recalled disclosure information received in the mailing, but neither group read or recalled information provided at intake, then the results of this study would be interpreted in a different way. The comparison would be between the control group who potentially read and recalled no pretherapy data and the treatment group who potentially read and recalled only personalized therapist and therapy information. If this was the case, then the possibility of negative effects on the treatment group would increase because they would have read and recalled only potentially negative and troublesome information. The lack of negative effects obtained in this study would therefore be even more meaningful. There were no procedures in this study to check whether or not information was read or recalled, so it is impossible to know if a difference between groups on those factors occurred. Future research should provide disclosure information to treatment and control participants at the same time in order to improve upon this potential limitation.

A second possible limitation was the ceiling effect on the CRF-S. Participants in this study rated therapists quite positively on the CRF-S, regardless of the amount of pretherapy information they received. Validation studies of the CRF-S documented that almost all participant ratings were at or above the midpoint of the scale (Corrigan & Schmidt, 1983; Epperson & Pecnik, 1985; Ponterotto & Furlong, 1985) with even
higher ratings occurring in field studies. If differences in perceptions of the therapist between control and treatment groups did occur in this study, this instrument may not have been sensitive enough to detect the distinctions. In practical terms, however, what value is there in measuring the differences between extremely high and very high perceptions of therapists? The main point is that the perceptions of both treatment and control groups, in this study and prior research, continue to be measured in the positive range on the rating scale of the CRF-S. It seems clear that despite ceiling effects, evidence thus far suggests that even if differences do occur, therapy disclosure does not result in a negative perception of the therapist.

A third possible limitation was that all participants in this study met with an intake counselor. This personal contact with a counselor (even though it was not their assigned therapist) may have influenced participants' perceptions and opinions about therapists and therapy in general. The effects of personal contact may have been more powerful than pretherapy disclosure. Additionally, intake counselors may have inadvertently reduced initial differences between the control and treatment group by providing disclosure information such as details on what therapy will be like or credentials of therapists. An intake session, however, is typical of university counseling centers and other agencies. Therefore, even if intake "white washes" initial differences between groups, the findings are likely to be representative of what occurs in the real world. Therapists who work in centers with intake procedures (whether intake "white washes" the influence of pretherapy disclosure or not) can probably disclose personalized and potentially negative therapy
issues to potential clients without negative consequences.

The final limitation is the generalizability of this study, due to the research setting, small sample size, and lack of data regarding racial background. This research was conducted in a university counseling center, which provided free therapy services to students. Since the counseling center may have been the only therapy option available to participants, their responses may not generalize to other settings where numerous options are available. The results may also not generalize to private practice or mental health agency settings where fees are charged. The results may be applicable only to settings in which an intake session occurs. The small sample size of 63 participants may also reduce the generalizability of results to the population in general. Finally, data regarding the racial background of participants were not obtained in this study, thereby limiting the generalizability of findings among specific racial groups.

**Implications for Future Research**

Based on the results of the current and prior studies on disclosure of therapy information, several suggestions for future research are apparent. These suggestions take into account the limitations of the current and prior studies, identify dependent and independent variables that warrant further investigation, and provide an idea for an interesting research project. Described next are the implications for future research.

To improve upon the current and prior studies, additional research in field settings is desirable. To provide more conclusive data on the effects of pretherapy disclosure, personal contact with therapists should
be controlled. The initial effects of disclosure should be measured before the client meets or talks with the therapist. Contact with intake therapists might be controlled as well. This procedure could be accomplished by eliminating the intake session entirely or by random assignment to intake and nonintake condition.

Research is needed on the differential effects of disclosure based on client and/or therapist racial background. To date, studies in the area of therapy disclosure have not addressed these important variables. Additional research is also needed on client recall of pretherapy disclosure. Future studies should provide a validity check to determine if information was read and remembered, in order to confirm the usefulness of participant responses. Client recall might also be an independent variable studied.

Suggestions for future researchers regarding dependent variables are as follows: Researchers might consider developing or finding a more sensitive measure of perception of the therapist than the CRF-S. Continuing research on whether opinions and attitudes result in behavioral change would add to the current research findings on the effects of pretherapy disclosure. Perhaps in other settings, requests for a change in therapist or attendance at the first session would provide significant findings.

There are several independent variables that might be studied. Suggested client variables are gender, ethnicity, and presenting problem. Suggested therapist variables are years of experience and educational level. Another research variable that needs additional study is readability of the disclosure document. In particular, the question of gender and
readability level of written documents warrants further investigation.

An interesting research design would be to provide prospective clients with personalized disclosure statements and have them select their therapist based on the contents of the statement. Data could be obtained from clients on reasons for their selection. Differences between these clients and a control group could be obtained on such treatment outcome measures as premature termination, accomplishment of goals, changes in behaviors, etc. Not only would this design potentially provide important research results, but it would also uphold the basic ethical underpinnings of client rights, the freedom of choice.

Conclusions

Disclosure of comprehensive pretherapy information to university counseling center clients in this study did not have negative effects on their perceptions of therapists or attitudes about therapy. Comprehensive disclosure also did not result in requests for a change in therapist, lack of attendance at the first appointment, or an increase in client-initiated termination. The lack of a negative impact of comprehensive pretherapy disclosure obtained in this study concurs with results obtained in prior research. The current findings, however, substantially add to the research literature because of the improvements in methodology used in this study. The current study used a client sample, disclosed information to participants and measured its effects prior to contact with the assigned therapist, and provided 12 issues of personalized pre-therapy data to treatment group participants. The use of a client sample in the current study increased the relevance of findings to actual practice
settings. Pretherapy disclosure and pretherapy measurement of effects helped isolate the influence of disclosure apart from contact with therapists. This methodology allowed a more conclusive statement regarding the absence of negative effects of pretherapy disclosure. Finally, the pretherapy data provided to the treatment group in this study consisted of potentially troublesome data on risks and alternatives to therapy, qualifications of therapists, and personalized material from which participants may have inferred the racial and ethnic identity, values, and other features of their therapist. Even with the provision of such potentially troublesome information, which is often not disclosed by practitioners, no negative effects upon participants were measured.

The results of the current and prior research fail to demonstrate negative effects of disclosure of therapy information by practitioners. Instead, findings suggest that it is possible to adhere to the general ethical principles of protecting client rights and increasing client autonomy and participation without risking harm to the client or the therapy relationship.

Hopefully, the results of this study will stimulate further practical research in clinical field settings and increase the use of professional disclosure documents.
CHAPTER II

REVIEW OF LITERATURE

Organization of Chapter

This chapter is presented in nine sections. The first section provides a brief description of the historical background of informed consent and the expansion of this concept into the arena of human rights. The second section discusses disclosure in the mental health field by reviewing and summarizing the theoretical writings of counselors and psychologists supporting the application of informed consent principles into therapy practice. The third section summarizes the major emphases in the nonempirical writings of counselors and psychologists, including the recent recommendation that such information be provided to clients in writing. The fourth section highlights the segments of the ethical codes of the American Psychological Association (APA) and the American Counseling Association (ACA) that pertain to disclosure. The fifth section provides a summary of the licensing requirements in various states regarding professional disclosure, indicating a trend toward written disclosure.

The major portion of this chapter is presented in Sections 6, 7, and 8, which includes a review of the research literature. The sixth section describes studies of the actual practices of therapists. The seventh section details the research studies on the effects of pretherapy disclosure. Presented in the seventh section are reviews of studies that
investigated the disclosure of one therapy issue and studies that investigated the disclosure of multiple (two or more) therapy issues. The eighth section provides information from the research literature on variables that might have an interaction effect with disclosure. Chapter II concludes with the ninth section, which presents the rationale for the current study.

Historical Background

The issue of pretherapy information has its roots in the field of medicine. This history, labeled informed consent, dates back to 1767 when the first medical malpractice suit was filed in England (Bray et al., 1985). Since then, the doctrine has developed to its present form which includes the requirement that physicians disclose the risks and alternatives of proposed treatment (Katz, 1984). Before medical care can begin, the patient must consent to it and give the doctor the power to act. The doctrine of informed consent was initiated as a method of protecting physicians from liability; however, a new medical ethic has developed which emphasizes respect for human rights and freedom (Faden & Beauchamp, 1986).

In the 1960s and 1970s, societal demands expanded the philosophy of individual autonomy and choice into many other realms. Civil rights, women's rights, and fair treatment of prisoners and the mentally ill were accentuated. Consumers began to demand knowledge of the ingredients of products they were purchasing. The concept of freedom and self-determination quickly expanded to include the consumers of mental health care services.
Disclosure in the Mental Health Field

Presented below is a review of the theoretical writings of counselors and psychologists supporting the application of informed consent principles into therapy practice. A summary of the disclosure issues discussed in journal articles is included.

Counseling

In the late 1970s, articles began to appear in counseling journals, recommending that various types of therapy information be shared with clients. Weinrach and Morgan (1975) created a bill of client rights and responsibilities that provided greater involvement of clients in the counseling process. They described three groups of information that clients had the right to know. These included length of treatment, counseling process, and outcome. With each client right, a client responsibility was also described. For example, a client had the right to terminate treatment but also the responsibility of informing the counselor of this decision.

Winborn (1977) utilized the concept of consumer protection and applied it to the honest labeling of counseling services. He proposed that specific information be provided to clients to enable them to make a knowledgeable decision about entering therapy. This information was provided in writing and included the counselor's competencies, type of services provided, and basic procedures. The information was discussed during the first session and questions were encouraged.
A professional disclosure statute was proposed by Gross (1977) as an alternative to counselor licensure. He suggested that a written document be posted conspicuously in the office, as well as provided to clients before they began counseling. The document should contain the counselor's name, address, phone number, philosophy of counseling, formal education, association memberships, and fee schedule. Also included was the name and address of the governing agency responsible for regulating the practice of counseling.

Witmer (1978) subscribed to Gross's (1977) idea of a professional disclosure document, but suggested it be required as a part of counseling licensure. Swanson (1979) further expanded Gross's concept by proposing that professional disclosure documents be collected and published into counseling directories and consumers' guides. In this manner, the documents would be helpful in making referrals as well as assisting potential clients in selecting their counselors.

Psychology

Psychology journals also published articles endorsing the provision of therapy information to clients. Morrison (1979) recommended a written contract which included a description of how effective a particular therapy is with what type of clients and under what circumstances.

The importance of explaining the possible risks involved in therapy was also endorsed, particularly preparing a client for changes in relationships (Morrison, 1979) and belief systems (Coyne, 1976). Hare-Mustin et al. (1979) suggested that clients also be provided with available sources of help other than therapy.
D. Smith (1981) warned that therapists need to inform clients that diagnostic labels will be shared with third parties, particularly insurance companies.

**Summary of Disclosure Issues**

Hedstrom and Ruckel (1992) summarized the literature on the sharing of therapy information and developed 12 components of disclosure that have been advocated. These are (1) therapy process or techniques; (2) services provided and/or type of clients; (3) expectations and/or anticipated results; (4) possible risks; (5) alternatives to therapy; (6) qualifications of therapist; (7) rights and limits of confidentiality, including third party issues; (8) length and frequency of sessions; (9) right to terminate treatment, or description of rights if involuntary; (10) cost and method of payment; (11) identification of supervisor; and (12) identification of board of licensing.

**Emphases in Nonempirical Articles**

This section contains a summary and discussion of the major emphases in the nonempirical literature pertaining to disclosure of therapy issues.

**General Principles**

Articles endorsing the provision of information to clients emphasized the need to uphold two underlying principles of informed consent. These were (1) understanding relevant information and (2) freedom of choice. Proponents have suggested that written information, as well as
verbal, be provided to clients. To increase understanding, documents should be clearly written in language a person can comprehend and at a grade level that can be easily read (Handelsman et al., 1986). To assure true freedom of choice, this information should be provided before therapy begins and before a fee is charged (Bray et al., 1985; VanHoose & Kottler, 1985).

The purpose for which information is shared with clients has also been considered a crucial element (Jordan & Meara, 1990). Of those who provide written disclosure, two different positions can be identified; therapists who are protecting the rights of the client and those protecting the therapist from litigation (Bray et al., 1985; Haas, 1991). Advocates of client rights include information and wording in disclosure documents to develop an atmosphere of mutual trust and respect. Opportunities for open discussion and questioning are provided. When therapy information is presented to promote client autonomy and participation, therapist integrity is emphasized. Disclosure statements can also be written as proof that information regarding confidentiality, fees, and other issues required by licensure laws have been provided. Legalistically defensive documents may be more difficult to read (Handelsman et al., 1986) and may initiate a different (more negative) response on the part of clients (Haas, 1991).

Written Information Sharing

Many authors have suggested that providing information in writing is preferable to sharing it verbally. Therapy contracts (Hare-Mustin et al., 1979; Morrison, 1979) and guidelines (Weinrach, 1987, 1989) have
been described in the literature. Documents of client rights have also been proposed (Everstine et al., 1980; Handelsman & Galvin, 1988). Various forms of written professional disclosure statements have repeatedly been advocated in the theoretical literature over the past 17 years (Gill, 1982; Gross, 1977; Haas, 1991; Weinrach, 1989; Weinrach & Morgan, 1975; Witmer, 1978).

Advocates of written disclosure contend that it has several advantages. Their position includes the idea that a written document can protect the therapist by providing proof of informed consent (Hare-Mustin et al., 1979; VanHoose & Kottler, 1985). It may also guide the therapist to be professionally honest and open and to follow ethical standards (Corey et al., 1988). Providing ground rules in writing may reduce the likelihood that nontherapeutic issues (such as missed appointments) will become a source of conflict (Weinrach, 1989). The act of stating personal beliefs, strengths, and weaknesses in writing could help therapists clarify their professional identities (Gill, 1982). None of the above ideas have been researched empirically.

Some possible negative aspects of written statements have also been addressed in the literature. Disclosure statements might detract from the therapeutic process and reduce the spontaneity of the therapist (Winborn, 1977). Written information could move attention away from conversation and be overly legalistic in nature (Haas, 1991). In a recent survey of the practices of psychologists (Somberg et al., 1993), practitioners' beliefs determined whether or not therapy issues were disclosed. Reasons for not disclosing issues such as confidentiality, risks, treatment length, procedures, and alternatives were "issue is not relevant or
necessary, client is not interested, client is already aware" (Somberg et al., 1993, p. 157). These ideas have not been subjected to study.

Other possible disadvantages have been examined by research methods. These are: written documents may be difficult to understand (Handelsman & Galvin, 1988), may produce a negative set in the client (Jordan & Meara, 1990), and could give the impression of a cold and uncaring professional (Handelsman et al., 1986). Another possible disadvantage studied was that the personal values of the therapist might be at odds with the client, resulting in lowered trust (Lewis et al., 1983). The results of recent studies on the effect of disclosing two or more pretherapy issues (multiple disclosure) in writing have generally demonstrated no negative effects. (These studies will be reviewed in more detail in Disclosure of Multiple Therapy Issues, Chapter II, beginning on page 64).

Ethical Codes

An examination of the recent revised ethical principles for psychologists (American Psychological Association [APA], 1992) and the latest revision of the ethical standards for counselors (American Association for Counseling and Development [AACD], 1988) reveals that their principles regarding information sharing procedures are less rigorous than has been recommended in the theoretical literature and summarized by Hedstrom and Ruckel (1992). Highlighted below are segments of the APA and ACA ethical codes pertaining to disclosure of therapy issues.
The APA ethical principles (APA, 1992) require that psychologists reveal information about the (a) therapy process, (b) expectations, (c) fees, (d) confidentiality and its limits, and (e) identification of the supervisor, if applicable. Psychologists should describe "the nature and results of psychological services" in "language that is reasonably understandable" (Standard 1.07, p. 1600). Additionally, the "nature and anticipated course of therapy" should be discussed. The psychologist should "make reasonable efforts to answer patients' questions and to avoid apparent misunderstandings about therapy" (Standard 4.01, p. 1605). When third-party requests for services are made, the psychologist clarifies "the nature of the relationship with each party" (Standard 1.21, p. 1602). "Informed consent to therapy" should be obtained by sharing "significant information concerning the procedure" (Standard 4.02, p. 1605). "Compensation and the billing arrangements" (Standard 1.25, p. 1602) and "fees" (Standard 4.01, p. 1605) are to be discussed and agreed upon. "Confidentiality" (Standard 4.01, p. 1605) and the "limitations on confidentiality" (Standard 5.01, p. 1606) are to be discussed. If the psychologist is supervised and/or is an intern, the patient is informed of those facts (Standard 4.01, p. 1605). The APA code includes 5 of the 12 areas of disclosure that have been identified by Hedstrom and Ruckel (1992). It does not include (a) possible risks (b) alternatives to therapy, (c) right to terminate treatment, (d) length and frequency of sessions, (e) services provided and/or type of client typically seen, (f) qualifications and experience of the psychologist, or
(g) name and address of the licensing board.

The APA document mentions timing of disclosure. Information is to be shared "at the outset of the service" (Standard 1.21, p. 1602), "at the outset of the relationship" (Standard 5.01, p. 1606), and "as early as is feasible" (Standard 1.25, p. 1602; Standard 4.01, p. 1605). Nowhere in the code is it explicitly stated that information be shared before the relationship begins. Further, the APA code does not specifically state whether the above information should be provided orally or in writing. Data is to be "discussed" (Standard 4.01, p. 1605; Standard 5.01, p. 1606), clients are to be "informed" (Standard 4.02, p. 1605) and "provided" with information (Standard 1.07, p. 1600), and issues are to be "clarified" (Standard 1.21, p. 1602). "Whenever possible, psychologists provide oral and/or written information, using language that is reasonably understandable to the patient" (Standard 4.01, p. 1605). Informed consent is "appropriately documented" (Standard 4.02, p. 1605).

American Counseling Association

The ACA code of ethics (AACC, 1988) requires that therapists "recognize the need for client freedom of choice. Under circumstances where this is not possible, the member must apprise clients of restrictions that may limit their freedom of choice" (Section B, p. 387). The following information must be disclosed:

The member must inform the client of the purposes, goals, techniques, rules of procedure and limitations that may affect the relationship at or before the time that the counseling relationship is entered (Section B 7, p. 388). . . . [In advertising] . . . the member may list the following: highest
relevant degree, type and level of certification or license, type and/or description of services, and other relevant information (Section F 2, p. 391).

The ACA requires 5 of the 12 areas of disclosure identified by Hedstrom and Ruckel (1992). These are (1) the purposes and techniques, (2) expectations, (3) rules of procedure (fees), (4) rules of procedure (length and frequency of appointments), and (5) limitations to confidentiality that may affect the relationship. In advertising, a counselor "may" list (6) educational and experience information. The ACA standards do not include the remaining six areas of disclosure: (1) risks, (2) alternatives to therapy, (3) right to terminate treatment, (4) identification of supervisor, (5) anticipated results of treatment, or (6) name and address of the licensing board.

The ACA document contains language about the timing of disclosure. Clients are to be informed "at or before" the time the counseling relationship is entered (Section B 7, p. 388).

The standards do not indicate whether the information should be provided orally or in writing.

State Licensing Requirements

State licensing regulations regarding the provision of therapy information by counselors and psychologists are likewise less inclusive than has been recommended in the theoretical literature.

According to a review of current licensure laws (Hedstrom & Ruckel, 1992), most states have the same or fewer requirements for disclosure than do ethical codes. Of the 50 states that license psychologists, 45 do not mention disclosure or quote or adopt the APA ethical
codes. Likewise, 21 of 34 states that license counselors have little mention of disclosure.

There are, however, several states that recently addressed specifically the issue of information sharing. In 1980, the American Personnel and Guidance Association (now ACA) recommended that counselor licensure include the stipulation that a professional disclosure statement be given to clients (Gill, 1980; McFadden & Brooks, 1982). Since then, written documentation of various aspects of information sharing has been included in the licensing codes of 13 states for counselors and 5 states for psychologists. The information that generally is required in writing is the name and address of the licensing board, fees, therapy techniques, and client rights.

Actual Practices of Therapists

In this section, information regarding the disclosure procedures followed by practitioners in the field are presented. Despite the theoretical literature advocating the importance of providing therapy information (and more recently, of sharing it before therapy begins), this procedure is not routinely accomplished. Journal articles continue to indicate by anecdotal report that therapists seem unaware of or unwilling to inform clients of their rights (Bray et al., 1985; Eberlein, 1977; Haas, 1991). The information sharing procedures of therapists in the field have been described as haphazard and rarely documented in retrievable form (Everstine et al., 1980).

Four studies have been conducted to investigate actual therapist information sharing practices. Handelsman et al. (1986) surveyed 196
members of one state psychological association who were licensed psychologists and listed themselves as private practitioners. There were 104 respondents. In that study, psychologists preferred to share information orally; only 28.8% used written forms. Nineteen written forms were submitted by respondents. Most of the content of those forms involved financial issues, followed by explanations of the limits of confidentiality. Handelsman et al. (1986) concluded that the written forms did not satisfy the requirements of informed consent because they did not increase client autonomy or understanding of information provided.

Talbert and Pipes (1988) requested brochures and other printed materials from a nonrandomized sample of therapists practicing in rural and urban settings in five states. At each geographic location, the sample consisted of four licensed psychologists, two community mental health centers, one university with an enrollment of more than 10,000, and one college or university with an enrollment of less than 10,000. The written material was analyzed according to a 19-item checklist of possible informed consent issues. Only 1 of 40 sites had a written form that contained more than half the elements. The forms predominantly included information on confidentiality and financial obligations. It was concluded that few sites offering psychological services provided clients with extensive written informed consent.

Hedstrom and Ruckel (1992) surveyed a randomized national sample of practicing psychologists and counselors who were members of the American Psychological Association (APA) or the American Counseling Association (ACA). Surveys were sent to 1,000 therapists listing 12 types of information that might be disclosed to clients. (For a
description of the 12 types of information, see Summary of Disclosure Issues, Chapter II, p. 43). The 12 issues were similar to the 19 identified by Talbert and Pipes (1988); however, they were stated more succinctly. Participants were asked which information they disclosed, whether the issues were addressed orally and/or in writing, and the timing of the information sharing. Surveys were returned by 614 respondents. Results indicated that a great majority of practicing therapists continue to prefer to present information orally. Of 12 types of information, 6 types were shared orally by 83% or more of the sample. On only one item, name and address of the licensing board, did participants prefer to provide information in writing. Of practicing therapists who did provide written disclosure, the areas most likely to be included in writing were explanation of the limits of confidentiality, fee structure, and the name and address of the board of licensing. Samples of 32 written disclosure statements were received. Eighty-one percent of those documents contained information about the rights and limits of confidentiality and 75% had data regarding cost and method of payment. Fewer than 10% of the disclosure statements included information regarding the risks of or alternatives to therapy.

A study very similar to that done by Hedstrom and Ruckel (1992) was completed by Somberg et al. (1993). A random national sample of 189 practicing psychologists completed a survey on the use, importance, reasons, communication, methods, and timing of five consent issues. Those issues were confidentiality, risks, length of treatment, procedures, and alternatives to treatment. Therapists in this study informed clients of confidentiality and therapy procedures significantly
more often and considered those issues more important than the other disclosure items. Participants shared a strong preference for providing information in verbal form rather than in writing or by audio or visual methods. Disclosure was made during the first session, except that confidentiality issues were described prior to the beginning of therapy. The reasons given by therapists for not informing clients were variable and included statements such as "client is not interested, client is already aware, and issue is not necessary." Therapists reported beliefs that disclosure would have a negative impact on clients and the therapeutic relationship. Lack of awareness and knowledge of informed consent practice were not major factors in this study. The authors concluded that the unique context of therapists is an important variable in explaining the reluctance to disclose therapy information. The beliefs, values, and theoretical orientation of therapists are some of those unique variables. Cognitive-behavioral therapists used informed consent procedures more often than psychodynamic or eclectic therapists. Practitioners who did not consider disclosure relevant or practical shared information less often with clients than those who valued such disclosure. The authors advocated that research is needed regarding the possible negative impact of consent procedures, since this fear has relevancy for therapy practice.

Research Studies on Effects of Pretherapy Disclosure

The review of the empirical literature on the effects of providing therapist and therapy information to clients is presented below in six parts. Most of the research studies investigated the impact of disclosing
only one specific therapy issue. The results of those studies are presented first. Part 1 reviews studies investigating the disclosure of confidentiality information. Part 2 reviews studies of the impact of disclosing therapy procedure information. Part 3 presents research results of several investigations on the disclosure of therapist values. Part 4 is a summary of the research on specific disclosure issues. Next, Part 5 presents the results of more recent studies investigating the disclosure of multiple (two or more) therapy issues. Part 6 summarizes the data from multiple disclosure research.

**Disclosure of Confidentiality Information**

Woods and McNamara (1980) examined the effect of orally promising various levels of confidentiality on self-disclosure. The subjects were 60 undergraduate students who participated in two interview sessions regarding their opinions and feelings about certain aspects of their lives. The nonclient sample was randomly assigned to three groups. One group was told that all information would be confidential. The second group was told that information might not be confidential. Responses would be transcribed by a secretary and might be available to other university personnel and might be added to their university file. The third group received no instructions regarding confidentiality. Participants were asked 20 interview questions. Two judges (unaware of the treatment or control group assignment) rated responses on a 9-point Likert scale regarding the depth of self-disclosure made by participants. The amount of self-disclosure in the nonconfidential group was significantly less than that in the other two groups. Disclosure was about the
same for females and males in the confidential situation. In the nonconfidential condition, however, females were less likely to disclose information. The authors concluded that the possible release of confidential information is less negatively valued by males than females.

Muehleman et al. (1985) expanded the above study by using a target population that might be more similar to individuals seeking therapy and by providing written disclosure statements. Eighty-one undergraduate students were administered the Beck Depression Inventory (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961). This instrument provides data on self-rated depressive symptomology. From this group, 24 persons who scored within the mild, moderate, or severe range of depression were selected to participate in an interview. Each subject received one of three written consent forms. One form contained a brief statement regarding the limits of confidentiality, described as occurring very rarely. The second and third groups received additional explanations about limits, risks and benefits, and subject rights. The third group also received an explicit rationale for risking self-disclosure. Eleven measures of willingness to disclose personal information were obtained from three sources: a preinterview privacy questionnaire, interview, and postinterview. The preinterview privacy questionnaire contained three dependent measures. It consisted of questions regarding willingness to self-disclose to a (1) same-sex stranger, (2) opposite-sex stranger, and (3) male researcher. Subjects rated their willingness on a 3-point scale. Information on seven more measures was obtained during an interview. Those measures were (1) satisfaction with current relationships and goals, (2) physiological complaints, (3) feelings, (4) mood,
(5) cognitions, and (6) toll on emotional well-being. Subjects rated themselves during the interview on the above measures. The seventh interview measure, interview depression, consisted of the sum of the above six scores. The 11th and final dependent measure was a questionnaire to assess subjects' trust of the interviewer. On only one of the 11 dependent measures was there an effect on willingness to disclose information or trust. Subjects who were provided with more detailed information on the limits to confidentiality were less likely to reveal information on mood. This small inhibitory effect was wiped out when subjects were encouraged to disclose. The authors concluded that informing clients about the limits to confidentiality does not inhibit self-disclosure.

**Disclosure of Therapy Procedures**

Another aspect of information sharing that has been researched is the effect of written disclosure of therapy procedures on client perception. In an analogue study conducted with 157 college students (Nathan et al., 1978), participants were provided information describing the services available at a counseling center and the appropriateness of the center for personal/social therapy, as well as vocational and college routine issues. Four methods of presentation were provided: staff presentation, personal letter, traditional brochure, and control group receiving no information. Subjects were administered the Counseling Appropriateness Check List (CACL) (described in Warman, 1960) 2 weeks after receiving the information about the center. This instrument consists of 66 problem items which are rated on a 5-point Likert
scale with regard to their appropriateness for discussion with a therapist. The items are factored into personal/social, vocational choice, and college routine problems. The results of the study indicated that students who received any source of information significantly increased their ratings of the appropriateness of vocational and college routine issues to be discussed with a therapist, in comparison with the control group. There was no significant difference between treatment and control groups regarding attitudes about the appropriateness of personal/social concerns. Subjects who received information by staff presentation and personal letter techniques had the highest means on the CACL. The authors concluded, therefore, that personal letters were just as effective in influencing student attitudes as the more expensive direct contact with staff. In this study, then, written disclosure was more cost efficient and resulted in similar perceptions of appropriate issues to discuss in therapy.

A second study (Mardirosian et al., 1990) measured the effect of providing informed consent information on attitudes toward counselors, the counseling situation, and decision making in a pro-life pregnancy counseling center. Sixty clients were randomly assigned to the control or experimental group. The experimental group received "enhanced" informed consent information. That group was provided with an information sheet describing the policies, procedures, and goals of the center, including the pro-life philosophy and nonprofessional status of the counselors. The control group did not receive this information. Both groups met with an educator who answered questions and described the possible risks and alternatives to abortion. At the end of each client's
individual counseling session, the participant completed the Counselor Rating Form (CRF) (Barak & LaCrosse, 1975) and a Likert-type questionnaire regarding the likelihood of requesting an abortion. There was no difference found between the two groups regarding counselor perception or the decision to abort. The authors concluded that the study demonstrated the importance of facilitating client autonomy and self-determination and that sharing information did not negatively affect client attitudes toward therapists or counseling.

Disclosure of Therapist Values

A series of investigations was conducted on the effect of the disclosure of the values of a specific therapist (rather than the overall center values). The results of these studies provided differing conclusions. One of the seminal studies was done by Lewis and Walsh (1980) in which they examined participants' reactions to counselors who implicitly or explicitly expressed personal values. One hundred and twenty female undergraduates were placed in two groups, based upon their pro or con attitude toward premarital sex. They were then randomly placed in an experimental or control situation. Participants in the experimental groups listened to an interview in which the counselor was either explicit or implicit about her pro or con attitude toward premarital sex. In the control condition, the explicit or implicit references were deleted. Participants were administered the Counselor Rating Form (Barak & LaCrosse, 1975) as well as a Likert-type scale. There were no significant differences between the control and experimental group in the way counselors were perceived. However, participants expressed more
willingness to see counselors who had values similar to their own. Participants who heard the explicit counselor rated her as more attractive and trustworthy if their own values were similar to those of the counselor.

In a later study (Lewis et al., 1983), the authors concluded that stating values explicitly in writing can result in a more negative impression of the therapist. In that study, 36 female students were selected who had scores of 58 or higher on the Attitudes Towards Women Scale (Spence, Helmreich, & Stapp, 1973). These women, considered pro-feminists, were randomly assigned to three groups. Each group received differing amounts of pretherapy information about a female therapist's theoretical orientation and values. One group received a telephone directory listing, the second group had the added words "feminist psychologist," and the third group received a more explicit description of feminist therapists' assumptions and values. Participants were asked to rate the therapist on two Likert scales, (1) degree of confidence in therapist regarding 14 areas of personal concern and (2) perception of similarity to the therapist on values and opinions. Participants were also asked about their willingness to see the therapist. The results indicated that explicit disclosure of value information had a negative effect on potential clients. The participants who received explicit information on therapist values did not perceive themselves as similar to the therapist, did not think she would be helpful, and were not as willing to see her as participants were in the other two conditions.

The above study was duplicated and expanded by Schneider (1985). Using samples of 52 men and 52 women enrolled in psychology
classes, participants were administered two preexperimental assessments: Spence et al.'s (1973) Attitudes Toward Women Scale (ATW) and Fischer and Turner's (1970) Attitudes Toward Seeking Professional Psychological Help Scale (ATSPH). The ATW was used to determine subjects' feminist orientations. Total scores on the ATSPH assessed participants' willingness to consult service providers. Participants were randomly assigned to the same three conditions regarding advertisement of therapy services as described in the Lewis et al. (1983) study. A fourth group was provided a detailed traditional (nonfeminist) therapist description that was identical in length to the explicit feminist therapist description. All participants were administered the Counselor Rating Form (Barak & LaCrosse, 1975) and Likert scales regarding the degree of confidence in the therapist of handling 20 specific problem areas and the likelihood of recommending the counselor to a friend. The results of the study indicated that the length of advertisements and disclosure of values of therapists had no impact on male or female participant perceptions of therapists' personal characteristics as measured by the CRF. The exception was that female participants rated feminist therapists as less trustworthy. Participants expressed least confidence in the helpfulness of the explicit feminist in resolving marital and parental problems and expressed less general optimism about benefiting from counseling from her.

A fourth study (Lewis & Lewis, 1985) investigated the effect of disclosure of religious values. A sample of 96 college women were shown a videotaped counseling session containing either neutral or influential counselor statements regarding engaging in sexual intercourse.
An example of an influential statement was "Making love is a big step, one that people jump into and later regret" (Lewis & Lewis, 1985, p. 154). The neutral condition deleted the above statement and replaced it with a reflective statement. Participants were also provided minimal or explicit information about the therapist's Christian values. Both groups received information about the therapist's experience and reputation. The experimental group received additional information describing the therapist as a committed Christian whose values are based on the Bible and its moral code. The participants completed a student attitude survey used to divide them into pro verses con premarital intercourse groups. After seeing the videotape and reading the counselor description, participants completed the Counselor Rating Form (Barak & LaCrosse, 1975) and a counselor reaction questionnaire. The reaction questionnaire contained questions designed to assess the participants' awareness of counselor influence attempts, as well as questions regarding willingness to see the counselor and similarity between counselor and participant values. Explicit pretherapy value information increased students' ability to correctly identify a counselor's values and to recognize influence attempts. It also produced somewhat negative perceptions of the counselor. The author concluded that although providing pretherapy information may be ethically sound, it might violate clients' expectations of therapist neutrality and therefore might decrease confidence in the counselor's potential helpfulness and result in a loss of clientele.

Keating and Fretz (1990) concurred that a potential negative effect exists when value disclosure is made, particularly when the
expressed values are at odds with those of the client. Participants con­sisted of 301 Christian students or adult volunteers of the Christian faith. Participants were given a Likert scale measuring the strength of their religious beliefs and anticipation about non-Christian counselors. They were provided a disclosure statement describing a Christian, secular, or spiritual-empathic secular counselor. The results of the study confirmed that participants with high religiosity scores had more negative anticipations about secular counselors and least negative ones about Christian counselors.

Two studies regarding value disclosure indicated that it was not as deleterious as was previously suggested regarding the willingness to see a therapist. Epperson and Lewis (1987) improved the previously described Lewis et al. (1983) study by editing the description of feminist therapist from a listing to a narrative form, adding a neutral therapist description, using the Attitudes Toward Feminism Scale (E. Smith, Feree, & Miller, 1975) rather than Attitudes Toward Women Scale, and including male subjects. Participants consisted of 232 college students. The results indicated that female and male subjects receiving explicit pre-therapy information formed a more complete picture of the counselor and her orientation than did subjects who received a label alone. Receiving explicit information decreased the willingness of female and male participants to see the feminist therapist, but did not affect the willingness to see the traditional counselor. The above results of male and female participants were statistically significant; however, the pattern was more pronounced for females than for males. There was no signifi­cant interaction effect between participants and counselors with feminist
value orientations.

The Epperson and Lewis (1987) study was replicated using a sample of 149 women entering treatment in a hospital or clinic system (Lewis et al., 1989). The same results were obtained in that more explicit information about therapist feminist values enhanced the ability of clients to accurately identify therapist beliefs. Pretherapy information in this study, however, did not significantly affect the willingness to see the counselor. The authors concluded that explicit pretherapy information is needed to enable clients to make an informed decision about entering therapy, particularly with a therapist with a more value-laden orientation.

Summary of Research on Specific Disclosure Issues

In summary, studies investigating the effects of sharing one aspect of pretherapy information were mainly conducted by analogue design and provided differing conclusions. Sharing information about the therapy process had no differential effect on client attitudes toward counseling or the counseling process (Mardirosian et al., 1990) or perception of appropriate topics for therapy (Nathan et al., 1978). Discussing the limits of confidentiality had no effect on the amount of self-disclosing statements made by clients (Muehleman et al., 1985) unless participants were told that information might not be confidential. In that case, participants in the nonconfidential condition made less self-disclosing statements (Woods & McNamara, 1980). Studies investigating disclosure of value-laden information such as views on religion, abortion, and premarital sex produced differing results. Two studies suggested
that explicit disclosure of religious or feminist values created negative perceptions of the therapist (Lewis et al., 1983; Lewis & Lewis, 1985). Other studies demonstrated that feminist value disclosure enabled clients to more accurately identify therapist beliefs (Epperson & Lewis, 1987; Lewis et al., 1989) and had no significant negative effect on perception of the therapist (Schneider, 1985). Value disclosure may have a negative effect if the therapist's values are at odds with those of the client (Keating & Fretz, 1990; Lewis & Walsh, 1980).

Disclosure of Multiple Therapy Issues

Investigations of the effects of the disclosure of multiple (two or more) informed consent issues were conducted recently. Descriptions of studies that demonstrated positive effects are described first, followed by studies showing no significant effects. To date, negative effects of multiple disclosure have not been documented in the research literature. These investigations are described in greater detail because the current study investigated comprehensive disclosure of all 12 informed consent issues (Hedstrom & Ruckel, 1992).

Positive Effects

Handelsman (1990) published the results of two analogue studies on the effect of written forms on first impressions of prospective clients towards therapists. In the first study, 129 male and female college students were randomly assigned to one of eight groups. All groups were given information about a hypothetical therapist, including data on the therapist's age, degree, and years in practice. Participants also
received a combination of other disclosure information including a legal
disclosure form, question sheet, and/or a brochure. One group received
no disclosure information, one group received all three documents, and
the other groups received a combination of documents. The legal dis­
closure form was prepared by the Colorado Psychological Association
(CPA) and contained information specific to the requirements of a new
state law. The legal form explained psychologist licensure and
encouraged the reader to inquire about treatment, fees, therapy process,
and confidentiality. The question sheet contained a list of questions a
client might ask a therapist (Handelsman & Galvin, 1988), such as "How
does your kind of therapy work?" The brochure was published by the
CPA Professional Standards Review Committee (1983) and contained
standard answers to general questions such as: "What is a psycholo­
gist?" "What kind of treatment might I receive?" and "Are my sessions
confidential?" All participants were given a questionnaire (the dependent
variable) containing seven questions regarding the likelihood of recom­
mending or seeing the therapist themselves, as well as opinions on
therapist likability, experience, and trustworthiness. Participants an­
swered the seven questions using a 7-point Likert scale. Results were
reported comparing the opinions of persons who received a particular
document with those who did not. Persons who received the legal
disclosure form (compared to those who did not receive it) were more
likely to refer themselves and a friend to the therapist and rated the
therapist higher on ability to help. Participants who received the legal
disclosure form and the brochure had an overall more positive reaction
and also rated more highly the therapist's experience. Persons who
received the question sheet rated the therapist as more trustworthy and likable and were more likely to refer a friend. Those who received the question sheet but not the brochure, were more likely to refer themselves to the therapist. Persons who received the brochure increased their judgments of therapist trustworthiness compared to those who did not receive the brochure. The author concluded that any type of written disclosure enhanced client perceptions of the therapist and therapy process.

The second study reported by Handelsman (1990) assessed the influence of therapist experience on the impact of written forms. The legal disclosure form and question sheet (described above) were included in this study. The legal form was given to each of 137 college students. Randomized group assignments were made to the following conditions: (a) presence or absence of question sheet and (b) low, moderate, or high experience statement about the therapist. Therapist experience was disclosed as 1 (low), 9 (moderate), or 19 (high) years of practice. The dates therapists received their degree and state license were also revealed. Persons who received the question sheet rated their therapist as more trustworthy and were more willing to see the therapist than those who did not receive the question sheet. Therapists with at least 9 years of experience (moderate and high groups) were recommended more and elicited a more positive reaction than those with 1 year of experience (low group). Therapists with low experience (1 year) were rated as significantly less experienced when the question sheet was absent. When the sheet was present, however, there was no effect on client perception of therapist experience. The author concluded that the use of
any written form had a positive effect on first impression, even if the therapist had less experience.

The impact of a combination of oral and written disclosure on first impressions of potential clients was measured in another study (Sullivan et al., 1993). Participants consisted of 124 college students who were randomly assigned to two groups. One group received the question sheet (Handelsman & Galvin, 1988) and were shown a therapy transcript containing informed consent material. In the transcript, the therapist and client discussed issues regarding risks, alternatives, confidentiality and its limits, and the length of treatment. The second group read the same therapy transcript with the informed consent material deleted and were not given the question sheet. Two other therapist variables were paraprofessional versus professional status and high versus low experience. Years of experience were presented as less than 1 year for the low and more than 9 years for the high group. Participants rated the therapist using the CRF-S (Corrigan & Schmidt, 1983). They were also asked three questions to rate on a 7-point Likert scale. These questions regarded the likelihood they would recommend the therapist to a friend, the likelihood they would see the therapist themselves, and an overall rating of the therapist. Persons who received a combined transcript and written informed consent procedure rated the therapist higher on the CRF-S and were more likely to refer a friend or say they would see the therapist themselves than those who received no informed consent material. Additionally, persons provided with informed consent procedures rated professional therapists as more trustworthy and expert than paraprofessionals. Participants rated experienced therapists higher.
overall on the CRF-S, and more expert, than inexperienced therapists. The authors concluded that in no instance did the presence of a consent procedure lead to more negative impressions of therapists.

**No Significant Effects**

Studwell (1984) investigated the effect of a professional disclosure statement on expectations about counseling. This field study utilized a sample of first time clients in a university counseling center. The 41 participants were alternately assigned to a treatment or control condition. The treatment group received a disclosure statement reflecting the philosophies and expectations of the counseling service staff. The control group received no disclosure information. Following the initial counseling session, participants completed the Expectations About Counseling, Form B (EAC) (Tinsley, Workman, & Kass, 1980). The staff also completed the instrument. No significant difference was found between the control, treatment, and staff groups on the total EAC score.

In an analogue study, the effect of disclosing information on expectations about counseling was also examined (Farley, 1987). Participants consisted of 186 undergraduate students enrolled in educational psychology classes. Participants were assigned to six groups, each group receiving disclosure information on a single topic. The topics were (a) process of counseling, (b) potential benefits of counseling, (c) rights in counseling, (d) confidentiality and its limits, (e) potential discomforts and risks in counseling, and (f) alternatives to counseling. A seventh group received information on all six topics, and a control group received no disclosure information. Three dependent variables were used. The
Expectations About Counseling Questionnaire (EAC) measured expectations about personal commitment, facilitative conditions, and counselor expertise and nurturance (Tinsley et al., 1980). The Counseling Preference Questionnaire (CPQ) was adapted and expanded from the Counselor Preference Questionnaire (Epperson & Lewis, 1987) and measured willingness to enter counseling for 15 problem areas. The Understanding of Counseling Questionnaire was designed by the researcher (Farley, 1987) and measured understanding of informed consent issues. Two findings were significant. Students who received information on (1) confidentiality and/or (2) potential alternatives to counseling scored significantly higher on the Understanding of Counseling Questionnaire than students who received no information on those topics. There was no significant difference between participants receiving no disclosure information, one disclosure issue, or comprehensive disclosure on counseling expectations or willingness to see a counselor.

In a field study conducted by Christiansen (1986), professional disclosure procedures likewise had no effect on client attitudes and perceptions. In this study, 48 students who requested counseling in a university counseling center were randomly assigned to a control or experimental condition. The experimental group was provided verbal and written disclosure information during the last 10 minutes of the initial counseling interview. The statement contained information on purposes, methods, techniques, and responsibilities involved in the counseling process, as well as brief biographical data on the counselor. The control group received no disclosure information. Participants completed the Attitude Toward Counseling Scale (ATC), the
Barrett-Lennard Relationship Inventory (BLRI), the Counselor Rating Form-Short (CRF-S), and the Information About Counseling Inventory (IAC). There were no significant differences between groups on any of the dependent variables.

Two other studies of multiple disclosure concurred that informed consent procedures had no effect on impressions of therapists (Handelsman & Martin, in press). In the first study, 72 college students were shown transcripts of an initial counseling session that included either positive or negative self-involving statements by the therapist. Self-involving statements were present tense, personal responses to the client by the therapist (e.g., "I like the good things I've seen about you"). Previous research indicated that self-involving statements produced higher initial ratings of therapists. The students were also randomly assigned to groups and received either no written informed consent material, difficult to read material, or highly readable informed consent information. The readability of the documents was measured by the Fry formula (Fry, 1977). The Fry readability graph provided a grade level score of written text based on the number of syllables per word and number of words per sentence of three 100-word samples. The Fry formula yielded scores corresponding to grade levels from 1 to 17+ (beyond college level). Although grade level scores do not necessarily predict understanding of material, a lower grade level score increases the potential for understanding. The informed consent material consisted of two versions of the Handelsman and Galvin (1988) question sheet. The sheet consisted of a list of questions that clients may ask therapists if they choose. The more readable (published) document was in outline
form and double spaced. It was written at a fourth grade readability level. The less readable document contained combined sentences and was single spaced. The Fry readability level of the less readable document was 10th grade. After participants read the therapy transcripts and informed consent materials, their responses were measured on three dependent variables: the CRF-S (Corrigan & Schmidt, 1983), a Likert scale, and a recall question. The Likert scale measured the likelihood that participants would recommend the therapist to a friend, the likelihood they would see the therapist themselves, and an overall rating of the therapist. The recall question asked participants to recall as many of the questions as possible from the informed consent material (question sheet) and write them down. Participants who received positive self-involving statements rated their therapist significantly higher on the Likert scale than those who did not. Informed consent procedures had no effect on perception or impression of the therapist; however, subjects recalled more of the readable material.

The second Handelsman and Martin (in press) study replicated the first, except that all 90 college students in the study received the positive self-involving transcript. Half the transcripts, however, contained statements regarding the right to informed consent. There was no significant difference in counselor ratings between participants who received the informed consent transcript statements and those who did not. Men recalled significantly more information from the highly readable form. Men who received the less readable form were less likely to recommend or counsel with the therapist and had a less positive reaction to the therapist than men who received no form at all. This final study
is the only one reported in the literature that demonstrated a negative
effect of providing multiple written disclosure issues. The negative
effect occurred only for men and only when the disclosure material was
difficult to read, contained long sentences, and was single spaced.

**Summary of Research on Multiple Disclosure**

Outcome data on the effect of providing several disclosure issues
to participants suggested that such disclosure had either no effect
(Christiansen, 1986; Farley, 1987; Handelsman & Martin, in press;
Studwell, 1984) or a positive effect (Handelsman, 1990; Sullivan et al.,
1993) on client perceptions of therapists or expectations of counseling.
The only negative impact demonstrated by research occurred with men
when written material was less readable (Handelsman & Martin, in
press).

**Other Relevant Variables**

A review of the research literature on the effects of pretherapy
disclosure suggested that several variables may have an interaction
effect with disclosure. Those variables (client gender, therapist experi-
ence, and educational level, and readability of disclosure documents) are
reviewed below.

**Gender**

Handelsman and Martin (in press) found that men had a signifi-
cantly poorer first impression of therapists and recalled less information
when they were given a less readable consent form. Woods and
McNamara (1980) found gender differences when participants were told that information might not be kept confidential. In that situation, women disclosed significantly less information than males.

**Years of Experience and Educational Level**

Handelsman (1990) found that therapists disclosing they had at least 9 years of experience were recommended to friends more than those with less experience. Sullivan et al. (1993) substantiated that therapists with 9 or more years of experience were rated higher on the expertness subscale and total score on the CRF-S. In the latter study, the effect of educational background was also investigated. Hypothetical therapists were described as paraprofessional (B.A. in English) or professional (Ph.D. in psychology). When participants were provided disclosure information, professionals received higher ratings than paraprofessionals on measures of trustworthiness and expertness.

**Readability**

Readability of the written disclosure statement was found to have an effect on recall (Handelsman & Martin, in press). Participants were provided with two versions of a consent form (Handelsman & Galvin, 1988). A highly readable version was written at a fourth grade level, as measured by the Fry (1977) formula. The less readable form utilized longer sentences and was single spaced, resulting in a 10th grade readability level. Participants remembered less of the less readable document.
Rationale for Present Study

Trends in the theoretical literature indicate the need to provide clients with comprehensive therapy information in writing and before therapy begins. The disclosure statements should be written with the purpose of protecting client rights and facilitating informed consent to participate in therapy. The effects of such disclosure methods need to be measured.

The review of literature provides several suggestions for study. Most importantly, there is a need for field studies using client populations. Published research on disclosure of multiple therapy issues has been conducted mainly by analogue design using nonclient populations (Handelsman, 1990, two studies; Handelsman & Martin, in press, two studies; Sullivan et al., 1993). Only two field studies involving disclosure of multiple therapy issues were found in the literature review and these were less recent (Christiansen, 1986; Studwell, 1984). A field study would increase the relevance of data to situations beyond the research setting.

There is also a need to provide clients with personalized therapist and therapy information. Current studies provide clients with a list of questions they might ask a therapist (Handelsman, 1990; Sullivan et al., 1993) or a general philosophical statement about therapy (Christiansen, 1986; Farley, 1987; Studwell, 1984). Theoretical articles, however, advocate the disclosure of individualized information about specific therapists and their techniques (Bray et al., 1985; Haas, 1991). Therefore, a study is needed utilizing such personalized disclosure
methodology.

The literature review has also identified several variables that have been related to the effect of therapist disclosure. These are gender (Handelsman & Martin, in press; Woods & McNamara, 1980), years of experience and educational level of the therapist (Handelsman, 1990; Sullivan et al., 1993), and readability of the written disclosure statement (Handelsman & Martin, in press). These variables are important considerations for inclusion in this study.

The dependent variable that has been utilized in prior research studies is the CRF and more recently, the CRF-S. Therefore, the same instrument will be included in this study to facilitate comparability (Heppner & Claiborn, 1988). (For a discussion of the CRF-S, see Instrumentation, CRF-S, Chapter III, p. 83). The general score, in addition to the three factors of expertness, attractiveness, and trustworthiness, should be obtained (Tracey et al., 1988). The CRF-S should be administered before actual client-therapist contact occurs, in order to separate the effect of disclosure from the impact of therapist verbal and nonverbal behaviors (Handelsman, 1992).

Prior studies on disclosure measured perceptions of participants, yet none investigated behaviors. Relying solely on self-report provides a narrow view and may contain considerable error (Heppner & Claiborn, 1989). The effect of disclosure on actual client behaviors should also be measured.

Drawing from the above literature review, research findings, and recommendations, the current study investigated the effect of comprehensive written pretherapy disclosure on client perceptions and
behaviors. An actual client population was utilized. Disclosure state­ments were personalized and written to facilitate informed consent to participate in therapy. The experimental group received information on all 12 therapy issues identified from the literature (Hedstrom & Ruckel, 1992). Other variables studied were client gender and therapist experience. Finally, the dependent variables consisted of client perceptions as well as the observed behaviors of client requests for a change in counselor, client attendance at the first session, and client-initiated termination of treatment. The CRF-S was utilized for comparison with prior studies and was administered before clients had contact with their therapists. The methodology of the present study is described in the next chapter.
CHAPTER III

METHODOLOGY

Overview of the Chapter

This chapter provides an extensive account of all the activities involved in this research project. The information is provided in temporal order. Therefore, the chapter begins by describing the preparation of the materials needed for the research study. The second section describes the instrumentation, the Pretherapy Questionnaire. A description of the items contained in the Pretherapy Questionnaire and justification for their inclusion in this study are given. The third section provides background information about the setting in which the research study took place. The fourth section describes the research procedures, which includes a flow chart to assist the reader in understanding the process. The fifth section describes the data analysis of the five issues investigated in this study. Chapter III concludes with a summary of the methodology.

Preparation of Research Materials

This section describes the materials that were prepared before the research study was conducted. Those materials included human subjects board approval for the study, development of the control and treatment group disclosure statements, determination of readability level of disclosure statements, and creation of the consent and random assignment forms.
Approval for the Study

Applications for approval of this study were submitted to the human subjects review boards at Northern Illinois University, DeKalb (where the study took place), and Western Michigan University, Kalama-zoo (where the researcher’s doctoral program is located). Both boards approved the study under the exempt classification (see Appendix J).

Control Group Statement

A written statement was prepared to be sent in the mail to all participants assigned to the control group. This statement contained information about the name of the therapist, time and date of appointment, and explanation of the procedure regarding missed appointments (see Control Group Statement, Appendix D). The control group statement contained one issue of pretherapy data (length and frequency of sessions). This statement duplicated procedural data provided to all Counseling and Student Development Center (CSDC) clients in the packet of forms given them prior to their intake session. Therefore, the control group did not receive information on any additional disclosure issues identified in the literature (Hedstrom & Ruckel, 1992).

Treatment Group Disclosure Statements

The treatment group disclosure statements contained the same information provided to the control group plus additional personalized information about their particular therapist. The statement also included information about the therapy process (e.g., risks and alternatives to
therapy) that was identical across all participating agency therapists.

All 17 therapists at CSDC volunteered to participate in this study, and a personalized disclosure statement was prepared for each. Therapists were instructed to provide approximately one typed page describing their education, experience (including the exact number of years of practice), therapy methods or techniques, area of specialization, and whether they were supervised and/or licensed. The data provided by therapists included two issues of pretherapy information identified in the literature (Hedstrom & Ruckel, 1992): description of therapy process and therapist qualifications (see Appendix G for Sample Therapist Statement).

Using data provided by therapists, standardized information was added to the statements regarding two additional pretherapy issues: supervision and the name and address of the board regulating the therapists' practice. The documents of nonlicensed therapists revealed the fact that they were supervised and provided the name, address, and telephone number of the director of CSDC as the person to contact in the event of questions or concerns regarding therapy practice. Ten of the 17 CSDC therapists were nonlicensed. Six of those persons were practicum students or interns with master's degrees in the area of psychology. Four persons had received their doctorate degrees in psychology but had not yet met the supervised experience requirements for licensure. The remaining disclosure documents stated that the therapist was licensed and gave the name, address, and telephone number of the appropriate board regulating that therapist's practice. Seven of the CSDC therapists were licensed. Five of those persons
were licensed psychologists, one was a licensed psychiatrist, and one was a licensed social worker.

Information on four additional pretherapy issues were added in standardized format to the treatment group disclosure statements: expectations or anticipated results, possible risks of therapy, alternatives to treatment, and cost. The disclosure statements, therefore, contained a total of eight issues of pretherapy information (see Sample Treatment Statement, Appendix E).

**Determination of Readability Level**

The readability levels of the Control Group Statement and Treatment Group Disclosure Statements were improved upon in this study. Prior research indicated that readability level was an important consideration in preparing a professional disclosure statement (Handelsman & Martin, in press). In their study, persons who received a more readable document recalled more of the data. The "more readable document" was written in outline form, double spaced, and at a fourth grade readability level. The "less readable document" contained combined sentences, was single spaced, and written at a 10th grade level. Samples of disclosure statements used in actual practice indicated that documents are typically written at a 12th to 14th grade level (Handelsman et al., 1986; Hedstrom & Ruckel, 1992). The importance of lowering the readability level of the disclosure statements was recognized in this study.

Therapists were asked to use short sentences with words containing few syllables and to avoid technical jargon in their disclosure
statements. The information provided by CSDC therapists was analyzed for readability level using the Grammatik Max computer software program (Reference Software, 1990). This program is based on the Flesch (1948) readability formula. The statements submitted by staff had a readability range from Grade 8 to 14. The documents were altered by this researcher until they reached a grade level of 8 to 10 and then were returned to therapists for approval. The standardized statements written by this researcher and added to the documents were written at an eighth grade level. The overall readability level of the finished treatment group documents therefore ranged from the eighth to ninth grade level equivalent. The control group statement was written at an eighth grade level.

Readability formulas are based on sentence length and number of syllables per word. It was therefore difficult to obtain a lower grade level for two reasons. The documents were written in letter form, thus necessitating full sentences rather than an outline. The personalized nature of the documents required names of institutions, degrees, and therapy procedures. These words generally contained many syllables. (University, for example, contains five syllables and graduated and psychology each contain four.) Although the eighth to ninth grade level was not as low as recommended in the literature, it was considerably lower than typical documents used in practice and seemed appropriate for use with a college population.

Consent Form

A consent form to participate in a research study (see Appendix B) was developed and approved by the human subjects research boards at
Northern Illinois University, DeKalb, and Western Michigan University, Kalamazoo. This document described the purpose, possible risks, and procedures of this study. Anonymity of responses was assured. Students were asked to volunteer to participate by signing the form and keeping one copy. Only students who volunteered were considered for inclusion in this study.

Random Assignment Form

A form was developed identifying the order in which participants were assigned to the control or treatment condition (see Random Assignment Form, Appendix C). The form was numbered from 1-77. Using a table of random numbers, an arbitrary starting point was selected by placing a finger on the table. Beginning at that point, odd numbers were listed as "treatment" and even numbers were listed as "control" on the assignment sheet.

Instrumentation

This section contains a description of the research instrument utilized in this study, the Pretherapy Questionnaire. The Pretherapy Questionnaire consisted of the Counselor Rating Form-Short (CRF-S) (Corrigan & Schmidt, 1983), four multiple choice questions, three open-ended questions, and demographic questions. The CRF-S is presented first, including a review of the literature on reliability and validity studies. Justification for the selection of the CRF-S is given. Two additional points are made regarding the CRF-S. The instrument should be given to participants before they have contact with their therapist and the total
score should be tabulated in addition to the subscale scores. Next, the development and justification of the multiple choice and open-ended questions on the Pretherapy Questionnaire are described. Finally, the demographic questions and the reasons for including each item are explained.

**Counselor Rating Form-Short (CRF-S)**

The CRF-S (Corrigan & Schmidt, 1983) was included in the beginning of the Pretherapy Questionnaire (see Appendix F). The CRF-S is a shortened version of the Counselor Rating Form (CRF), developed by Barak and LaCrosse (1975) to measure perception of the therapist. The CRF and CRF-S are based on social influence theory, which attempts to explain the process of change in therapy (Strong, 1968). According to this model, there are two stages in helping clients change. First, therapists must establish themselves as useful resources in the clients' eyes; and second, they must influence clients in a therapeutic manner. Three therapist characteristics have been identified that generate influence in the first stage. These are therapist expertness, attractiveness, and trustworthiness. Strong's social influence theory "has emerged as a major research theme in the counseling literature" (Heppner & Claiborn, 1989, p. 366). A review of the research literature based on social influence theory between 1981 and 1988 (Heppner & Claiborn, 1989) reveals that of 56 empirical investigations, most of the studies used the CRF or CRF-S.

The CRF was developed to measure the therapist attributes of expertness, attractiveness, and trustworthiness. This instrument con-
sists of 36 descriptions of therapist characteristics with 12 items meas-
uring each of the above three constructs. Clients rate their therapist on
a 7-point Likert scale containing negative and positive bipolar adjectives
(e.g., alert, unalert). The validation study of this instrument was based
on a sample of college students who viewed filmed excerpts of Carl
Rogers, Fritz Perls, and Albert Ellis conducting an interview with the
same client (Barak & LaCrosse, 1975). The internal consistency of the
scales for the three therapists ranged from .75 to .93 with a median
of .89. The CRF has been recognized as "the most commonly used and
best validated instrument for assessing these three social influence at-
tributes" (Epperson & Pecnik, 1985, p. 143).

The CRF-S (Corrigan & Schmidt, 1983) is a shortened version of
the CRF (Barak & LaCrosse, 1975). It was designed to decrease the
length of the instrument while maintaining reliability, reduce the reading
level, and facilitate the full use of the 7-point scale. The CRF-S reduced
the number of items from 36 to 12, with 4 items on each construct.
The reading level was reduced from 12th grade to 8th. The negative
adjective of each bipolar item was eliminated so that the scale read "not
very" and "very." This change was made in an attempt to reduce a
ceiling effect that had been noted on the CRF. Examples of adjectives
measuring expertness (one of the three constructs) are "experienced,
expert, prepared, and skillful."

The validation of the CRF-S consisted of two procedures (Corrigan
& Schmidt, 1983). The first procedure duplicated that used in the vali-
dation of the CRF, specifically the use of a sample of college students
rating the Rogers, Perls, and Ellis film. The second procedure used a
sample of actual clients. In the replication study, a sample of 133 subjects was obtained. In the extended study, 155 clients participated. This validation study indicated an internal consistency of the scales which ranged from .82 to .94 with a median of .91.

A validation study was completed comparing the results of the CRF with the CRF-S (Epperson & Pecnik, 1985). A sample of 215 college students viewed the Rogers, Perls, and Ellis film and rated the therapists on either the CRF or CRF-S. The internal consistency of the CRF scales for the three therapists ranged from .77 to .93 with a median of .87. The consistencies of the CRF-S ranged from .63 to .89 with a median of .82. The reliability of the trustworthiness scale on the CRF-S was significantly lower than the CRF. The interscale correlations in both instruments were similar, in that the correlation of attractiveness and expertness was lower than the correlation of either of these scales with trustworthiness. The interscale correlations on the CRF ranged from .30 to .92 with a median of .77. On the CRF-S, these correlations ranged from .27 to .72 with a median of .59. This study, then, found greater independence of the CRF-S scales.

A question that remains regarding the CRF and CRF-S is the interdependency of the three constructs of expertness, attractiveness, and trustworthiness (Heppner & Claiborn, 1989). The original model was a three factor orthogonal concept (Barak & LaCrosse, 1975). When the scales were found to be intercorrelated, a three factor oblique model was proposed (LaCrosse, 1977). This model still demonstrates a higher intercorrelation among the factors than would be expected. Heesacker and Heppner (1983) proposed a one factor, general satisfaction with the
counselor, model. Recently, these three models have been investigated in a factor analysis of the CRF-S (Tracey et al., 1988). According to this study, the CRF-S scores should be analyzed in terms of a two-step hierarchical factor structure. The first step is the three specific first-order factors of expertness, attractiveness, and trustworthiness. The second step is the factor of general satisfaction with the counselor.

In the review of research literature on disclosure, studies often used client perception of the therapist as the dependent variable (e.g., Handelsman, 1990; Lewis & Lewis, 1985; Sullivan et al., 1993). The instrument selected in many of the earlier studies was the CRF (Lewis & Lewis, 1985; Lewis & Walsh, 1980; Mardirosian et al., 1990; Schneider, 1985). More recent research on disclosure of multiple therapy issues used the CRF-S for instrumentation (Christiansen, 1986; Handelsman & Martin, in press; Sullivan et al., 1993). Heppner and Claiborn (1989) recommended the use of the CRF-S for comparability with previous studies and it was therefore selected for this research study. Permission to use the CRF-S was obtained from the author (see Appendix K).

Once it was determined that the CRF-S be used as a dependent variable in this study, two additional procedural decisions had to be made: Should the total or subscale scores be used and when should the instrument be provided to participants? As reported above in the review of the validation studies of the CRF-S (see CRF-S, p. 83), questions remain regarding the factor structure of the instrument. In Heppner and Claiborn's (1989) extensive review of social influence research in counseling, they suggested that in using the CRF-S "researchers need to follow the recommendation of Tracey et al. [1988] and interpret their
results in terms of the general factor as well as the three specific first-order factors" (p. 378). Therefore, the total score, as well as the subscale scores of attractiveness, expertness, and trustworthiness, was calculated in this study.

The second procedural question pertained to the timing of the CRF-S measurement. In research studies using the CRF or CRF-S, the instrument was administered after the first client-therapist session. In the review of social influence research (Heppner & Claiborn, 1989), several factors were found to have significant effects on client perceptions of therapist attractiveness, expertness, and trustworthiness. Some of these factors were counselor responsive nonverbal behavior, status cues (attire, diplomas) and verbal behaviors (self-disclosure, self-involving statements). In other words, the events clients experienced or saw during a session had a significant positive or negative effect on their perception of the therapist. In a recent study by Handelsman and Martin (in press), the positive effect of a disclosure statement was confounded by the addition of actual therapist behaviors. The conclusion drawn from the above research was that studies measuring the impact of a pre-therapy disclosure statement should measure such impact before actual therapist contact. It was recommended to this researcher (Handelsman, 1992) that the CRF-S be administered after clients received disclosure information but before they saw their therapist. The CRF-S was therefore given to clients before their first session.

Impact of Therapist Disclosure

The Pretherapy Questionnaire contained four multiple choice questions to assess the impact of disclosure information upon clients
(see Pretherapy Questionnaire, Appendix F, Questions 1-4). These questions were selected to investigate the claim made by some theorists that disclosure might have a negative effect on clients (Haas, 1991; Winborn, 1977). The first question was: "Which written information did you find most helpful?" Choices were: "1st session (intake)," "mailing," or "not sure." This question was selected to investigate whether typically-disclosed items that were provided at intake (e.g., confidentiality and type of clients) or seldomly-disclosed items (such as risks and alternatives to treatment) were considered most helpful (Hedstrom & Ruckel, 1992; Handelsman et al., 1986). The second question was: "From the written material you received, do you believe you have a good idea of what to expect in counseling?" Choices were: "no," "yes," or "somewhat." Question 2 was selected to investigate the claim that disclosure might produce a negative set in the client (Jordan & Meara, 1990). The third question was: "Did the information you read have an influence on your wish to participate in counseling?" Choices were: "no" or "yes." If participants answered yes, they were asked to indicate the type of influence. Choices were: "positive" or "negative." Question 3 was selected for comparability with recent analogue studies that measured the likelihood of participants recommending a therapist to a friend or seeing the therapist themselves (Handelsman, 1990; Handelsman & Martin, in press; Sullivan et al., 1993). The fourth question was: "Did the information you read help you better understand what counseling will be like?" Choices were: "no," "yes," or "not sure." Question 4 was selected for comparability with a prior study investigating the understanding of written documents (Handelsman & Galvin, 1988).
Suggestions for Improving Disclosure Statements

Three open-ended questions were included on the Pretherapy Questionnaire to obtain opinions from participants that might provide data to improve the content of future disclosure statements (see Pretherapy Questionnaire, Appendix F, Questions 4a, 4b, and 5). These questions were: "Which information was most helpful in understanding the counseling process?" "In what way was the information helpful?" "Is there other information that would have been helpful for you to receive about your counselor or the counseling process?" "(Please describe.)"

Client Descriptive Information

The Pretherapy Questionnaire collected the following descriptive information: gender, age, name of assigned therapist, and whether or not the participant had prior counseling (see Pretherapy Questionnaire, Appendix F). Client gender information was collected as an independent variable in this study, since differential gender responses were found in prior research studies. Handelsman and Martin (in press) found that males had a poorer impression of therapists and recalled less information when they were provided a less readable disclosure form. In another study (Woods & McNamara, 1980), women disclosed significantly less information when confidentiality was not assured by the therapist.

Therapist name data were collected on the Pretherapy Questionnaire to enable the researcher to determine the experience level of the therapist to whom the participant had been assigned. Therapist
experience was an independent variable used in analyzing treatment group results. Therapist experience was selected as an independent variable because prior research indicated that therapists with 9 or more years of experience were recommended to friends more than those with less experience (Handelsman, 1990) and were rated higher on the expertness subscale and total score of the CRF-S (Sullivan et al., 1993). The therapists in this study were divided into two experience groups: those with 9 or more years of therapy experience and those with less than 9 years. The 9-year cut-off was selected for comparison with prior studies. Of the 17 therapists providing disclosure statements, 11 reported 9 or more years of experience. The information regarding years of experience was provided to treatment group participants in the treatment letter (see Sample Treatment Statement, Appendix E).

Information on age was used to describe the sample and determine if research participants were representative of the general client population at CSDC. Prior therapy status provided anecdotal information about the sample; however, it was beyond the scope of this research project to study such data due to sample size restrictions.

A question on the Pretherapy Questionnaire was whether participants had prior knowledge about their therapist, in addition to that provided by CSDC (see Pretherapy Questionnaire, Appendix F, Question 6). This question was asked to control for the effect of personal contact on perception of the therapist. Participants who had seen their therapist for intake or prior therapy were eliminated from the study.

Finally, the Pretherapy Questionnaire itself was color-coded to identify control and treatment group participants, the main independent
variable in the study. White questionnaires indicated control group status, while off-white questionnaires indicated treatment group assignment.

Description of Research Setting and Typical Procedures

This section contains a description of the setting in which the research study took place. Since the researcher wanted to avoid interfering with the daily agency procedures and wanted a naturally occurring field setting, the study was designed to fit into the existing system as much as possible. Therefore, a description of the typical clientele and practices at the Counseling and Student Development Center (CSDC) at Northern Illinois University (NIU) are summarized as a backdrop for the current study. Flow charts are provided to assist in visualizing the temporal order of events.

This study was conducted in the CSDC at NIU during the 1992-93 school year. CSDC is the only mental health service agency on a campus of 25,000 students. The agency serves the entire university community through assessment, treatment, consultation, outreach, and referral services. The majority of clients (all of whom are students) are 18 to 30 years old, two-thirds female, and about 14% minorities (Hotelling, 1993).

The typical client experiences at CSDC are presented in temporal order in Figure 1. Students who requested personal therapy at CSDC were scheduled for an individual intake session. Prior to that appointment, they were asked to fill out several forms and read information about the center (see Appendix A, CSDC Intake Materials). Included in
the packet of forms was information on four pretherapy issues. These were (1) services provided and/or type of clients, (2) rights and limits of confidentiality, (3) length and frequency of sessions, and (4) right to terminate treatment (Hedstrom & Ruckel, 1992).

At intake, students met with therapists and received a recommendation regarding treatment (see Figure 1). Students were either closed at intake (issue resolved, client refused treatment, or referred to an outside agency), assigned to group therapy or career counseling, or asked to wait for assignment to an individual personal therapist. When therapist assignments were made, students were notified by telephone or letter of the date and time of their appointment, name of therapist, and a reminder of the CSDC policy on missed appointments. Finally, students attended their first session.

The internal procedures followed by staff after the intake appointment are presented in temporal order in Figure 2. The files of students who were recommended for individual personal therapy at CSDC were given to the clinical coordinator. The coordinator made
therapist assignments when openings occurred in therapist schedules. The assigned student files were sent to the secretary, who matched scheduling information obtained from students with therapist availability. Appointments were scheduled on the master calendar. Students were notified by the secretary of their appointment date and time. When clients terminated from treatment, the therapist completed a closing report, which included the reason for termination (see Closing Report, Appendix I).

Description of Research Procedures

Several changes were made in the routine CSDC procedures to accommodate this research study. The specific procedures that differed from the typical methods at CSDC are presented below in the order in which they occurred. This section begins with information on the selection of participants, including the requirement of a signed consent form and criteria for inclusion in the study. Data regarding numbers of students eliminated from and included in the study are provided. Second, information about random assignment to the control or treatment condition is presented. Third, the distribution of pretherapy information is described. The final section describes data collection procedures. Three types of data were collected before therapy began. These included
requests for a different therapist, attendance at the first therapy session, and completion of the Pretherapy Questionnaire. A fourth data collection procedure, tabulation of client-initiated terminations, occurred after treatment ended.

Figure 3 provides a temporal outline of the research procedures. The items presented in boxes represent client experiences. Events described inside circles represent internal staff procedures. Items enclosed in triangles are data collection processes.

Figure 3. Research Procedures.
Selection of Participants

A change was made in the routine procedure during the 1992-93 school year, due to this research study. Students were asked to read a new form before intake: the Consent to Participate in Research Study form (see Appendix B). Students volunteered for this study by signing the consent form and keeping a copy for their records. The original copy was placed in the student's file. The form was not offered to students in an emergency or crisis situation. Emergencies were defined by students as the need to see a therapist immediately, rather than wait for an intake appointment. Information regarding the consent form is presented in Table 4.

Table 4
Consent Form Data

<table>
<thead>
<tr>
<th>Emergency appointments (not given consent form)</th>
<th>Did not complete consent form</th>
<th>Signed consent form</th>
<th>Total students</th>
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<tr>
<td>n %</td>
<td>n %</td>
<td>n %</td>
<td>n %</td>
</tr>
</tbody>
</table>

169 27 45 7 403 65 617

Of 617 total students seeking therapy at CSDC, 403 (65%) signed the consent form. The consent form was not offered to 169 students with emergency appointments. Forty-five students (7%) did not complete the consent form (refused to participate or the form was mistakenly missing from the packet of materials).
Stringent participant selection procedures were followed to reduce the possibility of interaction of incidental variables. Table 5 presents client assignment information. Of the 403 students who signed the consent form, only 63 persons (16%) were deemed appropriate for the study. Only students assigned to individual personal therapy at CSDC were considered. Sixty-one students who were assigned to group therapy and one student assigned to career counseling were therefore eliminated. There was also a group of 187 students (46%) who were never provided a therapist assignment. The files of 183 of those

<table>
<thead>
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<th>Category</th>
<th>n</th>
<th>%</th>
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</thead>
<tbody>
<tr>
<td>Under age 18</td>
<td>3</td>
<td>1%</td>
</tr>
<tr>
<td>Group therapy</td>
<td>61</td>
<td>15%</td>
</tr>
<tr>
<td>Career counseling</td>
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<td>--</td>
</tr>
<tr>
<td>Individual counseling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assigned to researcher</td>
<td>18</td>
<td>4%</td>
</tr>
<tr>
<td>Assigned to intaker</td>
<td>70</td>
<td>17%</td>
</tr>
<tr>
<td>Assigned to research study</td>
<td>63</td>
<td>16%</td>
</tr>
<tr>
<td>Not assigned</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Closed at intake</td>
<td>183</td>
<td>45%</td>
</tr>
<tr>
<td>Waiting list</td>
<td>4</td>
<td>1%</td>
</tr>
<tr>
<td>Total students</td>
<td>403</td>
<td></td>
</tr>
</tbody>
</table>
students were "closed at intake." Those students were either referred to another agency, refused treatment, left school, or resolved their issues. The remaining 4 students were not assigned because of a waiting list situation at CSDC. There were several additional categories of exclusion. To comply with the human subjects research board requirements, 3 students under age 18 were excluded. To assure objectivity, 18 students who saw this researcher for intake or who were assigned to her for treatment were also eliminated. Additionally, to control for the possible effect of prior knowledge of the therapist, 70 students (17%) whose assigned therapist was the same person they saw at intake were omitted from the study. A total of 63 students (16% of those who signed the consent form) were selected for participation in this research project.

Control and Treatment Group Assignment

As per the usual CSDC procedure, the clinical coordinator was provided with the files of students waiting for assignment to an individual personal therapist. For the purpose of this study, the coordinator was also provided with a Random Assignment Form (see Appendix C). At therapist assignment time, volunteers selected for participation in this study were also assigned to the control or treatment group. The coordinator looked at the form and in sequential order, assigned participants to the control or treatment group as indicated on the form. A note was attached to the front of the participant's file indicating "c" or "t" and the name of the therapist to whom the participant had been assigned. Files were given to the secretary for scheduling. The
secretary assigned an appointment time as per usual routine and wrote a "c" or "t" after the participants' names on the calendar. A change in routine was made to accommodate this research study; appointment notification was conducted solely in writing, not by telephone, and by standardized procedures (see next section).

**Distribution of Disclosure Information**

After the secretary made the appointment on the calendar, control group participants were mailed a letter that stated the date and time of their appointment, name of therapist, and a reminder of the CSDC policy on missed appointments. (This was the same information that was given to nonparticipants; however, the data were provided to the control group by standardized letter.) The control group document did not contain information on any additional pretherapy issues (see Control Group Statement, Appendix D). The control group therefore received only the original four pieces of pretherapy information that was provided to all CSDC clients before the intake session. This information included: (1) services provided and/or type of clients, (2) rights and limits of confidentiality, (3) length and frequency of sessions, and (4) right to terminate treatment (Hedstrom & Ruckel, 1992).

Treatment group participants received the above information, plus additional data, by standardized letter. Their mailing included the personalized disclosure statement written by their therapist (see Sample Treatment Statement, Appendix E). Treatment group participants received information on eight more pretherapy issues. These were: (1) therapy process or techniques, (2) expectations and/or anticipated
results, (3) possible risks, (4) alternatives to therapy, (5) qualifications of therapist, (6) fees, (7) identification of supervisor, if applicable, and (8) identification of board of licensing. The treatment group therefore received information on all 12 pretherapy issues (Hedstrom & Ruckel, 1992).

Two procedural issues regarding the distribution of control and treatment group statements were considered in designing this study. These were timing of mailings and verification that information was received. These issues are discussed below.

**Timing of Mailings**

The control and treatment group letters were mailed to participants 5-10 days prior to scheduled appointments. CSDC often had a waiting list and some clients waited up to 2 months to secure an appointment time. The letters were therefore mailed near the appointment time to increase recall of written material.

**Verification That Mailings Were Received**

Participants were informed of their appointment dates and times only by letter. Therefore, attendance at their first therapy session confirmed that the mailing had been received. If clients did not attend, they were telephoned and asked if they wanted to reschedule their appointment. If they had not received a letter, their addresses were verified and a second mailing was sent.
Data Collection Procedures

In this study, four general types of data were collected. One type was opinions and perceptions of clients as reported on the Pretherapy Questionnaire. The other three types of data were behavioral outcome measures. Data were collected on requests for a different therapist, attendance at the first session, and client-initiated termination. The data collection procedures and the reasons these particular measurements and outcomes were chosen are described below in temporal order of their occurrence. The data collection procedures are encased in triangles on the flow chart in Figure 3 (p. 94).

Request for a Change in Therapist

Data were collected on the number of control and treatment group participants who requested a change in therapist after receiving pre-therapy disclosure but before attending their first therapy session. This outcome measure was chosen because results from surveys of therapists in the field suggested that practitioners believe written disclosure will create a negative impression of the therapist (Handelsman et al., 1986; Somberg et al., 1993). The current study investigated this issue empirically. Requests for a change in therapist were handled by the clinical coordinator. The coordinator filled out the Request for a Change in Counselor Form (see Appendix H) and indicated the reason for the request and whether receipt of pretherapy information was the basis for the request.
Attendance at First Session

Data were collected on the number of control and treatment group participants who attended their first session after receiving pretherapy information. This outcome measure was selected to improve upon measures obtained in prior studies of the effects of pretherapy disclosure. In analogue studies reported in the literature, data were collected on clients' opinions regarding whether they would recommend a hypothetical therapist to a friend or see the therapist themselves (Farley, 1987; Handelsman, 1990; Sullivan et al., 1993). Analogue studies can only infer whether disclosure may influence attendance in therapy. Studies using a client population have likewise not measured actual behaviors, but instead have used paper and pencil attitude and opinion tests (Christiansen, 1986; Studwell, 1984). This study collected data on the actual number of participants who attended their first therapy session after receiving pretherapy information. These data were obtained from the Closing Report (see Appendix I) that was filled out by therapists when treatment was terminated.

Pretherapy Questionnaire

Participants who attended the first therapy session completed the Pretherapy Questionnaire (see Appendix F) before they met with their therapist. This methodology was utilized to isolate the effects of written disclosure and avoid the confounding effects of actual therapist verbal and nonverbal behaviors. The reasons for the selection of the items in the Pretherapy Questionnaire were described in the section on
instrumentation (see p. 82).

The Pretherapy Questionnaire was color-coded to identify participants as members of the control or treatment group, since names were not used for anonymity purposes. By looking at the central calendar, the secretary gave the white questionnaire to students with a "c" by their name and an off-white questionnaire to those with a "t." Participants completed the instrument and handed it to the secretary. The secretary checked the document to be sure that the CRF-S was filled out entirely and that client gender and name of therapist were reported.

**Client-Initiated Terminations**

The final outcome measure was collected at the end of therapy. Data were tabulated on the number of control and treatment group participants who initiated termination of treatment. This outcome measure was selected to investigate empirically the speculation reported in theoretical articles that pretherapy disclosure will have a negative impact on therapy (Hare-Mustin et al., 1979; Jordan & Meara, 1990; Winborn, 1977). Information regarding the reason therapy was terminated was noted by the therapist on the Closing Report (see Appendix I). Choices provided to the therapist on the report form were that termination was initiated by the client, therapist, mutual decision, or other reason (referred to another agency, graduation, withdrawal from school, etc.). Client-initiated termination was selected for measurement since it best represented a "negative" (deliberate client choice) outcome. Client-initiated termination was reported by the therapist on the Closing Report.
when clients left therapy prematurely, either by stating they no longer wished to continue or by dropping out of treatment.

Research Design and Data Analysis

This research utilized an experimental design to investigate possible cause and effect relationships regarding the disclosure of pretherapy information. Participants were randomly assigned to treatment and control conditions. The treatment group was provided comprehensive pretherapy information on 12 issues, while the control group received information on only 4 issues identified in the research literature (Hedstrom & Ruckel, 1992). The results of treatment and control group participants were compared regarding three main areas of investigation. They were the effects of comprehensive versus partial pretherapy disclosure on (1) perception of the therapist, (2) opinions and attitudes toward therapy, and (3) actual client behaviors. The overall research hypothesis was that there would be no differential effect between participants who were provided comprehensive data and those who received only partial pretherapy information. This hypothesis was selected as a result of the review of the research literature on multiple disclosure. Most of those research studies demonstrated no significant effects (see Disclosure of Multiple Therapy Issues in the Review of Literature, p. 64).

Two other issues were investigated in this study. One issue was whether therapist experience affected clients' perceptions of therapists. Since only the treatment group was provided information on therapist experience, that issue was studied using only the treatment sample. The second issue investigated participants' suggestions for improving
pretherapy disclosure documents.

Data analyses were conducted and are described in detail below under five separate headings. The three main areas of investigation (differential effects of comprehensive versus partial disclosure on [1] perception of therapists, [2] opinions and attitudes toward therapy, and [3] client behaviors) are described first. These analyses utilized full sample data. Next, treatment group-only data are analyzed investigating the effect of therapist experience on perception of therapist. Under each of these first four headings, data analysis descriptions include justification for selecting the investigation area, statement of the research questions, description of independent and dependent variables, and statement of the null hypothesis. The statistical procedures used to test the null hypothesis, and justification of their selection, are provided.

The final section describes the qualitative data analysis procedures utilized to investigate participants' suggestions for improving pretherapy documents.

**Effect on Perception of the Therapist**

One main research area investigated was the effect of comprehensive versus partial pretherapy disclosure on perception of the therapist. This area was selected to improve on prior analogue studies by using an actual client sample. The review of literature identified client gender as a variable that might affect client perception of therapists. Therefore, gender was also investigated in this study. The analysis of data was conducted to address the following three questions:
1. What effect does comprehensive versus partial disclosure of pretherapy information have on clients' perceptions of therapists?

2. What effect does client gender have on clients' perceptions of therapists?

3. Does comprehensive disclosure have a differential effect on males and females in perception of therapists?

The independent variables in this study were control versus treatment group and client gender (male versus female). The dependent variables were scores obtained on the CRF-S. This instrument was selected to enable the research results to be compared with previous studies on multiple disclosure which used the CRF-S. The subscale scores of therapist expertness, attractiveness, and trustworthiness were calculated. In accordance with recent recommendations in the literature (Tracey et al., 1988) the total score was also tabulated.

The null hypothesis was that no significant difference would be found between the means of treatment, control, client gender groups, or their interactions, on the four variables of therapist expertness, attractiveness, trustworthiness, and combined attributes as measured by the CRF-S. Acceptance of the null hypothesis was anticipated.

Two statistical procedures were selected to test the null hypothesis. The first procedure was a multivariate analysis of variance (MANOVA). This test was selected to simultaneously evaluate mean differences between treatment versus control, male versus female, and the interaction of treatment by gender, on the three subscale scores of the CRF-S. If a significant effect was found, follow-up analyses of variance (ANOVAs) would be conducted to explain group differences.
The second statistical procedure selected was a two-factor ANOVA. This test evaluated mean differences between treatment versus control, male versus female, and the interaction of treatment by gender on the total score of the CRF-S.

The Statistical Package for Social Sciences (SPSS) was used to compute the data, utilizing multivariate tests of significance and univariate F tests (Norusis, 1990). Two multivariate test statistics were reported to compare obtained values to what would be expected if the null hypothesis was true. Those two tests, the Wilks' lambda and Pillai-Bartlett trace, were selected because they are considered the most widely used and most robust, respectively (Bray & Maxwell, 1985). A conventional alpha level of .05 (Isaac & Michael, 1989) was selected for significance.

Effect on Opinions and Attitudes Toward Therapy

A second area investigated in this study was the effect of pre-therapy disclosure on client opinions and attitudes toward therapy. This topic was selected to research empirically the speculations that have been advanced in the literature that disclosure will have a negative effect on treatment (Hare-Mustin et al., 1979; Jordan & Meara, 1990; Winborn, 1977). Research questions were developed for comparison with recent studies of comprehensive disclosure that suggest that disclosure may have an initial positive effect (Handelsman, 1990; Sullivan et al., 1993) or no effect (Christiansen, 1986; Farley, 1987; Handelsman & Martin, in press; Studwell, 1984) on clients' perceptions of therapists and/or willingness to see a hypothetical therapist. Four research
questions were developed:

1. Will participants who received personalized therapist information and data on risks and alternatives to treatment find such information more helpful than others who received just typically-disclosed therapy information?

2. Will participants who received comprehensive pretherapy data believe they have a better idea of what to expect in counseling than those who received only partial information?

3. Will the receipt of comprehensive pretherapy data have more of an influence on the wish to participate in therapy than the receipt of partial information? Will that influence be more positive or negative for participants who received comprehensive data?

4. Will participants who received comprehensive pretherapy data claim to have a better understanding of the counseling process than those who received only partial information?

The independent variable studied was treatment and control group status. The dependent variable was multiple choice answers to questions on the Pretherapy Questionnaire (see Appendix F). The questions were designed specifically to provide answers to the above four research questions.

Four null hypotheses were developed:

1. The proportion of participants who responded "1st session," "mailing," and "not sure" to the question "Which written information did you find most helpful?" would be the same for the control and treatment group.
2. The proportion of participants who responded "no," "yes," and "somewhat" to the question "From the written material you received, do you believe you have a good idea of what to expect in counseling?" would be the same for the control and treatment group.

3. The proportion of participants who responded "no," and "yes" to the question "Did the information you read have an influence on your wish to participate in counseling?" would be the same for the control and treatment group. Of those who responded "yes," the proportion of participants who responded "positive" and "negative" to the question what "type of influence?" would be the same for the control and treatment group.

4. The proportion of participants who responded "no," "yes," and "not sure" to the question "Did the information you read help you better understand what counseling will be like?" would be the same for the control and treatment group.

It was anticipated that null Hypotheses 1 and 3 would be accepted. A majority of prior research studies found no significant difference between control and treatment groups and these general questions were expected to obtain similar nonsignificant results. Questions 2 and 4, however, pertained to specific information about the counseling process itself. It was anticipated that a significantly larger proportion of treatment group participants would report a better understanding and idea of what to expect in counseling than control group participants.

The chi-square test was selected to determine whether observed proportions differed from expected proportions. This test was appropriate for use since the data were classification variables and they were
independent of each other (e.g., no-yes).

The SPSS statistical program was used with the crosstabs procedure (Norusis, 1990). Pearson critical values were reported. An alpha level of .05 was utilized for significance.

**Effect on Actual Client Behaviors**

The third major research area investigated was the effect of pre-therapy disclosure on actual client behaviors. This topic was selected to improve on prior studies that measured perceptions, attitudes, and beliefs, but could not research actual outcomes because the studies utilized an analogue design (e.g., Farley, 1987; Handelsman, 1990; Sullivan et al., 1993).

Three specific behavioral outcomes were selected to research empirically the speculation that pretherapy disclosure would have a negative effect on therapy. The three research questions were:

1. What effect does comprehensive versus partial disclosure of pretherapy information have on requests for a different therapist?
2. What effect does comprehensive versus partial disclosure of pretherapy information have on attendance at the first session?
3. What effect comprehensive versus partial disclosure of pretherapy information have on client-initiated termination?

The independent variable in this study was treatment versus control group status. The dependent variables were tabulations of specific participant behaviors. The dependent variables are described below:
1. Request for a change in therapist: Participants were divided into two groups: those who did and did not request a change in therapist after they received pretherapy information but before the first session. This information was recorded by the clinical coordinator on the Request for Change in Counselor form (see Appendix H).

2. Attendance at first session: Participants were divided into two groups: those who did and did not attend the first session with their assigned therapist. This information was obtained from the Closing Report (see Appendix I).

3. Client-initiated termination: Therapists reported on the Closing Report (see Appendix I) the reason therapy was terminated. Choices provided to the therapist on this form were client terminated, therapist terminated, mutual termination, and other (e.g., end of school year, graduated, hospitalized, referred to another agency). Participants were divided into two groups, those whose Closing Report indicated that the client initiated termination versus those whose Closing Report indicated therapist terminated, mutual termination, or other.

Three null hypotheses were developed. These were:

1. The proportion of requests for change of therapist would be the same for the treatment group and the control group.

2. The proportion of participants who attended the first session would be the same for the treatment group and the control group.

3. The proportion of client-initiated terminations would be the same for the treatment group and the control group.

It was anticipated that the null hypothesis will be accepted for all three cases, since the majority of prior research studies investigating
multiple disclosure suggested no differential effects on perception of therapists (see Research on Multiple Disclosure, Review of Literature, p. 72).

Since the behavioral data were classification variables, rather than continuous measurements, chi squares were calculated. The behavioral measures (e.g., attendance versus nonattendance) were independent of each other, thus meeting restrictions for the use of this statistical procedure. The chi-square analysis was calculated by hand and tables of critical values were used (Hopkins et al., 1987). Pearson critical values were reported. An alpha level of .05 was utilized for significance.

**Treatment Group Effect on Perception of the Therapist**

An additional area that was investigated in this study was the effect of therapist experience on perception of the therapist. A recent study indicated that therapists with 9 or more years of experience were rated higher on the CRF-S than those with less than 9 years of experience (Sullivan et al., 1993). That study utilized an analogue design. The current study investigated the effect of therapist experience on a client sample.

Information about therapist experience was provided only to the treatment group (see Sample Treatment Statement, Appendix E). Therefore, data were analyzed for only that group. Gender was also investigated in this study.

The analysis of data was conducted to address the following three questions regarding participants who had received comprehensive pre-therapy information:
1. What effect does therapist experience have on clients' perceptions of therapists?

2. What effect does client gender have on clients' perceptions of therapists?

3. Does therapist experience have a differential effect on males and females in perception of therapists?

The independent variables in this study were client gender (male versus female) and therapist experience (9 or more years versus less than 9 years). The dependent variables in this study were scores obtained on the CRF-S. This instrument was selected to enable the research results to be compared with previous studies on multiple disclosure which used the CRF-S. The subscale scores of therapist expertness, attractiveness, and trustworthiness were calculated. In accordance with recent recommendations in the literature (Tracey et al., 1988), the total score was also tabulated.

The null hypothesis was that no significant difference would be found between the means of therapist experience groups, client gender groups, or their interactions, on the four variables of therapist expertness, attractiveness, trustworthiness, and combined attributes as measured by the CRF-S. Acceptance of the null hypothesis was anticipated.

Two statistical procedures were selected to test the null hypothesis. The first procedure was a multivariate analysis of variance (MANOVA). This test was selected to simultaneously evaluate mean differences between therapists with 9 or more years of experience versus therapists with less than 9 years of experience, male versus
female, and the interaction of therapist experience by client gender, on the three subscale scores of the CRF-S. If a significant effect was found, follow-up analyses of variance (ANOVAs) would be conducted to explain group differences. The second statistical procedure selected was a two-factor ANOVA. This test evaluated mean differences between therapists with 9 or more years of experience versus therapists with less than 9 years of experience, male versus female, and the interaction of therapist experience by client gender, on the total score of the CRF-S.

The SPSS statistical package was used to compute the data, utilizing multivariate tests of significance and univariate F tests (Norusis, 1990). Two multivariate test statistics were reported to compare obtained values to what would be expected if the null hypothesis was true. Those two tests, the Wilks' lambda and Pillai-Bartlett trace, were selected because they are considered the most widely used and most robust, respectively (Bray & Maxwell, 1985). A conventional alpha level of .05 (Isaac & Michael, 1989) was selected for significance.

Suggestions for Improving Disclosure Statements

A final area investigated was participants' opinions about professional disclosure statements. This topic was included to provide an original contribution to the research literature. The research questions asked were:

1. "Which information was most helpful in understanding the counseling process?"

2. "In what way was the information helpful?"
3. "Is there other information that would have been helpful for you to receive about your counselor or the counseling process? (Please describe.)"

(See Pretherapy Questionnaire, Appendix F.) Responses provided implications for writing more comprehensive and helpful pretherapy disclosure statements.

A qualitative data analysis procedure was utilized whereby participants' data were disassembled through coding and then unified as descriptive findings (LeComte, Millroy, & Preissle, 1992). The researcher examined the responses made by participants and grouped them into categories. Five to six categories of responses were determined for each question and coded by short descriptive statements. A Qualitative Data Analysis form was developed for each question, listing the five to six coded response options (see Qualitative Data Analysis, Appendix L). The researcher typed individual responses to each of the three research questions on separate cards, writing on each card the identifying initials of the research question and whether the response was from a treatment or control group participant. Each response card was numbered for identification purposes. Three predoctoral psychology interns volunteered to assist in the data analysis procedure. Each intern was provided with a form containing the first research question and its coded response options (see Qualitative Data Analysis, Appendix L). They were also each provided with a packet of numbered participant response cards to the first research question. The interns were instructed to write the number of the response card under the coded response option that most closely described its content. Each intern completed
this assignment independently for all three research questions. The interns were then instructed to compare their answers and come to a consensus regarding any differences in their response options. The results of this qualitative data analysis procedure were summarized and reported to expand the research knowledge in this area.

Summary

This experimental study was conducted in a university counseling center with a sample of 63 students who requested personal therapy. The students were randomly assigned to a control or treatment group. The control group received four pieces of routine information describing therapy practice at the counseling center. The treatment group received eight pieces of additional personalized information about their therapist and therapy process.

One purpose of this study was to measure differences in client perceptions of therapists between those with comprehensive pretherapy information and those with partial pretherapy data. The effect of client gender and its possible interaction with treatment was also investigated. A 2 x 2 design was used to analyze the data with treatment versus control and client gender as the two factors. Two statistical procedures were used. Subscale scores on the CRF-S were analyzed using a MANOVA. Total scores on the CRF-S were analyzed using an ANOVA.

A second purpose of this study was to measure differences in client opinions and attitudes toward therapy between participants who received comprehensive pretherapy information and those who received partial data. The dependent variables were multiple choice responses.
regarding the helpfulness of disclosure information and if such data affected participants' expectations, wish to participate, and understanding of therapy. Chi-square analyses were conducted to explore differences between the groups.

Investigating differences in client behaviors between the control and treatment groups was a third purpose of this study. Data on requests for a change in therapist, attendance at the first session, and client-initiated termination were analyzed using a chi-square statistical procedure.

Two additional issues were investigated in this research study. Treatment group participants received data on therapist experience. A 2 x 2 design was used to analyze the treatment group data with therapist experience (more than 9 years, 9 years or less) and client gender as the two factors. Two statistical procedures were used. Subscale scores on the CRF-S were analyzed using a MANOVA. Total scores on the CRF-S were analyzed using an ANOVA.

Finally, qualitative data were collected from participants regarding which type of information was most helpful, how it helped, and what additional information is needed. These data were summarized to provide suggestions on how therapists might write more comprehensive pretherapy disclosure statements.
CHAPTER IV

RESULTS

Overview of the Chapter

The results of this study are presented in four sections. Tables are provided, when appropriate, to supplement the text. In the first section, descriptive data of the total sample is presented. Sample size is discussed. The second section presents results on the three major areas of investigation. Those areas were the effects of comprehensive versus partial pretherapy disclosure on (a) perception of the therapist, (b) opinions and attitudes toward therapy, and (c) actual client behaviors. The third section presents results of a second issue investigated in the study, whether therapist experience affected clients' perceptions of therapists. The fourth section addresses the final area of investigation, participant suggestions for improving pretherapy disclosure documents. The chapter ends with a summary of the research results.

Descriptive Data

Participants

Participants were 63 undergraduate and graduate students enrolled at Northern Illinois University in DeKalb, Illinois. These students requested personal therapy at the Counseling and Student Development Center (CSDC), agreed to participate in a research study, and were
assigned a counselor for individual therapy. The participants ranged in age from 18 to 41. The mean age of control group participants was 21. The mean age of the treatment group was 23. The sample consisted of 42 females (67%) and 21 males (33%).

There were several categories of students who were excluded from the study to reduce the possibility of interaction of incidental variables. Excluded were students in crisis, assigned to group or career counseling, and under age 18. Students assigned to the researcher or the intake therapist were also excluded. (For frequency data on categories of students excluded, see Tables 4 and 5, Chapter III).

Despite the stringent participant selection procedures, the sample used in this study was representative in terms of age and gender of students requesting personal therapy services at CSDC. According to the 1992-93 annual report (Hotelling, 1993), students seen at CSDC during the time of this study ranged in age from 17 to 63 years old with a mean age of 23.1. Sixty-nine percent of the clients were female.

Sample Size

The total number of participants in this study was 63. Data were collected from participants on four measures: requests for a change in therapist, attendance at the first session, Pretherapy Questionnaire, and client-initiated termination. Each collection procedure occurred at a different point in the process of the client moving from therapist assignment to treatment to termination (see Data Collection Procedures, Chapter III, p. 100). As a result, there was a loss of participants through attrition. Presented below is an explanation of the numbers of
participants whose responses were analyzed for each type of data collected.

Data from the full sample of 63 participants were collected to analyze requests for a change in therapist and attendance at the first session.

The Pretherapy Questionnaire was administered when participants came to the first therapy appointment. Data were collected from 57 participants on this measure. Two individuals did not attend the first therapy session and therefore were not offered the instrument. Completed Pretherapy Questionnaires were missing from four research participants. Names were not used in this study to assure anonymity of responses. Therefore, it was impossible to determine exactly what happened to these four participants. Most likely, they were not given the Pretherapy Questionnaire at their first appointment, due to secretarial error. Of the 57 Pretherapy Questionnaires collected, four were eliminated from this study by the researcher because participants indicated on the instrument that they had prior knowledge of their therapist. (The explanation for this procedure is found in Content of the Pretherapy Questionnaire, Chapter III, p. 82). Results from a fifth Pretherapy Questionnaire were eliminated because responses were missing on the rating scale. Pretherapy Questionnaire results were therefore analyzed for 52 individuals, 26 treatment and 26 control group participants.

The sample size used for data collection on client-initiated termination was 61. As reported above, two participants did not appear for their first appointment and therefore did not receive therapy.
Major Areas of Investigation

In this section, the results of the three major research issues are presented. For each issue, the source of data collection is noted and the null hypothesis is stated. Descriptive data are provided, followed by explanations of the statistical treatment and results.

Effect on Perception of the Therapist

One major research area was the effect of comprehensive versus partial pretherapy disclosure on perception of the therapist. Data regarding this issue were obtained from the Counselor Rating Form-Short (CRF-S) (Corrigan & Schmidt, 1983), which was included in the Pretherapy Questionnaire (see Appendix F). The sample consisted of 52 participants who were randomly assigned to treatment and control groups. By coincidence, equal numbers of participants were assigned to each group. Seventy-five percent of the total sample were females. The proportion of females to males in both the treatment and control condition was about 3 to 1.

The analysis of data was conducted to address the following three questions:

1. What effect does comprehensive versus partial disclosure of pretherapy information have on clients' perceptions of therapists?

2. What effect does client gender have on clients' perceptions of therapists?

3. Does comprehensive disclosure have a differential effect on males and females in perception of therapists?
The independent variables were comprehensive versus partial disclosure and client gender (male versus female). The dependent variables were the subscale scores (attractiveness, expertness, and trustworthiness) and the total combined score on the CRF-S. Acceptance of the null hypothesis of no significant differences between the means of treatment, control, client gender groups, or their interactions, on the four variables of therapist expertness, attractiveness, trustworthiness, and combined attributes as measured by the CRF-S was anticipated.

Table 6 contains the means and standard deviations for the subscale scores of attractiveness, expertness, and trustworthiness on the CRF-S. A multivariate analysis of variance (MANOVA) was conducted to simultaneously evaluate mean differences between treatment versus control, male versus female, and the interaction of treatment by

<table>
<thead>
<tr>
<th>Subscale</th>
<th>Group</th>
<th>n</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attractiveness</td>
<td>Treatment</td>
<td>26</td>
<td>21.9</td>
<td>3.3</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>6</td>
<td>20.5</td>
<td>2.6</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>20</td>
<td>22.3</td>
<td>3.4</td>
</tr>
<tr>
<td></td>
<td>Control</td>
<td>26</td>
<td>23.1</td>
<td>4.2</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>7</td>
<td>22.0</td>
<td>5.1</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>19</td>
<td>23.5</td>
<td>3.9</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>13</td>
<td>21.3</td>
<td>4.1</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>39</td>
<td>22.9</td>
<td>3.7</td>
</tr>
</tbody>
</table>
Table 6--Continued

<table>
<thead>
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<th>Subscale</th>
<th>Group</th>
<th>n</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expertness</td>
<td>Treatment</td>
<td>26</td>
<td>23.5</td>
<td>3.2</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>6</td>
<td>20.8</td>
<td>3.0</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>20</td>
<td>24.3</td>
<td>2.9</td>
</tr>
<tr>
<td></td>
<td>Control</td>
<td>26</td>
<td>23.2</td>
<td>3.8</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>7</td>
<td>21.3</td>
<td>4.9</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>19</td>
<td>23.9</td>
<td>3.3</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>13</td>
<td>21.1</td>
<td>4.0</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>39</td>
<td>24.1</td>
<td>3.1</td>
</tr>
<tr>
<td>Trustworthiness</td>
<td>Treatment</td>
<td>26</td>
<td>23.0</td>
<td>3.5</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>6</td>
<td>21.3</td>
<td>2.4</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>20</td>
<td>23.4</td>
<td>3.7</td>
</tr>
<tr>
<td></td>
<td>Control</td>
<td>26</td>
<td>24.2</td>
<td>3.3</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>7</td>
<td>23.0</td>
<td>4.2</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>19</td>
<td>24.7</td>
<td>2.9</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>13</td>
<td>22.2</td>
<td>3.5</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>39</td>
<td>24.0</td>
<td>3.3</td>
</tr>
</tbody>
</table>

gender on the three subscale scores of the CRF-S. The Statistical Package for Social Sciences (SPSS) multivariate test of significance (Norusis, 1990) was used to calculate the results. The Wilks’ lambda and Pillais-Bartlett trace test statistics are reported in Table 7. No statistically significant treatment effects ($F$ [3, 43] = .65, $p = .59$), gender
effects \( F[3, 43] = 2.10, p = .11 \), or treatment by gender effects \( F[3, 46] = .05, p = .98 \) were obtained. The null hypothesis was therefore accepted.

Table 7
MANOVA for the Subscale Scores on the CRF-S

<table>
<thead>
<tr>
<th>Source</th>
<th>Test</th>
<th>Value</th>
<th>df</th>
<th>Error df</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment</td>
<td>Pillais</td>
<td>.04</td>
<td>3</td>
<td>43</td>
<td>.65</td>
</tr>
<tr>
<td></td>
<td>Wilks</td>
<td>.96</td>
<td>3</td>
<td>43</td>
<td>.65</td>
</tr>
<tr>
<td>Gender</td>
<td>Pillais</td>
<td>.13</td>
<td>3</td>
<td>43</td>
<td>2.10</td>
</tr>
<tr>
<td></td>
<td>Wilks</td>
<td>.87</td>
<td>3</td>
<td>43</td>
<td>2.10</td>
</tr>
<tr>
<td>Treatment by gender</td>
<td>Pillais</td>
<td>.00</td>
<td>3</td>
<td>46</td>
<td>.05</td>
</tr>
<tr>
<td></td>
<td>Wilks</td>
<td>.10</td>
<td>3</td>
<td>46</td>
<td>.05</td>
</tr>
</tbody>
</table>

Note. No F value reached statistical significance at the .05 level.

The total scores on the CRF-S were also analyzed. Table 8 presents descriptive data on those scores. An analysis of variance (ANOVA) was calculated using the SPSS univariate F test (Norusis, 1990). The results are displayed in Table 9. A main effect of gender was obtained, \( F(1, 48) = 4.8, p < .05 \). Since there was no significant interaction effect of treatment by gender, the main effect was interpreted. There was a statistically significant difference between the means of males (\( M = 64.6 \)) and females (\( M = 71.0 \)) on the total scores of the CRF-S.
### Table 8
Means and Standard Deviations for Total Scores on the CRF-S for Total Sample

<table>
<thead>
<tr>
<th>Group</th>
<th>n</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment</td>
<td>26</td>
<td>68.3</td>
<td>8.7</td>
</tr>
<tr>
<td>Male</td>
<td>6</td>
<td>62.7</td>
<td>5.7</td>
</tr>
<tr>
<td>Female</td>
<td>20</td>
<td>70.0</td>
<td>8.8</td>
</tr>
<tr>
<td>Control</td>
<td>26</td>
<td>70.5</td>
<td>10.3</td>
</tr>
<tr>
<td>Male</td>
<td>7</td>
<td>66.3</td>
<td>13.8</td>
</tr>
<tr>
<td>Female</td>
<td>19</td>
<td>72.0</td>
<td>8.7</td>
</tr>
<tr>
<td>Male</td>
<td>13</td>
<td>64.6</td>
<td>10.6</td>
</tr>
<tr>
<td>Female</td>
<td>39</td>
<td>71.0</td>
<td>8.7</td>
</tr>
</tbody>
</table>

### Table 9
ANOVA for the Total Scores on the CRF-S for Total Sample

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>SS</th>
<th>MS</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment</td>
<td>1</td>
<td>75.0</td>
<td>75.0</td>
<td>0.9</td>
</tr>
<tr>
<td>Gender</td>
<td>1</td>
<td>415.4</td>
<td>415.4</td>
<td>4.8*</td>
</tr>
<tr>
<td>Treatment by gender</td>
<td>1</td>
<td>6.3</td>
<td>6.3</td>
<td>0.1</td>
</tr>
<tr>
<td>Error</td>
<td>48</td>
<td>4160.7</td>
<td>86.7</td>
<td></td>
</tr>
</tbody>
</table>

*p < .05.
This difference was significant at the .03 level. Females rated counselors significantly more positively overall than did males.

**Effect on Opinions and Attitudes Toward Therapy**

A second major area investigated in this study was the effect of pretherapy disclosure on client opinions and attitudes toward therapy. Data were collected from four multiple choice questions on the Pretherapy Questionnaire (see Appendix F). The analysis of each of these questions is presented below. In each section, the null hypothesis is stated first. Descriptive information is provided next, followed by the chi-square statistical analysis. The results were obtained from the SPSS statistical program, using the crosstabs procedure (Norusis, 1990).

**Most Helpful Information**

Question 1 asked: "Which written information did you find most helpful?" The null hypothesis was that the proportion of participants who responded "first session (intake)," "mailing," and "not sure" would be the same for the control (partial disclosure) and treatment (comprehensive disclosure) groups. It was anticipated that the null hypothesis would be accepted, since most prior studies on disclosure found no significant differences between groups when generalized questions were asked (i.e., overall helpfulness) and because both groups in this study received some pretherapy information. Frequency data and the chi-square analysis are presented in Table 10. Twelve of 26 treatment group participants as compared to 3 of 26 control group participants stated that the mailing was most helpful. A chi-square analysis was
computed for a two-tailed test. The Pearson test statistic indicated a statistically significant difference in the proportion of treatment versus control group participants in their opinions of which written data were most helpful, $\chi^2(2, N = 52) = 8.4, p = .01$. A greater proportion of treatment than control group participants found the mailing most helpful. The null hypothesis was therefore rejected.

Table 10
Chi-Square Analysis of Question 1: Which Written Information Did You Find Most Helpful?

<table>
<thead>
<tr>
<th>Group</th>
<th>Intake</th>
<th>Mailing</th>
<th>Not sure</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment</td>
<td>n</td>
<td>9 (13.5)</td>
<td>12 (7.5)</td>
<td>5 (5)</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>35</td>
<td>46</td>
<td>19</td>
</tr>
<tr>
<td>Control</td>
<td>n</td>
<td>18 (13.5)</td>
<td>3 (7.5)</td>
<td>5 (5)</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>69</td>
<td>12</td>
<td>19</td>
</tr>
<tr>
<td>Total</td>
<td>n</td>
<td>27</td>
<td>15</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>52</td>
<td>29</td>
<td>19</td>
</tr>
</tbody>
</table>

Chi square | df | Value  
---|----|-------
Pearson  | 2  | 8.4*  

Note. Expected frequencies presented in parentheses.

*p < .05.

What to Expect in Counseling

The second question on the Pretherapy Questionnaire was: "From the written material you received, do you believe you have a good idea..."
of what to expect in counseling?" The null hypothesis was that the proportion of participants who responded "no," "yes," and "somewhat" would be the same for the control and treatment group. Since only the treatment group received specific information on their therapists' style of counseling, it was anticipated that a larger proportion of treatment group participants would respond "yes." Since the research hypothesis predicted the direction of the difference, a one-tailed test of the null hypothesis was performed. It was anticipated that the null hypothesis would be rejected.

Table 11 presents descriptive data on participant responses and the results of the chi-square analysis. The responses of participants were similar and statistically significant results were not obtained ($\chi^2[2, N = 52] = 1.51, p > .05$). However, one-third of the expected cell frequencies (depicted in parentheses in Table 11) were less than 5, which violated the restrictions on the use of chi square (Isaac & Michael, 1989). Therefore, the results of this analysis were questionable. Since the research hypothesis was that a difference would be obtained in the proportion of treatment and control group participants who responded "yes" to Question 2, the data were combined into two columns: participants who answered "yes" and participants who answered "no" or "somewhat." Table 12 presents the analysis of the combined data for Question 2. The responses of participants were again similar. There was no statistically significant difference in the proportion of treatment versus control groups ($\chi^2[1, N = 52] = .31, p > .05$) and the null hypothesis was therefore accepted.
### Table 11

Chi-Square Analysis of Question 2: From the Written Material You Received, Do You Have a Good Idea of What to Expect in Counseling?

<table>
<thead>
<tr>
<th>Group</th>
<th>No (n)</th>
<th>Yes (14)</th>
<th>Somewhat (11)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment</td>
<td>1 (.5)</td>
<td>14 (13)</td>
<td>11 (12.5)</td>
<td>26</td>
</tr>
<tr>
<td>%</td>
<td>4</td>
<td>54</td>
<td>42</td>
<td>100</td>
</tr>
<tr>
<td>Control</td>
<td>0 (.5)</td>
<td>12 (13)</td>
<td>14 (12.5)</td>
<td>26</td>
</tr>
<tr>
<td>%</td>
<td>0</td>
<td>46</td>
<td>54</td>
<td>100</td>
</tr>
<tr>
<td>Total</td>
<td>1</td>
<td>26</td>
<td>25</td>
<td>52</td>
</tr>
<tr>
<td>%</td>
<td>2</td>
<td>50</td>
<td>48</td>
<td>100</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chi square</th>
<th>df</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pearson</td>
<td>2</td>
<td>1.51</td>
</tr>
</tbody>
</table>

**Note.** Expected frequencies presented in parentheses.

**Wish to Participate in Counseling**

The third question asked of participants was: "Did the information you read have an influence on your wish to participate in counseling?" The null hypothesis was that the proportion of participants who responded "no" and "yes" to the above question would be the same for the control and treatment group. If participants answered "yes," to Question 3, they were also asked to respond to Question 3a: "If yes, type of influence: positive or negative?" The null hypothesis was that of participants who responded "yes" to Question 3, the proportion of
Table 12

Combined Data Chi-Square Analysis of Question 2: From the Written Information You Received, Do You Have a Good Idea of What to Expect in Counseling?

<table>
<thead>
<tr>
<th>Group</th>
<th>No/somewhat</th>
<th>Yes</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment</td>
<td>n 12 (13)</td>
<td>14 (13)</td>
<td>26</td>
</tr>
<tr>
<td></td>
<td>% 46</td>
<td>54</td>
<td>100</td>
</tr>
<tr>
<td>Control</td>
<td>n 14 (13)</td>
<td>12 (13)</td>
<td>26</td>
</tr>
<tr>
<td></td>
<td>% 54</td>
<td>46</td>
<td>100</td>
</tr>
<tr>
<td>Total</td>
<td>n 26</td>
<td>26</td>
<td>52</td>
</tr>
<tr>
<td></td>
<td>% 50</td>
<td>50</td>
<td>100</td>
</tr>
</tbody>
</table>

Chi square | df | Value |
-----------|----|-------|
Pearson    | 1  | 0.31  |

Note. Expected frequencies presented in parentheses.

participants who responded "positive" and "negative" influence would be the same for the control and treatment groups. Acceptance of the null hypotheses for Questions 3 and 3a was anticipated.

The results of the chi-square analysis for Question 3 are presented in Table 13. One treatment group participant did not answer this question. Responses of treatment (comprehensive disclosure) and control (partial disclosure) participants were similar. The Pearson chi-square value of .02 was not statistically significant and the null hypothesis was accepted. Of the 23 respondents who answered "yes" to Question 3, all control and treatment group participants reported on Question 3a that
the influence of written data was positive. Since there was no absolute differences between groups on the type of influence, no statistical analysis was needed on this issue.

Table 13

Chi-Square Analysis of Question 3: Did the Information You Read Have an Influence on Your Wish to Participate in Counseling?

<table>
<thead>
<tr>
<th>Group</th>
<th>No</th>
<th>Yes</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment</td>
<td>n 14 (13.7)</td>
<td>11 (11.3)</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td>% 56</td>
<td>44</td>
<td>100</td>
</tr>
<tr>
<td>Control</td>
<td>n 14 (14.3)</td>
<td>12 (11.7)</td>
<td>26</td>
</tr>
<tr>
<td></td>
<td>% 54</td>
<td>46</td>
<td>100</td>
</tr>
<tr>
<td>Total</td>
<td>n 28</td>
<td>23</td>
<td>51</td>
</tr>
<tr>
<td></td>
<td>% 55</td>
<td>45</td>
<td>100</td>
</tr>
</tbody>
</table>

Chi square df Value

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Pearson</td>
<td>1</td>
<td>0.02</td>
</tr>
</tbody>
</table>

Note. Expected frequencies presented in parentheses.

Understanding of Counseling

The final multiple choice question was: "Did the information you read help you better understand what counseling will be like?" The null hypothesis was that the proportion of participants who responded "no," "yes," and "not sure" to the above question would be the same for the treatment and control groups. Since only treatment group participants
received information about what counseling would be like with their particular therapist, it was anticipated that a larger proportion of treatment group participants would respond "yes." Since the research hypothesis predicted the direction of the difference, a one-tailed test of the null hypothesis was performed. It was anticipated that the null hypothesis would be rejected.

Descriptive information and results of the chi-square analysis are presented in Table 14. One treatment group participant did not answer

Table 14
Chi-Square Analysis of Question 4: Did the Information You Read Help You Better Understand What Counseling Will Be Like?

<table>
<thead>
<tr>
<th>Group</th>
<th>No</th>
<th>Yes</th>
<th>Not sure</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment</td>
<td>n 1 (3.4)</td>
<td>19 (12.7)</td>
<td>5 (8.8)</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td>% 4</td>
<td>76</td>
<td>20</td>
<td>100</td>
</tr>
<tr>
<td>Control</td>
<td>n 6 (3.6)</td>
<td>7 (13.2)</td>
<td>13 (9.2)</td>
<td>26</td>
</tr>
<tr>
<td></td>
<td>% 23</td>
<td>27</td>
<td>50</td>
<td>100</td>
</tr>
<tr>
<td>Total</td>
<td>n 7</td>
<td>26</td>
<td>18</td>
<td>51</td>
</tr>
<tr>
<td></td>
<td>% 14</td>
<td>51</td>
<td>35</td>
<td>100</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chi square</th>
<th>df</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pearson</td>
<td>2</td>
<td>12.65*</td>
</tr>
</tbody>
</table>

Note. Expected frequencies presented in parentheses.

*p < .001, one-tailed.
this question. A statistically significant difference in the proportion of treatment versus control group participants was obtained, $\chi^2(2, N = 51) = 12.65, p < .001$, one tailed. A larger proportion of treatment than control group participants stated they understood what counseling would be like. However, one-third of the expected cell frequencies (depicted in parentheses in Table 14) were less than 5, which violated the restrictions on the use of chi square (Isaac & Michael, 1989). Therefore, the results of this analysis were questionable. Since the research hypothesis stated that a larger proportion of treatment group than control group participants would answer "yes" to Question 4, the data were combined into two columns: participants who answered "yes" and participants who answered "no" or "not sure." Table 15 presents the analysis of the combined data to Question 4. A statistically significant difference in the proportion of treatment versus control group participants was obtained, $\chi^2(1, N = 51) = 12.28, p < .001$, one-tailed. The null hypothesis was rejected.

**Effect on Actual Client Behaviors**

The third major research area was the effect of pretherapy disclosure on actual client behaviors. The three research questions were: What effect does comprehensive versus partial disclosure of pretherapy information have on (a) requests for a change in therapist, (b) attendance at the first session, and (c) client-initiated termination? The analysis of each of these questions is presented below. In each section, the source of the data is noted and the null hypothesis is stated. Descriptive information is provided and the chi-square statistical analysis is
Table 15
Combined Data Chi-Square Analysis of Question 4: Did the Information You Read Help You Better Understand What Counseling Will Be Like?

<table>
<thead>
<tr>
<th>Group</th>
<th>Yes</th>
<th>No/not sure</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment</td>
<td>19 (12.7)</td>
<td>6 (12.2)</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td>76</td>
<td>24</td>
<td>100</td>
</tr>
<tr>
<td>Control</td>
<td>7 (13.2)</td>
<td>19 (12.7)</td>
<td>26</td>
</tr>
<tr>
<td></td>
<td>27</td>
<td>73</td>
<td>100</td>
</tr>
<tr>
<td>Total</td>
<td>26</td>
<td>25</td>
<td>51</td>
</tr>
<tr>
<td></td>
<td>51</td>
<td>49</td>
<td>100</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chi square</th>
<th>df</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pearson</td>
<td>1</td>
<td>12.28*</td>
</tr>
</tbody>
</table>

Note. Expected frequencies presented in parentheses.

*p < .001, one-tailed.

presented. The results were obtained by calculating the chi square by hand and using a table of critical values (Hopkins et al., 1987).

Request for a Change in Therapist

Data were collected on the number of participants who requested a change in therapist after receiving pretherapy information, but before meeting with their counselor. These data were obtained from the Request for Change in Counselor form (see Appendix H). The null hypothesis was the proportion of requests for a change of therapist...
would be the same for the treatment and control group. It was antici-
pated that the null hypothesis would be accepted.

There were no participants from the control or treatment group in
this study who requested a change in therapist. Since there was no
absolute difference between groups, a statistical analysis was not
needed.

**Attendance at First Session**

Data were collected on the number of treatment and control group
participants who attended the first therapy session after receiving partial
or comprehensive information. The data were obtained from the Closing
Report (see Appendix I). The null hypothesis was the proportion of
participants who attended the first session would be the same for the
treatment and control group. Acceptance of the null hypothesis was
anticipated.

Descriptive data are presented in Table 16. Zero control group
participants and two treatment group participants did not appear for the
first appointment. A chi-square analysis was computed by hand (see
Appendix M, Chi-Square Computation for Attendance at the First Ses-
son). Using a table of critical values (Hopkins et al., 1987), the results
were not statistically significant at the .05 level ($\chi^2[1, N = 63] = 2.06,
p = .25$). One-half of the expected cell frequencies (depicted in paren-
theses in Table 16) were less than 5, which violated the restrictions on
the use of chi square (Isaac & Michael, 1989). Therefore, the results of
this analysis were questionable.
Table 16
Chi-Square Analysis of Attendance at the First Session

<table>
<thead>
<tr>
<th>Group</th>
<th>Attendance</th>
<th>No show</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment</td>
<td>31 (32)</td>
<td>2 (1)</td>
<td>33</td>
</tr>
<tr>
<td></td>
<td>% 94</td>
<td>% 6</td>
<td>100</td>
</tr>
<tr>
<td>Control</td>
<td>30 (29)</td>
<td>0 (1)</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td>% 100</td>
<td>% 0</td>
<td>100</td>
</tr>
<tr>
<td>Total</td>
<td>61</td>
<td>2</td>
<td>63</td>
</tr>
<tr>
<td></td>
<td>% 97</td>
<td>% 3</td>
<td>100</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chi square</th>
<th>df</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pearson</td>
<td>1</td>
<td>2.06</td>
</tr>
</tbody>
</table>

Note. Expected frequencies presented in parentheses.

Client-Initiated Termination

The third behavioral outcome measured was client-initiated terminations from therapy. Data on this measure were obtained from the Closing Report (see Appendix I). The null hypothesis was the proportion of client-initiated terminations would be the same for the treatment and control group. It was anticipated that the null hypothesis would be accepted.

Descriptive data and the chi-square analysis are presented in Table 17. Five treatment group and 7 control group participants initiated termination. A chi-square analysis was computed by hand (see
Appendix N, Chi-Square Computation of Client-Initiated Termination). Using a table of critical values (Hopkins et al., 1987), the results were not statistically significant at the .05 level ($\chi^2[1, N = 61] = .50, p = .50$). Therefore, the null hypothesis of no difference was accepted.

Table 17
Chi-Square Analysis of Client-Initiated Terminations

<table>
<thead>
<tr>
<th>Group</th>
<th>Client-terminated</th>
<th>Non-client-terminated</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment</td>
<td>n 5 (6.1)</td>
<td>26 (24.9)</td>
<td>31</td>
</tr>
<tr>
<td>%</td>
<td>16</td>
<td>84</td>
<td>100</td>
</tr>
<tr>
<td>Control</td>
<td>n 7 (5.9)</td>
<td>23 (24.1)</td>
<td>30</td>
</tr>
<tr>
<td>%</td>
<td>23</td>
<td>77</td>
<td>100</td>
</tr>
<tr>
<td>Total</td>
<td>n 12</td>
<td>49</td>
<td>61</td>
</tr>
<tr>
<td>%</td>
<td>20</td>
<td>80</td>
<td>100</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chi square</th>
<th>df</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pearson</td>
<td>1</td>
<td>0.50</td>
</tr>
</tbody>
</table>

Note. Expected frequencies presented in parentheses.

Therapist Experience Effect on Perception of the Therapist

Another issue addressed in this study was the effect of therapist experience on perception of the therapist. Since only treatment group participants received information on therapist experience, results were analyzed only with that group. Three questions were addressed
regarding participants who received comprehensive pretherapy information:

1. What effect does therapist experience have on clients’ perceptions of therapists?

2. What effect does client gender have on clients’ perceptions of therapists?

3. Does therapist experience have a differential effect on males and females in perception of therapists?

The independent variables were therapist experience (less than 9 years versus 9 or more years) and client gender (male versus female). The dependent variables were subscale scores (attractiveness, expertness, and trustworthiness) and total combined scores on the CRF-S. Acceptance of the null hypothesis of no significant differences between the means of therapist experience groups, client gender groups, or their interactions, on the four variables of therapist expertness, attractiveness, trustworthiness, and combined attributes as measured by the CRF-S was anticipated.

Data regarding this research issue were obtained from the CRF-S, which was included in the Pretherapy Questionnaire (see Appendix F). Therapists were divided into two groups, those who reported less than 9 years experience on their pretherapy disclosure statement and those who reported 9 or more years experience (see Sample Therapist Statement, Appendix G). The sample consisted of 26 participants. By coincidence, equal numbers of participants were assigned to therapist experience groups. Seventy-seven percent of the participants were females. The distribution of males and females in the therapist experience conditions
were fairly equal, considering the small sample size (females, 45% and 55% assigned to <9 and 9+ conditions; males, 67% and 33% assigned to <9 and 9+ conditions).

Table 18 contains the means and standard deviations for the subscale scores of attractiveness, expertness, and trustworthiness on the CRF-S for the treatment group. A multivariate analysis of variance (MANOVA) was conducted to simultaneously evaluate mean differences between therapists with 9 or more years experience versus therapists with less than 9 years experience, male versus female, and the interaction of therapist experience by client gender on the three subscale scores of the CRF-S. The SPSS multivariate test of significance (Norusis, 1990) was used to calculate the results. The Wilks' lambda

<table>
<thead>
<tr>
<th>Table 18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Means and Standard Deviations for the Subscale Scores on the CRF-S for the Treatment Group</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Subscale</th>
<th>Group</th>
<th>n</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attractiveness</td>
<td>Male</td>
<td>6</td>
<td>20.5</td>
<td>2.6</td>
</tr>
<tr>
<td></td>
<td>&lt;9 years</td>
<td>4</td>
<td>19.5</td>
<td>2.6</td>
</tr>
<tr>
<td></td>
<td>9+ years</td>
<td>2</td>
<td>22.5</td>
<td>0.7</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>20</td>
<td>22.3</td>
<td>3.4</td>
</tr>
<tr>
<td></td>
<td>&lt;9 years</td>
<td>9</td>
<td>21.4</td>
<td>3.6</td>
</tr>
<tr>
<td></td>
<td>9+ years</td>
<td>11</td>
<td>23.0</td>
<td>3.2</td>
</tr>
<tr>
<td></td>
<td>&lt;9 years</td>
<td>13</td>
<td>20.8</td>
<td>3.4</td>
</tr>
<tr>
<td></td>
<td>9+ years</td>
<td>13</td>
<td>22.9</td>
<td>3.0</td>
</tr>
</tbody>
</table>
Table 18--Continued

<table>
<thead>
<tr>
<th>Subscale</th>
<th>Group</th>
<th>n</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expertness</td>
<td>Male</td>
<td>6</td>
<td>20.8</td>
<td>3.0</td>
</tr>
<tr>
<td></td>
<td>&lt; 9 years</td>
<td>4</td>
<td>20.2</td>
<td>2.7</td>
</tr>
<tr>
<td></td>
<td>9+ years</td>
<td>2</td>
<td>22.0</td>
<td>4.2</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>20</td>
<td>24.3</td>
<td>2.9</td>
</tr>
<tr>
<td></td>
<td>&lt; 9 years</td>
<td>9</td>
<td>23.6</td>
<td>3.8</td>
</tr>
<tr>
<td></td>
<td>9+ years</td>
<td>11</td>
<td>24.9</td>
<td>1.9</td>
</tr>
<tr>
<td></td>
<td>&lt; 9 years</td>
<td>13</td>
<td>22.5</td>
<td>3.7</td>
</tr>
<tr>
<td></td>
<td>9+ years</td>
<td>13</td>
<td>24.5</td>
<td>2.4</td>
</tr>
<tr>
<td>Trustworthiness</td>
<td>Male</td>
<td>6</td>
<td>21.3</td>
<td>2.4</td>
</tr>
<tr>
<td></td>
<td>&lt; 9 years</td>
<td>4</td>
<td>20.7</td>
<td>2.6</td>
</tr>
<tr>
<td></td>
<td>9+ years</td>
<td>2</td>
<td>22.5</td>
<td>2.1</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>20</td>
<td>23.4</td>
<td>3.7</td>
</tr>
<tr>
<td></td>
<td>&lt; 9 years</td>
<td>9</td>
<td>23.1</td>
<td>3.2</td>
</tr>
<tr>
<td></td>
<td>9+ years</td>
<td>11</td>
<td>23.7</td>
<td>4.1</td>
</tr>
<tr>
<td></td>
<td>&lt; 9 years</td>
<td>13</td>
<td>22.4</td>
<td>3.1</td>
</tr>
<tr>
<td></td>
<td>9+ years</td>
<td>13</td>
<td>23.5</td>
<td>3.9</td>
</tr>
</tbody>
</table>

Note. <9 years = therapists reporting less than 9 years of therapy experience. 9+ = therapists reporting 9 or more years of therapy experience.

and Pillais-Bartlett trace test statistics are reported in Table 19. No statistically significant gender effects ($F[3, 18] = 1.34, p = .29$), experience effects ($F[3, 18] = 1.13, p = .36$), or gender by experience
effects ($F[3, 18] = .06, p = .98$) were obtained. The null hypothesis was accepted.

Table 19

MANOVA for the Subscale Scores on the CRF-S for the Treatment Group

<table>
<thead>
<tr>
<th>Source</th>
<th>Test name</th>
<th>Value</th>
<th>df</th>
<th>Error df</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>Pillais</td>
<td>.18</td>
<td>3</td>
<td>18</td>
<td>1.34</td>
</tr>
<tr>
<td></td>
<td>Wilks</td>
<td>.82</td>
<td>3</td>
<td>18</td>
<td>1.34</td>
</tr>
<tr>
<td>Experience</td>
<td>Pillais</td>
<td>.16</td>
<td>3</td>
<td>18</td>
<td>1.13</td>
</tr>
<tr>
<td></td>
<td>Wilks</td>
<td>.84</td>
<td>3</td>
<td>18</td>
<td>1.13</td>
</tr>
<tr>
<td>Gender by experience</td>
<td>Pillais</td>
<td>.01</td>
<td>3</td>
<td>18</td>
<td>0.06</td>
</tr>
<tr>
<td></td>
<td>Wilks</td>
<td>.99</td>
<td>3</td>
<td>18</td>
<td>0.06</td>
</tr>
</tbody>
</table>

*Note.* No $F$ value reached statistical significance at the .05 level.

The total scores on the CRF-S for the treatment group were also analyzed. Table 20 presents descriptive data on those scores. An analysis of variance (ANOVA) was calculated using the SPSS univariate $F$ test (Norusis, 1990). The results are displayed in Table 21. No statistically significant gender effects ($F[1, 22] = 2.67, p = .12$), experience effects ($F[1, 22] = 1.55, p = .23$), or experience by gender effects ($F[1, 22] = .13, p = .72$) were obtained. The null hypothesis was accepted.
### Table 20

Means and Standard Deviations for Total Scores on the CRF-S for Treatment Group

<table>
<thead>
<tr>
<th>Group</th>
<th>n</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>6</td>
<td>62.7</td>
<td>5.7</td>
</tr>
<tr>
<td>&lt; 9 years</td>
<td>4</td>
<td>60.5</td>
<td>4.4</td>
</tr>
<tr>
<td>9+ years</td>
<td>2</td>
<td>67.0</td>
<td>7.1</td>
</tr>
<tr>
<td>Female</td>
<td>20</td>
<td>70.0</td>
<td>8.9</td>
</tr>
<tr>
<td>&lt; 9 years</td>
<td>9</td>
<td>68.1</td>
<td>10.3</td>
</tr>
<tr>
<td>9+ years</td>
<td>11</td>
<td>71.6</td>
<td>7.7</td>
</tr>
<tr>
<td>&lt; 9 years</td>
<td>13</td>
<td>65.8</td>
<td>9.4</td>
</tr>
<tr>
<td>9+ years</td>
<td>13</td>
<td>70.9</td>
<td>7.5</td>
</tr>
</tbody>
</table>

*Note.* < 9 years = therapists reporting less than 9 years of therapy experience. 9+ years = therapists reporting 9 or more years of therapy experience.

### Table 21

ANOVA for the Total Scores on the CRF-S for the Treatment Group

<table>
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*Note.* No F value reached statistical significance at the .05 level.
Suggestions for Improving Disclosure Statements

The final area investigated in this study was participants' opinions about professional disclosure statement information. Three open-ended questions were asked on the Pretherapy Questionnaire (see Appendix F). Two of the open-ended questions were to be answered only by participants who responded "yes" to multiple choice Question 4 ("Did the information you read help you better understand what counseling will be like?"") Seven control group and 19 treatment group participants answered "yes" to multiple choice Question 4. Those participants were asked:

1. "Which information was most helpful in understanding the counseling process?"

2. "In what way was the information helpful?"

The third open-ended question was asked of all participants. That question was: "Is there other information that would have been helpful for you to receive about your counselor or the counseling process? (Please describe)." A content analysis of participant responses was conducted from a qualitative (LeCompte et al., 1992) and quantitative perspective. The researcher developed specific response categories for each question (see Qualitative Data Analysis, Appendix L, for a description of the categories). Participant responses were placed into these designated categories by three psychology interns (for an explanation of this procedure, see Research Design and Data Analysis, Suggestions for Improving Disclosure Statements, Chapter III, p. 113). Participant responses to the open-ended questions are presented below both
quantitatively (frequency of responses in each coded response category, as determined by doctoral interns) and qualitatively (narrative examples of actual responses).

**Which Information Was Most Helpful?**

Eight control group participants answered this question. Four of those participants (50%) gave an answer that was nonspecific. Examples were: The most helpful information was "the written information" or "the intake information." Two control group participants who responded to the question thought that general procedural information was most helpful. Those responses were: The most helpful information was "types of counseling available" and "the fact that it is ongoing and I could cancel my sessions permanently at any time." The remaining 2 control group participants who answered this question gave "other" responses ("I had seen a counselor before and knew what to expect" and "the information I received was not enough to understand the counseling process").

Twenty treatment group participants responded to this question. Fifty percent (10 participants) stated that personalized information about the specific counselor's approach or style of therapy was most helpful. Examples of those responses were: The most helpful information was "he told me what to expect, what might happen," "... the counselor's style," "... the approach and method," "outline of the process," "understanding that counseling can be difficult," and "... we would possibly have to deal with negative or painful feelings." Nonspecific answers were given by 25% of the treatment group (5 participants).
Examples were: The most helpful information was "the letter from my counselor" or "information mailed to me." Two treatment group participants stated that information about their particular counselors' qualifications or experience was most helpful. Those responses were: The most helpful information was "experience of counselor and background counseling style" and "... he was experienced and considered himself sympathetic." Two participants thought that general procedural information (received at intake) was most helpful. Those two responses were "It gave me a general framework of how a counseling session will be and what to expect" and "the confidentiality, emergency appointments if necessary."

In What Way Was the Information Helpful?

Ten control group participants answered this question. Six of those participants (60%) stated that basic information helped them know what to expect from the agency in general. Examples of those responses were: "helped me to understand how the counseling center would help me" and "explained what was to be expected from CSDC." Thirty percent of the control group participants (3 persons) who answered this question stated that information provided personal reassurance and comfort. Those responses were:

1. "It made me feel a little more comfortable, and somewhat know what to expect."

2. "It was reassuring, knowing that 'help was on the way'--that I would be receiving help and would have someone to vent to soon. I like the one-on-one counseling and find it helpful."
3. "Written information about CSDC helped by stating confidentiality. I also felt that it was more professional and sincere."

Twenty treatment group participants answered this question. Forty-five percent of treatment group participants (9 persons) who responded indicated that information was helpful because personalized counselor data were provided. Participants gave the following responses:

1. "It told me what kinds of people he usually deals with and also his credit."

2. Let me know he was experienced and considered himself 'sympathetic.'"

3. "It described to me my counselor's personal background, expectations, etc. I felt it was a good introduction to him which I think will help us get started in a good way when I meet with him."

4. "It helped me understand what was expected of me and what I could expect from him."

5. "The mailing gave me the educational background on my counselor--that was very good."

6. "Since I have been in counseling before and am familiar with the basic process, specifics about the counselor were most helpful."

7. "Let me know what kind of person I am seeing and a little bit of what to expect."

8. "Orienting in regard to boundaries and expectations and background and orientation of counselor."

9. "Knowing that the counselor was skilled and had experience in the area I needed."
Thirty percent of the treatment group participants who responded (6 persons) stated that information was helpful by providing personal reassurance and comfort. Those responses were:

1. "It made me feel more at ease."
2. "The information made me feel a little more comfortable about talking to a counselor."
3. "In depth, honest, and up front."
4. "Gives an idea of what to expect and what type of person you will be meeting--makes you feel like the person is not a stranger."
5. "I felt more comfortable in coming. The information made me less nervous."
6. "This information assured me that the counseling process would be thorough."

Twenty percent of the treatment group (4 persons) indicated that information was helpful by defining what to expect in general from the agency. Examples of those responses were "gave some idea of what counseling would be like" and "just generally what to expect."

**What Additional Information Would You Have Liked to Have Received?**

This open-ended question was asked of all research participants. Only about half (46%) of the control group answered this question. Of the 12 control group participants who did answer, 6 persons (50%) claimed that no additional information was needed. Three control group participants (25% of those who responded) would have liked information on the specialty or background of their counselor. Suggestions made by respondents were:
1. "A little more about my counselor's background."
2. "Some information on my counselor's background. Area of specialty, etc."
3. "The age of the counselor, his area of specialty."

Sixteen treatment group participants (61%) answered this open-ended question. Of treatment group participants who responded, 75% (12 persons) stated that no additional information was needed. Two treatment group participants stated that additional information on counseling expectations was needed. Those two responses were:

1. "Not much except perhaps more information regarding expectations/responsibilities of myself as client."
2. "I would have liked to have known why there was a mailing list. You should have described the intake better, as to know what to expect."

Two treatment group participants gave "other" responses. One response seemed to more accurately answer the previous open-ended question on how information was helpful. That response was: "The information I received from my counselor helped me to understand somewhat of what she is about and she also explained what we would be doing." The second response was: "The letter informing me of my appointment seemed a little stiff. If I'd never been to see a counselor before, I think I would have found it a bit intimidating." This last statement was the only negative comment made in this study regarding disclosure of pretherapy information.
Summary of Research Results

This research involved an experimental study of the effect of comprehensive versus partial pretherapy disclosure. Participants consisted of 63 clients who were assigned to individual counseling in a university counseling center. A randomized sample of control group participants received information on four pretherapy issues. The treatment group received information on the same four procedural issues, plus data on eight additional issues regarding their specific therapist and the therapy process.

The major areas of investigation were the effects of comprehensive versus partial pretherapy disclosure on (a) perceptions of therapists, (b) opinions and attitudes toward therapy, and (c) actual client behaviors. Data on perceptions of therapists were obtained from the Counselor Rating Form-Short (CRF-S), which was administered to participants after they received disclosure information, but before they met their therapist. A MANOVA performed on the subscale scores of the CRF-S indicated no statistically significant results. The null hypothesis of no difference between the means of treatment, control, client gender groups, or their interactions on the subscale scores of the CRF-S was accepted. An ANOVA was performed on the total scores of the CRF-S. No significant treatment or interaction effects were found; however, there was a main effect of gender. Females rated their therapists more positively overall than did males. Data on client opinions and attitudes toward therapy were obtained by multiple choice questions, administered after pretherapy disclosure but before therapy began. Chi-square
analyses of results were computed. There was no significant difference in the proportion of treatment versus control group in believing that they had a good idea of what to expect in counseling or in wishing to participate in counseling. There was a significant difference in the proportion of treatment versus control group in which type of information they found most helpful. The treatment group found the mailing helpful more frequently than did the control group. A significant difference was also found in the proportion of treatment versus control group in understanding what counseling would be like. A greater proportion of treatment group participants felt they understood what counseling would be like. Data on three client behaviors were collected: (a) requests for a change in therapist, (b) attendance at the first session, and (c) client-initiated terminations. Chi-square analyses were computed. There was no significant difference between the proportions of treatment versus control group on any of the three behavioral measures.

Another research area investigated was the effect of therapist experience on client perception of the therapist. Therapists were divided into two groups, those with less than 9 years of experience and those with 9 or more years experience. Data were collected from the CRF-S. Only treatment group participants received information on this variable, so only their data was analyzed. A MANOVA performed on the subscale scores and an ANOVA performed on the total scores of the CRF-S indicated no statistically significant results. The null hypothesis of no difference between the means of therapist experience groups, client gender groups, or their interactions on the subscale and total scores of the CRF-S was accepted.
The final area investigated was suggestions for improving disclosure statements. Three open-ended questions were analyzed utilizing quantitative and qualitative procedures. The questions were: Which information was most helpful, in what way was it helpful, and what additional information would you have liked to have received? An analysis of participant responses indicated that control group participants found general procedural information helpful because it defined what to expect from the agency and provided personal reassurance and comfort. Half of the control group that answered the open-ended questions responded that the partial pretherapy information they received was sufficient. Other control group participants wished they received specialty or background data about their therapist. The analysis of treatment group responses suggested that personalized data about the counselor's therapy approach or style was deemed most helpful. Such personalized data helped by furnishing specific information about the therapist and providing personal reassurance and comfort. Seventy-five percent of the treatment group that responded stated that the comprehensive pretherapy information they received was sufficient. Suggestions from treatment group participants on additional data that should be shared by therapists was information on client expectations and responsibilities at intake as well as during therapy.
CHAPTER V

DISCUSSION

Overview of the Chapter

This final chapter is presented in four sections. The first section contains a discussion of the research results, including the findings regarding the overall research hypothesis, other research issues (effects of client gender and therapist experience), and suggestions for improving disclosure documents. The second section presents limitations of the current study. The third section provides implications for future research in the area of pretherapy disclosure. The chapter ends with The fourth section, which is a summary of the conclusions.

Discussion of Results

Results of the Overall Research Hypothesis

The overall research hypothesis in this study was that no differential effects would be found between participants who were provided comprehensive data and those who received only partial pretherapy information. Three types of effects were measured: (1) effects on perceptions of therapists, (2) opinions and attitudes toward therapy, and (3) actual client behaviors. Discussion of the research results is presented next.
Perceptions of Therapists

The research hypothesis was confirmed in regard to perceptions of therapists. There were no significant differences between treatment group and control group participants in their ratings of therapists on the Counselor Rating Form-Short (CRF-S) (Corrigan & Schmidt, 1983). The lack of negative effects of therapy disclosure on perceptions of therapists was also found in prior studies that utilized the CRF-S as the dependent variable. Christiansen (1986) and Handelsman and Martin (in press) found no differential effects between participants who received therapy disclosure and those who did not. Sullivan et al. (1993) found that therapists who used an informed-consent procedure were rated more positively on the CRF-S than those who did not.

The lack of a negative impact on perceptions of therapists obtained in this study substantially adds to the current research literature because of the methodology used. The current study improved upon four prior research limitations: (1) use of analogue methodology, (2) timing of therapy disclosure, (3) timing of the dependent variable, and (4) lack of comprehensiveness. A summary of each of the improvements is presented next. First, this study used a client sample of students requesting therapy services in a university counseling center. Most prior research on disclosure of multiple (more than one) therapy issues used nonclient samples (Farley, 1987; Handelsman, 1990; Handelsman & Martin, in press; Sullivan et al., 1993). Disclosure of comprehensive pretherapy issues to a randomized sample of clients in this study did not result in negative perceptions of therapists. The relevance of this finding
may generalize to other university counseling centers and provides implications for other practice settings as well. The second methodological improvement in this study was that therapy disclosure was provided to participants before they met with their assigned therapist. Several prior studies of multiple disclosure provided information to participants during the first session (Christiansen, 1986; Handelsman & Martin, in press; Sullivan et al., 1993). Trends in the theoretical literature (Bray et al., 1985; VanHoose & Kottler, 1985) and changes in the ethical principles of mental health practitioners (AACD, 1988; APA, 1992) advocate pretherapy disclosure as an ethically responsible procedure. The present study was able to measure the impact of such pretherapy disclosure upon clients. The third methodological improvement was that in this study, the dependent variable (CRF-S) was administered before the client had contact with the therapist. Several prior studies of multiple disclosure measured the effects after the participant had read a therapy transcript or met the therapist (Christiansen, 1986; Studwell, 1984; Sullivan, et al., 1993). Direct contact with therapists exposed clients to counselor responsive nonverbal behavior, status cues, and verbal behaviors. Exposure to those variables in previous research resulted in significant positive or negative effects on perceptions of therapists (Heppner & Claiborn, 1989). Therefore, contact with therapists in prior studies may have overshadowed the effects of written disclosure. The methodology in the current study helped isolate the effects of therapist disclosure by measuring the effects before clients met their therapist. The lack of negative effects obtained in the current study can more conclusively be stated because the therapist contact factor was
improved upon. The fourth improvement on prior research limitations was that the participants in this study were provided with comprehensive therapy information. Comprehensive disclosure means that treatment group participants received information on all 12 disclosure issues identified in the literature (Hedstrom & Ruckel, 1992) and the data were personalized and descriptive of the particular therapist and his or her procedures. Prior studies were not comprehensive. Most studies that examined the effect of therapy disclosure investigated only one specific topic. Even some studies involving the disclosure of multiple therapy issues shared only a limited number of topics with participants (Christiansen, 1986; Farley, 1987). Disclosure information in prior studies was not personalized. Instead, participants were given generic therapist statements meant to apply to all therapists (Farley, 1987; Studwell, 1984) or provided with a list of questions they could ask their therapist (Handelsman, 1990; Sullivan et al., 1993), rather than a description of personalized procedures. The comprehensive pretherapy data in the present study provided opportunities for negative reactions of clients, which did not exist in prior studies where comprehensive disclosure did not occur. Therefore, the current findings of no negative effects on perceptions of therapists is particularly important. Presented next are specific examples of disclosure information shared with participants in the current study and a discussion of the ensuing opportunities for negative reactions. In the present study, the treatment group was provided with two main categories of personalized information. They were (1) information on potentially "negative" issues, such as risks and alternatives to therapy and the name and address of the person to
contact if concerns were raised about the therapist, and (2) data about the therapist's qualifications and practices. The potentially "negative" issues are often not disclosed by therapists (Hedstrom & Ruckel, 1992). One reason reported by practitioners for not disclosing therapy information was the belief that such data might have a deleterious impact on the client or the therapy relationship (Handelsman et al., 1986; Somberg et al., 1993). Information regarding the therapist's qualifications had the potential to influence client perceptions of therapists. Treatment group participants were provided with information on degrees earned, licensing status, and whether or not the therapist was supervised. In the current study, 10 of 17 therapists at the Counseling and Student Development Center (CSDC) were nonlicensed and were supervised. Those 10 therapists were overrepresented in the study, in that they were the assigned therapists for 77% of the treatment group. Therefore, all treatment group participants were informed about potentially "negative" therapy issues and 77% learned that their assigned therapist was not yet licensed and was under supervision. If these issues were of concern to participants, then the potential for negative effects of such disclosure existed in this study. Perhaps more importantly, however, the treatment group also received information from therapists that could have resulted in client inferences regarding the ethnic and racial identity, sexual orientation, and/or other distinctive characteristics of therapists (see Sample Therapist Statement, Appendix G). In this study, 12 therapists were Caucasian, 3 were African-American, and 2 were Asian. Although racial/ethnic background was not explicitly stated, it may have been presumed from therapists' names, areas of expertise, or type of college
attended. Examples contained in disclosure statements about areas of expertise were: "I work with gay men, focusing on 'coming out' and HIV-related concerns," "I have much experience working with ethnic minorities," and "I am a Certified Addictions Counselor and do evaluations of substance abuse problems." Other indications of diversity that may have been apparent from disclosure information were that two therapists were gay/lesbian, one was physically disabled, and others were of various ages, marital status, etc. Values of therapists might have been inferred by participants. Disclosure of value information in prior studies sometimes resulted in negative perceptions of the therapist (Lewis et al., 1983; Lewis & Lewis, 1985), particularly if the therapist's values were at odds with those of the client (Keating & Fretz, 1990; Lewis & Walsh, 1980). In the current study, if participants had strong feelings regarding race, ethnicity, values, etc., then the potential for negative perceptions of therapists existed because personalized information of that kind was disclosed. Even though potentially troublesome data were provided in this study to treatment participants, group differences between treatment and control participants on perceptions of therapists did not occur. These results are important because they add to the growing pool of data suggesting that the disclosure of pretherapy information, even personalized therapist data, does not have a negative impact on clients.

**Opinions and Attitudes Toward Therapy**

Effects of comprehensive versus partial pretherapy disclosure on opinions and attitudes toward therapy was a second issue measured in
this study. Data were obtained from multiple choice questions on the Pretherapy Questionnaire (see Appendix F). Presented next are the questions and a short discussion of their meaning. Question 1 asked: "Which written information did you find most helpful?" Choices were: information from first session (intake), mailing, or not sure. The treatment and control groups received the same information at intake, but different information in the mailing. Both groups received written information at intake regarding the general services offered at the agency, confidentiality and its limits, length of sessions, and the right to terminate therapy. The control group received appointment information in the mailing. The treatment group received the appointment information in the mailing, plus data on eight additional pretherapy issues. The eight issues were personalized and contained descriptions of risks and alternatives to therapy and the therapist's qualifications and practices. Question 2 was: "From the written material you received, do you believe you have a good idea of what to expect in counseling?" Choices were: no, yes, or somewhat. Question 3 was: "Did the information you read have an influence on your wish to participate in counseling?" Choices were: no or yes. If yes, choices were: type of influence, positive or negative. Question 4 was: "Did the information you read help you better understand what counseling will be like?" Choices were: no, yes, or not sure. Questions 2, 3, and 4 asked participants about the information they read. Therefore, the control group answered regarding the four issues disclosed at intake, while the treatment group answered regarding the combined disclosure of 12 issues provided at intake and the mailing. Discussion of the results is presented next.
There was no statistically significant difference in the proportion of treatment versus control group participants in believing they had a good idea of what to expect in counseling or in wishing to participate in counseling. Two statistically significant findings, however, were obtained. A greater proportion of treatment than control group participants found the mailing most helpful. Also, a greater proportion of treatment group participants felt they understood what counseling would be like than did the control group.

It is important to remember the main difference in the information provided to the treatment and control group in interpreting the results of the multiple choice questions. The receipt of comprehensive disclosure information, including personalized and potentially "negative" data did not make a difference in client expectations of counseling or change the desire to proceed with counseling. Those disclosures did, however, have a statistically significant positive impact. A greater percentage of persons who received the comprehensive information reported they understood what counseling would be like.

The finding that a greater proportion of treatment than control group participants found the mailing, rather than written information at intake, most helpful offers additional implications. The treatment group preferred the personalized and potentially "negative" data over the general procedural information received at intake. They found it most helpful.

Results of the multiple choice questions suggest that disclosure of personalized information by therapists can instruct clients about the therapy process. This can be accomplished without decreasing the
willingness of clients to proceed with counseling. This finding with a field sample is important because it suggests that practicing therapists can inform potential clients about their qualifications, methods of treatment, and the risks and alternatives to therapy without creating negative opinions which might lead to a loss of clientele.

**Actual Client Behaviors**

An improvement over prior studies was that this research involved a field study, allowing the measurement of actual client behaviors. This methodology provided data on whether behavioral measures were consistent with attitudes and opinions. According to a recent survey of practicing therapists (Somberg et al., 1993), some practitioners refrained from disclosing therapy issues because they believed the process would have a negative impact on the client and/or the therapeutic relationship. In the above survey, the particular negative impact was not defined. In this study, three behaviors were selected for investigation that might be considered "negative" outcomes of pretherapy disclosure. Each of the behaviors selected eliminated or reduced the contact with the therapist, usually without mutual discussion or explanation. The behaviors were requests for a change in therapist, lack of attendance at the first session, and client-initiated termination. The results of this study substantiated the major research hypothesis of no statistically significant differences between treatment and control groups in actual client behaviors. The lack of negative effects of pretherapy disclosure on these behaviors is consistent with the findings discussed above regarding opinions and attitudes of clients and their perceptions of therapists. Disclosure of
pretherapy information, including personalized therapist data, did not produce negative effects on clients in this study. Discussion of the results is presented next.

In this study, no participants in either group requested a change in therapist after receiving pretherapy information but before meeting the therapist. This finding was not unusual at the Counseling and Student Development Center (CSDC) where the study took place. During the 1992-93 school year when the study was conducted, no students made such a request (whether they were or were not participants in the study). It is crucial to note, however, that the treatment group was unique from the control group and all other clients who came to the center. Since only the treatment group received personalized and potentially negative information, written by the therapist to whom they were assigned, they were privy to data that could have made a difference in their desire to see a specific therapist. Examples of personalized and "negative" issues were discussed above (see Perceptions of Therapists, p. 152). Some statements from therapists about their areas of expertise (i.e., women's or men's issues, alcohol and drug abuse, physical disabilities) might have caused participants to wonder why they were assigned to this particular therapist, especially if the area of expertise did not fit the participants' presenting problems. It is important to recognize that in this study, the disclosure of comprehensive data, provided to participants and effects measured before contact with the therapist, did not result in requests for a change in therapist. It may be, however, that students believed it was unacceptable to ask for a different therapist and the strength of that unspoken norm overshadowed any differences.
between the control and treatment groups. If that was the case, then it might be expected that treatment group participants who had developed a negative impression of their therapist due to the receipt of disclosure information might not show up for their first appointment. Nonattendance at the first session is a behavior that occurs at CSDC (however, frequency data are not available). The results obtained in this study on the attendance variable is discussed next.

There was no statistically significant difference between the proportion of treatment versus control group participants in attendance at the first session. These results with an actual client population enhanced similar findings in analogue studies measuring participant willingness to see a potential counselor. In those studies, written disclosure had no effect (Farley, 1987) or a positive effect (Handelsman, 1990; Handelsman & Martin, in press; Sullivan et al., 1993) on willingness to see a counselor. These behavioral results also augmented the results of the opinion question asked in this study: "Did the information you read have an influence on your wish to participate in counseling?" As discussed above (see Opinions and Attitudes Toward Therapy), there was no statistically significant difference in the proportion of control and treatment groups on this question. In this study, participants who decided to ask for therapy seemed convinced to proceed with it, regardless of the amount or type of therapy information disclosed.

Client-initiated termination was the third behavioral measure included in this study. Client-initiated termination was noted by therapists on the Closing Report (see Appendix I) when the client dropped out of therapy (did not appear for appointments) or prematurely asked to
terminate. This measure was selected to provide an indication of a longer-term outcome of the use of disclosure statements, beyond the initial impact on clients. There was no statistically significant difference in the proportion of treatment versus control group in client-initiated termination of treatment. These results provide some evidence to rebut the claim that pretherapy disclosure would have a deleterious effect on therapy, such as lower the placebo effect or detract from the therapeutic process (Winborn, 1977) and potentially lead to premature termination. The results may also, however, be indicative of the overriding effect of client contact with therapists. Handelsman and Martin (in press) recently found that actual therapist behaviors were more influential than the use of written informed consent materials. Thus, any differences that may occur as a result of pretherapy disclosure could be wiped out by direct contact with the therapist. It is difficult to determine whether there are no long-term effects of pretherapy disclosure or if initial effects are superseded by contact with therapists. Regardless, in the real world, contact with therapists does occur and there is no practical reason to try to separate the effects of disclosure from the effects of contact. Pre-therapy disclosure followed by therapist contact appears to have no negative effects on the longer-term outcome of clients dropping out of therapy prematurely.

Results of Other Research Issues

Two independent variables other than comprehensive versus partial disclosure were investigated. The effects of client gender and therapist experience on perceptions of therapists were studied. The
dependent variable was scores on the CRF-S. The results are discussed next.

A main gender effect was obtained on the total scores on the CRF-S for the total sample. Females rated therapists more positively overall on the CRF-S than did males, regardless of the number and personalization of pretherapy disclosure issues received. These results are both statistically significant (at the .03 level) and clinically significant. A discussion of the size of the effect is presented next. The actual difference between the means of male and female respondents on the total scores of the CRF-S was 6.42 (males: \( M = 64.61, \ SD = 10.61 \); females: \( M = 71.03, \ SD = 8.72 \)). Given that possible total scores on this instrument could range from 12 to 84, a raw difference in mean scores of 6.42 may not at first glance seem very meaningful. In this study, however, only the top quarter (approximately) of the Likert scale was utilized, due to a ceiling effect on the CRF-S. Therefore, a difference between groups of six points has a greater implication. There is more than a 0.5 standard deviation difference between the male and female groups. This difference is practically significant as well as statistically significant. These results add credence to those obtained by Handelsman and Martin (in press) who found in an analogue study that men had a poorer first impression of therapists. In their study, the negative effect occurred only with men who were given a less readable (single-spaced, with longer sentences and syllables) disclosure document written at a 10th grade level. The more readable document was written in outline form at the fourth grade level. In the present study, the readability level of disclosure statements was improved upon; however,
the final documents were written at Grade 8 and Grade 8-9 for the control and treatment groups, respectively. The methodology used in this study, then, resulted in finished disclosure statements being written at a grade level that was closer to the less-readable document than the more-readable document used in the Handelsman and Martin (in press) study. A question that remains is whether the present findings represent a gender effect or the influence of a relatively high readability level on males. More research needs to be done in this area.

Therapist experience was a second variable investigated in this study. Only treatment group data obtained from the CRF-S were analyzed, since the control group did not have information on this factor. There was no statistically significant difference in the ratings of therapists on the CRF-S between those with less than 9 years experience and those with 9 or more years experience. These results differed from those obtained in prior studies where positive effects on perceptions of therapists were determined. Handelsman (1990) found that therapists with 9 or more years experience were more likely to be referred to friends than less-experienced therapists. Sullivan et al. (1993) found that therapists with 9 or more years experience were rated higher on the expert subscale and total score on the CRF-S than less experienced therapists. A possible explanation for these differences is that the prior studies used an analogue design with student volunteers, while the present study consisted of an actual client sample. Perhaps all therapists in a university-endorsed counseling center were seen as acceptable, thus overriding any effect of therapist experience on participants. A second explanation is that the current study provided considerable
personalized data about the counselor, only one component of which was years of experience. The experience factor may have been embedded in the disclosure statement and not as obvious to clients, or other factors may have been more influential. Finally, the prior studies stated that the therapist in the low experience category had less than one year of experience. In the present study, no therapists listed less than 5 years of experience. Therefore, the results may not be comparable. The effects of the disclosure of therapist experience on client perceptions needs additional investigation.

**Suggestions for Improving Disclosure Documents**

The final area investigated in this study was client suggestions for improving disclosure documents. Suggestions were obtained from open-ended questions on the Pretherapy Questionnaire (see Appendix F). Participants were asked: "Which information was most helpful in understanding the counseling process? In what way was the information helpful? Is there other information that would have been helpful for you to receive about your counselor or the counseling process?" The results of the quantitative and qualitative analysis of the answers to the open-ended questions are discussed next.

The most frequent response of treatment group participants was that specific data about the counselor and his or her therapy approach or style were the most helpful information received. This same type of specific data were often mentioned by control group participants as information they wished they had received. Members of both the control and treatment groups often stated that the information they received
was helpful because it defined what to expect in therapy and provided personal reassurance and comfort. Most participants from both the control and treatment groups were satisfied with the amount and type of information they were given. Two treatment group participants requested additional data on therapy expectations, such as what to expect during the intake session and client responsibilities in therapy. One treatment group participant stated that the disclosure statement "seemed a little stiff . . . [and] intimidating."

Responses from participants to open-ended questions in this study provide ideas for therapists as to the type of information that is helpful to clients entering therapy. Provided next are implications for writing disclosure statements that were derived from participant reactions in this study. It seems that specific data about the therapist and therapy process should be included in disclosure statements. An explanation of what can be expected from the therapist and what is required (desired) from the client might also be described. Statements should be written in a way that is not intimidating, but instead provides reassurance to clients. Therapists who wish to improve their written therapy statements might ask potential clients to read the document and offer suggestions before it is produced for distribution.

Limitations of the Study

There were five potential limitations of this study. They were:
(1) The treatment group may have been more likely to read and recall disclosure information than the control group; (2) a ceiling effect on the CRF-S may have reduced the likelihood of finding potential differences
between groups; (3) the methodology used with data from the open-ended questions may have limited the meaningfulness of the results; (4) clients had contact with counselors during intake and sometimes in prior therapy, which may have influenced their responses and reduced differences between groups; and (5) the populations to which the results can be generalized may be limited. Discussion of the limitations is presented next.

One limitation was that the treatment group may have been more likely to read and recall pretherapy information than the control group. Since reading and remembering disclosure information were not measured in this study, it is difficult to know if they had an impact on the results. Ordinarily, the random assignment of participants to the control or treatment condition would balance the potential effects of the above variables. However, the methodology employed in this study may have favored the treatment group in two respects: time span and personalization. Both groups received four pieces of therapy information in the packet of materials given before intake. The time lag between the receipt of intake materials and the first therapy appointment (when data were collected on the Pretherapy Questionnaire and attendance) ranged from 1 week to 2 months. The treatment and control groups each received a mailing within 1 week of their therapy appointment, which included appointment information. The treatment group, however, also received eight pieces of disclosure information in that mailing, just before their appointment. A shorter time span would favor recall. Personalization was another factor that may have influenced whether disclosure information was read or remembered. The material received by both
groups at intake was impersonal, included in a packet with other CSDC material, and sent home with clients. The material received in the mail by the treatment group, however, was personalized with individualized disclosure information about the assigned therapist. No other potentially "distracting" CSDC routine data were included in the mailing. Personalized data might also favor recall. If the treatment group read and recalled disclosure information received in the mailing, but neither group read or recalled information provided at intake, then the results of this study would be interpreted in a different way. The comparison would be between the control group who potentially read and recalled no pretherapy data and the treatment group who potentially read and recalled only personalized therapist and therapy information. If this was the case, then the possibility of negative effects on the treatment group would increase because they would have read and recalled only potentially negative and troublesome information. The lack of negative effects obtained in this study would therefore be even more meaningful. Reading and recalling pretherapy data were not measured in this study. Responses from participants on the open-ended questions on the Pretherapy Questionnaire, however, indicated that some participants did read and remember disclosure data. Treatment group participants tended to answer the questions with specific reference to information contained in the mailing, such as "[he] let me know he . . . considered himself 'sympathetic'," and "[I was given information] orienting [me] in regard to boundaries and expectations." The control group participants tended to provide nonspecific answers to questions in which it was difficult to determine whether or not they read or recalled the pretherapy
information provided to them. Examples of nonspecific responses were: 

The most helpful information was "the written information" or "the intake information." There was also a difference in the response frequency between treatment and control group participants on the last open-ended question, which was asked of all participants. Only 39% of the control group answered the question regarding additional information needed, while 77% of the treatment group answered the question. It is difficult to determine why there was such a difference in response frequencies between the two groups. Whether or not it was related to the reading and/or recall of disclosure information is not known. In the real world, potential clients may or may not read disclosure information. This study mirrored the real world; however, the methodology utilized may have increased the likelihood of treatment group participants reading and recalling data. Future research should provide disclosure information to treatment and control participants at the same time in order to improve upon this potential limitation.

A second possible limitation was the ceiling effect on the CRF-S. Participants rated therapists quite positively on the CRF-S, regardless of the amount of pretherapy information they received. The CRF-S is known to have a ceiling effect. In developing the CRF-S, a goal was to facilitate greater use of the lower end of the item rating scale than had been apparent with the CRF (Corrigan & Schmidt, 1983). In validation studies of the CRF-S, however, almost all ratings were at or above the midpoint of the scale (Corrigan & Schmidt, 1983; Epperson & Pecnik, 1985; Ponterotto & Furlong, 1985). Additionally, field ratings were higher than ratings obtained in analogue studies. Research in the area of
therapy disclosure substantiates the existence of a ceiling effect on the CRF-S with the highest ratings occurring in field studies. Examples of comparisons of scores on the CRF-S between prior analogue studies and the current field study are presented next. Ratings of therapist trustworthiness and expertness in a recent analogue study (Sullivan et al., 1993) were lower (M = 16.37 to 21.81) than ratings of the same constructs obtained in the present study (M = 21.08 to 24.35). Since subscale ratings on the CRF-S can potentially range from 4 to 28, the above findings also indicate a ceiling effect. The total scores on the CRF-S in the above example leads one to the same conclusion; the measure could not go higher even if ratings were higher. In a second recent analogue study (Handelsman & Martin, in press), mean scores were above the midpoint of the rating scale and lower (M = 51.94 to 59.69) than ratings obtained in the present field study (M = 64.61 to 71.03). (Ratings of total therapist attributes can potentially range from 12 to 84.) Ponterotto and Furlong (1985) suggested that the higher scores in field studies were the result of context cues (i.e., diplomas, lush furnishings) or personal knowledge of the therapist. In the present study, however, this aspect was improved upon since participants rated therapists before actual contact. Corrigan and Schmidt (1983) explained that the higher field study scores were more pronounced because of cognitive consistency (e.g., participants believed they would be getting help from a particular therapist, therefore that therapist must be good). Regardless of the explanation, the ceiling effect on the CRF-S may be problematic, especially in field research like the current study where only the top three scores on a 7-point scale were typically used by
respondents. If differences in perceptions of the therapist between control and treatment groups did occur, this instrument may not have been sensitive enough to detect the distinctions. In practical terms, however, what value is there in measuring the differences between extremely high and very high perceptions of therapists? The main point is that the perceptions of both treatment and control groups, in this study and prior research, continue to be measured in the positive range on the rating scale of the CRF-S. It seems clear that despite ceiling effects, evidence thus far suggests that even if differences do occur, therapy disclosure does not result in a negative perception of the therapist. Evidence of a negative effect of disclosure on perceptions of therapists continues to be unsubstantiated.

A third possible limitation of the current study was the methodology used in developing and analyzing data from the open-ended questions. The amount and type of information received from participants on the open-ended questions may have been restricted for three reasons. First, the open-ended questions may not have been written precisely enough to generate specific answers. Secondly, participants may not have read or remembered disclosure information provided to them, thereby making it difficult to produce useful responses on the open-ended questions. Thirdly, the procedure of analyzing responses may have weakened the qualitative component of the findings. As reported in the chapter on methodology (see Suggestions for Improving Disclosure Statements, Chapter III, p. 89), three psychology interns placed participant answers to the open-ended questions into predetermined response categories. Interns were instructed to place participant
answers into only one category. If differences in intern decisions occurred, they were instructed to come to a consensus. This methodology may have weakened the qualitative component by forcing responses into only one category when several categories may have been more descriptive of participant responses. Additionally, the categories into which the interns placed the responses sometimes differed from the categories into which the researcher would have placed them. Although this procedure reduced subjectivity, the researcher's depth of knowledge and understanding of the material may have been sacrificed. It would be helpful in future studies to interview participants shortly after pretherapy disclosure in order to gather a richer and more meaningful understanding of how to improve disclosure documents.

A fourth potential limitation was the impact of contact with counselors. Although methodology in the present study was designed to measure client responses before contact with therapists, communication with other counselors did occur. All participants met with an intake counselor and some participants had prior therapy experience. Contact with the intake counselor and prior therapists may have influenced responses and decreased differences between groups. A discussion of this limitation is provided next. Prior research indicated that face-to-face contact with a therapist had significant effects on perceptions of therapists (Heppner & Claiborn, 1988). The present study improved upon prior research limitations by measuring participant responses before contact with the therapist and eliminating from the sample those individuals who had met with their assigned therapist for intake or prior therapy. All participants, however, had direct contact with an intake
counselor. Many participants also had prior therapy experiences (treatment group, 50%; control group, 36%). Although the intake counselors and prior therapists were not the currently assigned therapists, interactions with them could have influenced participants' perceptions and opinions about therapists and therapy in general. The effects of personal contact with counselors at intake and in prior therapy may have been more powerful than pretherapy disclosure, thus superseding any differences between the treatment and control groups had contact not occurred. Additionally, the intake procedure may have reduced initial differences between the groups. Intake counselors may have inadvertently provided disclosure information to control group participants that this study was reserving for treatment group only (e.g., description of what therapy will be like, credentials of therapists). The intake session may have equalized differences between groups, thereby interfering with the measurement of the main independent variable in this study: the disclosure of comprehensive versus partial pretherapy information. An intake session, however, is typical of university counseling centers and other agencies. Therefore, even if intake "white washes" initial differences between groups, the findings are likely to be representative of what occurs in the real world. Therapists who work in centers with intake procedures (whether intake "white washes" the influence of pretherapy disclosure or not) can probably disclose personalized and potentially negative therapy issues to potential clients without negative consequences.

The final limitation was the generalizability of this study due to the research setting, small sample size, and lack of data regarding racial
background. This research was conducted in a counseling setting at one particular university; and therefore, this sample may not be representative of all student populations requesting therapy services. This counseling center offered free therapy services to students and may have been the only therapy option available to participants. Participant responses in this study may not generalize to other settings where numerous therapy options are available or where fees are charged. The results may also be generalizable only to settings in which an intake session occurs and may not apply to private practice settings or mental health agencies. The small sample size of 63 participants may also reduce the generalizability of results to the population in general. A small sample size increases the likelihood that chance factors (sampling error) will occur. Stringent participant selection procedures, however, were maintained to isolate the effects of pretherapy disclosure and to obtain a sample representative of persons seeking individual personal therapy. Finally, data regarding the racial background of participants were not obtained in this study, thereby limiting the generalizability of findings among particular racial groups.

**Implications for Future Research**

Based on the results of the current and prior studies on disclosure of therapy information, several suggestions for future research are apparent. These suggestions take into account the limitations of the current and prior studies, identify dependent and independent variables that warrant further investigation, and provide an idea for an interesting research project. Described next are the implications for future research.
To improve upon the current and prior studies, additional research in field settings is desirable. Research conducted in private practices or mental health clinics would allow comparisons of current findings from university settings with those obtained from other clinical groups.

To provide more conclusive data on the effects of pretherapy disclosure, personal contact with therapists should be controlled. The initial effects of disclosure should be measured before the client meets or talks with the therapist, as was done in this study. Contact with other therapists at intake might be controlled as well, which was not accomplished in the present study. This procedure could take place by eliminating the intake session entirely or by random assignment to intake and nonintake conditions. Investigation into the possible interaction effects of prior therapy might also be completed.

To improve upon limitations of the current and prior studies, research is needed on the differential effects of disclosure based on client and/or therapist racial background. To date, studies in the area of therapy disclosure have not addressed these important variables. Additional research is also needed on client recall of pretherapy disclosure. Future studies should provide a validity check to determine if information was read and remembered, in order to confirm the usefulness of participant responses. Client recall might also be an independent variable studied. Prior analogue studies (Handelsman & Martin, in press) suggested that recall is improved if material is written at a lower grade level, double spaced, and presented in outline form.

Additional data are needed from clients regarding therapy information they require in order to make a knowledgeable decision about
entering treatment with a particular therapist. These data might best be obtained through qualitative procedures, such as personal interviews.

Suggestions for future researchers regarding dependent variables are as follows: Researchers might consider developing or finding a more sensitive measure of perception of the therapist than the CRF-S. The CRF-S has a ceiling effect, particularly in field settings. One consideration would be to gather qualitative data from participants regarding their perceptions of therapists. Participants could be interviewed following pretherapy disclosure, but before meeting with their therapist. Continuing research on whether opinions and attitudes are consistent with behavioral change would add to the current research findings on the effects of pretherapy disclosure. Perhaps in other settings, requests for a change in therapist or attendance at the first session would provide significant findings.

There are several independent variables that might be studied. Suggested client variables are gender, ethnicity, and presenting problem. Suggested therapist variables are years of experience and educational level. To improve upon the current and prior studies, continuous measures of therapist variables could be analyzed (e.g., 1 year, 5 years, 14 years of experience) rather than using dichotomous categories (e.g., less than 9 years versus 9 or more years). Another research variable that needs additional study is readability of the disclosure document. In particular, the question of gender and readability level of written documents warrants further investigation. Results from a recent analogue study (Handelsman & Martin, in press) and questions raised in this study suggest that males may have a more negative opinion of therapists than
females if disclosure documents are more difficult to read.

An interesting research design would be to provide prospective clients with personalized disclosure statements and have them select their therapist based on the contents of the statement. Data could be obtained from clients on reasons for their selection. Differences between these clients and a control group could be obtained on such treatment outcome measures as premature termination, accomplishment of goals, changes in behaviors, etc. Not only would this design potentially provide important research results, but it would also uphold the basic ethical underpinnings of client rights: the freedom of choice.

Conclusions

Disclosure of comprehensive pretherapy information to university counseling center clients in this study did not have negative effects on their perceptions of therapists or attitudes about therapy. Comprehensive disclosure also did not result in requests for a change in therapist, lack of attendance at the first session, or an increase in client-initiated termination. The lack of a negative impact of comprehensive pretherapy disclosure obtained in this study concurs with results obtained in prior research. The current findings, however, substantially add to the research literature because of the improvements in methodology used in this study. The current study used a client sample instead of analogue methodology. This design increased the relevance of findings to actual practice settings. Information was disclosed to participants and effects were measured prior to contact with the assigned therapist, rather than during or after the first session. This methodology helped isolate the
effects of written disclosure and allowed a more conclusive statement regarding the absence of negative effects of pretherapy disclosure. In this study, the treatment group was provided with comprehensive information on all 12 issues of therapy disclosure recommended in the literature (Hedstrom & Ruckel, 1992) and the data were personalized and specific to the particular therapist. The comprehensive data consisted of potentially troublesome data on risks and alternatives to therapy, qualifications of therapists, and personalized material from which participants may have inferred the racial and ethnic identity, values, and other features of their therapist. Even with the provision of such potentially troublesome information, which is often not disclosed by practitioners, a negative effect upon participants was not measured.

The results of the current and prior research demonstrate no negative effects of disclosure of therapy information by practitioners. Based on these findings, it seems possible to adhere to the general ethical principles of protecting client rights and increasing client autonomy and participation without risking harm to the client or the therapy relationship.

Hopefully, the results of this study will stimulate further practical research in clinical field settings and increase the use of professional disclosure documents.
Appendix A

CSDC Intake Materials
Counseling and Student Development Center

220 Swen Parson Hall
(815) 753-1206

Northern Illinois University
The Counseling and Student Development Center (CSDC) provides professional assistance in coping with issues of a personal nature, adjusting to the demands of a higher education environment, selecting and achieving educational goals, and reducing sources of interference to learning. Toward those ends, seven major services are provided: Psychological counseling, career counseling, educational skills assistance, developmental programming and workshops, consultation, training, and research and evaluation.

Counseling and Student Development Center Services

Psychological Counseling
The psychological services component of the CSDC addresses the various personal problems and interpersonal issues of students, including chemical use and/or abuse. Psychological counseling is provided through individual, group, and couples counseling or therapy and crisis intervention. Staff members are available to provide after-hours emergency care.

Career Counseling
Career counseling is provided through individual counseling and testing, career development workshops, computer-assisted guidance, printed materials, and professionally-guided exploration.

Educational Skills Assistance
Individual counseling, workshops, audio tapes, and handouts are available for educational skills assistance. The Learning Assistance and Study Skills Lab (LASSL) is designed to assist students in improving learning skills. Trained staff offer skill development in the following areas: general study skills, memorization, time management, preparing for examinations, listening skills, taking examinations, and notetaking.

Developmental Workshops
Developmental workshops are designed to facilitate the personal, intellectual, and social growth of participants and to assist them in attaining or improving specific skills. Workshops are offered on a variety of topics (e.g., eating disorders, stress management, acquaintance rape, depression) upon request by students, faculty, and staff.

Consultation
Mental health consultation is available to address concerns that faculty, staff, students, and family have regarding specific students. Consultation is also available to the university community regarding program development and organizational development.

Training
The CSDC maintains a strong commitment to the training of undergraduate and graduate students. Undergraduate paraprofessional training programs are offered, as are externships and assistantships for graduate students. An internship for doctoral level students in psychology is provisionally accredited by the American Psychological Association.

Research and Evaluation
Research and evaluation services regarding the college experience and the development and delivery of services are an ongoing component of the CSDC.

Programs for Student-Athletes and Minority Students
The CSDC provides programs for two specific populations of students: athletes and minorities. These programs cut across the service areas above, but are targeted to the special needs of these groups.

The Athletic Counseling Program (ACP)
(140 Carroll Avenue, Apt. B4) offers specific activities designed to insure the academic success of student athletes.

Specific services for minority students
include support groups, drop-in hours for minority students, workshops, and a mentoring project. The staff at CSDC is committed to expanding services to minority students; we invite your suggestions for additional services that will be of assistance to you.
Arranging for Services

We invite you to stop by or call our center any time. We are here to help you. There are minimal charges for testing, but all other services are free. To schedule an intake (first) appointment, call or visit the CSDC during office hours and speak with our receptionist. You will be asked to fill out a confidential form that will assist us in identifying the appropriate resource for your concerns. During the intake appointment, you and your counselor will discuss your concerns and decide if the CSDC is the most appropriate place for you to receive assistance. If it is, you will be assigned a counselor who will meet with you on a regular basis.

Our Standards for Service

Quality Care

We are committed to providing you with the best service possible. We hope you will participate fully in our services and assist us in the evaluation of our activities. We can also provide you with referral assistance should alternative services be desirable.

Confidentiality

The information you share with your counselor will be treated confidentially by the CSDC. We assure you that your visits to the CSDC will not be disclosed to anyone without your written consent. Exceptions to confidentiality occur as a safeguard against imminent danger to yourself or others, including child abuse, or in the case of a court subpoena.

Client Responsibilities

Given our heavy service demand, we request that you:

- Keep all scheduled appointments
- Reschedule appointments as far in advance as possible

Emergencies

Call 753-1206 during regular office hours if you need assistance with a mental health emergency. You may speak with a counselor by phone or in person.

Call 753-9770 (University Health Service) if you need assistance with an after-hours mental health emergency.

Staff of the Counseling and Student Development Center

The senior staff of the CSDC are psychologists and counselors trained and experienced in providing the services described in this brochure. We are also a training center and as such provide training and supervision for graduate assistants and interns who are preparing to work in similar settings. In addition, undergraduate students serve as paraprofessionals in our developmental, career, and learning assistance programs.

Northern Illinois University is an equal opportunity institution and does not discriminate on the basis of race, color, religion, sex, age, marital status, national origin, handicap, or status as a disabled or Vietnam-era veteran. The Constitution and Bylaws of Northern Illinois University afford equal treatment regardless of political views or affiliation, and sexual orientation.

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Counseling and Student Development Center
Northern Illinois University

IMPORTANT INFORMATION FOR ALL CLIENTS

Due to the high demand for our services at the Counseling and Student Development Center, the staff has implemented a new policy which will affect you. The policy states that if you need to cancel an appointment you must call the center and inform us of the cancellation. If you miss a scheduled appointment and do not notify the center, we will assume you do not wish to continue using our services. Consequently, your file will be closed after 48 hours. Please try to call at least 24 hours in advance of your appointment to cancel. Thank you for your consideration in this matter. The number to call at the counseling center is 753-1206.

If there is a psychological emergency, you may still use the on-call service by calling 753-9770 after 4:30 p.m. and before 8 a.m.
Your upcoming appointment is what we call an "intake interview." We hope that the following information will help you understand our procedures so that you can make the best use of them.

The goals of the intake interview are for you and your intake counselor to discuss your concerns and decide upon a course of action that may best meet your needs. During this discussion, you and your intake counselor may decide upon one or more of the following possibilities:

1. that you have resolved your concern satisfactorily and the further appointments are not indicated at this time;

2. that you need to speak with some other resource person; if this is the case, your intake counselor will help you identify resources and/or assist you by referral;

3. that you might benefit from further counseling here at the Counseling and Student Development Center, either on an individual or a group basis.

   a. If you and your counselor decide upon individual counseling, you will discuss whether you would like to continue working together or whether it would be best for you to work with someone else. Preference will be honored whenever scheduling concerns permit, so please inform your intake counselor of your preferences.

   b. If you and your counselor decide upon group counseling, your intake counselor will refer you to the leader of the group you're interested in. The group leader and you will review your concerns and reach a final decision about the appropriateness of the group for you.

   c. At times, we have more requests for counseling than we have time available. If your intake occurs during one of these high-demand periods and you wish further counseling here, you may be placed on a waiting list, to be seen as soon as time becomes available.

Please feel free to discuss these various options with your intake counselor.
Your Rights and Responsibilities as a Client

When you enter into a counseling relationship at the Counseling and Student Development Center, you have the following rights:

1. The right of confidentiality as outlined in the "Assurance of Confidentiality" statement.
2. The right to request a different counselor than the one assigned to you.
3. The right to terminate counseling at any time.
4. The right to review your counseling records in the presence of your counselor or another counselor on our staff.
5. The right to a defined counseling goal mutually decided upon by you and your counselor.
6. The right to be informed, if at all possible before your scheduled appointment time, if your counselor is ill or for other reasons unable to meet you.

When you enter the counseling relationship, you have the following responsibilities:

1. To inform the appointment secretary by phone as soon as possible if you cannot meet your appointment time.
2. To be on time for appointments with your counselor.
3. To inform your counselor if you wish to terminate the counseling relationship or if you wish to request a different counselor.

2/23/89
Appendix B

Consent to Participate in Research Study
Consent to Participate in Research Study

You are invited to participate in a research study that is being conducted in the Counseling and Student Development Center at NIU. The purpose of the study is to determine the effect of providing students with various types of information about counseling. Your participation could assist us in the important task of revising the manner in which we help students learn about the counseling process.

If you agree to participate in this study, you will be asked to complete a short survey when you arrive for your appointment with your personal counselor. The survey will ask your opinion and perception of counseling. It should take about 10 to 15 minutes to fill out these forms. Information will also be collected regarding any change in counselor you might request. When counseling is over, data regarding the reason for termination will be collected.

The responses you make will be anonymous. Your name will not be attached to any of the forms and will not be listed in any manner. Information obtained in this study may be published in a journal or presented at a professional meeting. Since names are not used, your responses are completely anonymous and in no way can you be identified as a participant.

The decision to take part in this study is completely voluntary. Your decision will not affect in any way the service you receive at CSDC. You may also elect to withdraw from the study at any time.

We anticipate no personal risks involved in taking part in this study. If you have any questions, problems, or concerns about the information you receive or any inquiries about the study please contact:

Kathy Hotelling, Ph.D.
Counseling and Student Development Center
Northern Illinois University
DeKalb, IL 60115-2854
(815) 753-1209

Your participation in this study will assist us in improving our services to students.

Your signature on this form indicates that you have read, understood, and received a copy of this form. It also indicates that you have agreed to participate in the study.

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Signature                       Date
Appendix C
Random Assignment Form
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<td>C</td>
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Appendix D

Control Group Statement
Dear [Client name]:

I am the counselor who will be meeting with you at the Counseling and Student Development Center. I have scheduled your first appointment with me for [day] [date] at [time].

Our counseling center often has a waiting list. Therefore, if you cannot make this appointment, please call 753-1206 to cancel or reschedule. If we don’t hear from you within 24 hours of a missed appointment, we will assume you are not interested in counseling at this time.

I look forward to meeting you on [date].

Sincerely,

[Counselor name]
Appendix E

Sample Treatment Statement
[Date]

[Client Name]
[Client Address]

Dear [Client name]:

I am the counselor who will be meeting with you at the Counseling and Student Development Center (CSDC). I have scheduled your first appointment with me for [day] [date] at [time].

CSDC often has a waiting list. Therefore, if you cannot make this appointment, please call 753-1206 to cancel or reschedule. If we don’t hear from you within 24 hours of a missed appointment, we will assume you are not interested in counseling at this time.

I would like to provide you with information about my counseling style and me so that you will have a better idea of what to expect when we meet. I am currently completing a doctoral program in Counseling Psychology at Western Michigan University. I plan to earn my doctoral degree by December, 1993. I have a master's degree in School Psychology from Temple University. I have been doing therapy with adults and children for eight years.

I have worked with people of all ages who have a range of problems. I have special training to help women deal with issues such as depression, eating problems, divorce, and abuse. I also specialize in school problems. I have had much experience with people who have physical or mental handicaps.

In our sessions together, I will try to create a trusting environment where you will feel safe to share your thoughts, ideas, and feelings. I will listen carefully to understand the meanings you have made of events and relationships in your life. Most of these meanings will have developed while you were growing up, and therefore we will talk about your family history. Our main focus, however, will be on what is happening in your life now. Sometimes we will find that ways of responding that were useful to you in the past are now getting in the way. If so, I may help you to recognize and consider other alternatives or meanings that will be more effective for you.

Our sessions together will last about 50 minutes. I will probably suggest that we meet on a weekly basis. We will discuss and decide together how many weeks we will meet. There is no fee at CSDC for counseling. The only possible cost would be a charge for a written test that might help me better understand you.

The benefits of counseling can be increased understanding, self-confidence, control, and accomplishment of goals. However, there also
may be some risks involved. Painful memories or feelings can be re-called. You may decide to change some aspects of your life. This could result in changes in relationships with your friends, family, or others. We can work together to resolve any difficulties the counseling may cause in your life. Most people find that the benefits of counseling outweigh the risks.

You may choose to leave counseling any time; however, it is best if we discuss and plan together for the end of counseling. There are alternatives you might like to consider, such as workshops, reading materials, or support groups.

My counseling work is supervised by a Licensed Psychologist at CSDC. My supervisor will keep confidential all information he or she may learn about you. If you have concerns about my work, you may contact Kathy Hotelling at CSDC at 753-1206.

I look forward to meeting you on [date].

Sincerely,

Patricia W. Ruckel, M.Ed.
Appendix F

Pretherapy Questionnaire
Thank you for agreeing to participate in this research study. The purpose of the study is to learn about the effects of providing students with various types of information about counseling. Your opinions will help us in the important task of revising the manner in which we help students learn about the counseling process.

You received written information about the Counseling and Student Development Center (CSDC) at (1) your first appointment (intake) and (2) in the letter you received setting your appointment time with your personal counselor. The material you have read has probably given you some ideas or impressions about your personal counselor and the counseling process. We will ask for these opinions in the following survey. Even though you probably have never met your personal counselor, please share the ideas you have formed from the written materials.

Remember that this information is anonymous. Your name does not appear on any of the materials and there is no way to identify your responses from others who are participating in the study. It should take 10 to 15 minutes to complete these forms.

**Counselor Rating Form-Short Form**

Please rate several characteristics of your counselor. For each characteristic, there is a seven-point scale that ranges from "not very" to "very". Please mark an "x" at the point on the scale that best represents your impression of how your counselor might be. For example:

**FUNNY**

not very ___ : ___ : ___ : ___ : ___ : ___ : very

**WELL DRESSED**

not very ___ : ___ : ___ : ___ : ___ : ___ : very

These ratings might show that the counselor isn’t expected to joke around much, but could dress well.

(Please continue to next page)
Though all of the following characteristics we ask you to rate are desirable, counselors may differ in their strengths. We are interested in knowing how you view these differences.

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Scale</th>
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<tr>
<td>FRIENDLY</td>
<td>not very _______ : _______ : _______ : _______ : _______ : _______ : _______ : _______ : very</td>
</tr>
<tr>
<td>EXPERIENCED</td>
<td>not very _______ : _______ : _______ : _______ : _______ : _______ : _______ : _______ : very</td>
</tr>
<tr>
<td>HONEST</td>
<td>not very _______ : _______ : _______ : _______ : _______ : _______ : _______ : _______ : very</td>
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<tr>
<td>LIKEABLE</td>
<td>not very _______ : _______ : _______ : _______ : _______ : _______ : _______ : _______ : very</td>
</tr>
<tr>
<td>EXPERT</td>
<td>not very _______ : _______ : _______ : _______ : _______ : _______ : _______ : _______ : very</td>
</tr>
<tr>
<td>RELIABLE</td>
<td>not very _______ : _______ : _______ : _______ : _______ : _______ : _______ : _______ : very</td>
</tr>
<tr>
<td>SOCIABLE</td>
<td>not very _______ : _______ : _______ : _______ : _______ : _______ : _______ : _______ : very</td>
</tr>
<tr>
<td>PREPARED</td>
<td>not very _______ : _______ : _______ : _______ : _______ : _______ : _______ : _______ : very</td>
</tr>
<tr>
<td>SINCERE</td>
<td>not very _______ : _______ : _______ : _______ : _______ : _______ : _______ : _______ : very</td>
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<tr>
<td>WARM</td>
<td>not very _______ : _______ : _______ : _______ : _______ : _______ : _______ : _______ : very</td>
</tr>
<tr>
<td>SKILLFUL</td>
<td>not very _______ : _______ : _______ : _______ : _______ : _______ : _______ : _______ : very</td>
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<tr>
<td>TRUSTWORTHY</td>
<td>not very _______ : _______ : _______ : _______ : _______ : _______ : _______ : _______ : very</td>
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Please answer the following questions:

Prior to your first (intake) session, you were given written information about CSDC (eg. description of services, confidentiality, student responsibilities). After your first (intake) session, you were mailed information about your counselor and appointment time.

1. Which written information did you find most helpful?  
   Information from:  
   1st session (intake) ____  
   Mailing ____  
   Not sure ____

2. From the written material you received, do you believe you have a good idea of what to expect in counseling?
   No ____  Yes ____  Somewhat ____

3. Did the information you read have an influence on your wish to participate in counseling?
   No ____
   Yes ____  If yes, type of influence:  
   Positive ____  
   Negative ____

4. Did the information you read help you better understand what counseling will be like?
   No ____  Yes ____  Not Sure ____

   a. If yes, which information was most helpful in understanding the counseling process?

   b. In what way was the information helpful?

---

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5. Is there other information that would have been helpful for you to receive about your counselor or the counseling process? (Please describe).


6. Other than the material you received from CSDC prior to your first session (intake) or in the mail, did you have other knowledge about your personal counselor with whom you are meeting today?

No ___ Yes ___

If yes, what was your source of information about your counselor? (Check as many as applicable)

___ 'Word of Mouth'

___ Counselor Presentation (eg. workshop, residence hall program, guest speaker)

___ This counselor met with me for first (intake) session

___ I previously received counseling from this counselor

___ Other ____________________________

Please complete the following information about yourself:

Gender: Male ___ Female ___

Age: ___

Have you received counseling before? No ___ Yes ___

Name of the counselor with whom you are meeting today:

(The information from this survey will not be shared with your personal counselor)

Thank you for agreeing to participate in this study. Please hand in your completed forms to the receptionist.
Appendix G
Sample Therapist Statement
I am currently completing a doctoral program in Counseling Psychology at Western Michigan University. I plan to earn my doctoral degree by December 1993. I have a master's degree in School Psychology from Temple University. I have been doing therapy with adults and children for eight years.

I have worked with people of all ages who have a range of problems. I have special training to help women deal with issues such as depression, eating problems, divorce, and abuse. I also specialize in school problems. I have had much experience with people who have physical or mental handicaps.

In our sessions together, I will try to create a trusting environment where you will feel safe to share your thoughts, ideas, and feelings. I will listen carefully to understand the meanings you have made of events and relationships in your life. Most of these meanings will have developed while you were growing up, and therefore we will talk about your family history. Our main focus, however, will be on what is happening in your life now. Sometimes we will find that ways of responding that were useful to you in the past are now getting in the way. If so, I may help you to recognize and consider other alternatives or meanings that will be more effective for you.

Patricia W. Ruckel, M.Ed.
Appendix H

Request for a Change in Counselor
Request for a Change in Counselor

___ Control group
___ Treatment group

Reason client requested a change:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Was the request the result of written information the client received at intake or in the mail?

___ No  ___ Yes

If yes, information from:

___ Intake  ___ Mail
Appendix I

Closing Report
CLOSING REPORT

Client __________________________ Treament Mode ______________________

# of Sessions July 1 - June 30
- Individual ______
  (include intake(s) and group screenings)
- Group ______

Cumulative # of Sessions
- Individual ______
  (totals for all individual and group sessions)
- Group ______

SUMMARY OF TREATMENT (goals, process, response)

COUNSELOR'S IMPRESSIONS (conceptualization, diagnosis, further treatment, etc.)
COUNSELOR'S IMPRESSIONS (diagnosis, further treatment, etc.) (cont.)

Counseling directly assisted this client's progress towards a degree.

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<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Unsure</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
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<td>3</td>
<td>4</td>
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Progress / ________________/______________________/ NA

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DISPOSITION:

1. Transferred (Mode: ___________________ Counselor: ___________________)
2. Closed (select one)
   a. client terminated
   b. counselor terminated
   c. mutual termination
   d. closed following medical withdrawal
   e. end of fiscal year closing
   f. other
3. No show after intake
4. Referred to outside agency
5. Other ______________________________________________________

Tests Given ______________________________________________________

________________________________________
Counselor Signature

________________________________________
Supervisor Signature

Present Date _________________
6/92
Appendix J

Institutional Review Board Documents
July 1, 1992

MEMORANDUM

TO: Patricia W. Ruckel
    Counseling & Student Development Center

FROM: James H. Grosklags
      IRB Chair

RE: Faculty research project involving the use of human subjects entitled
    "The effect of pre-therapy information on perception of the counselor
    and counseling process"

This is to inform you that your above-named research project has been approved by this office as exempt from the Code of Federal Regulations (45 CFR 46) for protection of human subjects. The rationale for exemption is section 46.101 (b), paragraph 2.

Because this research project has been designated "exempt", this approval is final. You will not need any further review of this project unless you decide to modify it. If you intend to change the procedures, subject pool, or otherwise to modify the protocol, you will need to contact the Office for Research Compliance about approval of the changes.

Please accept my best wishes for success in your research endeavors.

JHG/sa

cc: K. Hotelling
    N. Willott
Date: July 15, 1992
To: Patricia W. Ruckel
From: Mary Anne Bunda, Chair
Re: HSIRB Project Number 92-07-08

This letter will serve as confirmation that your research protocol, "The effect of pre-therapy information on perception of the counselor and counseling process" has been approved after expedited review by a subcommittee of the HSIRB. The conditions and duration of this approval are specified in the Policies of Western Michigan University. You may now begin to implement the research as described in the approval application.

You must seek reapproval for any change in this design. You must also seek reapproval if the project extends beyond the termination date.

The Board wishes you success in the pursuit of your research goals.

xc: Croteau, CECP

Approval Termination: July 15, 1993
Appendix K

Permission to Use CRF-S
August 5, 1993

J.D. Corrigan, Ph.D.
480 W. 9th Avenue
Columbus, OH 43210

Dear Dr. Corrigan:

Thank you very much for sending me articles reviewing the reliability and validity data of the CRF-S. They were most helpful in preparing my dissertation proposal.

As I explained to you on the phone, I will be using the CRF-S in my dissertation. Participants will receive either minimum or maximum counseling information prior to entering the counseling relationship. I want to measure the effect of written disclosure on client perception of the counselor. The CRF-S has been used in similar studies, so I selected it for comparability of results.

I also want to thank you for giving me permission to use the CRF-S and sending a copy of it to me. This letter will be included in the appendix of my dissertation as proof that your permission was given.

Sincerely,

Patricia W. Ruckel
1307 W. Lincoln Highway - Apt. 1102
DeKalb, IL 60115
Appendix L

Qualitative Data Analysis
Qualitative Data Analysis

Question 1: Which information was most helpful in understanding the counseling process?

Directions: You have been provided with participant responses to the above question. Each response is quoted on a separate card and each card is numbered. Read each of the categories below. Determine which category best describes the response made by the participant. Enter the number of the response on this page under the selected category.

A. Nonspecific general answer/insufficient information

B. Counselor qualifications/experience

C. Description of personal counselor's process/approach/method/style

D. General procedural information

E. Other

F. Client did not respond
Qualitative Data Analysis

Question 2: In what way was the information helpful?

Directions: You have been provided with participant responses to the above question. Each response is quoted on a separate card and each card is numbered. Read each of the categories below. Determine which category best describes the response made by the participant. Enter the number of the response on this page under the selected category.

A. Provided basic information/defined what to expect from CSDC

B. Provided personalized information about my counselor

C. Provided personal reassurance and comfort

D. Other

E. Client did not respond
Question 3: Is there other information that would have been helpful for you to receive about your counselor or the counseling process? (Please describe.)

Directions: You have been provided with participant responses to the above question. Each response is quoted on a separate card and each card is numbered. Read each of the categories below. Determine which category best describes the response made by the participant. Enter the number of the response on this page under the selected category.

A. Counselor background/specialty

B. Counselor personal information

C. Counselor expectations

D. Other

E. No other information needed/none

F. Client did not respond

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Appendix M

Chi-Square Computation for Attendance at the First Session
\[ x^2 = \sum \frac{(O - E)^2}{E} \]
\[ x^2 = \frac{(1)^2}{32} + \frac{(1)^2}{1} + \frac{(1)^2}{29} + \frac{(1)^2}{1} \]
\[ x^2 = .03 + 1 + .03 + 1 \]
\[ x^2 = 2.06 \]
Appendix N

Chi-Square Computation for Client-Initiated Termination
\[ \chi^2 = \sum \frac{(O-E)^2}{E} \]

\[ \chi^2 = \frac{1.21}{6.1} + \frac{1.21}{24.9} + \frac{1.21}{5.9} + \frac{1.21}{24.1} \]

\[ \chi^2 = .198 + .049 + .205 + .05 \]

\[ \chi^2 = .50 \]


Handelsman, M., & Martin, W., Jr. (in press). Effects of readability on the impact and recall of written informed consent material. Professional Psychology: Research and Practice.


