THE INFLUENCE OF CLIENT GENDER, SOCIOECONOMIC STATUS AND ALCOHOLIC STATUS ON CLINICAL JUDGMENTS

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CHAPTER I

INTRODUCTION

Alcoholism is one of the major problems facing our society today. It has been called by some the nation's number one health problem (Tamerin & Neumann, 1971). Results of the Epidemiologic Catchment Area Program, the most comprehensive survey of mental disorders ever conducted in the United States, indicated that approximately 4.5% of persons surveyed presently suffer from alcohol abuse or dependence as defined by current psychiatric nomenclature. On a lifetime basis alcohol abuse and dependence affected approximately 12.5% of the survey's respondents (Grant, Noble, & Malin, 1985). In another national survey conducted by Gallup in 1982, one-third of the interviewed individuals stated that alcohol had caused problems in their families (U. S. Department of Health and Human Services, 1983). While these statistics are alarming, they do not tell the whole story. Much more alarming is the unknown number of individuals who are hidden alcoholics (Rubington, 1971). Rubington (1972) has estimated that 70% of alcoholics are hidden; that is, they go undetected and thus untreated.

Although alcoholism pervades all ages, races, sexes and social statuses, the most common stereotype of the alcoholic is that of the skid row derelict (Rosenberg, 1971). Skid row derelicts in actuality

comprise only 5% of the total alcoholic population. Furthermore, only about one-third of the skid row residents are actually alcoholic. Nevertheless, this skid row symbol remains and has become a major obstacle to the progress of the alcoholism movement because it has provided ". . . camouflage for millions of problem drinkers in the United States during the past fifty years" (Rubington, 1971, p. 125). The nonderelicts can tell themselves that they have jobs, homes, and families, and, thus, cannot be alcoholics. The stereotype of the alcoholic fits very comfortably into the denial system that is inherent in alcoholics (Black, 1986; Rubington, 1971).

This derelict stereotype of the alcoholic is not merely maintained by the general public but may also be held by many health professionals. For example, results of a study conducted at the Massachusets General Hospital (Blane, Overton, & Chafetz, 1963) indicated that physicians perceived alcoholism as a disorder occurring primarily among derelicts. Another finding of the same study suggested a reluctance by physicians to make a diagnosis of alcoholism with socially intact individuals. This finding concurs with Chafetz and Gatozzi's statement (1968) that the label of alcoholic is more readily given to alcoholics who have allowed their lifestyles to deteriorate. Thus, only the late stage alcoholics, those with serious social, occupational and familial impairments who most resemble the skid row derelict, are diagnosed as alcoholics and referred for treatment (Chafetz, 1968). While the rehabilitation of this type of alcoholic is not impossible, it can be very difficult and, consequently, may serve to reinforce attitudes of hopelessness toward treating alcoholic clients.

It is this very hopelessness that makes alcoholic clients undesirable candidates for therapy (Hanna, 1978). Hopelessness is often interpreted as lack of motivation by the client. But, as Chafetz (1968) suggested, the lack of motivation attributed to alcoholic clients may be a reflection of lack of motivation by the therapists themselves as a result of their moralistic view of alcoholics as hedonistic and weak willed individuals. Indeed, since our culture is oriented toward treatment of individuals who are sick and suffering, the implied pleasure that alcoholics supposedly receive from their drinking tends to result in moralizing and punitive attitudes (Mendelson & Chafetz, 1959). For instance, Sterne and Pittman (1965) found that psychiatric staff with moralistic attitudes toward alcoholism tended to be pessimistic concerning recovery and considered alcoholic patients as poorly motivated toward improvement. Haller-Johnson (1980), in her evaluation of clinical judgments about alcoholics, found that poor prognosis is the most frequently cited reason for an unwillingness to treat a client. It is not surprising, therefore, that helping professionals, irrespective of discipline, appear to have negative attitudes about working with alcoholic clients (Cornish & Miller, 1976; Fisher, Keeley, Mason, & Fisher, 1975; Hanna, 1978; Knox, 1973; Stafford & Petway, 1977).

Attitudes clearly influence therapeutic behavior. For instance, negative attitudes may result in clients being found unacceptable for treatment or may lead them to terminate or be terminated prematurely (Goldstein, 1973). Attitudes can also impact on diagnostic decisions. While most clinicians have middle socioeconomic status, the vast majority of alcoholics seen in

treatment are lower socioeconomic status individuals. Dissimilar attitudes between such divergent socioeconomic groups are understandably to be expected. Consequently, dissimilar attitudes are assumed and socially unacceptable individuals are marked as less moral and more poorly adusted by society. A growing body of research supports the hypothesis that broader societal attitudes and values affect caregivers' perceptions of deviant stereotypes and, thus, impact on the caregivers' treatment of clients (Rivers, Sarata, & Anagnostopulos, 1986). Accordingly, one might expect clinical judgments to reflect not only therapists' attitudes but society's as well.

Since for the most part skid row is a male society (Rubington, 1972), the derelict stereotype has excluded females. As a result, most of the research in the area has pertained to male alcoholism. There is existing literature, however, indicating that alcoholism is more disapproved among women than among men (Gomberg, 1976). Several studies also document that both men and women condemn drunkenness in women more than they do in men. For instance, in a study conducted by Gomberg (1984), using a group of alcoholic women in treatment and a comparison group of female nonalcoholics as subjects, 96% of the total sample agreed with the statement that "People find it more acceptable for a man than for a women to be drunk" and 91% agreed that "People look down on women problem drinkers more than they do on male problem drinkers." Expressions such "as hold your liquor like a man" give credence to the notion that there may even be in some instances approval of heavy drinking among men. Such expressions may also help explain why female

alcoholics are held in greater disdain than their male counterparts. Research indicated that alcoholic women deviate more from female normative behavior (Gomberg, 1976). Although Gomberg assumes that while greater deviance elicits greater social condemnation, she cautions against assigning greater pathology to female alcoholism.

Whether clinicians have been able to guard effectively against this view in their treatment of alcoholics is a largely unanswered question. Reported prognostic differences between male and female alcoholics are often conflicting with some studies reporting female patients as more improved and others reporting better outcome with male patients (Gomberg, 1976). There is some empirical support for the influence of therapists' attitudes on treatment outcome (Selzer, 1957). For example, in Selzer's observational study, a relationship between negative attitudes toward the alcoholic and treatment failure was found. It may be contended, therefore, that negative attitudes toward female alcoholics bias clinical judgments thereby contributing to a less successful outcome.

Some of the bias that affects perceptions of alcoholics appears to involve socioeconomic status. Lower socioeconomic status individuals are more likely to receive the diagnosis of alcoholism because of their closer approximation to the skid row stereotypical alcoholic (Chafetz, 1968). Complicating this are correlational studies indicating that lower socioeconomic status alcoholics are less motivated for treatment (Tamerin & Newmann, 1971). Consequently, therapists often have more negative attitudes about lower socioeconomic status alcoholics, tend to give them poorer

prognoses than higher socioeconomic status alcoholics, and are often unwilling to treat them (Wolf, Chafetz, Blane, & Hill, 1965).

Diagnosing alcoholism on the basis of the derelict stereotype has deleterious implications for middle and upper socioeconomic status alcoholics as well. Indeed, it may preclude identification and treatment of the vast majority of the alcoholic population (Chafetz, 1968). Rubington (1972) has asserted that therapists are less likely to label higher socioeconomic status individuals as alcoholics which allows these alcoholics to keep their drinking problems hidden. This is unfortunate since, ironically, upper-middle socioeconomic status alcoholics, because of their social stability, have a relatively good prognosis once diagnosed (Blane, Overton, & Chafetz, 1963). Until therapeutic attitudes change vis-a-`vis the stereotypical alcoholic, however, many alcoholics will not receive treatment until their social statuses have deteriorated. By that time, the alcoholism may be so far advanced that "treatment becomes highly complicated, therapeutic goals limited and necessary resources extremely expensive" (Blane, Overton, & Chafetz, 1963, p. 659).

In contrast to the sparse amount of research that has been done on the influence of client socioeconomic status on clinical judgments, extensive study has been done on client gender. The landmark study by Broverman, Broverman, Clarkson, Rosenkrantz, & Vogel (1970) which investigated the influence of sex role stereotypes on clinical judgments spurred a multitude of similar studies (Coie, Pennington, & Buckley, 1974; Cowan, 1976; Hayes & Wolleat, 1978; Johnson, 1978; Nowacki & Poe, 1973). This study by Broverman and her colleagues was the first empirical demonstration of a double

standard of mental health relative to sex role sterotypes among mental health professionals, and was replicated by Nowacki and Poe (1973).

Zeldow (1984) observed, however, that there were flaws in the Broverman study and inaccuracies in later descriptions of its results. Furthermore, he pointed to recent studies that suggest that sex role stereotypes have altered over the last decade and hence suggested that the double standard may be eroding. Billingsley (1977), for example, found that the majority of clinicians do not use sex role sterotypes in making clinical judgments. Zeldow (1984) concluded that the gender of a client by itself is rarely a factor in determining diagnosis, prognosis, degree of psychopathology, or treatment goals. The only exceptions he noted were various diagnostic entities, including alcoholism. As has already been discussed, there is a greater bias by the general public against alcoholic women than against alcoholic men. While it can be expected for health professionals to share the norms and values of their society, few studies have empirically investigated the influence of client gender on clinical judgments about alcoholics.

Statement of the Problem

The purpose of this study was to assess the influence of certain client characteristics on clinical judgment. More specifically, the characteristics investigated were gender, socioeconomic status and alcoholic status of the client. The clinical judgments of interest included therapist perceived client attractiveness, prognosis

(including the number of sessions required for substantial progress), decision to hospitalize, and diagnosis.

The specific questions addressed in this investigation were:

1. What effect does client gender, socioeconomic status and alcoholic status have on therapist perceived client attractiveness, prognosis, decision to hospitalize, and diagnosis?

2. Are there any two-way or three-way interactions between client gender, socioeconomic status and alcoholic status on the variables of therapist perceived client attractiveness, prognosis, decision to hospitalize, and diagnosis?

Significance of the Study

Although research has well documented the derelict stereotype of alcoholics as lower socieconomic status individuals (Blane, Overton, & Chafetz, 1963; Hanna, 1978; Wolf, Chafetz, Blane, & Hill, 1965), there has been a paucity of recent studies to determine the durability of the phenomenon. Furthermore, there have been few studies that have investigated the possible interaction between socioeconomic status and gender of the alcoholic client. Turner (1982) studied the effect of severity of the drinking problem, socioeconomic status of the client and therapist gender on clinical assessment but did not include gender of the client. Brodsky and Hare-Mustin (1979) posited that all research should include gender of the subjects as a variable unless there is already clear documentation that it has no effect either independently or in interaction with other variables. They also suggested that

multivariate designs be given priority in order to examine gender's interaction with other variables. The present study hoped to accomplish these objectives by using a multivariate procedure to examine possible interaction effects between gender, socioeconomic status and alcoholic status of the client. In addition, this study hoped to provide information on the psychometric qualities of the shortened version of the Therapist Personal Reaction Questionnaire (Ashby, Ford, Guerney, & Snyder, 1957) which was used to measure client attractiveness. Although this modified version of the TPRQ has been used in several studies (Davis, Cook, Jennings, & Heck, 1977; Goldstein, 1971; Lewis & Lewis, 1985), its reliability has not been reported.

Statement of the Hypotheses

In view of the relevant research, the following research hypotheses were formulated:

H_1: Client attractiveness, as perceived by the therapist, is influenced by the gender, socioeconomic status and alcoholic status of the client.

H_2: Prognosis is influenced by the gender, socioeconomic status, and alcoholic status of the client.

H_3: The number of sessions believed by the therapist to be required for substantial progress is influenced by the gender, socioeconomic status and alcoholic status of the client.

H_4: Decision to hospitalize is influenced by the gender, socioeconomic status and alcoholic status of the client.

H_5: Diagnosis is influenced by the gender, socioeconomic status and alcoholic status of the client.

Definition of Terms

The terms of particular significance to this study were defined as follows:

A. Alcohol dependence is defined by the following criteria set forth in the Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM III; American Psychological Association, 1980) which indicates that alcohol dependence is the same as alcoholism:

> 1. Manifestation of either a pattern of pathological alcohol use or impairment in social or occupational functioning due to alcohol use. Pattern of pathological alcohol use is defined as a need for daily use of alcohol for adequate functioning; an inability to cut down or stop drinking; repeated efforts to control or reduce excess drinking to certain times of the day; binges; occasional consumption of a fifth of spirits; amnesic periods for events occurring while intoxicated; continuation of drinking despite a serious physical disorder that the individual knows is exacerbated by alcohol use; drinking of nonbeverage alcohol. Impairment in social or occupational functioning due to alcohol use entails behavior such as violence while intoxicated, absence from work, loss of job, legal difficulties, arguments or difficulties with family or friends because of excessive alcohol use.
>
> 2. Manifestation of either tolerance or withdrawal. Tolerance defined as a need for markedly increased amounts of alcohol to achieve the desired effect, or markedly diminished effect with regular use of the same amount. Withdrawal is the development of alcohol withdrawal (morning shakes and malaise relieved by drinking) after cessation of or reduction in drinking.

B. Alcoholic is an individual who is suffering from alcohol dependence as described above.

C. Prognosis is the prediction of the probable course of an illness and the chances of recovery (Webster's New World Dictionary, 1962) and is operationalized in the present study by the Prognosis Evaluation Instrument (Graham, 1980) to measure appropriateness for therapy at a community mental health center, selection for a therapist's caseload, severity of impairment, motivation to change, capacity for insight and a likelihood of making substantial progress in therapy.

D. Attractiveness is an individual's apparent familiarity, friendliness, likability and relevant attitudinal or group membership similarity. It is operationalized in the present study by the modified form the the Therapist Personal Reaction Questionnaire (Ashby et al., 1957) as a measure of therapist perceived client attractiveness.

Assumptions of the Study

Based on the chosen statistical analyses, certain assumptions were drawn. First, assumptions were made based on the analyses of variance that were performed in the study. These assumptions were that within group variances were homogeneous, population scores within groups were normally distributed and that subjects were independent from one another (Jaccard, 1983). An additional assumption made on the basis of the multivariate analysis of variance was that the interrelationships among dependent variables were linear within each group (Tabshnick & Fidell, 1983).

Assumptions for the chi square analyses were that the expected frequency for any group was nonzero, each frequency was based on different individuals, and that the sample was relatively large (Jaccard, 1983).

Based on the definition used in the study of attractiveness as a familiarity and attitudinal similarity to an individual, it was assumed that a high attractiveness score, as measured by the TPRQ, connoted a positive attitude toward the client by the therapist. An other assumption of the present study was that the students drawn from counseling psychology programs had similar knowledge bases to those drawn from clinical psychology programs. Also, it was assumed that the subjects were not biased by prior knowledge of this research.

Limitations of the Study

Certain limitations of the study were recognized. First, due to the analogue nature of the study and the nonrandom selection of subjects, the generalizability of findings are limited. Additionally, there was limited information on the Prognosis-Evaluation Instrument (Graham, 1980). Finally, failure to consider drinking patterns of subjects may have had a confounding effect on the results of the study.

Organization of the Study

Chapter I includes a brief introduction to the study, statement of the problem under investigation, significance of the study, the

research hypotheses, definition of relevant terms, assumptions and limitations of the study, and the organization of the study. Chapter II consists of a review of the related research in the area being examined. Chapter III includes a presentation of the method and procedures utilized in the study divided into description of subjects, instrumentation, design, procedure and data analysis. Chapter IV presents the results of both the preliminary and main analyses used in the study. Chapter V consists of the summary, conclusions and recommendations.

CHAPTER II

REVIEW OF LITERATURE

This chapter consists of a review of theoretical positions and empirical findings pertinent to the present study. First, an overview of the influence of therapists' attitudes and values on clinical judgments is provided followed by a more specific discussion on the impact of counselor's attitudes about alcoholics/alcoholism on therapeutic decisions with alcoholic clients. Next, a review of the literature on therapist perceived client attractiveness is presented. The chapter concludes with the relevant literature on the influence of client characteristics (socioeconomic status and gender, respectively) on clinical judgments.

Therapists' Attitudes

Attitudes have been demonstrated to affect how individuals interact with others. Attitudes about other persons or groups may either increase or lessen the potential for relating to them as distinct and separate individuals rather than as the embodiment of one's own biases and stereotypes (Mackey, 1969). For instance, Leake and King (1977) asserted that traditional stereotypes and attitudes about the low motivation and apathy of underprivileged individuals serve as self-fulfilling prophecies of their poor performance. They pointed to

the findings in educational, psychological and medical research that provide evidence that in the interaction between two or more individuals, one person's expectation for the behavior of another can become self-fulfilling. Wallston, Wallston, and DeVellis (1976) commented that stigmatizing labels elicit negative stereotypic responses with deleterious ramifications for the individuals labeled.

For many decades it was contended that the potential danger in stereotyping did not apply to therapeutic relationships since the expectation was for therapists to keep their personal values out of therapy (Lewis & Walsh, 1980). However, during the course of the last several years, empirical findings have prompted the abandonment of the notion of value-free psychotherapy (Lewis & Lewis, 1985). Indeed, Schwartz and Abramowitz (1975) suggested that personal values of therapists can and do bias the assessment and treatment of clients. For example, therapist expectancies about clients can determine whether the clients are accepted and how they are assessed (Graham, 1980). According to Szasz (1970), the wider the disparity between therapist and client values, the more likely the client is to receive a severe diagnosis and poor prognosis. Lewis and Walsh (1980) concurred and added that the similarity of counselor-client values affect therapeutic outcome by ". . . increasing client susceptibility to counselor-influence attempts" (p. 306).

Several studies have attempted to identify value-relevant variables that might influence clinical judgments. Review of these studies suggests that there is a consistent and often strong relationship between convergence of clients' and therapists' value systems and subsequent psychotherapy improvement (Beutler,

1981). In his review of 21 studies, Beutler found that in 12 studies client/therapist value similarity was facilitative of treatment progress. Six of these 12 studies, however, were of an analogue nature and, therefore, of limited generalizability. Furthermore, as Beutler, Crago, and Arizmendi (1986) pointed out, it is unclear if value/attitude congruency produces improvement or if it is simply a reflection of other processes.

Instead of investigating value similarity between clients and therapists, some studies have examined the influence of therapist attitudes on clinical judgments of specific client populations. For example, Lewis and Lewis (1985), using psychologists as subjects, found that the religious client was assessed as requiring fewer therapy sessions that was the nonreligious client. In another analogue study, Graham (1980) sampled 100 therapists in community mental health centers to compare their acceptance and assessment of offender and nonoffender clients. Results indicated that nonoffenders were rated more appropriate for therapy than were offenders. Further, there appeared to be a trend toward rating offenders as less motivated.

Interestingly, the two preceding studies identified different aspects of the therapeutic process as possible danger zones. Graham (1980) found differences in acceptance/appropriateness for therapy based on offender/nonoffender status. Conversely, Lewis and Lewis (1985) found that the perceived number of required sessions difffered with the religious client seen as requiring fewer sessions than the nonreligious client. It should be noted that due to the analogue nature of both studies, generalizability is limited. Direct

contact with clients may elicit biases not identified in the analogue situation. Nevertheless, in view of the findings, further empirical investigation of the influence of therapists' attitudes on the entire therapeutic process is warranted. Further examination of the influence of therapists' attitudes on clinical judgments of specific client populations is also needed.

Therapists' Attitudes toward Alcoholic Clients

Countless articles have documented that negative attitudes are held by mental health professionals toward alcoholics. For example, the findings of a study conducted by Blane, Overton and Chafetz (1965) revealed that many mental health workers believe that alcoholics are derelicts. Furthermore, such sentiment seems to pervade all the disciplines within the mental health profession. For instance, several studies have reported negative attitudes of physicians toward alcoholics (Blane, Overton, & Chafetz, 1963; Ferneau & Gertler, 1971; Fisher, Keeley, Mason, & Fisher, 1975; Knox, 1971; MacDonald & Patel, 1975; Mendelson, Wexler, Kubzansky, Harrison, Leiderman, & Salsman, 1969; Wolf, Chafetz, Blane, & Hill, 1965). Studies by Blane et al. (1963) and Wolf et al. (1965), both of which were conducted at Massachusetts General Hospital, concluded that physicians perceive alcoholism as a disorder found primarily among derelicts. Ferneau and Gertler (1971), using first year psychiatric residents as subjects, found the belief that alcoholism was a fault that resided within the individual. Fisher et al. (1975) found that family practice residents rated alcoholics as weaker, sicker, and

more helpless and aimless than the average person. Furthermore, their attitudes became more negative through the four years of medical school, thus implying a correlation between experience with alcoholics and negative attitudes. Knox (1971) in her survey of Veterans Hospitals found psychiatrists reluctant to treat alcoholics. An attitude survey of psychiatrists in Scotland (MacDonald & Patel, 1975) showed that alcoholism was the least favored of the organic and psychiatric illnesses thus suggesting a bias toward alcoholics that is not unique to psychiatrists in this country.

Nurses have also been shown to have negative attitudes about alcoholics (Cornish & Miller, 1976; Wallston et al., 1976). In comparison to nonalcoholic patients, alcoholics were viewed by nurses as having less self-control and being less well adjusted (Cornish & Miller, 1976). Wallston and his colleagues (1976) found that a hypothetical patient without a label was viewed much more favorably than either the same patient with a label of alcoholism or the stereotypical alcoholic patient.

In several studies, social workers have been assessed regarding their attitudes about alcoholics (Bailey, 1970; Duxbury, 1983; Knox, 1973; Manohar, DesRoches, & Ferneau, 1976; Peyton, Chaddick, & Gorsuch, 1980). Bailey (1970) reported that between 32 and 48% of professional social workers expressed some moralistic sentiment with respect to alcoholism. Another study (Knox, 1973) indicated that 15% of the social workers surveyed expressed a willingness to work full-time with alcoholics. This number exceeds the number of both the psychiatrists and psychologists who indicated they would work full-time with alcoholics. Peyton et al. (1980), however, found

a significant bias against alcoholic clients by graduate social work students on both direct and indirect measures, a finding replicated by Duxbury.

Surprisingly, few studies have been conducted using psychologists as subjects. Knox (1969; 1971) found that the typical psychologist employed at a Veterans Hospital was not committed to working with the alcoholics. Indeed, many of them indicated that they would resign if they had to work with alcoholics full-time.

The only finding of a postive nature comes from a study conducted with rehabilitation counselors (Hart, 1975-1976). Counselors in the study viewed alcoholism as an illness, thus seemingly accepting the disease concept of alcoholism. Since the sample size was small (n = 6), generalizability is difficult. Nevertheless, Hart viewed the results encouraging since they supported the notion that replacement of the moralistic view with the illness model leads to the philosophy that alcoholics deserve and profit from professional help. This philosophy, in turn, may lead alcoholics to seek and accept treatment more readily (Mulford & Miller, 1964).

The historical roots of negative attitudes toward alcohlics emanate from the moralistic view; that is, the view that the use of alcohol is a matter of personal choice. From this perspective, excessive use is seen as representing weakness of character (Chappel, Veach, & Krug, 1985). Illustrating the implications of this view, Sterne and Pittman (1965) reported that psychiatric staff with moralistic attitudes toward alcoholism tended to be more pessimistic about recovery and viewed alcoholic clients as poorly motivated

toward treatment. Conversely, staff who subscribed to the illness model of alcoholism were more optimistic regarding patient motivation and recovery potential.

In spite of the conclusive evidence that helping professionals harbor negative attitudes toward alcoholics, few studies have investigated the impact of these attitudes on clinical judgments. Indeed, the vast majority of studies have utilized attitudes as the dependent variable. An exception to this is Selzer's study (1957) which found a correlation between negative attitudes toward the alcoholic and treatment failure.

In another study, Blane et al. (1963), examining diagnosis, found that individuals most closely resembling the derelict stereotype were more likely to be diagnosed as alcoholics. Further, it was found that, as a result of the stereotype, socially intact alcoholics were less likely to be referred by physicians for specialized treatment of alcoholism, despite the fact that their prognosis was relatively good. The researchers concluded, therefore, that alcoholic clients who might benefit most from treatment were least likely to be referred for treatment due to the persistence of the stereotype.

Studies have also found prognosis to be affected by therapists' attitudes about alcoholic clients. Indeed, most mental health professionals assign a poor prognosis to alcoholics since alcoholics are perceived as having poor motivation to quit drinking (Hanna, 1978). For example, Knox (1971) reported that 80% of psychiatrists surveyed and 86.7% of psychologists surveyed believed that the prognosis for the alcoholic remaining sober is poor.

Therapists' attitudes also influence their willingness to treat alcoholic clients. Alcoholics are often perceived to be among the most undesirable candidates for psychotherapy (Hanna, 1978). Peyton et al. (1980) sampled 80 social work graduate students and asked them to select from a variety of case vignettes clients they would be willing to treat. Results showed a significant bias against alcoholics.

In a more recent and global study, Haller-Johnson (1980) investigated the effects of patient labels (alcoholic, psychiatric) and patient psychopathology (neurosis, personality disorder) on clinical judgments. Results indicated that alcoholics were treated differently than psychiatric clients with the latter receiving more active and progressive treatment and the former receiving more custodial and regressive treatment.

Summary

There is ample empirical support for the contention that therapists' values and attitudes influence the therapeutic process. Moreover, there is extensive documentation in the literature that mental health professionals, irrespective of discipline, maintain negative attitudes toward alcoholics. There is, however, a scarcity of studies that have investigated the impact of these negative attitudes on clinical judgments. The present study examined this interaction by using therapist perceived client attractiveness as an independent variable with the assumption that the more attractive the client was found to be by the therapist, the more similar, and thus more positive, were the attitudes shared by them.

Client Attractiveness

Several research studies have supported the notion that the more attractive the therapist views the client, the more willing the client is to disclose problems (Goldstein, 1971). Many of these studies define attractiveness in terms of physical appearance. Other studies, however, have examined and described characteristics inherent in the preferred, and hence more attractive, client, such as desiring a relationship, talking about oneself and viewing oneself as responsible for therapy (Heine & Trosman, 1960).

Byrne (1971) found a strong relationship between attraction and similarity. He concluded that subjects were more attracted to stimulus persons who have similar attitudes than stimulus persons holding dissimilar attitudes. This conclusion is supported by social psychology research that asserts that receivers will perceive sources similar to themselves as more attractive than they do dissimilar sources (Simons, Berkowitz, & Moyer, 1970). It is, however, in contrast to the finding by Schwartz and Abramowitz (1975) that pseudoclients, as depicted in case vignettes, were viewed by a sample of predominantly white psychiatrists as more attractive when they were identified as black rather than white. This finding, however, should be viewed cautiously since a response set (i.e., social desirability) may have been operating.

Davis and his colleagues (1977) investigated the effects of variations in conceptual complexity level of counselor and client on counselor attraction to the client. Two groups of counselor trainees

characterized as having either high or low conceptual levels rated the attractiveness of clients following each of two counseling analogue tasks in which the client manifested either a high or low conceptual level. Rating was accomplished by the completion of the Paragraph Completion Test and the Therapist Personal Reaction Questionnaire. Results indicated that both groups of subjects perceived only the high conceptual level pseudoclients as attractive.

These findings have implications for socioeconomic status and its relation to conceptual level. Conceptual level has been found to have a positive correlation with socioeconomic status (Hunt & Dopyera, 1966). Davis et al. (1977) suggested that the perception of SES may vary with the manipulation of the client's perceptual level. If this is the case, there may exist on the part of some therapists a preconceived bias that low socioeconomic status equates with low conceptual level. Since low conceptual level has been shown to be an undesirable characteristic in counseling, therapists may have a negative expectation for counseling outcome with lower socioeconomic status clients, based on this preconceived bias.

Summary

Alcoholics are assumed by many therapists to be dissimilar from themselves. There is an absence of empirical support for this assumption, however. Further, few studies have investigated the relationship between client alcoholic status and therapist perceived client attractiveness. In order to test this assumption, the present study examined this relationship and viewed attractiveness in terms

of familiarity and attitudinal similarity rather than physical appearance.

Client Characteristics

Socioeconomic Status

Although recent literature is replete with investigations of the reciprocal influence of client and therapist on the therapeutic process (Atkinson & Schein, 1986), most of the focus has been on personality variables or on characteristics such as gender and race. Few studies have examined the influence of socioeconomic status as a possible variable in clinical judgments (Haase, 1964). Further, many of the studies that do exist are generally over twenty years old. For example, in a broad survey by Hollingshead and Redlich (1958), it was found that the upper classes preferentially received more intensive insight therapy while the lower socioeconomic status individuals were more apt to receive supportive type of therapies. While some of this difference might be attributed to the economic status of the client, other studies conducted in outpatient clinics where finances were not a concern drew the same conclusions. It has also been reported that the upper SES client was more likely to be considered appropriate for treatment than was the lower SES client (Brill & Starrow, 1960; Schaffer & Myers, 1954). Further, Nash, Hoehn-Saric, Battle, Stone, Imber, and Frank (1965) found that socioeconomic status was related to therapists' ratings of client attractiveness, ease of establishing rapport and prognosis, each of which, in turn, was associated with a continuation in therapy.

Cole, Branch, and Allison (1962) conducted a study at their own outpatient clinic examining the impact of the patients' social status on the type, nature and/or progress in psychotherapy. The sample consisted of 322 consecutive applicants for outpatient treatment. Routine identifying data, including SES data, were collected. At the completion of the sample collection, the SES data and the life history of each applicant were analyzed. Social status assignment was based on Hollingshead's (1958) "Two Factor Index of Social Position" which delineated five statuses with Class I being business and professional and Class V being the semi-skilled, unskilled and unemployed groups.

Results of the data analysis indicated that the Class V group had the lowest acceptance for treatment rate (31%). Furthermore, number of therapy sessions steadily dropped across the social statuses with 42% atending more than 30 interviews for Classes I and II, 38% for Class III, and only 10% and 13% for Classes IV and V, respectively. The greatest loss of individuals from the lower statuses appears to occur in the first ten sessions. Relative to prognostic expectations, the upper class rated a 65% chance of being discharged "improved", irrespective of length of stay in the clinic, while the lower SES client had only a 52% chance. This last finding suggests a slight bias in favor of the upper socioeconomic status individuals.

In another study, Haase (1964) hypothesized that Rorschach protocols interpreted as originating from individuals having a lower SES would be diagnosed as less well adjusted than the same records designated as from a higher status individuals. A total of 75 psychologists served as participants in the study. Four artificial pairs

of Rorschachs were constructed with accompanying social histories. The only factor that distinguished the histories was the socioeconomic status of the client so that there were two versions of each history. Subjects were randomly assigned a protocol and a social history and asked for an interpretation. Analysis of the data revealed a bias in favor of the middle socioeconomic status individuals.

Lee (1968) also found evidence of social status bias in his study of psychiatric residents. Prior to listening to a tape recorded interview between a pseudotherapist and pseudopatient, subjects were read case histories of the patient reflecting either lower, middle or upper socioeconomic status. Results showed a tendency for the residents to ascribe more severe psychopathology to the patient who was thought to be from a lower social status background.

In a reexamination of Lee's findings, Routh and King (1972) asked 15 clinical psychologists and 32 college students to rate a series of paragraphs. The stimulus persons in the paragraphs were described as having either lower or middle social status, as indicated by their occupations. (This is in contrast to Lee's classification which used several criteria such as educational level, area of residence, source and amount of income to define socioeconomic status.) As in Lee's study, a significant effect for SES on judgments of likelihood of need for counseling was found, albeit in the opposite direction from Lee's findings. Middle SES individuals in Routh and King's study were generally rated as more likely to need help than were lower SES individuals.

In a more recent study (Wright & Hutton, 1977), 16 counseling psychology graduate students were asked to interview an actor and actress whom the students believed to be actual clients. The role players presented themselves as well-to-do individuals to half of the subjects and as working class individuals to the other half. At the beginning of the interview, the "clients" mentioned their socioeconomic status and then told the counselor about some of the problems they were experiencing. When the clients were presented as having lower socioeconomic status, a significant relationship existed between the counselor's self-reported degree of personality similarity to the client and the counselor's self-reported liking for the client. Additionally, a significant correlation was found between the counselor's self-reported liking for the client and the counselor's estimate that the client would benefit from long-term counseling. The authors of the study claimed that the results suggested employment of a different decision making process for higher and lower SES clients.

Conclusions from these studies largely support the hypothesis of a bias against the lower socioeconomic status clients. It is unknown, however, if the the SES of the therapist influences this bias; hence, studies to investigate possible interaction effects are needed. Further, studies assessing biases toward alcoholics as a result of their socioeconomic status is a relatively unexplored research area (Turner, 1982). This is somewhat surprising in light of the highly maintained stereotype of the alcoholic as the skid row derelict; a stereotype that generally assumes membership in a lower socioeconomic status.

A study that has examined this topic is a recent one conducted by Turner (1982). She examined the effects of severity of the drinking problem, socioeconomic status of the client and gender of the therapist on clinical assessment. Subjects were 42 male and 42 female therapists employed at mental health centers, each of whom was presented with one of six posible case vignettes and asked to evaluate the pseudoclient on a Likert-type questionnaire. The questionnaire included typical decisions made by therapists such as diagnosis and prognosis. Results demonstrated, as hypothesized, that lower SES clients were considered less desirable clients than upper-middle SES clients. Further, as drinking severity increased, more lengthy medical intervention was likely to be recommended. An interaction effect between therapist gender and severity of client drinking was found for patient desirability. Female therapists indicated more comfort in working with moderate problem drinkers as opposed to severe problem drinkers. Conversely, male therapists stated a preference for working with severe problem drinkers.

Gender

Over the last two decade increasing societal attention has been directed to sex roles and their ramifications vis-a-`vis stereotypes and biases. Concomitant with this heightened attention has been an appraisal of the mental health professions for evidence of ". . . discrimination, exploitation, and oppression in the treatment of women" (Zeldow, 1984, p. 355). The search for evidence of sex role

stereotyping in clinical judgments has yielded numerous and conflicting studies.

Perhaps the most stimulating and most frequently cited study is the one conducted by Broverman, Broverman, Clarkson, Rosenkrantz, and Vogel (1970). Broverman and her colleagues tested the hypothesis that clinical judgments about traits characterizing healthy, mature individuals differed as a function of the gender of the person judged. Seventy-nine clinically trained psychologists, psychiatrists and social workers were asked to describe a mature, healthy, socially competent male, female or adult of unspecified gender in terms of a list of known sex role stereotypes. Results of the study showed no differences due to raters' gender but indicated that significantly more male than female traits comprised the healthy adult description. Clinicians were less likely to attribute traits that characterize healthy adults to a woman than they were to a man. The researchers suggested that their finding was the first empirical demonstration of a double standard of mental health among mental health professionals.

Nowacki and Poe (1973) investigated the generalizability of the Broverman findings. Introductory psychology students serving as subjects were asked to rate a mentally healthy male and mentally healthy female using Broverman's Sex Role Stereotypic Scale and the Poe and Matias Semantic Differential Scale. Results for both instruments supported the hypothesis that the conception of mental health for a male is different than for a female.

In another study (Hayes & Wolleat, 1978), counselors reacted to a particular client rather than to a hypothetical client as was used by

Broverman et al. (1970). Subjects were 20 male and 20 female counseling psychology graduate students who were randomly assigned to one of two treatment groups: an audiotape of either a male or female client. The interviews contained on the tapes were rated using the Broverman questionnaire. Although no interaction effect was found between counselor and client gender, there was a tendency for counselors to rate clients of the opposite gender more deviant from cultural stereotypes than those of their own gender.

Aslin (1977), also using Broverman's questionnaire, studied therapists' expectations of mental health for women. Seventy-seven female and 55 male community mental health center therapists and 82 feminist therapists were asked to rate mentally healthy adults, females, wives or mothers. Contrary to previous findings that gender of the judge was not a source of variance in judgments of mental health, this study found that male therapists' perceptions for females and mothers differed significantly from those perceived by the female and feminist groups. Furthermore, none of the items found to be stereotypic of females by Broverman et al. (1970) were found to be stereotypic in Aslin's study. This finding may suggest the current state of flux of the female sex role stereotype.

Cowan (1976) also reported findings different from Broverman et al. (1970). Thirty subjects, all of whom were members of a state society of consulting psychologists, were asked to compare the problems of women and men in psychotherapy by making judgments on the basis of the hypothetical average male or female client seen in practice. Results indicated that women in therapy are seen by therapists as too feminine while mens' problems are not viewed in

sex role dimensions. Thus, stereotypic femininity is perceived as unhealthy, a finding that is in stark contrast to Broverman's contention that for a woman to be healthy she has to adjust and accept the behavioral norms for her gender (Phillips & Gilroy, 1985).

These studies, while all attempting to approximate Broverman's study, have yielded conflicting results. Inspection of other studies further highlights the inconsistency of findings. For example, Zeldow (1975) described a study in which 40 male and 40 female subjects, all of whom had taken a psychology course and/or had some other mental health experience, were presented with eight case histories covering a broad range of psychiatric disturbances (i.e., anxiety reaction, obsessive thinking, schizophrenia). Subjects were asked to make three judgments about each case concerning degree of emotional maladjustment, need for therapeutic intervention and prognosis. Of of the 24 Anova's performed, five were significant for the main effect of gender of judge. Female judges recommended intervention more often than did male judges for four of the eight cases. Female judges were also more optimistic about prognosis than were male judges in a case of suicidal depression. Gender of client, however, did not influence any of the judgments, either alone or in interaction with gender of judge. Further, there was no evidence that judge of either gender was biased toward their own gender. This result conflicts with Hayes and Wolleat's (1978) finding reported earlier.

Billingsley (1977), in a replication of Broverman's study, was interested in determining whether therapists' own attitudes about sex role stereotypes affect judgments of mental health in males and

females. The subjects, all practicing psychotherapists, recommended treatment goals for either two male or two female pseudoclients all of whom presented with different but clearly serious problems. It was found that the majority of therapists did not conceptualize or employ sex role stereotypes in ways that biased their judgments of females. Therapists seemed to respond to clients' pathology rather than to their gender when developing treatment goals. Billingsley (1977) concluded that either client gender is not important in determining treatment goals or that client gender influences treatment goal choice only when pathology is vague or nonsevere.

Zeldow (1984) in a recent review of the influence of sex roles on psychological assessment, concurred with Billingsley. Indeed, he asserted that client gender by itself is rarely a factor in determining degree of psychopathology, need for professional help or prognosis. Such sentiment is supported by the most recent replication of Broverman's study (Phillips & Gilroy, 1985). Results of 104 mental health professionals who completed the Stereotype Questionnaire (Broverman et al., 1970) revealed no significant differences relative to either therapist or client gender. In view of these findings, Phillips and Gilroy (1985) speculated that the Broverman results were either an artifact of their forced choice methodology or that progress toward nonsexism has been made during the last fifteen years.

In studies where client gender bias has been supported, generalizability of differences is questionable. For instance, Stein, DelGaudio, and Ansley (1976) found that depressed female outpatients were offered more therapy sessions and were more

likely to be prescribed psychotropic medication than were their male counterparts. However, in a later study (DelGaudio, Carpenter, & Morrow, 1978) designed to test the generalizability of these findings, the results indicated nonsignificant gender-related differences. The researchers concluded that limits should be placed on the generalization that differential psychiatric treatment is afforded to men and women.

Despite the findings that client gender seldom creates a main effect for differences (Turner, 1982), gender-related effects do occur, albeit they are usually embedded in complex structure. Zeldow (1984), however, has stated that evidence is lacking in certain diagnostic categories, such as hysteria, antisocial personality and alcoholism, as to whether gender of client can by itself influence clinical judgments. He cited a need for more studies with these diagnostic entities as well as further studies that consider interaction effects between therapist and client gender, and between in-role versus out-of-role behavior. To date, few researchers have responded to this concern and, thus, there remains a paucity of research in these areas.

An exception is a study by Israel, Raskin, Libow, and Pravder (1978) which asked 48 male and 48 female undergraduate raters to make attributions of mental disorder, personality traits, and diagnostic and treatment judgments for four case studies in which gender of client and sex role appropriateness of client behavior were manipulated. The four case studies corresponded to the following categories: paranoid schizophrenic, depressed neurotic, phobic compulsive and alcoholic. Equal number of female and male subjects

were randomly assigned to one of four groups determined by the type of cases they read (female appropriate, female inappropriate, male appropriate, male inappropriate). Subjects in each group read the four diagnostic cases and then responded for each case to a five category diagnostic judgment based on an abbreviated DSM II manual which was made available to them. Contrary to the equivocal nature of previous findings relative to gender of therapist differences, the results of this study revealed both main effects and interaction effects. Females, for example, judged clients as having control over their behavior and as assuming less responsibility. Also, females were inclined to make harsher attributions about clients who behaved inappropriately and suggested stronger treatments for them. Significant interactions for sex role appropriateness with both client gender and therapist gender demonstrated the relevance of sex role stereotypes in the attribution of mental disorders by nonprofessionals. This data suggested that the stereotypes had the strongest negative effect for females and the female sex role.

Another finding of Israel et al.'s (1978) investigation, of particular interest to this current study, concerned the alcoholic client. Female raters judged inappropriately sex role behaved alcoholic clients as more disturbed than did male raters. Conversely, male and female raters did not differ significantly in their judgments of appropriate clients. There was a trend by female subjects to rate female inappropriately sex role behaved alcoholic clients as more severely disturbed than their male counterparts. Similarly, Stafford and Petway (1977), in their investigation of the stigmatization of men and women problem drinkers and their spouses, found that

drunkenness in women was more stigmatizing than drunkenness in men.

In a more recent study (Rice & Shaw, 1984) examining alcoholic clients, 71 subjects employed at alcoholism treatment facilities were asked to read two pseudo-admission summaries and to respond to a questionnaire concerning each summary. The summaries included a client case history and presenting problem, and were written to manipulate gender. One summary described a 38 year old school teacher and the other a 59 year old indigent. Half of the subjects received the summaries of the female teacher and male indigent; the other half received the summaries in which the gender was reversed.

Results indicated that individual therapy was rated as less desirable for the woman teacher than for the male teacher while inpatient alcoholism rehabilitation units and daytime outpatient clinics were judged as less appropriate for female indigents than male indigents. Contrary to the researchers' hypothesis, female staff judged female teachers as less appropriate for treatment than did male staff members. This study provides some evidence of less favorable attitudes toward women by female alcoholism treatment staff and suggests that therapist-client matching by gender may not be optimal in all situations.

Summary

It is apparent upon review of the relevant literature that biases do exist relative to client characteristics that, in turn, influence clinical judgments. There is not, however, enough research

investigating the impact of socioeconomic status on therapeutic judgments. Further, while there is extensive research on client gender and its relationship to clinical judgments, the findings are inconsistent and therefore more studies are warranted.

More research is needed examining possible interaction effects between gender and other client variables such as socioeconomic status. Additional study is also needed investigating the influence of these variables with specific populations such as alcoholics. Because of this recognized deficit in the literature, the present study investigated the interaction between client gender and socioeconomic status on the alcoholic client.

CHAPTER III

METHODOLOGY

The methods and procedures utilized in this study are presented in this chapter. The chapter is divided into the following sections: (a) subjects, (b) instrumentation, (c) design, (d) procedure, (e) data analysis, and (f) summary.

Subjects

Subjects were 185 graduate students in clinical and counseling psychology programs at three state-supported universities in the Southwestern United States. The sample consisted of 23 clinical psychology students and 162 counseling psychology students, all of whom had taken or was currently enrolled in either an abnormal psychology/psychopathology or a practicum course. Forty-nine of the subjects were doctoral level students and the remaining 136 were master level students. Of the 185, 86 had no previous practicum experience; 49 had six months or less; 17 had between seven and twelve months; 17 had between 13 and 24 months; and 12 had more that 24 months of practicum experience. Of this same number, 102 subjects had no professional (excluding practicum) experience; 29 had up to two years; 24 had two years to five years; and 20 had more than five years of professional experience.

In the sample, there were 125 females and 60 males. Age of subjects ranged from 26 to 56 with a mean age of 34.7. The racial composition of the subjects included 165 Caucasians, 10 blacks, two Asian Americans, two Hispanics, and one Native American. (Five subjects did not specify race.)

Instrumentation

Case Vignettes

A description of the clients in the case vignettes were developed from established correlates of a MMPI code type (2-7) frequently found among the psychiatric client population (Haller-Johnson, 1980). This code has a high probability of yielding a diagnosis such as depression or generalized anxiety disorder (Lachar, 1982). A prepilot study was conducted at the University of Alabama (Haller-Johnson, 1980; Turner, 1982) to validate the diagnosis the client description would receive. Out of 15 clinical psychology graduate students who participated in the study, all of whom had at least one year of therapy experience and at least one course in psychopathology, 14 correctly diagnosed the client.

Eight versions of the vignette were developed in the current study by systematically interchanging male-female, lower socioeconomic-upper middle socioeconomic status, and alcoholic-nonalcoholic attributes. The socioeconomic attributes were based on characteristics appropriate to lower and upper-middle socioeconomic status individuals as found in the U. S. Bureau of Census (1977)

statistics and included information on career (business executive versus painter) and salary ($40,000 annually versus $7,000 annually). Attributes for the alcoholic status of the client were adapted from a study by Haller-Johnson (1980) and included a description of 15 years of excessive drinking, blackouts and other physical problems, and numerous social, family and legal problems. The resulting case vignettes were lower SES nonalcoholic female; lower SES alcoholic female; upper-middle SES nonalcoholic female; upper-middle SES alcoholic female; lower SES nonalcoholic male; lower SES alcoholic male; upper-middle SES nonalcoholic male; and upper-middle SES alcoholic male (Appendix A).

Therapist Personal Reaction Questionnaire

A modified form of the Therapist Personal Reaction Questionnaire (TPRQ; Ashby, Ford, Guerney, & Guerney, 1957) was used in this study as a measure of the dependent variable, therapist perceived client attractiveness (Appendix B). The questionnaire was developed by having six advanced graduate students in clinical psychology write items to fit definitions for the scale. These definitions included feelings of progress, achievement, and accomplishment with the client in therapy; feelings of identification and involvement with the client; feelings of comfort, pleasure and anticipation in relationship to the interview hour; feelings of respect, admiration, sympathy, and affection for the client; and gratification of existing needs such as those for approval, respect and therapeutic competence (Ashby et al., 1957). Each of the items thus obtained was given a rating from one to four (poorest to best) by each of the

four authors. Those items with the highest average ratings were included in the scale (Ashby et al, 1957).

The questionnaire, although originally 35 items in length, has been shortened to 15 items (Davis, Cook, Jennings, & Heck, 1977). Goldstein (1971) has used the TPRQ extensively in his studies on psychotherapeutic attraction and considers it appropriate for analogue studies. Lewis and Lewis (1985) used the TPRQ in their study on the impact of religious affiliation of therapists' judgments of clients. Test-retest reliability (with a four week interval) has been reported for the full scale at .81 ($p \leq .001$) (Ashby et al., 1957). There is, however, no available reliability data for the shortened version.

The fifteen items consist of a five point scale anchored at each pole by the phrases "not characteristic of my present feelings (1) and "highly characteristic of my present feelings (5). Nine items are positively worded (range = 9 to 45) and the remaining six items are negatively stated (range = -6 to -30). The total attractiveness score is calculated by adding the positive and negative scale totals, resulting in a possible range of -21 to 39.

For the current study, the wording of the items was changed to reflect the fact that subjects were responding to case vignettes rather than to actual clients. For instance, "I like this client more than most" became "I think I would like this client more than most." Other revised items included, "I think I would have a warm, friendly reaction to this client" and "I think I would resent the client's attitude at times."

Prognosis Evaluation Instrument

An eight question schedule (Appendix C) adapted from Graham (1980) was used to measure the dependent variable, therapists' prognostic expectations. The first six questions require rating the client on four-point scales for appropriateness for therapy at a community mental health center, selection for the therapists' caseload, severity of impairment, motivation to change, capacity for insight, and likelihood of making substantial progress in therapy. The score for each item is simply the rating assigned by the therapist with "1" denoting the positive end of the pole and "4" the negative end. The seventh question asks for the number of therapy sessions the therapist believes is necessary for the client to make substantial progress. The final question asks if the therapist believes hospitalization is necessary for the client.

No validity data was reported in Graham's study (1980) in which the Prognosis Evaluation Instrument was first used. Lewis and Lewis (1985) used the instrument in conjunction with the TPRQ in their study previously described, but did not report any validity data.

Diagnosis Sheet

The Diagnosis Sheet was used to obtain a primary and secondary diagnosis of the client depicted in the case vignette (Appendix D). It consists of the 12 major categories in the Diagnostic Statistical Manual, Third Edition (DSM III) along with a brief description of each as found in the DSM III (American Psychological Association, 1980). Subjects were asked to indicate their primary and secondary

diagnosis of the client in the vignette by marking "1" and "2", respectively, in the blank next to the selected diagnostic categories.

Therapist Information Sheet

The Therapist Information Sheet (Appendix E) was used to obtain demographic information on the subject such as gender, age, race, type of program enrolled in (counseling or clinical) and level of training (masters or doctoral). Subjects were asked to indicate any completed courses in psychopathology, the number of months of practicum experience and the number of months of professional experience. Additionally, they were asked to "please check the problems which you feel this client may be experiencing." Problems included depression, hypersensitivity, obsessive thinking, alcoholism, and medical problems.

Design

This analogue study was a 2 x 2 x 2 factorial design. The factors were gender (male, female), socioeconomic status (lower, upper-middle) and alcoholic status (alcoholic, nonalcoholic) of the client. Figure 1 shows this design which was selected so that each independent variable could be examined individually as well as in interaction with the other independent variables. Since the independent variables were arbitrarily manipulated by the researcher through the use of case vignettes, the study was considered fixed effects experimental. Dependent variables in the study were therapist perceived client attractiveness, prognostic

	Socioeconomic Status			
	Lower		Upper-Middle	
	Alcoholic Status			
	Alcoholic	Nonalcoholic	Alcoholic	Nonalcoholic
Male	n=26	n=23	n= 21	n= 23
Female	n=24	n=25	n= 21	n=22

Figure 1. 2 x 2x 2 Design of Study

expectations (including number of sessions thought required for substantial progress), decision to hospitalize and diagnosis.

Procedure

Subjects were randomly assigned to one of eight possible case vignettes. Each subject received a packet containing the following: Case Vignette, Therapist Personal Reaction Questionnaire, Prognosis Evaluation Instrument, Diagnosis Sheet and Therapist Information Sheet. In an effort to avoid experimenter bias, an individual other than the researcher distributed the packets. Instructions were supplied for completing the packets (Appendix F). The packets were completed either individually or in groups. However, subjects were asked not to speak to each other while completing the packet. Additionally, subjects were asked not to discuss the experiment until all of the data had been collected. They were informed verbally that results of the experiment would be made available to them.

Data Analysis

Preliminary Analyses

A series of statistical analyses were conducted on several therapist variables to test for significant differences. The five therapist variables analyzed were gender (male, female), program (clinical, counseling), level of education (masters, doctoral), practicum experience (0-99 months) and professional experience (0-999 months).

A multivariate analysis of variance (Manova) was performed with therapist gender as the independent variable. Dependent variables were client attractiveness (as measured by the total score on the TPRQ), and the first seven items on the Prognosis Evaluation Instrument (appropriateness for therapy at a community mental health center, selection for the therapist's caseload, severity of impairment, motivation to change, capacity for insight, likelihood of making substantial progress in therapy and the number of sessions required for substantial progress).

A 2 x 3 chi square test of independence was performed on the relationship between gender and the decision to hospitalize (yes, no, don't know). The 11 nonsubstance abuse DSM-III categories were collapsed into a single category and compared with the single substance abuse disorder. The relationship between gender and diagnosis was then assessed through a 2 x 2 chi square.

All of the preceding analyses were repeated substituting therapists' program as the independent variable. They were performed a third time using therapists' level of education as the independent variable.

A stepwise multiple regression analysis was performed with therapists' practicum experience as the dependent variable. The independent variables were the scores on the TPRQ, Items 1-7 on the Prognostic Evaluation Instrument, decision to hospitalize, and diagnosis. Another stepwise multiple regression analysis was performed with the same independent variables but substituting therapists' professional experience as the dependent variable.

Main Analyses

Based on the assumption of independence, separate analyses were used to test the hypotheses of this study. A 2 x 2 x 2 factorial analysis of variance (Anova) was conducted to test the first hypothesis of the study. The independent variables were gender (male, female), socioeconomic status (lower, upper-middle) and alcoholic status (alcoholic, nonalcoholic) of the client. The dependent variable was client attractiveness, as measured by the TPRQ. The strength of association was indexed by eta squared.

A 2x2x2 factorial Manova was performed to test the study's second hypothesis. The independent variables were gender (male, female), socioeconomic status (lower, upper-middle) and alcoholic status (alcoholic, nonalcoholic) of the client. The dependent variables were the first six items on the Prognostic Evaluation. Strength of association was measured by eta squared (1-Wilks lambda). Univariate analyses were employed to determine which of the dependent variables were individually associated with the independent variables.

The third main analysis performed was a 2 x 2 x 2 factorial Anova. The independent variables were gender (male, female), socioeconomic status (lower, upper-middle) and alcoholic status (alcoholic, nonalcoholic) of the client. The dependent variable was the number of sessions believed by the therapist to be required for substantial progress. Strength of association was measured by eta squared.

A series of chi square analyses were conducted to test the study's fourth hypothesis. First, a 2 x 8 chi square test was performed on the independent variables decision to hospitalize (yes, no) and the eight possible variations of the case vignettes (lower SES alcoholic female; lower SES nonalcoholic female; upper-middle SES alcoholic female; upper-middle SES nonalcoholic female; lower SES alcoholic male; lower SES nonalcoholic male; upper-middle SES alcoholic male; and upper-middle SES nonalcoholic male). Responses of "I don't know" were not included the the main analyses. Cramer's statistic was used to measure strength of association (Jaccard, 1983). and Ryan's Procedure was utilized to accomplish specific comparisons (Linton & Gallo, 1975).

Next, a 2 x 2 chi square analysis was calculated with the Yates' Correction for Continuity (Jaccard, 1983). The independent variables were the decision to hospitalize (yes, no) and the alcoholic status of the client (alcoholic, nonalcoholic). The strength of association was indexed by the fourfold point correlation (Jaccard, 1983). Another 2x 2 chi square analysis was performed on the independent variables decision to hospitalize (yes, no) and gender (male, female). A third 2 x 2 chi square test examined the relationship between decision to hospitalize (yes, no) and socioeconomic status (alcoholic, nonalcoholic).

To test the fifth hypothesis, a similar series of chi square analyses were performed on the independent variable of diagnosis. The 11 nonsubstance abuse DSM-III categories were collapsed into a single category and compared with the single substance abuse category. The relationship between diagnosis and type of client was

then examined through a 2 (Nonsubstance abuse disorder, Substance abuse disorder) x 8 (Possible variations of case vignettes). Cramer's statistic measured strength of association and Ryan's Procedure was used to accomplish specific comparisons.

A 2 x 2 chi square test calculated with the Yates' Correction for Continuity assessed the association between diagnosis and alcoholic status of client. Strength of association was measured by the fourfold point correlation. Another 2 x 2 chi square analysis examined the relationship between diagnosis and gender. A third 2x 2 chi square analysis assessed the association between diagnosis and socioeconomic status.

Summary

A total of 185 psychology graduate students were tested in order to determine the influence of client gender, socioeconomic status and alcoholic status on client attractiveness, prognostic expectations, decision to hospitalize and diagnosis. The study was experimental in design since the independent variables were manipulated by the researcher through the use of case vignettes. The independent variables in the study were gender (male, female), socioeconomic status (lower, upper-middle) and alcoholic status (alcoholic, nonalcoholic) of the client. The dependent variables were client attractiveness (as measured by the total score on the Therapist Personal Reaction Questionnaire), prognostic expectations including the number of sessions believed required by the therapist for substantial progress (Items 1-7 on the Prognostic Evaluation

Instrument), decision to hospitalize, and diagnosis (using the 12 major categories of the DSM-III).

Preliminary data analyses were performed to determine if certain therapist variables (gender, program, level of education, practicum and professional experience) affected the dependent variables. For the main analyses, separate tests were performed for each dependent variable.

CHAPTER IV

RESULTS

Introduction

This chapter presents the results of the preliminary and main analyses that were performed in this study. The results of the preliminary analyses are addressed first followed by a discussion of the results utilized to test the five main hypotheses. The chapter concludes with a summary of the results of the main analyses.

Preliminary Analyses

Separate analyses were conducted on several therapist variables in order to test for significant differences. The five therapist variables analyzed were gender (male, female), Program (clinical, counseling), level of education (masters, doctoral), practicum experience (0-99 months), and professional experience (0-999 months). A discussion of the results for each variable follows.

Therapist Gender

A multivariate analysis of variance (Manova) was performed with therapist gender as the independent variable. Results indicated that gender had no statistically significant effect, $F(8, 180) = .674$,

p>.714, on the dependent variables of client attractiveness, as measured by the total score on the TPRQ, or on the seven items on the Prognosis Evaluation Instrument (appropriateness for therapy at a community mental health center, selection for the therapists' caseload, severity of impairment, motivation to change, capacity for insight, likelihood of making substantial progress in therapy and the number of sessions required for substantial progress.)

A 2 x 3 chi square test of independence was performed on the relationship between gender and the decision to hospitalize (yes, no, don't know). Results showed gender was not significantly associated with the decision to hospitalize, $\chi^2(2, N = 185) = .146$, $p>.929$.

To assess the effects of gender on therapists' diagnosis, the 11 nonsubstance abuse DSM-III categories were collapsed into a single category and compared with the single substance abuse category. The relationship between Gender and diagnosis was then assessed through a 2 (Gender) x 2 (Diagnosis) chi square using Yates' Correction for Continuity. Results indicated a nonsignificant association, $\chi^2(1, N = 157) = .530$, $p>.466$.

Program

A Manova was performed with therapists' program as the independent variable. Results revealed that program had no statistically significant effect, $F(8, 180) = 1.20$, $p>.300$, on the dependent variables of the scores on the TPRQ, and the first seven items on the Prognostic Evaluation Instrument.

A 2 x 3 chi square test of independent was performed on the relationship between program and decision to hospitalize (yes, no, don't know). Results indicated that therapists' program was not significantly associated with the decision to hospitalize $\chi^2(2, N = 185) = 1.397, p > .497$.

A 2 x 2 chi square test was calculated using the Yates' Correction for Continuity to determine the relationship between program and diagnosis (as described in preceding section). Results showed no significant association between the two variables, $\chi^2(1, N = 157) = .00, p > 1.00$.

Level of Education

A Manova was performed with the therapists' level of education (masters or doctoral) as the independent variable. Results indicated that the level of education had no statistically significant effect, $F(8, 180) = .786, p > .786$, on the dependent variables of the scores on the TPRQ and the first seven items on the Prognostic Evaluation Instrument.

A 2 x 3 chi square test of independence was performed on the relationship between level of education and decision to hospitalize (yes, no, don't know). Results demonstrated no significant association between them, $\chi^2(2, N = 185) = .113, p > .944$.

Results of a 2 x 2 chi square test performed on the relationship between program and diagnosis (nonsubstance abuse disorder, substance abuse disorder) and calculated with the Yates' Correction for Continuity showed no significant association between them, $\chi^2(1, N\ 157) = .00, p > 1.00$.

Practicum Experience

A stepwise multiple regression analysis was performed with therapists' practicum experience as the dependent variable. The independent variables were the scores on the TPRQ, the first seven items on the Prognostic Evaluation Instrument, decision to hospitalize, and diagnosis. As can be seen in Table 1, results showed none of the variables proved to be a significant predictor of practicum experience thus indicating lack of a relationship between the variables and practicum experience.

Professional Experience

A stepwise multiple regression analysis was performed with therapists' professional experience as the dependent variable. The independent variables were the same ones utilized in the preceding analysis. Results indicated, as shown in Table 2, that none of the variables proved to be a significant predictor of professional experience thus suggesting lack of a relationship between the variables and professional experience.

Summary

Results of the preliminary analyses revealed that none of the therapist variables (gender, type of program, level of education, practicum experience, professional experience) significantly affected the dependent variables used in this study. Accordingly, all therapist variables were collapsed for the main analyses.

TABLE 1

MULTIPLE REGRESSION ANALYSIS OF THERAPIST PRACTICUM EXPERIENCE

Variable	Multiple R	β	F	p
Item #1[a]	.13184	-1.640243	3.18	.0760
Item #2[a]	.17595	2.763175	2.86	.0599
Item #4[a]	.20385	-1.736856	2.57	.0556
Total[b]	.21206	.132663	2.08	.0849
Item #5[a]	.21717	.823871	1.74	.1273
Item #6[a]	.21882	.574992	1.47	.1922
Item #7[a]	.21959	.011069	1.26	.2733
Item #3[a]	.22009	- .254524	1.10	.3649

Note: Variables are listed in the order in which they entered the equation.

[a]Items 1- 7 on the Prognostic Evaluation Instrument (appropriateness for therapy at a community mental health center, selection for the therapist's caseload, severity of impairment, motivation to change, capacity for insight, likelihood of making substantial progress in therapy, and number of sessions required to make substantial change, respectively)

[b]total score on the Therapist Personal Reaction Questionnaire

TABLE 2

MULTIPLE REGRESSION ANALYSIS OF THERAPIST PROFESSIONAL EXPERIENCE

Variable	Multiple R	β	F	p
Item #3[a]	.10715	5.166407	2.09	.1500
Item #2[a]	.14010	7.794878	1.79	.1696
Item #4[a]	.16999	-5.139756	1.77	.1555
Item #5[a]	.03716	5.550188	1.71	.1503
Total[b]	.21135	.641756	1.64	.1503
Item #6[a]	.22243	4.302212	1.52	.1747
Item #7[a]	.23103	- .113993	1.40	.2074
Item #1[a]	.23341	-1.284818	1.24	.2752

Note: Variables are listed in the order in which they entered the equation.

[a]Items 1- 7 on the Prognostic Evaluation Instrument (appropriateness for therapy at a community mental health center, selection for the therapist's caseload, severity of impairment, motivation to change, capacity for insight, likelihood of making substantial progress in therapy, and number of sessions required to make substantial change, respectively)

[b]total score on the Therapist Personal Reaction Questionnaire

Main Analyses

Based on the assumption of indendence, five separate analyses were utilized to test the hypotheses of this study. Each of these hypotheses is addressed separately.

Hypothesis One

The first hypothesis of the study postulated that client attractiveness, as perceived by the therapist, is influenced by the gender, socioeconomic status and the alcoholic status of the client. Client attractiveness was operationalized by the total score on the Therapist Personal Reaction Questionnaire (TPRQ). Coefficient alpha, a measure of the internal reliability of the instrument (Cronbach, 1971), was calculated for the TPRQ. Results provided an adjusted coefficient alpha of .71, representing moderate internal consistency.

A 2 x 2 x 2 factorial analysis of variance (Anova) was performed analyzing client attractiveness as a function of client gender (male, female), client socioeconomic status (lower, upper-middle), and alcoholic status of the client (alcoholic, nonalcoholic). Table 3 provides the summary table for this Anova. The only statistically significant effect was the main effect for alcoholic status of client, $F(1, 185) = 5.58$, $p<.019$. The mean score for the nonalcoholic client (14.85) was significantly greater than that for the alcoholic client (12.52). This indicates that the nonalcoholic client was considered more attractive than the alcoholic client. The strength of the effect, as indexed by eta squared, was .03, indicating that 3% of the variance

TABLE 3

ANALYSIS OF VARIANCE FOR THERAPIST PERCEIVED CLIENT ATTRACTIVENESS[a]

Source	SS	df	MS	F	p
Alcoholic Status (AS)	238.240	1,185	238.240	5.576	.019
Gender (G)	19.569	1,185	19.569	.458	.499
SES	132.265	1,185	132.265	3.096	.080
AS x G	27.885	1,185	27.885	.653	.420
AS x SES	92.838	1,185	92.838	2.173	.142
G x SES	110.189	1,185	110.189	2.579	.110
A x G x SES	.936	1,185	.936	.022	.883
Error	7561.958	177,185	42.723		

[a]As measured by the Therapist Personal Reaction Questionnaire

in the total attractiveness score could be accounted for by the alcoholic status of the client.

Hypothesis Two

The study's second hypothesis was that therapists' prognosis is influenced by the gender, socioeconomic status and alcoholic status of the client. To test this hypothesis, a 2 x 2 x 2 factorial Manova was performed. Independent variables were client gender (male, female), socioeconomic status (lower, upper-middle) and alcoholic status (alcoholic, nonalcoholic), and the dependent variables were the first six items on the Prognostic Evaluation Instrument (appropriateness for therapy at a community mental health center, selection for the therapists' caseload, severity of impairment, motivation to change, capacity for insight, and likelihood of making substantial progress in therapy). Table 4 reports the inter-correlations of the dependent variables.

Table 5 provides the results of the Manova and indicates that the only statistically significant effect was the main effect for alcoholic status, $F(6, 182) = 3.70$, $p<.002$. The strength of the effect, as measured by eta squared, was .12, indicating 12% of the variance in prognosis could be accounted for by the alcoholic status of the client.

Subsequent univariate analyses of variance, as reported in Table 6, revealed significant differences on Item 2 ($F(1, 174) = 4.99$, $p<.027$), Item 4 ($F(1, 174) = 9.04$, $p<.003$), and Item 6 ($F(1, 174) = 10.26$, $p<.002$). Table 7 provides the mean scores and standard

TABLE 4

PEARSON PRODUCT MOMENT CORRELATIONS AMONG SIX ITEMS OF THE PROGNOSIS EVALUATION INSTRUMENT

Item #	1	2	3	4	5	6
1[a]	-					
2[b]	.0213	-				
3[c]	.0804	-.0408	-			
4[d]	.0658	.2344	.0178	-		
5[e]	.1214	.2595	.1778	.4179	-	
6[f]	.0588	.3471	-.1077	.3617	.1728	-

[a]appropriateness for therapy at a community mental health center

[b]selection for the therapist's caseload

[c]severity of impairment

[d]motivation to change

[e]capacity for insight

[f]likelihood of making susbstantial progress in therapy

TABLE 5

MULTIVARIATE ANALYSIS OF VARIANCE FOR SIX ITEMS OF THE PROGNOSIS EVALUATION INSTRUMENT

Source	F	df	p
Alcoholic Status (AS)	3.705	6, 182	.002
Gender (G)	.729	6, 182	.627
AS x G	.668	6, 182	.676
AS x SES	1.411	6, 182	.213
G x SES	.257	6, 182	.956
A x G x SES	.846	6, 182	.536

TABLE 6

UNIVARIATE ANOVA'S FOR SIX ITEMS OF THE PROGNOSTIC EVALUATION INSTRUMENT

Item #	SS	df	MS	F	p
1[a]	2.32836	1, 174	112.63768	3.59679	.060
2[b]	1.96118	1, 174	68.41634	4.98778	.027
3[c]	.92318	1, 174	68.72369	2.33739	.128
4[d]	4.66916	1, 174	89.82300	9.04482	.003
5[e]	.43442	1, 174	83.73753	.90269	.343
6[f]	2.87827	1, 174	48.82731	10.25694	.002

[a]appropriateness for therapy at a community mental health center

[b]selection for the therapist's caseload

[c]severity of impairment

[d]motivation to change

[e]capacity for insight

[f]likelihood of making susbstantial progress in therapy

TABLE 7

MEANS AND STANDARD DEVIATIONS FOR ITEMS TWO, FOUR AND SIX OF THE PROGNOSIS EVALUATION INSTRUMENT

	Item #								
	2[a]			4[b]			6[c]		
	M	s	N	M	s	N	M	s	N
Lower SES Male									
Alcoholic	2.17	.702	24	2.88	.741	24	2.00	.590	24
Nonalcoholic	1.74	.619	23	2.47	.730	23	1.87	.548	23
Upper-Middle SES Male									
Alcoholic	1.76	.625	21	2.76	.831	21	2.00	.447	21
Nonalcoholic	1.81	.501	22	2.23	.752	22	1.64	.492	22
Lower SES Female									
Alcoholic	1.92	.776	24	2.83	.702	24	2.00	.511	24
Nonalcoholic	1.72	.458	25	2.60	.707	25	1.80	.500	25
Upper-Middle SES Female									
Alcoholic	1.81	.601	21	2.62	.669	21	1.90	.539	21
Nonalcoholic	1.54	.670	22	2.61	.732	22	1.59	.590	22

[a]selection for the therapist's caseload

[b]motivation to change

[c]likelihood of making susbstantial progress in therapy

deviations of these items. The mean score for the alcoholic client for Item 2 (selection for the therapists' caseload) was significantly greater (mean = 1.91) than the mean score for the nonalcoholic client (mean = 1.70). This indicates that the therapist was more likely to want the nonalcoholic client as part of his/her caseload than he/she was the alcoholic client. For Item 4 (motivation to change) the mean score for the alcoholic client (mean = 2.77) was significantly greater than the mean score for the nonalcoholic client (mean = 2.44) This suggests that the therapist evaluated the alcoholic client as less motivated to change than the nonalcoholic client. On Item 6 (likelihood of making substantial progress in therapy), the mean score for the alcoholic client was significantly greater (mean = 1.98) than the mean score for the nonalcoholic client (mean = 1.72). This indicates that the therapist thought the alcoholic client was less likely to make progress than was the nonalcoholic client.

Hypothesis Three

The third hypothesis of the study stated that the number of sessions believed by the therapist to be required for substantial progress is influenced by the gender, socioeconomic status and alcoholic status of the client. A 2 x 2 x 2 factorial Anova was performed to test the hypothesis. The independent variables were gender (male, female), socioeconomic status (lower, upper-middle) and alcoholic status (alcoholic, nonalcoholic) of the client, and the dependent variable was the number of sessions thought required for substantial progress. Table 8 provides a summary of the analysis

TABLE 8

ANALYSIS OF VARIANCE FOR NUMBER OF THERAPY SESSIONS

Source	SS	df	MS	F	p
Alcoholic Status (AS)	47.285	1, 185	47.285	.155	.694
Gender (G)	1592.810	1, 185	1592.810	5.221	.024
AS x G	2.648	1, 185	2.648	.009	.926
AS x SES	62.154	1, 185	62.154	.204	.652
G x SES	2.435	1, 185	2.435	.008	.929
A x G x SES	12.108	1, 185	12.108	.040	.842
Error	54,000.782	177, 185	305.089		

and reveals the only statistically significant effect was the main effect for gender, $F(1, 184) = 5.22$, $p<.024$). The mean score for the female client was significantly greater (mean = 22.10) than the mean score for the male client (mean = 16.23). These results indicate that the therapist believed it would take the female client more sessions than the male client to make substantial progress. The strength of association between gender and the number of required sessions, as indexed by eta squared, was .03, indicating that 3% of the variance in the number of required sessions could be accounted for by the gender of the client.

Hypothesis Four

The fourth hypothesis of the study postulated that therapists' decision to hospitalize the client is influenced by the gender, socioeconomic status and alcoholic status of the client. A series of chi square analyses were performed to test this association between gender (male, female), socioeconomic status (lower, upper-middle) and alcoholic status of the client (alcoholic, nonalcoholic), and decision to hospitalize (yes, no).

First, a 2 x 8 chi square was performed. The independent variables were decision to hospitalize (yes, no) and the eight possible client variations used in the vignettes (lower SES nonalcoholic female; lower SES alcoholic female; upper-middle SES nonalcoholic female; upper-middle SES alcoholic female; lower SES nonalcoholic male; lower SES alcoholic male; upper-middle SES nonalcoholic male; upper-middle SES alcoholic male). The chi square was statistically

significant, $\chi^2(7, N = 182) = 25.36$, $p<.0007$. Cramer's statistic, a measure of the strength of association, yielded a value of .37 indicating a mild relationship between the variables. Table 9 provides the results of Ryan's Procedure utilized to accomplish specific comparisons. These results indicate that the upper-middle socioeconomic status alcoholic female differed significantly from the upper-middle socioeconomic status nonalcoholic female with the former more likely to be hospitalized and latter more likely not to be hospitalized. Additionally, the lower socioeconomic status alcoholic male differed significantly from the upper-middle socioeconomic nonalcoholic female with the former more likely to be hospitalized and the latter more likely not to be hospitalized.

A 2 x 2 chi square test was performed on the independent variables of the decision to hospitalize (yes, no) and the alcoholic status of the client (alcoholic, nonalcoholic). The chi square, calculated with the Yates' Correction for Continuity, was statistically significant, $\chi^2(1, N = 182) = 17.812$, $p<.000$, thus, supporting an association between the decision to hospitalize and the alcoholic status of the client. The strength of association, as indexed by the fourfold point correlation, was calculated at .31, indicating a mild relationship between the variables. The nature of the relationship was such that the nonalcoholic client was less likely to be hospitalized than was the alcoholic client.

Another 2 x 2 chi square test was performed, using the Yates' Correction for Continuity, on the independent variables of the decision to hospitalize (yes, no) and gender (male, female). The chi square was statistically nonsignificant, $\chi^2(1, N = 182) = 1.109$,

TABLE 9

NATURE OF THE RELATIONSHIP BETWEEN DECISION TO HOSPITALIZE AND DESCRIPTION OF CLIENT[a]

Description	MUN	FUN	d	d-1	α	Tabled
FUA .57	4.41	12.68				
			8	7	—	9.80
MLA .56	4.53	11.99				
			7	6	—	9.55
MUA .45		7.35	6	5		9.18
			5	4		8.76
FLA .33			4	3		8.18
FLN .25			3	2		7.51
			2	1		6.25
MLN .23						
MUN .22						
FUN .04						

Note: F represents female; M represents male; U represents upper-middle SES; L represents lower SES; N represents nonalcoholic; and A represents alcoholic

[a]As determined by Ryan's Procedure

$p>.2924$, indicating the lack of a relationship between decision to hospitalize and gender.

A third 2 x 2 chi square analysis was conducted using the Yates' Correction for Continuity. Independent variables were decision to hospitalize (yes, no) and socioeconomic status of the client (lower, upper-middle). Results showed a nonsignificant association between the two variables, $\chi^2(1, N = 182) = .0145$, $p>.9043$.

Hypothesis Five

The fifth hypothesis stated that therapists' diagnosis is influenced by the gender, socioeconomic status and alcoholic status of the client. The 11 nonsubstance abuse DSM-III categories were collapsed into a single category and compared with the single substance abuse category. A series of chi square analyses were then performed to test the hypothesized association between diagnosis (nonsubstance abuse disorder, substance abuse disorder) and gender, socioeconomic status and alcoholic status of the client.

First, a 2 x 8 chi square analysis was performed on the independent variables of diagnosis (nonsubstance abuse disorder, substance abuse disorder) and the eight possible client variations of the case vignettes (lower SES nonalcoholic female, lower SES alcoholic female, upper-middle SES nonalcoholic female, upper-middle SES alcoholic female, lower SES nonalcoholic male, lower SES alcoholic male, upper-middle SES nonalcoholic male, upper-middle SES alcoholic male). Results showed a significant relationship between the two variables, $\chi^2(7, N = 157) = 108.29$, $p<.000$. Cramer's statistic,

a measure of the strength of association, was calculated at .83, indicating a strong relationship between the two variables. Table 10 provides the results of Ryan's Procedure used to accomplish specific comparisons. Results of this follow-up procedure indicated that the upper-middle SES alcoholic male differed significantly from the four nonalcoholic clients with the former more likely to be diagnosed with a substance abuse disorder and the four nonalcoholic clients more likely to be diagnosed with a nonsubstance abuse disorder. Also, the other three alcoholic clients (the lower SES alcoholic female, the lower SES alcoholic male, and the upper-middle alcoholic female) were all significantly different from the nonalcoholic clients in that the alcoholic clients were more likely to be diagnosed with a substance abuse disorder while the second four clients were more likely to be diagnosed with a nonsubstance abuse disorder. Of the four alcoholic clients, the upper-middle SES alcoholic male was most likely to be diagnosed with a substance abuse disorder followed by the lower SES alcoholic female, the lower SES alcoholic male and the upper-middle SES alcoholic female.

A 2 x 2 chi square test was performed on the independent variables of diagnosis (nonsubstance abuse disorder, substance abuse disorder) and alcoholic status of client (alcoholic, nonalcoholic). The chi square, calculated with the Yates' Correction for Continuity, was statistically significant, $\chi^2(1, N = 157) = 103.029$, $p<.000$. The fourfold point correlation, an index of strength of association, was computed at .81, indicating a strong correlation between the two variables.

TABLE 10

NATURE OF THE RELATIONSHIP BETWEEN DIAGNOSIS AND DESCRIPTION OF CLIENT[a]

Description	FUA	MLA	FLA	MUA	d	d-1	$\sqrt{2}$ Tabled
FUN 1.00	21.46	27.17	32.26	27.12	8	7	9.80
FLN .90	19.43	25.32	30.38	25.22	7	6	9.55
MUN .86	17.56	23.32	28.30	23.28	6	5	9.18
MLA .81	14.40	19.68	24.41	19.87	5	4	8.76
FUA .13					4	3	8.18
MLA .09					3	2	7.51
FLA .04					2	1	6.25
MUA .00							

NOTE: F represents female; M represents male; U represents upper-middle SES; L reprsents lower SES; N represents nonalcoholic; A represents alcoholic

[a]As determined by Ryan's Procedure

The results indicate that alcoholic clients were significantly more likely to be diagnosed with a substance abuse disorder and nonalcoholic clients were significantly more likely to be diagnosed with a nonsubstance abuse disorder.

Another 2 x 2 chi square test was performed on the independent variables of diagnosis (nonsubstance abuse disorder, substance abuse disorder) and gender (male, female). The chi square, calculated with the Yates' Correction for Continuity, was found to be statistically nonsignificant, $\chi^2(1, N = 157) = .0052$, $p > .942$, indicating the lack of a significant association between diagnosis and gender.

A final 2 x 2 chi square analysis was conducted with Yates' Correction for Continuity. Independent variables were diagnosis (nonsubstance abuse disorder, substance abuse disorder) and socioeconomic status (lower, upper-middle). Results indicated a nonsignificant relationship, $\chi^2(1, N = 157) = .9941$, $p > .319$ between diagnosis and socioeconomic status.

Summary

No interaction effects between the independent variables were found in any of the main analyses. Several main effects, however, were found. Results showed that alcoholic status of the client had a significant effect on client attractiveness indicating that the nonalcoholic client was considered by therapists as more attractive than the alcoholic client. Client's alcoholic status was also shown to have a significant effect on prognosis. The findings revealed that therapists evaluated the alcoholic client as less motivated to change,

and less likely than the nonalcoholic client to make progress in therapy. Further, these findings indicated that therapists were more likely to want the nonalcoholic client as part of their caseload than they were the alcoholic client.

Results indicated that both the upper-middle SES alcoholic female and the lower SES alcoholic male were more likely to be hospitalized than was the upper-middle SES nonalcoholic female. Other results showed that the nonalcoholic client was less likely to be hospitalized than was the alcoholic client.

In addition, the results revealed that the four alcoholic clients were more likely to be diagnosed with a substance abuse disorder than were the four nonalcoholic clients. Of the four alcoholic clients, the upper-middle SES alcoholic male was most likely to be diagnosed with a substance abuse disorder followed by the lower SES alcoholic female, the lower SES alcoholic male and the upper-middle alcoholic female.

Finally, a significant association was found between gender and the number of sessions thought required by therapists for substantial progress. The results suggested that therapists believed it would take female clients more sessions than male clients to make substantial change.

CHAPTER V

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Summary

The purpose of this analogue study was to investigate the influence of client's gender, socioeconomic status and alcoholic status on clinical judgments through the use of case vignettes. The clinical judgments examined were perceived client attractiveness (as measured by the Therapist Personal Reaction Questionnaire), prognosis, including the number of sessions thought required for substantial progress (as measured by Items 1-7 on the Prognosis Evaluation Instrument), decision to hospitalize, and diagnosis. Independent variables were gender (male, female), socioeconomic status (lower, upper-middle) and alcoholic status (alcoholic, nonalcoholic) of the client. Subjects were 185 graduate students in clinical and counseling psychology programs from three state supported universities in the southwestern United States, all of whom had taken or were currently enrolled in either an abnormal/psychopathology or practicum course.

Five hypotheses were formulated. The first three hypotheses posited that therapist perceived client attractiveness, prognostic expectations and the number of sessions required for substantial

progress, respectively, are influenced by the gender, socioeconomic status and alcohlic status of the client. The fourth hypothesis postulated that the the decision to hospitalize is influenced by the gender, socioeconomic status and alcoholic status of the client. The final hypothesis stated that diagnosis is influenced by the gender, socioeconomic status and alcoholic status of the client. Separate analyses were performed to test each of the study's five hypotheses. No interaction effects were found in the first three analyses and thus the first three hypotheses were not supported. Several main effects, however, were found throughout the analyses most of which involved the alcoholic status of the client. Further, interaction effects were found for the last two hypotheses. This chapter presents the conclusions and recommendations drawn from the results of these analyses.

Conclusions

The derelict stereotype of the alcoholic was not upheld in this study. This may reflect an increasing attention to the "hidden alcoholic" by graduate psychology training programs as well as by society. Television movies such as the recent Betty Ford Story can go a long way in educating the public therefore allowing upper-middle SES alcoholics to come out of hiding. While it is certainly encouraging that the derelict stereotype was not supported, the negative bias found in the present study toward alcoholics in general is disturbing. The next section of this chapter presents the conclusions drawn from each of these findings as they relate to the study's five hypotheses.

Before this discussion, however, it should be noted that all of the

results of this study are viewed with caution for several reasons. Therapists, for instance, may have responded differently to the case vignettes than they would have in the naturalistic setting. Also, the subjects in the study were students many of whom had the benefit of recent courses in which substance abuse was a covered topic and, therefore, may have responded differently from professionals who have been out in practice for some years. Finally, the response set of social desirability may have been in operation.

Client Attractiveness

Statistical analysis of the first hypothesis revealed a significant effect on therapist perceived client attractiveness by client's alcoholic status. The scores on the TPRQ, the measure of client attractiveness in this study, were significantly higher for nonalcoholic clients than they were for alcoholic clients. According to Ashby et al. (1957), the authors of the TPRQ, higher scores reflect a variety of feelings by the therapists including feelings of identification and involvement with the client. It can be extrapolated, therefore, that the therapists in this study were less likely to identify and feel involved with the alcoholic client than they were with the nonalcoholic client.

This conclusion relates to the social psychology research that proposes that receivers will perceive sources similar to themselves as more attractive than they do dissimilar sources (Simons et al., 1970). Based on this proposition, it is conjectured that therapists in this study considered themselves as more dissimilar from the alcoholic clients than they did from the nonalcoholic clients and, consequently, scored them as less attractive.

An assumption, however, cannot be made that the dissimilarity is solely a function of alcoholic status. The drinking patterns of the therapists sampled in this study were not examined, and thus, there is no way of ascertaining if a similarity exists with respect to alcoholic status. The failure to consider therapists' drinking patterns is an acknowledged limitation of the study.

Therapists-client group membership similarity on the basis of alcoholism is an area which has received considerable attention in recent years. Although studies have concluded that recovering alcoholics are more effective in reducing drinking behavior than are counselors with no history of alcohol problems (Lawson, 1982; Root, 1973), the results appear equivocal. For example, Argeriou and Manohar (1978) found that recovering alcoholics were more effective than their nonalcoholic counterparts but only with patients under 35 years of age. Further, as Atkinson and Schein (1986) pointed out in their recent review of similarity effects, ". . .true similarity effect has not and cannot be studied because it makes little sense for nonalcoholic clients to be receiving alcoholic counseling" (p. 331).

Prognostic Expectations

Results of the analysis which tested the second hypothesis showed a significant relationship between prognostic expectations and client's alcoholic status. Specifically, the findings revealed that therapists were more likely to select nonalcoholic clients as part of their caseload than they were alcoholic clients. Additionally, they were likely to evaluate alcoholic clients as less motivated to change and less likely to make substantial progress than nonalcoholic clients.

These findings are not surprising in view of the preceding results relative to attractiveness. Indeed, Davis et al. (1977) report that when the counselor finds the client attractive, the client talks more, is more spontaneous, and is less resistive. It can be surmised that the converse is also true thereby supporting the role of attractiveness as a mediator of clinical judgments.

The results are also consistent with existing research on mental health attitudes about alcoholic clients. Knox (1969) in her survey of 480 psychologists employed at VA Hospitals found that the majority of them were willing to spend only 10% of their time working with alcoholics. Further, 20% of this same sample indicated that they would resign upon notification that their positions were to be primarily devoted to the treatment of alcoholism; another 22% responded that they would grudgingly comply.

In a more recent study, Peyton et al. (1980) found that only 36% of a sample of social work graduate students indicated a willingness to treat alcoholics. Therapist gender, year in school and prior experience with alcoholics were found not to be significant predictors to willingness to treat. Duxbury (1983) replicating Peyton et al.'s study found that 42% of her sample of social work graduate students expressed ambivalence or a negative bias toward treating alcoholics. In selecting desirable clients, common criteria seemed to be the amenability of the presenting problem and the client's motivation to change. Alcoholic clients were viewed negatively on both criteria.

Much has been written about alcoholic clients' lack of motivation. Chafetz (1968) has suggested, however, that the lack of motivation attributed to these clients may, in fact, be a reflection of a

lack of motivation by the therapists themselves because of their moralistic view of alcoholics as hedonistic and weak willed individuals. Chafetz' suggestion relates to Sterne and Pittman's (1965) finding in their survey of mental health professionals that many respondents equated the concept of motivation with will power. Based on this finding, the researchers hypothesized that will power is the "... crux of a broader moralistic orientation toward alcoholism in which the individual's behavioir is considered completely susceptible to his rational control; as such his behavior is properly judged with moral value" (p. 48). The hypothesis was supported by their later finding that psychiatric staff with moralistic attitudes toward alcoholism tended to be pessimistic regarding recovery and consequently considered the alcoholic patient as poorly motivated toward improvement. Conversely, staff members expressing illness-oriented attitudes were more optimistic regarding patient motivation and recovery potential.

Acceptance of the disease model of alcoholism does appear to be a predictor of willingness to treat alcoholics (Duxbury, 1983). Indeed, perhaps the only way to bring a great majority of alcoholics out of hiding is for mental health professionals to discard their moralistic views and to adopt the disease model. Research is ambiguous as to whether progress is being made toward this end. For instance, Knox (1971) in another survey reported that both psychologists and psychiatrists rarely endorsed the disease model of alcoholism. In a more recent study (Romney & Bynner, 1985), alcoholics were labeled by hospital psychiatric staff as unstable, weak and passive - labels which clearly support the moralistic view.

In another study (Casswell & McPherson, 1983), New Zealand general practitioners largely supported the disease model but concomitantly admitted to a moralistic attitude toward alcoholism.

In the present study, it is unclear what factors contributed to the subjects' reluctance to select alcoholics for their caseloads. While it is possible that they possess moralistic attitudes about alcoholics, it may be that their unwillingness to treat them is due to their perception of a lack of a viable cure (other than total abstinence) to the "disease."

Number of Therapy Sessions Thought Required

Statistical examination of the third hypothesis showed therapists believed that it would take more sessions for females to make substantial progress than it would males. While these results seem inconsistent with the other findings of the present study, they match the results of the landmark study by Broverman et al. (1970) which found that clinicians had a double standard of mental health for men and women and that women are perceived as less healthy than men by adult standards. This finding by Broverman et al. has not been supported by studies in recent years (Aslin, 1977; Cowan, 1976). In fact, it has been hypothesized that the double standard is eroding (Zeldow, 1984).

While the finding of this present study questions this erosion, it may be that the depression and suicidal ideations experienced by the client depicted in all of the case vignettes influenced the responses. For example, Stein et al. (1976) found that depressed female outpatients were offered more therapy sessions than their male

counterparts. Furthermore, statistics indicate that females are more likely to make actual suicide attempts than males (Santrock, 1984). Accordingly, it is possible that therapists took the suicidal thoughts by the female more seriously and, thus, evaluated her as requiring more therapy sessions. Allowing subjects an opportunity to qualify their response (i.e., "Please state the reason for your response") might have ameliorated some of this ambiguity.

Conversely, it cannot be stated absolutely that females were found to be less well adjusted than males simply on the basis of being assessed as requiring more therapy sessions. Indeed, therapists have been found to recommend "once weekly or more" individual therapy sessions for women more than for men despite the fact that the women were not seen as less well adjusted or more in need of therapy (Murray, & Abramson, 1983). Heatherington, Stets, and Mazzarella (1986), using 164 outpatient clients as subjects, found that male clients were ascribed more negative interpersonal characteristics and poorer social skills, and thus were expected to remain in treatment less time. Before any unequivocal conclusions can be made, therefore, much more research is needed. A limitation of many existing studies, including the present one, is the failure to take into account potential interaction between therapist and client gender.

Decision to Hospitalize

Testing of the fourth hypothesis revealed the alcoholic client as more likely to be hospitalized than the nonalcoholic client. An argument could be made that this result lends support to the

increasing acceptance of the disease model. Knox (1969; 1971), however, found in her studies that the same groups of psychologists and psychiatrists who rejected the disease model identified the hospital as the disposition of choice for the alcoholic. Concomitantly, these respondents generally considered the help to be gained by hospital care as minimal. It appears, therefore, that additional research is required before any conclusions can be drawn about the correlation between the decision to hospitalize and the therapist's view toward alcoholism.

Diagnosis

Results of the fifth statistical analysis showed a significant association between alcoholic status and diagnosis. Alcoholics were more likely to be diagnosed with a substance abuse disorder while nonalcoholics were more likely to be diagnosed with a nonsubstance abuse disorder. These results suggest an increasing awareness by psychology students of the symptoms of alcoholism. This growing awareness is substantiated by a study by Schlesinger (1984). In his survey of 436 graduate psychology training programs, it was found that 25% of the responding programs required exposure to issues of substance abuse as part of their curricula and another 52% of them offered students exposure to the topic through elective study or experience.

Hopefully, as more and more psychology graduate schools accept substance abuse education as an integral part of their programs, more of their students will be willing to accept alcoholics as their clients. Such acceptance will, of course, facilitate alcoholics'

prognosis. Indeed, the sooner alcoholics get into treatment, the greater their likelihood of recovery. Improved prognosis will hopefully foster a greater liking for alcoholics. This more positive attitude by therapists will hopefully, in turn, encourage more alcoholics to seek and accept treatment.

Recommendations

Future research needs to compare the effects of various types of membership-group similarity to determine the relative importance of each as well as to examine possible interaction effects (Atkinson, & Schein, 1986). For instance, therapist socioeconomic status may have been a confounding variable in the present study. Although it is largely assumed that the majority of therapists have a middle-upper SES status, few studies have investigated how therapist SES interacts with client SES. Furthermore, graduate students with a dual role of therapist (i.e., in practicum, etc.), while perhaps having middle-upper SES as a function of their families of origin, may identify more closely with lower SES individuals because of their own current financial status.

Future studies may wish to embed alcoholism in a presenting problem other than depression (the presenting problem in the present study) in order to better determine the degree to which subjects are sensitive to the symptomatology of alcoholism. Because of the association between alcoholism and depression (e.g., many depressed individuals use alcohol as a way of self-medicating), it is possible that the depressive symptoms presented in the case vignettes "tipped the subjects off" to alcoholism. Indeed, several

subjects in the present study who were presented with a nonalcoholic depressed pseudoclient indicated the possibility of alcoholism.

It is recommended that studies be undertaken to update Sterne and Pittman's (1965) study to ascertain current mental health attitudes (moralistic vs. the disease model) about alcoholism. Likewise, future studies may wish to consider investigating the role of hospitalization (custodial care vs. rehabilitation) in order to elucidate better the finding that alcoholic clients are more likely to be hospitalized then their nonalcoholic counterparts.

More studies in naturalistic settings are needed. It would be interesting, for example, to replicate the present study, using therapists already in practice as subjects. Finally, it is recommended that more studies be conducted to determine how prior experience with alcoholics affects mental health attitudes. For instance, the study by Fisher et al. (1975) found that attitudes of family practice residents became more negative the longer they worked with alcoholics. In addition to examining the influence of prior professional experience with alcoholics, studies are needed that investigate the influence of therapist drinking patterns on clinical judgments about alcoholics.

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APPENDIXES

APPENDIX A

CASE VIGNETTES

CASE VIGNETTE

Client is a white female. She attended school through the seventh grade. Although she is currently unemployed, she often works as a waitress. Her average annual income is approximately $7,000 per year.

Client reports that she has had many emotional upsets over the last fifteen years. Currently, she is depressed. She has been verbalizing suicidal thoughts as well as feelings of hopelessness. Additionally, she acknowledges insomnia, appetite loss, anxiety, fatigue, and muscle tension.

A serious individual who generally anticipates problems, she has recently spent her time brooding nonproductively. She seems to be preoccupied with deficiencies, is self-devaluating, and intropunitive. She has always desired recognition from others, but is currently experiencing a loss of efficiency, initiative and self-confidence. Feelings of inadequacy and inferiority are evident.

CASE VIGNETTE

Client is a white female. She attended school through the seventh grade. Although she is currently unemployed, she often works as a waitress. Her average annual income is approximately $7,000 per year.

Client reports that she has had many emotional upsets over the last fifteen years. She also reports a fifteen year history of excessive drinking. As a result, she has had numerous social, family, and legal problems, as well as many blackouts and other physical problems. Currently, she is depressed. She has been verbalizing suicidal thoughts as well as feelings of hopelessness. Additionally, she acknowledges insomnia, appetite loss, anxiety, fatigue, and muscle tension.

A serious individual who generally anticipates problems, she has recently spent her time brooding nonproductively. She seems to be preoccupied with deficiencies, is self-devaluating, and intropunitive. She has always desired recognition from others, but is currently experiencing a loss of efficiency, initiative and self-confidence. Feelings of inadequacy and inferiority are evident.

CASE VIGNETTE

Client is a white female. She attended college and received a degree in business. She is currently employed as an executive in a large company. Her average annual income is approximately $40,000 per year.

Client reports that she has had many emotional upsets over the last fifteen years. Currently, she is depressed. She has been verbalizing suicidal thoughts as well as feelings of hopelessness. Additionally, she acknowledges insomnia, appetite loss, anxiety, fatigue, and muscle tension.

A serious individual who generally anticipates problems, she has recently spent her time brooding nonproductively. She seems to be preoccupied with deficiencies, is self-devaluating, and intropunitive. She has always desired recognition from others, but is currently experiencing a loss of efficiency, initiative and self-confidence. Feelings of inadequacy and inferiority are evident.

CASE VIGNETTE

Client is a white female. She attended college and received a degree in business. She is currently employed as an executive in a large company. Her average annual income is approximately $40,000 per year.

Client reports that she has had many emotional upsets over the last fifteen years. She also reports a fifteen year history of excessive drinking. As a result, she has had numerous social, family, and legal problems, as well as many blackouts and other physical problems. Currently, she is depressed. She has been verbalizing suicidal thoughts as well as feelings of hopelessness. Additionally, she acknowledges insomnia, appetite loss, anxiety, fatigue, and muscle tension.

A serious individual who generally anticipates problems, she has recently spent her time brooding nonproductively. She seems to be preoccupied with deficiencies, is self-devaluating, and intropunitive. She has always desired recognition from others, but is currently experiencing a loss of efficiency, initiative and self-confidence. Feelings of inadequacy and inferiority are evident.

CASE VIGNETTE

Client is a white male. He attended school through the seventh grade. Although he is currently unemployed, he often works as a painter. His average annual income is approximately $7,000 per year.

Client reports that he has had many emotional upsets over the last fifteen years. Currently, he is depressed. He has been verbalizing suicidal thoughts as well as feelings of hopelessness. Additionally, he acknowledges insomnia, appetite loss, anxiety, fatigue, and muscle tension.

A serious individual who generally anticipates problems, he has recently spent his time brooding nonproductively. He seems to be preoccupied with deficiencies, is self-devaluating, and intropunitive. He has always desired recognition from others, but is currently experiencing a loss of efficiency, initiative and self-confidence. Feelings of inadequacy and inferiority are evident.

CASE VIGNETTE

Client is a white male. He attended school through the seventh grade. Although he is currently unemployed, he often works as a painter. His average annual income is approximately $7,000 per year.

Client reports that he has had many emotional upsets over the last fifteen years. He also reports a fifteen year history of excessive drinking. As a result, he has had numerous social, family, and legal problems, as well as many blackouts and other physical problems. Currently, he is depressed. He has been verbalizing suicidal thoughts as well as feelings of hopelessness. Additionally, he acknowledges insomnia, appetite loss, anxiety, fatigue, and muscle tension.

A serious individual who generally anticipates problems, he has recently spent his time brooding nonproductively. He seems to be preoccupied with deficiencies, is self-devaluating, and intropunitive. He has always desired recognition from others, but is currently experiencing a loss of efficiency, initiative and self-confidence. Feelings of inadequacy and inferiority are evident.

CASE VIGNETTE

Client is a white male. He attended college and received a degree in business. He is currently employed as an executive in a large company. His average annual income is approximately $40,000 per year.

Client reports that he has had many emotional upsets over the last fifteen years. Currently, he is depressed. He has been verbalizing suicidal thoughts as well as feelings of hopelessness. Additionally, he acknowledges insomnia, appetite loss, anxiety, fatigue, and muscle tension.

A serious individual who generally anticipates problems, he has recently spent his time brooding nonproductively. He seems to be preoccupied with deficiencies, is self-devaluating, and intropunitive. He has always desired recognition from others, but is currently experiencing a loss of efficiency, initiative and self-confidence. Feelings of inadequacy and inferiority are evident.

CASE VIGNETTE

Client is a white male. He attended college and received a degree in business. He is currently employed as an executive in a large company. His average annual income is approximately $40,000 per year.

Client reports that he has had many emotional upsets over the last fifteen years. He also reports a fifteen year history of excessive drinking. As a result, he has had numerous social, family, and legal problems, as well as many blackouts and other physical problems. Currently, he is depressed. He has been verbalizing suicidal thoughts as well as feelings of hopelessness. Additionally, he acknowledges insomnia, appetite loss, anxiety, fatigue, and muscle tension.

A serious individual who generally anticipates problems, he has recently spent his time brooding nonproductively. He seems to be preoccupied with deficiencies, is self-devaluating, and intropunitive. He has always desired recognition from others, but is currently experiencing a loss of efficiency, initiative and self-confidence. Feelings of inadequacy and inferiority are evident.

APPENDIX B

THERAPIST PERSONAL REACTION

QUESTIONNAIRE

THERAPIST PERSONAL REACTION QUESTIONNAIRE

During counseling, counselors have many different feelings and reactions. These reactions are sometimes negative, sometimes positive and sometimes mixed. Theorists seem to agree that having varied feelings and reactions toward clients is not undesirable as long as the counselor recognizes and understands them. This scale is designed to assess your feelings concerning the client in the case vignette.

There are five possible answers to each of the items:

1. Not characteristic of my feelings
2. Slightly characteristic of my feelings
3. Moderately characteristic of my feelings
4. Quite characteristic of my feelings
5. Highly characteristic of my feelings

Put a circle around the answers most representative of your feelings with respect to the client in the vignette. Be sure to put a circle around one answer for each item. Do not spend too much time on any item.

1.	I think I would like this client more than most.	1	2	3	4	5
2.	I think I would have a warm, friendly reaction to this client.	1	2	3	4	5
3.	I would seldom be in doubt about what the client was trying to say.	1	2	3	4	5
4.	In general, I don't think I could ask for a better client.	1	2	3	4	5
5.	I think that I would find significant things to respond to in what the client said.	1	2	3	4	5
6.	I think I would feel pretty ineffective with this client.	1	2	3	4	5
7.	I think I would do a pretty competent job with this client.	1	2	3	4	5
8.	I think I would disagree with this client about some basic matters.	1	2	3	4	5
9.	I think this client is trying harder to solve his/her problems than most others.	1	2	3	4	5
10.	It would be hard to know how to respond to this client in a helpful way.	1	2	3	4	5
11.	It would be easier for me to see exactly how this client would feel in situations than it is with other clients.	1	2	3	4	5
12.	I would be more confident this client will work out his/her problems than I am with other clients.	1	2	3	4	5
13.	In comparison with other clients, I would find it hard to get involved with this client's problems.	1	2	3	4	5
14.	It would be difficult feeling warmth toward this client.	1	2	3	4	5
15.	I think I would resent the client's attitude at times.	1	2	3	4	5

APPENDIX C

PROGNOSIS EVALUATION INSTRUMENT

PROGNOSIS-EVALUATION INSTRUMENT

1. How would you rate this clients' appropriateness for therapy at a community mental health center?

____Very appropriate
____Fairly appropriate
____Fairly inappropriate
____Very inappropriate

2. Would you want this client as part of your own caseload?

____Would very much want this client
____Would want this client somewhat
____Would not want this client very much
____Would definitely not want this client

3. How would you characterize the degree of disturbance of this client?

____Very mildly disturbed
____Mildly disturbed
____Moderately disturbed
____Severely disturbed

4. How would you rate this client's motivation to change?

____Very high
____Moderately high
____Moderately low
____Very low

5. How well do you think this client seems to understand his/her problem?

____A great deal
____A fair amount
____Relatively little
____Very little

6. What is the likelihood that this client will make substantial progress in counseling?

____She/he will probably make substantial progress
____She/he will probably make some progress
____She/he will probably make little progress
____She/he will probably make no progress

7. How many therapy sessions do you believe will be required to make substantial progress? _____

8. Do you believe this client should be hospitalized?
____Yes ____No

APPENDIX D

DIAGNOSIS SHEET

Below are the 12 major categories in the DSM III. Indiate your diagnosis for the client depicted in the case vignette by marking "1" for the primary diagnosis and "2" for the secondary diagnosis.

___ Adjustment Disorders	(Essential feature is a maladaptive reaction to an identifiable psychosocial stressor, that occurs within three months after the onset of the stressor.)
___ Affective Disorders	(Essential feature is a disturbance of mood, accompanied by a full or partial manic or depressive symptom, that is not due to any other physical or mental disorder.)
___ Anxiety Disorders	(Essential feature is the existence of anxiety as the predominant disturbance or anxiety is experienced if the individual attempts to master the symptoms.)
___ Dissociative Disorders	(Essential feature is a sudden, temporary alteration in the normally integrative functions of consciousness, identity, or motor behavior.)
___ Factitious Disorders	(Essential feature is physical or psychological symptoms that are produced by the individual and are under voluntary control.)
___ Organic Mental Disorders	(Essential feature is a psychological or behavioral abnormality associated with transient or permanent dysfunction of the brain
___ Paranoid Disorders	(Essential features are persistent persecutory delusions or delusional jealousy not due to any other mental disorder.)
___ Personality Disorders	(Essential feature is the existence of personality traits which are inflexible and maladaptive and cause either significant impairment in social or occupational functioning or subjective distress.)
___ Psychosexual Disorders	(Essential feature is the existence of psychological factors which are assumed to be of major etiological significance in the development of the sexual disorders.
___ Schizophrenic Disorders	(Essential features are the presence of certain psychotic features during the active phase of the illness, characteristic symptoms involving multiple psychological processes, deterioration from a previous level of function, a duration of at least six months, and onset before the age of 45.)
___ Somatoform Disorders	(Essential features are physical symptoms suggesting a physical disorder for which there are no demonstrable organic findings or known physiological mechanisms.)
___ Substance Use Disorders	(Essential feature is the occurrence of behavioral changes including impairment in social or occupational functioning as a consequence of substance use, and the development of serious withdrawal symptoms after cessation of or reduction in substance use.)

APPENDIX E

THERAPIST INFORMATION SHEET

THERAPIST INFORMATION SHEET

Please provide us with the following information.

Gender: _____ Age: _____ Race: _____

Type of Program Enrolled In: (Counseling or Clinical) _____

Level of Training: (Masters or Doctoral) _____

What courses have you taken in psychopathology? _____

_____

How many months of practicum experience have you had? _____

How many months of professional experience have you had (excluding practica)? _____

Please check the problems which you feel the client in the vignette may be experiencing:

_____ obsessive thinking

_____ simple phobia

_____ paranoia

_____ bipolar disorder

_____ depression

_____ schizophrenia

_____ alcoholism

_____ hypersensitivity

_____ medical problems

APPENDIX F

INSTRUCTIONS

This is a study in clinical decision making. We are interested in inter-judge reliability based on a very limited amount of clinical information. While your participation is entirely voluntary and you may withdraw at any time, your assistance is greatly appreciated. Please read the case vignette and complete the enclosed questionnaires. Be sure to answer all questions; failure to do so will result in our being unable to use the data you provide. All of your responses will be kept strictly confidential. Thank you for your participation.

VITA

Dana M. Hardy

Candidate for the Degree of

Doctor of Philosophy

Thesis: THE INFLUENCE OF CLIENT GENDER, SOCIOECONOMIC STATUS AND ALCOHOLIC STATUS ON CLINICAL JUDGMENTS

Major Field: Applied Behavioral Studies

Minor Field: Counseling Psychology

Biographical:

Personal Data: Born in Alton, Illinois, October 5, 1953, the daughter of Daniel J. and Geraldine A. Hartnett.

Education: Received Bachelor of Social Work Degree from Georgia State University in June, 1983; received Master of Social Work Degree from Florida State University in April, 1984; completed requirements for the Doctor of Philosophy degree at Oklahoma State University in July, 1987.

Professional Experience: Teaching Assistant, Department of Applied Behavioral Studies in Education, Oklahoma State University, August, 1984, to May, 1986; Predoctoral Psychology Intern, Counseling and Psychological Services, Duke University, August 1986, to July, 1987.