An investigation of psychoeducational interventions about therapy

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(Received 7 June 2005; revised 27 September 2005; accepted 27 September 2005)

Abstract
This study assessed the effects of psychoeducational interventions on undergraduates’ expectations and fears about psychotherapy. Block randomization was used to determine intervention assignment: a multimedia program, information-only presentation, or a no-intervention control group. Pre- and postintervention scores from the Expectations About Counseling–Brief Form (EAC-B) and Thoughts About Psychotherapy Survey (TAPS) were assessed for changes in expectations and fears. Results showed that the multimedia and information-only interventions significantly reduced fears about therapy, although the reduction in fears by the multimedia program was more significant compared with the information-only intervention. The multimedia program also significantly and positively influenced 3 EAC-B subscales, Client Characteristics, Client Attitudes and Behaviors, and Counseling Process and Outcome, compared with the other 2 conditions. Clinical implications of using educational interventions are discussed.

Educational interventions have become commonly accepted as a means of familiarizing patients about a wide variety of health care procedures, ranging from routine practices to specialized procedures. Fields such as pain management for cancer, spinal surgery, and dentistry have used preparatory educational programs with increased frequency, a practice that has improved patient expectations and increased adherence with treatment recommendations (Block, Gatchel, Deardorff, & Guyer, 2003; Docherty, 1989; Wells, Hepworth, Murphy, Wujcik, & Johnson, 2003). Educational interventions within these areas have increasingly used sophisticated technology such as computerized multimedia programs that are enriched with video examples. For example, Tappen, Whitehead, Folden, and Hall (2003) used video intervention to prepare patients for hip repair surgery and found that patients who viewed videos showed improved postphysical performance relative to a control group.

Although the creation of preparatory educational programs within psychotherapy has lagged behind these medical advances, there is good reason to believe that their usage would also be effective in allaying client fears about therapy. Evidence from the research literature suggests that pretreatment education of psychotherapy clients may decrease fearfulness, anxiety, and role confusion (McLeod & Deane, 1994; Reis & Brown, 1999; Tinsley, Bowman, & Barich, 1993). Pretreatment interventions also appear to facilitate improved client expectations, positive therapeutic relationships, and reduced dropout rates (Deane, Spicer, & Leathem, 1992; Docherty, 1989; Gaston, Marmar, Gallagher, & Thompson, 1989; Tinsley, Bowman, & Barich, 1993).

The most frequently used technique to prepare clients for therapy is didactic instruction, commonly referred to as role induction. The center of this technique is the education of clients regarding the basis for therapy, realistic expectations for change, the therapeutic process and outcomes, and examples of appropriate therapist and client behaviors (Walitzer, Dermer, & Connors, 1999).

Expectations, fearfulness, and therapy

The expectations that a client brings into the initial therapy session have long been hypothesized to be one of the most important common factors in psychotherapy (Frank & Frank, 1993). Goldstein (1962) posited that there were two types of client expectations: (a) the expectation of treatment efficacy and (b) expectations of the contribution of both the client and the therapist to the process of therapy. In other words, clients’ expectations are thought to focus on both the process and outcome of therapy. Results of additional studies have shown that client expectations had significant impact on therapeutic
were viewed as the most effective methods for developing a preparatory educational program for the format and methodology that should be used in therapy if the client is seen on a regular basis. First, they deemed the use of direct human interactions in the preparatory intervention as unnecessary; audio- and video-enriched interventions were viewed as the most effective methods for educating clients. Second, they highlighted the importance of the intervention remaining independent of the therapy itself (i.e., the interventions should be provided before therapy begins). Finally, more methodologically sophisticated designs should be implemented, including the use of manipulation checks, to gauge the amount of educational information retained by the target audience.

**Effectiveness of preparatory educational interventions for psychotherapy**

Research has shown that preparatory educational interventions for psychotherapy have provided some promising results relating to overall effectiveness on processes and outcome. With regard to process, clients who completed a preparatory educational intervention tended to show improved expectations and reported a better understanding of the therapeutic process and the role of the client (Reis & Brown, 1999); display more desirable in-therapy behavior, such as self-exploration and initiation of communication; develop better relationships with therapists; and report greater satisfaction (Heitler, 1973, as cited in Reis & Brown, 1999). Preparational tools can increase client awareness of the therapeutic process and reduce role confusion (Anderson & Strupp, 1996) and may reduce negative attitudes and treatment fearfulness, which likely contribute to mental health service avoidance (Giles & Dryden, 1991).

Effects on outcomes tend to be more limited, but several studies have shown beneficial impact of preparational interventions on outcome. Deane et al. (1992) found that a brief preparational videotape improved client knowledge about therapy and reduced anxiety but showed no improvements on therapeutic outcomes. However, others have found that prepared clients reported greater symptom reduction and lower rates of attrition than a group without the intervention (Larsen, Nguyen, Green, & Attkisson, 1983), a greater decrease in self-reported symptoms (Zwick & Attkisson, 1985), significantly more accurate expectations, and decreased state and trait anxiety (Douglas, Noble, & Newman, 1999).

Although these studies are promising, the overall trend of findings on the effectiveness of preparatory interventions has been mixed. A review of studies by Tinsley et al. (1988) found that educating clients about therapy yielded positive effects in 10 of 24 studies. Tinsley et al. suggested that the low effectiveness rate may have been due to methodological flaws in the development of these programs (e.g., lack of manipulation checks), which may have limited the inclusion of optimal educational content and presentational format. For example,
the addition of manipulation checks would allow those who designed the study to measure the impact of the information that was presented to the target audience and fine-tune the content of their interventions.

Current study

Although brochures appear to be the most widely used method of therapy preparation, there may be more effective ways to address client expectations, such as a more in-depth or interactive educational program. A program of this kind might be capable of gaining and retaining the attention of its audience while disseminating information aimed at correcting erroneous therapy conceptions. The present study used a newly developed educational program with content drawn from a comprehensive review of the literature. The content of the preparatory educational intervention was enriched with a multimedia presentational format. Video examples, selected from reenacted scenes from actual therapy sessions, were used to highlight important learning points. This study examined the extent to which the educational program with video enhancement was successful in altering expectations about therapy relative to an information-only version (i.e., non-video enriched) and a no-intervention control. We hypothesized that those who viewed the multimedia program would show less fearfulness and would evidence a better understanding of therapy as reflected by their expectations.

Method

Study Design

An analogue study with an experimental design was created to test the newly developed multimedia program. Three conditions were created: multimedia intervention, information-only intervention, and no-intervention control. Baseline fearfulness and expectation scores were collected from participants at Time 1. At Time 2, 48 hr later, participants returned, and interventions were assigned using block rotation. This method was used until a sample of 30 was obtained for each condition. Participants viewed the assigned intervention and completed questionnaires.

Participants

Ninety undergraduate students participated in this study, including 62 (69%) women and 28 (31%) men. The average age was 20.34 years (range = 18–55, SD = 4.52). The majority of the sample was self-identified as Caucasian (n=77, 86%), and the remainder self-identified as African American (n = 6, 7%), Asian or Pacific Islander (n = 2, 2%), Hispanic (n = 2, 2%), American Indian (n = 1, 1%), and “other” (n = 2, 2%).

Measures

Expectations About Counseling–Brief Form (EAC-B; Tinsley et al., 1980; Tinsley, de St. Aubin, & Brown, 1982). The EAC-B consists of 66 items rated on a 7-point scale with response options that range from not true (1) to definitely true (7). The EAC-B consists of five different scales: Client Attitudes and Behaviors, Client Characteristics, Counselor Attitudes and Behaviors, Counselor Characteristics, and Counseling Process and Outcome, which are collectively composed of 18 smaller subscales. Scale scores are determined by simply adding the subscales and then combining designated subscales together. Internal consistency of these subscales has been reported to range from .69 to .82 (Mdn α=.77; Tinsley et al., 1982). Test–retest reliabilities for a 2-month interval range from 0.61 to 0.87 (Mdn = .71), with the exception of .47 on the Responsibility scale. Research has demonstrated that the EAC-B discriminates between client expectations about counseling and two other client constructs: perception of and preference for therapy (Tinsley & Westcott, 1990). For this sample, alphas were computed at Time 1. The EAC-B total score had an alpha of .92. The alphas for the subscales were as follows: .84 for Client Attitudes and Behaviors, .89 for Counselor Attitudes and Behaviors, .52 for Client Characteristics, .83 for Counselor Characteristics, and .80 for the Counseling Process and Outcome subscale.

In four of the subscales, an increase in scores on expectations at postintervention would represent a more realistic change of expectations (i.e., Client Attitudes and Behaviors, Counselor Attitudes and Behaviors, Counselor Characteristics, and Counseling Process and Outcome). However, for Client Characteristics, a decrease of scores on expectations at postintervention would indicate a more realistic change of expectations in this setting.

Thoughts About Psychotherapy Survey (TAPS; Kushner & Sher, 1989). The TAPS is used to assess the fearfulness of mental health services among persons who may or may not be in psychotherapy. Kushner and Sher (1989) derived the TAPS from the Thought About Counseling Survey by Pipes, Schwarz, and Crouch (1985). Kushner and Sher used instructions that were designed for individuals who were not currently in psychotherapy or counseling to imagine seeing a therapist for the first time. Items are scaled on a 5-point Likert-type scale, ranging from 1 (I have not been concerned about this)
to 5 (I am very concerned about this). The items are scored by adding the responses. The scale consists of three subscales: Therapist Responsiveness, Image Concerns, and Coercion Concerns. Internal consistency (Cronbach’s alpha) among the three scales ranged from .87 to .92 (Deane & Todd, 1996). The TAPS had an internal consistency alpha of .92 when completed at Time 1.

Marlowe-Crowne Social Desirability Scale (SDS—Short Form; Reynolds, 1982; Crowne & Marlowe, 1960). The original SDS was developed as a 33-item scale to measure socially desirable behaviors (Crowne & Marlowe, 1960) and has been used frequently to control for the influence of socially desirable responses. The items consist of a list of socially undesirable behaviors that are unlikely to occur, which are rated as either true or false. Reliability of the original form is .75. A short form was derived from the full measure and consists of 13 items that can be used as a substitute for the full 33-item scale. Item factor loadings, with SDS—Short Form total scale correlations and correlations between SDS—Short Form and the Edwards Social Desirability Scale, were conducted. Internal consistency reliability was .70 for the short form. This sample revealed an alpha of .63.

Demographic information. The demographic questionnaire gathered personal information, such as age, gender, major, and ethnicity. Participants were asked to answer either “yes” or “no” to questions about personal use of mental health services, whether they knew anyone who had been in therapy, whether they had ever felt like they needed counseling services, and the likelihood they would recommend therapy to others. Participants rated, on a 7-point Likert scale, how well they understand the process of therapy, how likely they are to seek therapy in the future, and the level of satisfaction with prior mental health services (if applicable).

Postintervention questionnaires. Questions addressed issues such as the helpfulness of the information presented, the amount of information presented that the participants did not know, whether the intervention changed their opinion of therapy, and whether they were more likely to consider therapy in the future after viewing the intervention on a 5-point Likert scale. They were asked to rate the length of time in which the information was presented as either “too short,” “about right,” or “too long.” Participants were also asked an open-ended question for suggestions on how to improve the intervention. This scale showed an alpha of .67 for all questions except the open-ended question.

Short quiz material. A separate quiz was developed for each intervention; the multimedia quiz was composed of 12 questions, and the information-only quiz was composed of 6 questions (there were more questions for the multimedia intervention because of the additional video material present). The questions are multiple choice and refer to information that was directly presented during the relevant intervention.

Procedure
Participants responded to a posted advertisement in the Ohio University Psychology Building and participated in exchange for course credit. This experiment was conducted at two 1-hr meetings spaced approximately 48 hr apart. At Time 1, all participants filled out the Marlowe-Crowne short form (as a manipulation check) and a demographic questionnaire. Next, participants were presented with a role induction, adapted from Tinsley et al. (1980), using a one-page instruction that asked each participant to think about a stressful life event and then to imagine setting up an appointment to see a counselor or therapist for the first time. After choosing the event and imagining they had an appointment, clients completed the EAC-B and the TAPS.

At the beginning of Time 2, participants were randomized into one of three conditions: the multimedia condition, an information-only condition, and a no-intervention control condition, in which participants were administered questionnaires but were not exposed to any intervention. Groups of participants were small (<15 at a time), and participants were partitioned from one another so as to not reveal group assignments. After completing the intervention, a short quiz was administered to those in the information-only and multimedia interventions as a manipulations check for whether participants were familiar with the content of the interventions. All participants also completed the TAPS, EAC-B, and posttest and follow-up questionnaires. Those in the no-intervention control condition simply filled out the TAPS, EAC-B, and the follow-up questionnaire.

Multimedia Therapy Education Program
The multimedia-enhanced program was designed specifically for this study with the intention of providing information about therapy as a role induction to those who are unfamiliar with the process. To begin, a thorough literature review was conducted to determine possible aspects of therapy that would be useful for clients to know. Several specific types of client expectations were chosen, including the roles of the client and therapist, the work the client
expects to perform, anticipated results of therapy, confidentiality, establishing goals, reasons someone might seek therapy, content of the first session, and potential benefits of therapy. These expectations are discussed in both interventions using information taken from brochures available in two university clinics and on the American Psychological Association Web site. In addition to this information, an informal survey was developed from the topics gathered in the literature review and distributed among a small group of practicing clinicians. Results of the literature review and informal survey were then combined to create a comprehensive multimedia program for pretherapy clients.

To provide participants with realistic examples of good therapeutic interactions, short segments of actual therapy sessions were included to highlight some examples of good working relationships that are described in the text of the presentation. Sections of videotape-recorded sessions from the Vanderbilt II Study (Strupp, 1993) were chosen based on scores from the Vanderbilt Psychotherapy Process Scale to represent cases of good therapist–client interaction. Sections were chosen to represent examples of the program content, including client confidentiality concerns, negotiation of role definitions, and therapist-initiated inquiries into the tasks and goals of therapy. Actors were hired to reenact the selected therapy sessions on videotape to preserve confidentiality of the original session. The multimedia program itself is an integration of the narrated and printed educational text with the video clips. The length of this intervention is approximately 20 min.

Information-Only Therapy Education Program

To contrast the effects of the multimedia program, an information-only PowerPoint presentation was developed using the same information collected for the design of the multimedia program. The material was presented on black-and-white slides to participants as a timed sequence to parallel the visual format and timing of the multimedia presentation. Unlike the multimedia program, there is no audio narration of the text or video clips of therapy session in the information-only presentation. The length of this presentation is approximately 10 min. The additional length in the multimedia presentation is accounted for solely by inclusion of video clips (i.e., the content of the information presented was timed to be identical in both conditions). This format was chosen to represent a computerized version of the information commonly found in brochures available in waiting rooms where mental health services are provided or a standard care intervention.

Results

Manipulation Check and Preliminary Analyses

In the multimedia group, 26 of 30 participants missed one or no questions, 3 missed two questions, and 1 missed seven questions. In the information-only group, 29 missed one or no questions and 1 missed two questions. Therefore, it was determined that most paid attention to their respective interventions.

Preliminary analyses were conducted for all analyses for covariate effects of gender and Marlowe-Crowne social desirability on TAPS Fearfulness and EAC-B Expectations subscale scores. These covariates were not significant in the analyses and, therefore, were removed. An alpha of .05 was used for all analyses.

Fearfulness and Expectations About Therapy

Means and standard deviations for TAPS and EAC-B scores at Time 1 and Time 2 are provided in Table 1. Unstandardized residual change scores were created by regressing Time 2 scores on Time 1 scores and saving the residuals for the TAPS Fearfulness and EAC-B Expectations subscale scores. Multivariate analysis of variance (MANOVA) was conducted using the residual change scores with the assigned condition (multimedia, information only, and control) as the independent variable and the TAPS Fearfulness and the five EAC-B Expectations scores as dependent variables. The omnibus (Wilke’s) MANOVA was significant, $F(12, 164) = 3.81, p < .001$.

Planned comparisons were conducted on the TAPS and EAC-B residual change scores to identify whether the multimedia condition differed from the (a) information-only condition (Comparison 1) and (b) the no-intervention control condition (Comparison 2). Planned comparisons followed standard procedures of calculating $F$ statistics for each specific group mean difference (i.e., a mean square of weighted group mean differences divided by the within-groups mean square that includes the within sum of squares for all treatment groups; see Keppel, 1982, pp. 109–118). When there were repeated measures (i.e., the TAPS and EAC-B), effect sizes (ESs) were derived by taking pre–post differences divided by the pooled variance. ES for each measure’s pre- and postdifferences provides a more specific index of change within a condition and allows the reader to consider the relative level of change by comparing each condition’s ES. For measures that were collected at one setting, comparative effect sizes between condition means are reported.
The multimedia condition showed a greater decrease in TAPS Fearfulness (ES = 1.02) compared with the information-only condition (ES = 0.43), $F(1, 87) = 4.49$, $p = .04$, as well as the control condition (ES = 0.13), $F(1, 87) = 6.19$, $p = .01$. For the EAC-B Client Characteristics subscale, the multimedia condition showed a change toward more realistic expectations about being a client (ES = 0.63) compared with the information-only condition (ES = 0.06), $F(1, 87) = 10.64$, $p = .002$, and the control condition (ES = 0.13), $F(1, 87) = 16.47$, $p < .001$. The multimedia condition also had more changes toward more realistic Client Attitudes and Behaviors (ES = 0.23) than the control condition (ES = 0.05), $F(1, 87) = 6.19$, $p = .01$, but was not significantly different from the information-only condition (ES = 0.27), $F(1, 87) = 0.68$, $ns$. The multimedia condition displayed changes toward having more realistic expectations on the Counseling Process and Outcome subscale (ES = 0.40) than the control condition (ES = 0.09), $F(1, 87) = 7.30$, $p = .008$, but there was no difference with the information-only condition (ES = 0.27), $F(1, 87) = 0.66$, $ns$.

**Discussion**

The data suggest that both the multimedia program and information-only interventions were successful in reducing fears associated with therapy. The multimedia presentation was successful in changing selected subcategories of expectations relative to the nonintervention control, whereas the information-only presentation demonstrated no significant effects on expectations compared with the control group.

**Fears**

Results showed that TAPS Fearfulness scores from both the multimedia and information-only interven-

tions were significantly lower than the scores from the no-treatment intervention, with the multimedia presentation demonstrating the most effectiveness in reducing fearfulness scores. Therefore, it seems that presenting information about therapy in either of these two manners is helpful in reducing fearfulness about therapy. One explanation for this finding is provided by self-regulation theory (McLeod & Deane, 1994). This theory posits that if educational information is presented in an accurate and non-emotional format before stressful procedures, it facilitates the development of nonthreatening expectations about the approaching event for those who may hold negative expectations about the event (such as the counseling process) or consider the process of therapy to be threatening (McLeod & Deane, 1994). This indicates that fears about therapy may be reduced by methods that provide only information (without the video enhancement) to prospective clients, such as brochures and leaflets. Therefore, this could explain why both interventions were successful in reducing fears. However, additional comparisons showed that those who viewed that multimedia presentation reported significantly reduced fears than those who viewed the information-only intervention. This indicates that some component of the video-enhanced intervention was responsible for additional fear reduction within that group. It is hoped that the videos may have provided the participants with some of their first exposures to therapy sessions, thereby decreasing the ambiguity of the therapeutic process and reducing fearfulness or that the format of the enhanced program was able to address fears about therapy more effectively.

**Expectations**

These results indicate that the video-enhanced multimedia program effectively addressed certain client expectations, whereas the information-only
intervention was not able to attend to these issues. Selected categories of client expectations of psychotherapy were also improved by providing educational information. Expectations represented by the Client Characteristics, Client Attitudes and Behaviors, and Counseling Process and Outcome subscales were more realistic (as defined by the EAC-B) at Time 2 for those who viewed the multimedia intervention. Those who viewed the information-only intervention did not demonstrate a significant change in expectation scores.

It may be that some components of the video-enhanced program cause greater change than the information-only presentation. One possibility is that the video enhancement provides the participants with exposure about a previously unknown situation in the form of taped vignettes of psychotherapy interactions. This can simultaneously allay fears about therapy or therapists and provide a model for a prototypical encounter between a therapist and a client through the role-induction process. In addition, the video clips offer a more concrete example of therapeutic interactions than abstract or vague descriptions often found with simple information distribution. In this way, participants may be able to personalize the experience a little more with the aid of video enhancement. However, the multimedia program did not have a significant effect on all expectations subscales, and it may be that the scope of the multimedia program and the information-only interventions was not comprehensive enough to address these particular scales. It is important to note that the actual effects of the individual components of the video-enhanced program were not tested in this study; therefore, the impact of their potential effect is not proven.

It is interesting to note that the multimedia intervention was able to affect expectations related to attitudes, behaviors, and characteristics of clients but not expectations related to counselors. This is consistent with the goals of role-induction programs, which aim to educate clients. The format of these programs may not be sufficient to improve expectations regarding counselors and may be limited to expectations clients have about themselves and the processes and outcomes of therapy, such as the expectations affected by the multimedia intervention. It may also be that the Counselor Characteristics and Counselor Attitudes and Behaviors subscales contain features that are difficult to alter with a short intervention and may represent areas that the clients would prefer to assess for themselves once they meet with their therapist.

Finally, the most parsimonious explanation for the results of the current study may be that the multimedia intervention did not demonstrate a greater success rate because of the complexity of its design. Tinsley et al. (1988) found that more complicated interventions were unnecessary when attempting to disseminate information about the process of therapy. On some subscales of the EAC-B, the multimedia intervention was no better than the information-only intervention, suggesting that simpler methods of educating clients are just as effective for these subscales. These results imply that the original concept behind the design of the multimedia program might not show superior results to the information-only presentation in some instances.

Limitations and Future Directions

Perhaps the greatest limitation of the present study is that, as an analogue study, participants were role-playing clients. Therefore, these findings may not be generalizable to clinical populations. Still, the data indicate that this program is effective in educating students about therapy and has a positive effect on changing attitudes about therapy. In future research, we hope to test this program with other groups, such as using it as an educational intervention for clients who have a propensity for early dropout as well as an outreach intervention for persons who experience distress but would normally not seek out professional help for their problems. Other groups that may benefit include patients with no treatment history and court-ordered clients. We hope to investigate these avenues in future research.

As previously noted, the scope of this study did not include examining specific components of the multimedia and information-only interventions, such as the length of the presentation, possible modeling implications, and the presentation of the therapy vignettes. This information would be particularly useful in the creation of future psychoeducational interventions and should be examined more thoroughly.

Another important aspect to consider is the clinical applicability of the multimedia intervention. It is hoped that this intervention will positively affect those who use it by increasing their likelihood of seeking therapy as well as decreasing attrition and improving outcomes of therapy. The multimedia program demonstrated significant effects on three of the expectations subscales (Client Characteristics, Client Attitudes and Behaviors, and Counseling Process and Outcome) as well for fears about the therapeutic process. However, is this enough to affect attrition levels and outcomes of therapy? The scope and design of this study are not broad enough to give a satisfactory answer to this question. Future research will need to examine the effects of the multimedia program on those who may be
apprehensive about starting therapy. The next step for this program will be to test its effects on those entering therapy for the first time while also observing dropout levels and assessing therapy outcomes.

Acknowledgements

An earlier version of these results was presented as part of a panel, “The Role of Client Expectations in Therapy,” presented at the conference of the Society for Psychotherapy Research, North American Chapter, Springdale, UT, November 2004. This study is based on a master’s thesis completed by Jennifer M. Fende. The authors thank Laurie Fox for her help with reviewing an earlier version of this article and Bruce Carlson for statistical assistance.

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