INFLUENCE OF TREATMENT FACTORS ON THE THERAPY PERCEPTIONS OF MAJORITY AND MINORITY SUBJECTS

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CHAPTER I

INTRODUCTION

Mental health professionals continually search for better ways to conduct the process of psychotherapy. A primary objective of this search is to find the means to bring the psychotherapy of particular clients to a satisfactory completion, i.e., with a positive treatment outcome. In pursuit of this goal, a number of studies have been done in which pre- and early-interview therapeutic techniques are correlated with their influence on outcomes. Two major areas studied have been the treatment expectations of clients entering psychotherapy and the effect of therapist impression-management on the client.

Much of the research looking at pre-therapy expectations has utilized a lower class clientele. These studies, along with others which include higher class clients in their samples, have shown that clients in general have expectations of therapy which are discrepant from their subsequent experience (Hollingshead & Redlich, 1958; Hornstra, Lubin, Lewis, & Willis, 1972; Levitt, 1966; Lorion, 1974). Prospective clients have been found to expect therapy to be similar to going to a doctor for a

broken finger. They expect quick relief for the pain and a definite set of rules and directions to follow in order to get well. Clients also expect to be generally inactive in the process with the professional doing the major part of the work. Some researchers claim that such expectancies occur at higher rates among minority clients than majority clients, but there is growing evidence that these expectations are widespread among nearly all clients (Lorion, 1974). The New Haven studies of Hollingshead and Redlich (1958) suggest that all social classes have large percentages of persons who have inaccurate expectations of psychotherapy. Leonard and Bernstein (1960) suggest that the major reason why patients drop out of treatment is that they have expectations of therapy discrepant from what actually goes on. From studying their data they believe that these misperceptions are due to lack of information by clients of what they are supposed to do in therapy and of how therapy can help them.

The second area of concern involves attempts to regulate the impressions of clients, with respect to the therapist. Recent research on minority clients has highlighted the possibility that client perception of the therapist influences the outcome of therapy (Padilla, Ruiz, & Alvarez, 1975). Ziemalis (1974) and Devine and Fernald (1973) accepted the notion that clients have differing perceptions of therapists and definite preferences for certain therapists. Clients

matched with their preferred therapists on the basis of initial perceptions showed greater improvement and higher quality interactions in therapy than did patients assigned to their less preferred therapists. Jackson and Thompson (1971) have suggested that the problem of communication between therapist and patient may stem more from attitudinal biases in the mental health community (i.e., lower class clients cannot do insight therapy, Asian Americans do not have mental illnesses, etc.) than from gaps in mutual understanding of background differences. One means of influencing these attitudes is through regulating the early impressions of prospective clients. Studies of medical interns, physicians, and medical patients indicated that expectations of the doctor's omnipotence can be used to direct the treatment of medical problems (Cousins, 1977; Frank, 1961; Mason, Clark, Reeves, & Wagner, 1969). In the same way, Boulware and Holmes (1970) believe that client perceptions of therapist competence and understanding of the the client may be important to successful treatment outcomes of both majority and minority clients. According to Danish and D'Augelli (1976) and Ho (1976), some of these perceptions can be regulated prior to or during early interviews and the effect studied as it relates to different facets of the psychotherapy process.

In determining the effectiveness of the pre- and early-intervention therapeutic techniques used to counter clients'

false expectations of therapy, the investigator is faced with the task of measuring therapy outcome results. Instruments are also needed to record the use of specific impression management by the therapist. One means of determining the effect of a therapeutic intervention has been use of client questionnaires (Barrett-Lennard, 1962; Overall & Aronson, 1963; Snelbecker, 1967). These questionnaires allow the patient to describe and rate the therapist with respect to perceived therapeutic abilities. If experimental attempts to manage specific impressions are successful, and/or discrepant treatment expectations are confronted, therapists involved may be rated more positively on a therapy rating scale. Singer (1977) and Snelbecker (1967) have shown this to be true in some cases.

Another method of measuring the effect of psychotherapy is to look at the termination patterns of clients exposed to various interventions. From the work of Frank, Hoehn-Saric, Imber, Liberman, and Stone (1978), assumptions may be made that clients who discover that therapy is different from their expectations and/or who fail to perceive their therapist as competent are likely to terminate prematurely. Premature terminations include (a) stopping therapy attendance before there is relief of symptoms and (b) stopping therapy before the therapist feels it is indicated. Efforts to increase the duration of therapy and reduce premature terminations have met with mixed success. An increased

discrepancy between patient and therapist treatment expectations as the independent variable has been shown to increase the number of clients dropping out of treatment in at least five studies (Garfield, Affleck, & Muffly, 1963; Goldstein, 1960b; Heine & Trosman, 1960; Rickels, 1968; Singer, 1977). Although Korchin (1980) showed treatment styles to affect termination rates, Holliday (1978) and Jurich (1979) were unable to verify statistically the effects of treatment variables on dropout rates.

Research concerned with minority issues has raised questions with respect to both majority and minority populations. It has often been shown that lower class and ethnic minority populations have the largest number of erroneous expectations of therapy (Goin, Yamamoto, & Silverman, 1965; Lorion, 1974; Reissman & Scribner, 1965), and are the most likely to drop out of therapy after the initial interviews or terminate prematurely (Heine & Trosman, 1960; Imber, Nash, & Stone, 1955; Overall & Aronson, 1963). Even though the issue has been found by Heitler (1976) to extend beyond the boundaries of minority concerns, Hunt and Cushing (1970) suggest ranking socio-economic status in order to address this issue if it is found to influence psychotherapy data. In their research they rank the socio-economic status of college students on the basis of occupation of the head of a student client's parental family. The high rank includes professional and

technical categories. The medium ranks include the clerical, sales, and skilled workers. The low rank includes the semi-skilled, operative, service workers, and unskilled laborer categories. From their study they determined that low and high rank subjects should be offered different types of therapy.

Statement of the Problem

One problem facing the psychotherapist is that clients drop out of treatment before they have gained even the minimum benefits of therapy. After studying the statistics of mental health problems, Abad, Ramos, and Boyce (1974), Fujii (1976), and Kim (1973) claimed there are too few persons utilizing mental health services. Dodd (1971) and Wilder and Coleman (1963) found that in general psychiatric clinics 20% to 57% of the patients fail to return after the initial interview, and 31% to 56% attend no more than four times. Baekeland and Lundwall (1975) found a positive relationship between temporal variables and outcome in ten of twenty studies they surveyed. However, they state that treatment length or intensity and prognostic factors were confounded in these studies and that the issue of treatment length and outcome must remain an open one until clarified by further studies. They do note, however, that despite spontaneous improvement and entry or reentry into treatment, on the average the dropout seems to do worse than the non-dropout

who perseveres in treatment. The dropout, when contacted, is less likely than the client continuing in therapy to report symptom relief and satisfaction with life.

There is a recognizable waste of time and energy resources which occurs when a client terminates prematurely. The same waste is experienced when a client fails to utilize therapy because of possible poor impression management on the part of the therapist. Ways must be found to increase the chances for success in treatment. These may include, among other things, methods to develop positive perceptions of the therapist. Utilization of the psychotherapy model forwarded by Luborsky, Auerbach, Chandler, Cohen, and Bachrach (1971) suggests that encouraging understanding and positive feelings toward therapy (and therapist) might facilitate maximal use of therapy.

Goldstein, Heller, and Sechrest (1966) have advanced their findings that clients learn best when they are given a cognitive set within which they can integrate new information. Providing realistic sets or norms for therapy early in the course of treatment may be beneficial to the client and the process of therapy. Support for this notion comes from the findings that explaining various aspects of therapy has improved the outcome of therapy (Gould, 1967; Sloane, Cristol, Peppernik, & Staples, 1970) and facilitated a quicker cooperative working relationship (Orne & Wender, 1968). To date, however, populations studied have remained

limited and few comments can be made with respect to generalized conditions.

Goldstein et al. (1966) also found that cooperative problem solving took place most effectively when both persons accepted the same goals and utilized the same methods for achieving these goals. In addition, patients' perceptions of the therapist as being competent to clarify and facilitate achievement of these goals are likely to increase the probability that the client will return to therapy and work while there. Although racial minority groups (Yamamoto, James, & Palley, 1968) and low socio-economic status (SES) minority clients (Overall & Aronson, 1963) gain the least from psychotherapy and terminate therapy at higher rates than majority clients, the issues of early termination and poor therapy utilization occur across all races, classes, and economic levels (Sue, 1977). New intervention methods which increase the utilization of mental health services are needed for majority well as minority populations.

In the present study, minority and majority student subjects were asked to imagine themselves in a client role, while listening to the voice of a client and watching the video film of a therapist doing therapy with the client. Experimental factors were manipulated by introducing the therapy interview and the therapist in differing ways. Following exposure to a particular therapeutic intervention, subjects were asked to complete a therapist rating form and

a predicted client termination/continuation scale. Subjects rated a therapist on empathic understanding, level of regard, and congruence using the Barrett-Lennard (1962) Relationship Inventory.

Degree of empathic understanding is conceived as the extent to which one person is conscious of the immediate awareness of another. Qualitatively it is an active process of desiring to know the full present and changing awareness of another person, of reaching out to receive his/her communication and meaning, and of translating his/her words and signs into experienced meaning that matches at least those aspects of his/her awareness and sense of context that are most important to him/her at the moment.

Level of regard is the general tendency (at a given time) of the various affective reactions of one person in relation to another. This may include various qualities and strengths of "positive" and "negative" feelings such as respect, dislike, contempt, and affection.

Congruence is the degree to which one person is functionally integrated in the context of his/her relationship with another. High levels imply that the person (therapist) is psychologically unthreatened and, therefore, maximally open to awareness of what the other person is communicating to him/her. It also means that the individual's capacity to discriminate between his/her own feelings or attitudes, and those of the other person, is at a maximum. An overall

rating of a person's therapeutic qualities is a Total Score which includes the factors discussed.

It was an hypothesis of this study that explaining therapy norms and the role expectations of client and therapist to subjects who could be potential clients would influence subjects' perception of a therapist in a positive direction, as predicted by Orne and Wender (1968). Subjects not receiving role or norm explanations were expected to rate these therapist traits in a less positive direction. In recognition of the literature, which portrays minority clients at a disadvantage in their association with the mental health system, a secondary hypothesis was made that minority subjects would undergo change when influenced by the experimental conditions, even when majority subjects did not.

Findings by Brabham and Thoreson (1973) lend credence to the idea that clients prefer physically disabled therapists to those who are not. In this study, an introduction with minority experience was regarded as identification with a potentially disadvantaged population. Especially with minority subjects and in keeping with the preliminary findings of Green (1974), it was therefore hypothesized that a therapist perceived as trained and experienced in minority issues would get higher ratings of empathy, regard, and congruence than a therapist perceived as not necessarily having had such specialized training.

The present study also assumes that premature terminations occur and are deleterious in enough cases to warrant efforts to decrease them. Partially supported by the research of Heine and Trosman (1960) and Heitler (1976), the purposeful establishment of therapist credibility and open consideration of discrepant therapy expectations may be two factors which can serve to alleviate much of the tendency for all clients to leave therapy after an initial interview or before indicated. This may be particularly true for minority clients. The present research was an effort to further answer the question, "Does impression management and concern for discrepant therapy expectations alleviate the drop out rate of majority and non-majority clients?" The study compared rates of predicted terminations of majority and non-majority subjects with subjects' responses following exposure to the experimental conditions of specific impression management and discrepancy clarification.

It was a hypothesis of this study that, in comparison to the condition where pre-therapy expectations were not specifically dealt with and a minority introduction by the therapist was not used, utilization of either of these factors singly or in combination would influence subjects to predict longer participation in therapy for an identified with client. A secondary hypothesis stated that minority subjects would register change when influenced by the experimental conditions even when majority subjects did not.

In keeping with some of the earlier research which has attempted to look at the differences in progression within therapy by a majority and non-majority clientele, some over all differences were expected between the majority/non-majority groups in the present research. It was hypothesized that majority persons would significantly differ from non-majority persons in their overall more positive ratings of therapist' empathy, regard, and congruence. Also bearing in mind that a non-majority clientele typically does not remain in therapy for as long as a majority clientele, it was hypothesized that in the present research, a similar pattern would be observed in the predicted terminations of the research subjects.

CHAPTER II

REVIEW OF THE LITERATURE

Introduction

In looking empirically at the process and outcome of psychotherapy, one is immediately faced with the task of identifying specific factors related to certain aspects of the psychotherapeutic phenomenon. The following review of literature pertinent to the present study begins with an overview of studies looking at the expectations of clients prior to entering psychotherapy. This is followed by a survey of some of the methods used to educate people to the reality of therapy.

Some attention is given to the roles therapists fill in relation to the client. This includes some attention being given to the results of minority research which looks at the match between therapist and client. Some of the means by which therapist role definitions can be manipulated are then outlined.

Finally, the outcome determinants of therapies are surveyed. Premature termination is one major area within this topic area. Rating scales to measure therapist attributes are also reviewed.

Client Expectations of Psychotherapy

An entire subject area, which the present study will ignore, is that of therapist expectations of the client when he or she enters therapy. The present review looks, rather, at the expectations clients may have of therapy and of the therapist. Early observational studies noted that, in general, low-income clients came to therapy uncertain about the appropriateness and efficacy of therapy (Hollingshead & Redlich, 1958) and frightened and ashamed of needing therapy (Redlich, Hollingshead, & Bellis, 1955). Later studies, which used more direct assessment techniques to determine patient expectations, have found more specific and varying responses.

Kadushin (1969) observed few social class related differences in initial attitudes and expectations of clients on an extensive questionnaire. Similar results were found in large student samples (Fisher & Cohen, 1972; Fisher & Turner, 1970). These studies dealt mainly with white subjects and thus are not necessarily representative of minority subject expectations. Two studies (Aronson & Overall, 1963; Overall & Aronson, 1963) using at least some non-majority subjects showed some differences between lower and upper socio-economic status clients. Low SES clients had stronger expectancies for an active supportive therapist. A later replication of these studies by Williams, Lipman, Uhlenhuth, Rickels, Covi, and Mock (1967)

reported similar results but the differences between upper and lower SES groups were not so apparent. Lorion (1972) did a follow up study and found that subjects from all social levels were equal in their expectancies prior to the therapy encounter. Although Garfield (1971) concludes that all social groups share misconceptions about treatment equally, the issue is not conclusively settled in the minds of contemporary researchers.

Atkinson, Maruyama, and Matsui (1978) believe that much clarification of expectations of therapy has yet to be done. They found that although majority subjects expect and prefer affective therapy techniques, Asian American minority subjects expect and prefer a logical, rational, structured therapy approach. There is further support for these ideas by a number of authors who have suggested that affective therapeutic techniques may actually be counter-productive for minority clients when they are expecting the more structural type of therapy (Banks, 1972; Sue, 1973; Williams & Kirkland, 1971). Affective therapy is conceived of in this case as the Rogerian style of therapy which facilitates therapeutic process through reflection and non-directive acceptance.

All possible matched samples of clients from different economic, cultural, and racial backgrounds have not been studied. Thus it is impossible to state as fact that there are differences in the mean expectations of different

groups. At any rate, when one looks at expectations of clients prior to therapy, one can find support for Garfield's (1971) findings that expectations tend to be similar in any group of naive psychotherapy clients. Garfield (1971) and Lorion (1972) reported that all their subjects expected therapy to require only a few sessions - generally five to ten. Not surprisingly, these expectations did not differ much from the actual national statistical mean of temporal duration in therapy. Other expectations noted by Overall et al. (1963) are that therapists will assume an active, medical role in the interview. Therapists are thus expected to do most of the talking and provide and prescribe cures for the problems. Although Abad, Ramos, and Boyce (1974) attempted to describe Spanish speaking minorities as different from majority clients, they too found that their samples typically hoped for advice giving rather than introspective reflection. Gould (1967) and Heine and Trosman (1960) found that patients generally expected the therapist to have nearly full responsibility for the cure process. Again, although attempting to make a differential point, Berman (1979) found that black clients preferred their therapists to take an active role.

In looking at the literature, although there is some confusion with respect to degrees of difference, researchers have documented the preferences and expectations of individuals initially seeking therapy. They discovered that many of

them want an active, problem solving therapist who refrains from excessive passivity and reflection. Therapists feel they offer services different from the expectations of some clients (Overall et al., 1963), and attempts have been made to educate prospective clients to the probable therapies likely to be offered.

Wilkins (1973) reviewed much of the early literature which has claimed that the clients' expectancies determined the outcome of psychotherapy. He pointed out in his paper that the historical background of this belief is linked with retrospective accounts of placebos, brainwashing, witchcraft, and religious beliefs. Empirically this expectancy has been treated either as a trait characteristic of a subject or a state experimentally induced by instructions. He further claimed that from the results of empirical studies, there is no certainty that a causal relationship exists between expectancy and therapeutic gain. He pointed out that many studies used client self reports, some of them based on predictions prior to actual therapy. None of these studies, however, related expectancy factors to objective measures of symptom reduction. Because studies which found that therapeutic gains increased with manipulation of expectancies were generally not blind studies, the issue was not fully delineated. Other studies indicated therapeutic gain may be mostly determined by the therapist's expectancies. Wilkins further reported that in the studies reviewed, the presence

or absence of expectancy state was identified by the outcome which expectancy was said to produce. This reasoning is circular and therefore a caution from this review seems to be that an effort needs to be made to specify the variables of observed change.

Pre- and Early-Interview Techniques

The issue of clients' expectations prior to therapy may be divided into many different facets, but a basic need is to inform clients of what they could expect (Duckro, Beal, & George, 1979). A number of different methods have been used, one of them being the anticipatory socialization interview by Orne and Wender (1968). Jacobs, Charles, Jacobs, Weinstein, and Mann (1972) used a variant of this socialization-to-therapy interview. It consisted of a 15-minute orientation for treatment given by a professional other than the therapist. The presentation attempted to differentiate, for the client, treatment received from the family doctor or surgeon and that received from or with a pschotherapist. It also mentioned discrepant expectations of some clients entering psychotherapy and attempted to remediate this as a problem by explaining the active role expected of a client in therapy. A secondary purpose was to provide some rational basis for the patient to accept psychotherapy as a means of dealing with problems, questions, or actualization.

Albronda, Dean, and Starkweather (1964) utilized early interview techniques to deal with expectations of patients entering psychotherapy. They trained psychiatric social workers to help clients formulate their problems and treatment goals. Barton (1971) and Mann (1973) lend theoretical support to the necessity of spending early contact time in specifically dealing with problem areas and hoped for solutions in therapy.

In studies at the Phipps Psychiatric Clinic, Hoehn-Saric, Frank, Imber, Nash, Stone, and Battle (1964) used a "role induction interview" which was designed to develop accurate therapy expectations. This study along with later ones (Frank, 1978; Heitler, 1973;Schonfield, Stone, Hoehn-Saric, Imber, & Pande, 1969; Sloane et al., 1970; Strupp & Bloxom, 1973) basically informed prospective clients of high probability occurences in therapy. It taught them some of the guidelines useful in taking on the role of a psychotherapy client. Some of them attempted to give reasons for entering therapy and the validity of such an experience.

A variant on the verbal role induction pre-interview session is the use of modeling films of tape recordings to educate potential clients. Films and tape recordings have been used to convey much detailed and explicit additional information about expected behaviors in therapy (Heller, 1969; Long, 1968; Truax & Carkhuff, 1968; Truax & Wargo, 1969; Whalen, 1969). By using this media, clients could be

taught how other clients often explore themselves and their feelings in therapy.

One final variant to be mentioned is the use of ongoing intake groups which attempt to educate patients within the intake procedure. Such a group was studied and used by Dibner, Palmer, Cohen, and Gofstein (1963) to prepare patients to accept psychotherapy and to offer a means to best utilize it. It helped clients mainly by orienting them to the requirements and the potential benefits of treatment.

Perceptions of the Therapist

Another major area which has been explored, related directly to the process of psychotherapy, is the perceptions of the therapist by the client. Research on minority and majority clients has looked at this area in a particular way, attempting to define the best therapist for a given client. A great deal of work has gone into attempts to decide whether particular clients work best with particular racial or cultural background therapists. Although no conclusive evidence has been found stating that, in all cases, one type of therapist is better perceived than any other, a look at some of the studies may prove beneficial in understanding the issue.

Some of the research takes a polemic stance in suggesting that clients of particular social class and racial backgrounds benefit most in therapy, and are matched best in

their expectations, with therapists from similar racial and social backgrounds (Banks, Berenson, & Carkhuff, 1967; Carkhuff & Pierce, 1967; Thompson & Cimbolic, 1978; Wolkon, Moriwaki, & Williams, 1973). These authors claim that in most circumstances, clients will not feel understood by or put trust in a therapist who is of a different color or social background from themselves. Even though white clients filling out response forms depict themselves as open to any type of therapist, the same responses are not found among minority clientele (Wolkon et al., 1973).

Other authors are quick to point out that one major issue which needs consideration when looking at client therapist match is that of language (Brown, Stein, Huang, & Harris, 1973; Smith, Burlew, Mosley, & Whitney, 1978; Sue, 1973). Banks (1972) suggests that client therapist similarity is important because of his finding that therapists are often unable to transcend the parameters of their own cultural reference points. Vontress (1971) believes that it is an injustice to minority clients to give them anything but a therapist who has lived at some time in a similar cultural mileau. The implication here, taken to an extreme degree, is that many successful client therapist matches will be difficult to obtain. This is in keeping with the idea that most everyone is a minority to some degree considering the context given.

There are researchers who disagree with those persons who stress the necessity of pairing similar background therapists with clients. Sue (1978) has made several statements suggesting that because of ignorance, majority therapists at times fail to perceive pathology and illness in minority clients. A logical extension of this suggestion is that with lack of and deficiencies in any kind of therapist training, pathology might go unperceived. Olmedo and Lopez (1977) state that when attempts are made to treat minority clients, differences in culture and interactional norms, prejudices, linguistic barriers, and cultural insensitivities inhibit successful outcomes. Zaro, Barach, Nedelman, and Dreiblatt (1977), in their primer for beginning therapists, imply that any time differences are not dealt with by any therapist, successful outcomes stand to be inhibited.

In recent years the American Psychological Association ("Minority Graduate Enrollments," 1977) has given heed to demands for an effort to remediate past and continuing deficiences in the area of minority mental health needs. Some of this effort has assumed the necessity of training therapists in minority issues. Siegel (1974) promotes the idea that despite much clinical speculation about the possible inability of white clinicians to help black patients, there is little research evidence to suggest that this is the case. In an outpatient setting he found that blacks

responded well to competent whites in helping roles. Abad, Ramos, and Boyce (1974) found that when therapists were sophisticated and sensitive enough to recognize the clients' needs to learn the discrimination between personal and social problems, there was the chance for positive treatment outcomes with a Hispanic clientele. Babcock and Caudill (1958) state that, despite the strong influence of culture and race on behavior, problems are basically similar and were resolved in their study, regardless of client and therapist matching. Duckro, Beal, and George (1979) found that therapists could be trained to transcend the differences in background. Lorion (1973), taking somewhat of a middle stance, claims that although therapists from a low SES background are equally successful with clients from all social classes, therapists from middle and upper SES backgrounds are not as successful in working with low SES clients. At present it is impossible to say whether this is due to deficiencies in training and/or therapist characteristics and/or client perceptions.

Other researchers have pointed out that although racial groups can often be differentiated with respect to their pathologies and expectations for treatment (Osako, 1976; Sue, 1973; Tanaka-Matsumi & Marsella, 1976), differences are not necessarily found between racially different or similar therapists being able to understand those differences. Both can be equally qualified to treat and diagnose pathology.

Luborsky et al. (1971) reviewed a number of studies that dealt with client-therapist ratings. They found that a feeling of similarity on variables such as social-class, interests, and values was important to client raters. Boulware and Holmes (1970) suggest that client perceptions of therapist competence and ability to understand may be more important than perceptions of similarity. Frank (1961) reported a study which found that 70% of 150 clients returning for therapy, following an initial interview, made that decision based on their liking of the therapist. This liking was influenced by perceived sincerity, amount of energy, and controlled warmth. Liked therapists were also rated as tolerant, respectful, supportive, accepting, and self confident. Acosta and Sheehan (1976) found that therapist's ratings fluctuated according to perceived attributes of skill, understanding, trustworthiness, and attractiveness--sometimes linked to racial factors.

One of the outcomes of research looking at clients' perceptions of therapists has been the fostering of studies which have deliberately varied the profile definition of the therapist. Brabham and Thoreson (1973) report that physically disabled and able bodied clients significantly differed in their preference for disabled therapists over normals. The implication is that handicapped or disadvantaged therapists who are subject to stereotyping and discrimination may command greater credibility than the more

conventional therapist. Acosta et al. (1976) found similar results in that a minority non-professional therapist had better therapeutic results than did a professional therapist of the clients' race.

An extension of the idea that therapist impressions can be managed is shown in the work of researchers (Greenberg, 1969; Greenberg, Goldstein, & Gable, 1971; Greenberg, Goldstein, & Perry, 1970) who varied client perceptions of therapists through pre-interview impression management. Subjects received varying information structuring the therapists along continuums of warm or cold and experienced or unexperienced. Therapists perceived as warm and experienced were rated higher than their counterparts. Even a 15-minute lecture to therapists, stressing issues often encountered in working with clients with misperceptions and differing cultural expectations, has increased the appropriateness of in-therapy behavior (Jacobs et al., 1972). Greenberg's research has implications for simply creating a set in the client, such that he/she perceives the therapist as experientially and culturally labile as well as overall professionally knowledgeable.

Outcome Determinants

There is some theoretical and research evidence to suggest that some mutuality of patient - therapist role expectations is crucial to positive therapy outcomes (Clemes &

D'Andrea, 1965; Heine & Trosman, 1960; Orne & Wender, 1968). There is also some experimental evidence that an explicit attempt to socialize the patient's role expectations in a preparatory interview prior to therapy can enhance the patient's use of psychotherapy (Heitler, 1973; Hoehn-Saric et al., 1964; Jacobs et al., 1972; Sloane et al., 1970; Strupp and Bloxom, 1973).

Rates of premature termination have been one of the means used to determine pre- and early-interview technique effectiveness. Jacobs et al. (1972) testify to the significance of the initial interview and premature terminations in noting that, in their clinic, more than one-third of all the patients who terminated did so after their first interview. In their study, preparatory sessions decreased the rate of premature termination. A discrepancy between patient and therapist treatment expectations has been shown to correlate with premature termination in at least some other studies (Freedman, Engelhardt, Hankoff, Glick, Kaye, Buchwald, & Stark, 1958; Garfield, Affleck, & Muffly, 1963; Goldstein, 1960b; Heine et al., 1960; Overall et al., 1963; Rickels, 1968; Rickels & Anderson, 1969).

Patient's expectations about appropriate role behaviors in therapy also shape the course of treatment. The importance of patient expectations to treatment variables such as duration (Lorr & McNair, 1964), attrition rates (Overall et al., 1963) and outcome (Leonard & Bernstein, 1960), as well

as patient discomfort (Baum & Felzer, 1964) and participation (Kamin & Caughlin, 1963; Levitt, 1966; White, Fichtenbaum, & Dollard, 1964), have been demonstrated. A more recent study by Holliday (1979) found that the longer a person stays in treatment the more likely there is to be improvement, but preparation for therapy did not appear to decrease the drop-out rates. In work with a military population, Jurich (1978) found similar results. Singer (1978) found the greater the discrepancy between a patient's anticipations and perceptions of the initial interview, the less likely that patient was to continue in therapy. The implication here is that pre-interview techniques may have little effect on termination rates if the patient correctly anticipates therapy in the way it is offered. If the discrepancies are large, early interview interventions may be crucial with respect to continuation in therapy.

With regard to clients' ratings of what they expect from their therapist, feelings of warmth and perceptions of expertise appear to be important (Acosta et al., 1976). According to rating scales used by Baekeland and Lundwall (1975), therapist attitudes and behavior seems to loom even larger than SES and motivation in determining whether a patient will stay in treatment. These researchers also found that traits of ethnocentrism, unconcern, permissiveness, introversion, and detachment correlate with dropping out of treatment. A significant positive relationship has

been found between therapist experience and length of patient stay (Baum, Felzer, D'Zmura, & Shumaker, 1966; Poser, 1966). Greenwald and Bartemeier (1963) found that a global rating of resident effectiveness was significantly related to the frequency of discharge of general psychiatric inpatients from psychiatric inpatient treatment against medical advice.

Various research scales have been developed in order to determine the attitudes and perceptions of clients seeking professional help for psychological disturbances. Truax and Carkhuff (1967) have developed and directed a great deal of research on a scale for assessment of interpersonal functioning. This scale which measures empathy, communication of respect, facilitative genuineness and self-disclosure, among other traits, has been used to gather information from clients concerning their therapists attributes. The scale has been found to differentiate, therapists on their abilities to facilitate better treatment outcomes dependent on trait factors such as empathy and/or congruence (Carkhuff, 1969). Another attitude scale developed by Fisher and Turner (1970) was able to rate therapist openness and general expertise. Fisher and Turner (1970) suggest that a clients' perceptions of the therapist can be crucial to a clients' decision to remain in therapy or drop out.

Barrett-Lennard (1962) developed the Relationship Inventory scale on which a client rates a therapist with

regard to empathic understanding, level of regard, unconditionality of regard, and congruence. Empathic understanding is the active process of desiring to know the full present and changing awareness of another person. Level of regard refers to the quality and strength of "positive" and "negative" feelings. Unconditionality of regard refers to the variability of the regard. Congruence implies a person is psychologically non-threatened and, therefore, maximally open to awareness of what another is communicating, while at the same time being able to discriminate between the self and an other. The scale upheld the hypothesis of its being able to differentiate between "expert" and "non-expert" therapists and to show a correlation between expertness and greater change in therapy. The scale was later used by Snelbecker (1967) to determine client preferences for directive or non-directive therapists and was able to differentiate the two types.

Choosing one aspect of a therapist's rated profile such as empathy, Banks et al. (1967) found evidence that therapists with high empathy ratings are preferred by minority clients to those with less empathy. Using their own questionnaire which looked at therapist variables such as active, passive, and supportive, Overall and Aronson (1963) found support for the idea that when therapist ratings are low in terms of what they expect, clients are less likely to return for further treatment. Truax and Carkhuff (1967) studied

client ratings of therapists and the correlation of the ratings to different outcomes. They found that clients valued the constructs of therapist genuineness, non-possessive warmth, and empathy. Patients who showed improvement in therapy had therapists with highly rated accurate empathy. Patients showing little improvement rated their therapists as being unable to be empathic, and deficient in their ability to show high levels of positive regard. These findings tended to hold true only for outpatient clients and not with inpatient clients. Truax and Carkhuff discovered that client variableness did not affect the typical empathy and congruence traits of a given therapist. They also found that patients tend to equate successful treatment with being able to express their feelings and gain insights in the presence of interested and understanding therapists. McNair, Lorr, and Callahan (1963) found that therapists perceived as not interested in their problems are most likely to be terminated by their clients. There seems to be some justification for the implication suggesting poor ratings of therapists by their clients is linked to utilization and outcome in therapy.

A final summary of the literature reviewed must note an inability to generalize from research results when dealing with pre- and early-interview intervention studies. It appears that, in some cases, discrepant therapy expectations are linked to early termination and under-utilization of

therapy. Although there appears to be growing awareness that perhaps the majority of first-time clients to psychotherapy have expectations discrepant from the view of therapists, there is still some question whether differences exist among persons from differing economic levels and cultural backgrounds. There is as yet no certainty that attempts to reduce early terminations work; although for the most part, early terminations appear to indicate poorer results in therapy and wasted effort on the part of the mental health professions. There is surely the need for clarification of the presently reviewed factors in the psychotherapeutic process. With these summary statements in mind, it is a hypothesis of this study that in attempting to clarify for prospective clients the conditions of therapy and expertise of a therapist, factors within the therapeutic process can be affected. More specifically, discussion of expectancies and therapist claims of expertise in minority issues are expected to increase (a) the predicted duration of therapy attendance and (b) the positive ratings of therapist traits including empathy, congruence, and conditions of regard.

CHAPTER III

METHODOLOGY

Subjects

The subjects were 48 male and 48 female white (majority) students and 48 male and 48 female black (non-majority) students enrolled in social science classes at two midwestern universities. One university was predominantly white and the other was predominantly black. Blacks from both universities were used as well as whites. The participating subjects were randomly selected from a pool of students, from the previously mentioned universities, who volunteered to participate in research. Subjects selected were United States citizens between the ages of 18 and 25 and all were registered as undergraduates in at least one social science course. Following their participation, subjects were assigned a socio-economic status rank of high, medium, or low based on the occupation of the head of their parental family. These status assignments were made from students' responses concerning parental occupation, given on the demographic questionnaire referred to in the Procedure section. The three occupational ranks were those developed by Hunt and Cushing (1970).

Apparatus

Two audio-visual tapes of a simulated psychotherapy interview were produced. The scripts were written by the present investigator and were developed by him to be as free as possible from sex-bias. Graduate students familiar with the procedure of psychotherapy were used to enact the roles of therapist and client. The role of therapist was played by a majority male actor who appeared on both of the audio-visual tapes. He was shown in the film sitting at a 30 degree angle to the subject viewer. The role of client was enacted by a second male actor on both tapes. The client actor made only a voice recording which sounded male with respect to sex, and as nonidentifiable with respect to a specific cultural background as was possible. The sound recordings of the client were identical on both tapes and the client actor was never seen by the subjects involved in this research.

The main difference between the two performances of the therapist-actor was that in one tape he introduced himself as having been trained in minority issues, as having had a difficult time earlier in life, and as having had a wide background of experiences in understanding cultural and personal variables. The therapist in the other tape was depicted as having been trained only in a standard majority culture setting.

The therapy tape presented an anxious, depressed, and at times angry sounding young person participating in an initial therapy interview. Client statements were identical in both tapes. Therapist responses included questions, reflections, and occasional silence--and were identical in both tapes. The therapy transcript is included in Appendix A.

Procedure

Ninety-six subjects in the majority group were randomly assigned to one of four experimental condition (I, II, III, and IV), with equal numbers of males and females in each. Ninety-six minority subjects were similarly divided. Male and female subjects participated in separate groups in all cases. This separation allowed the investigator to present the client voice as potentially nonsignificant with respect to sex as well as to race. Each subject completed a brief demographic questionnaire (see Appendix B), followed by the experimental conditions which included viewing one audio-visual tape. The subjects were told to assume, for the duration of the experiment, they were the client being interviewed by the therapist. They were told, however, that the client voice they heard would enact their lines for them. They needed only to watch the therapist and listen to the lines being spoken. The specific introduction was as follows:

> During the next ten minutes you will be participating in a psychotherapy session. It is a first time interview. On the screen you will observe a therapist working with a client. As best you can, put yourself into the client role. We have arranged for your lines to be spoken for you by the person you will hear on the tape. Even though it is unlikely the voice will sound exactly like your own, keep in mind the content and feeling of the discussion are important - rather than the identity of the voice. While the tape is running, imagine yourself seated in your present position, about five feet away from the therapist.
>
> The psychotherapist you are about to meet on this tape is a graduate student in clinical psychology. He has all but completed the requirements for his doctoral degree. His training includes the usual comprehensive training received by clinical psychologists who attended accredited institutions. [Condition II - In addition, because of interests stemming from his own background, he has received specialized training in dealing with minority issues and concerns.]
>
> Act now as though you are relating to this therapist, with the voice saying your lines for you.

Experimental group I then observed Tape #1 which showed an enactment of a standard trained therapist in session with a client. Experimental group II was first presented with a brief lecture which highlighted client expectations of therapy possibly discrepant from the professional community (see Appendix C). The group then observed Tape #1. Experimental group III observed Tape #2 depicting a therapist allegedly trained and experienced with minority issues. Experimental group IV received the brief lecture on possibly discrepant expectations and observed Tape #2. The experimental conditions and group number locations are shown in Figure 1.

	No Pre-Interview Expectations Discussion	Pre-Interview Expectations Discussion
Standard Pitch	Group I	Group II
Minority Pitch	Group III	Group IV

All groups included equal numbers of subjects with respect to sex and race.

Figure 1. Graphic Portrayal of the Treatment Design

Following the interview observation, each group was asked to rate the therapist on the Barrett-Lennard scale, Relationship Inventory, depicting therapist traits of empathy, congruence and regard (Barrett-Lennard, 1962). (See Appendix D.) Subjects were then asked to state their determination of whether the client would return for therapy and for how many sessions, using a termination scale constructed by the present investigator. (See Appendix E.) Subjects were also given an opportunity to state what factors would determine termination or continuation in therapy. Finally, subjects were debriefed and given an opportunity to ask questions, critique, and/or discuss the study.

Design

The experimental design is a 2 (sex) x 2 (race) x 2 (introduction) x 2 (pitch) factorial design consisting of the two experimental factors of Introduction versus No Introduction and Pitch versus No Pitch and the classification factors of Sex and Race. A four-way fixed-effects analysis of variance was used to test for main effect differences due to race and sex, as well as simple main effects on each of the treatment factors across race and sex. Significance was determined by comparing the F statistics against a .05 probability for a Type I error. Interactions were also tested with respect to the effect of race combined with the treatment factors. When interactions were

found to be significant following the analysis of variance, further tests of significance were determined in a post hoc fashion.

CHAPTER IV

RESULTS

The analysis of the data is presented in two sections. The first analysis assesses the influence of the independent variables of sex, race, introduction to therapy, and claim of minority concern on the rating of therapeutic traits which include empathy, positive regard, and congruence. An overall summation of these trait scores is referred to as the Total Score whereby a therapist is rated positively or negatively. In all cases, the higher the score, the more positive is the assessment of the therapist.

The second section looks at predictions of termination as the dependent variable. The possible selections are coded with a score of "8" meaning the person would terminate therapy after the first session and "1" meaning termination would not occur until the therapist suggested it. Values in between stand for incremented lengths of time for therapy varying from one session to one year.

One final introductory statement must be made with reference to the sociocultural status of the sample population. A Chi-square test was performed to determine if sociocultural differences occurred in the research sample,

between sex groups and race groups . In terms of upper, middle, and lower status, no differences existed between male and female subjects, $\underline{X}^2 = 1.08$, $\underline{p} < .58$. Between the black and white race groups, there was a significant difference, $\underline{X}^2 = 15.74$, $\underline{p} < .001$. Even though there was a similar number of middle status subjects in each group, there were significantly greater numbers of lower status blacks than whites, as well as fewer upper status blacks than whites. As a result of this finding, comments made throughout the results section with reference to race will also imply a sociocultural difference in status between the two groups. In this case, minority or non-majority references will include not only the race factor but also a factor due to occupational status in the family.

Assessment of Therapist Traits

The overall analysis of variance for the total sum of the combination of variables used to rate the therapist is shown in Table I. The main effects of therapy introduction and minority pitch impression management were not found to be significant in the overall design. Thus the general research hypothesis that, by themselves, introduction and pitch would effect change in the subjects was not upheld. The classification variable of race was found significant with white subjects rating a therapist more positively than black subjects. Table II shows a list of means and standard

TABLE I

ANOVA OF THE EFFECTS OF SEX, RACE, INTRODUCTION, AND MINORITY PITCH ON THE OVERALL RATING OF A THERAPIST

Source	SS	df	MS	F
A (Race)	10650.52	1	10650.52	10.98 **
B (Sex)	2836.69	1	2836.69	2.92
C (Introduction)	927.52	1	927.52	0.96
D (Pitch)	1073.52	1	1073.52	1.11
A X B	2.08	1	2.08	0.00
A X C	4408.33	1	4408.33	4.54 *
B X C	44.08	1	44.08	0.05
A X D	2914.08	1	2914.08	3.00
B X D	1260.75	1	1260.75	1.30
C X D	3780.75	1	3780.75	3.90 *
A X B X C	0.02	1	0.02	0.00
A X B X D	25.52	1	25.52	0.03
A X C X D	117.19	1	117.19	0.12
B X C X D	77.52	1	77.52	0.08
A X B X C X D	60.75	1	60.75	0.06
Error	170728.33	176	970.05	
Total	198907.67	191		

**p less than .01.
*p less than .05.

TABLE II

MEANS AND STANDARD DEVIATIONS OF THERAPIST RATING SCORES, DIVIDED BY RACE

Variables	N	Mean	Standard Deviation
		Race: Black	
Total	96	36.09	33.07
Regard	96	17.72	14.03
Empathy	96	7.66	10.17
Congruence	96	10.72	13.08
		Race: White	
Total	96	50.99	29.79
Regard	96	24.86	11.06
Empathy	96	9.69	11.57
Congruence	96	16.44	11.55

deviations. The higher Total Score mean for white subjects is support for the hypothesis that white subjects will rate a white therapist more positively than their black counterparts.

There is a significant two way interaction of race with introduction to therapy (see Table I). Analysis of variance on the simple main effects with regard to introduction shows that when there is no introduction given, white subjects rate a therapist significantly more positive than black subjects, F (1, 176) = 14.826, $p < .01$ (see Figure 2.). When an introduction to therapy is given, these two race groups cannot be differentiated, F (1, 176) = .698, n.s. Looking at this effect with regard to race, (see Figure 3.), when black subjects are given an introduction to therapy and then asked to rate a therapist in a simulated therapy scene, they rate the therapist more positively than when they are given no introduction, F (1, 176) = 4.83, $p < .05$. White subjects, on the other hand, do not show a significant difference when introduced to therapy norms and when dealing with a therapy experience unprepared, F (1, 176) = .667, n.s. The interpretation of this interaction effect is in support of one secondary hypothesis that black subjects may be affected by the experimental manipulation of an introduction to therapy even though white subjects may not be.

On the overall or Total therapist rating variable, the

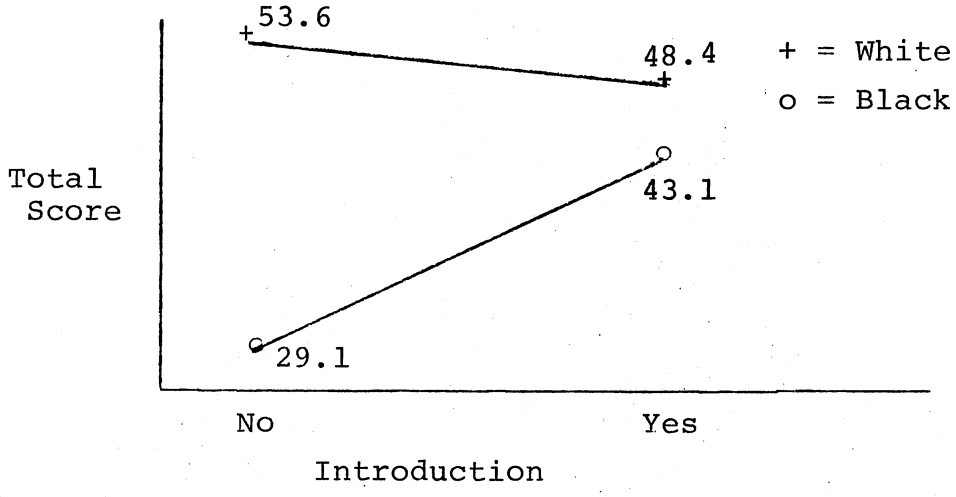

Figure 2. For Total Score, Interaction Effect of Race at Each Level of an Introduction

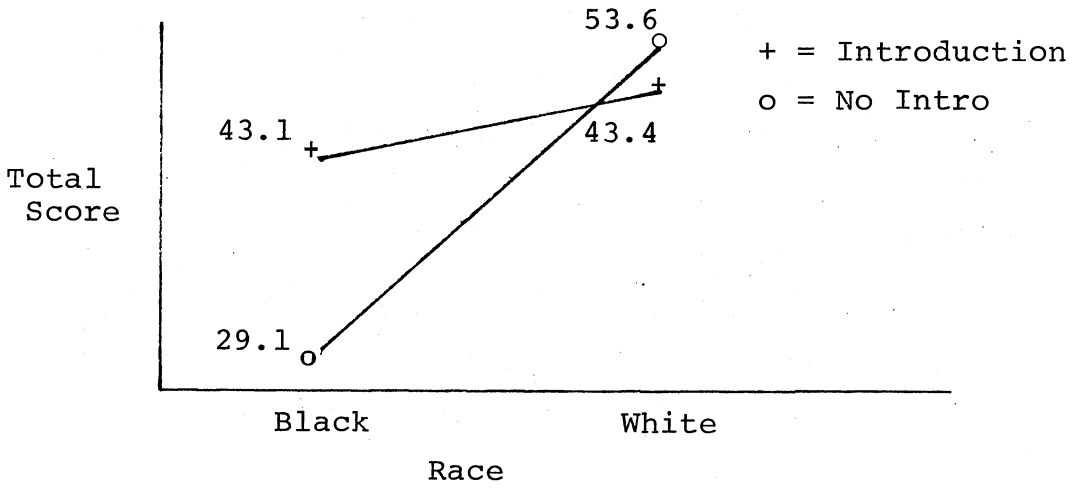

Figure 3. For Total Score, Interaction Effect of an Introduction at Each Level of Race

final interaction which proved significant was the interaction between the therapy norm introduction and impression management by reference to minority training, i.e., the pitch (see Table 1). When looking at the simple main effects at the two levels of the introduction variable, when no introduction was given subjects in general rated a therapist more positively when they were also told he had a background dealing with minority issues, $\underline{F}$ (1, 176) = 4.58, $\underline{p}$ < .05 (see Figure 4.). In the case where an introduction to therapy was given, the additional effect of the therapist claiming training with a minority emphasis had no effect, $\underline{F}$ (1, 176) = .425, n.s. When analyzed from the perspective of change on the minority pitch variable, the results again are basically similar. In a situation in which the therapist claims no specialized background in minority issues, subjects told what to expect in a therapy experience rated a therapist more positively than did subjects given no such introduction, $\underline{F}$ (1, 176) = 4.36, $\underline{p}$ < .05.

When the therapist claimed expertise in minority issues, an introduction to therapy or lack thereof did not effect a significant difference, $\underline{F}$ (1, 176) = 0.50, n.s. (see Figure 5.). Interpretation of this particular interaction between introduction and impression management shows support for the hypothesis that attempts to influence therapy expectations and presentation of specific therapist credentials will effect subjects' ratings of a therapist, but

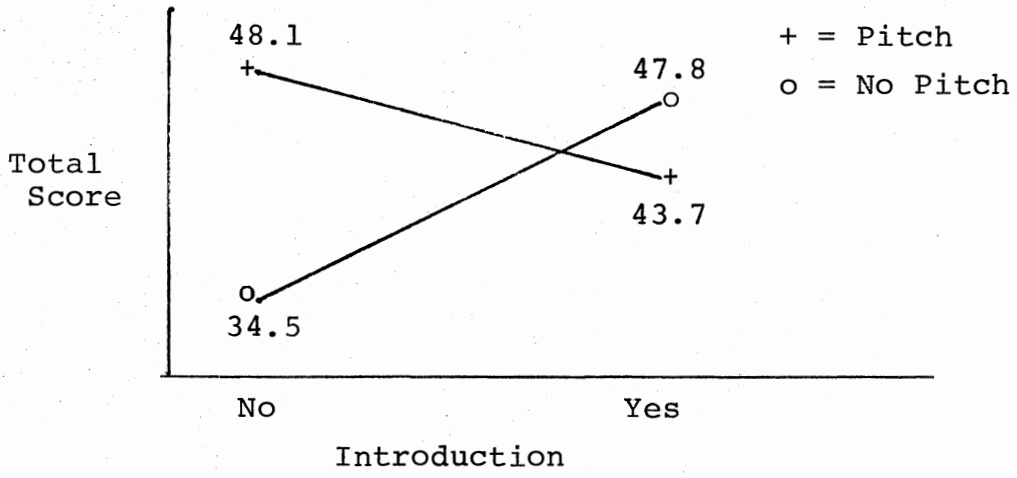

Figure 4. For Total Score, Interaction Effect of Minority Pitch at Each Level of an Introduction

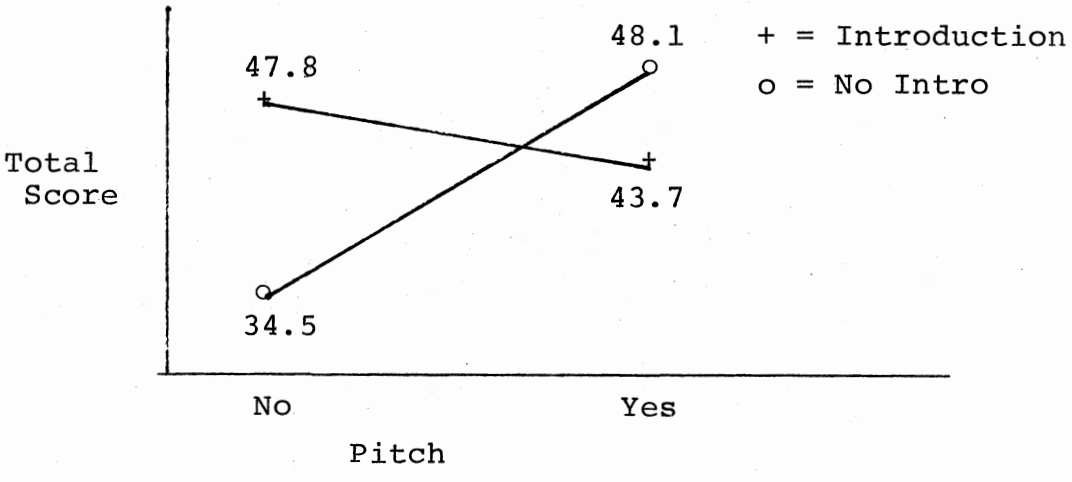

Figure 5. For Total Score, Interaction Effect of an Introduction at Each Level of a Minority Pitch

only when both variables are considered together. In either way of analyzing the interaction, it appears that in the absence of one condition or the other, there is some advantage in presenting either a therapy introduction, or to claim specialty training in minority issues. To include both early therapy techniques at once is not likely to influence a person in the direction of rating the therapist more positively.

In order to determine the feasibility of analyzing the specific components of the overall therapist ratings which include ratings of empathy, regard, and congruency, correlation coefficients for each of these variables with the Total were computed. From Table III it is apparent that the probability each of these scores is positively correlated with the Total Score is highly significant. The correlation coefficients are all above 0.85. Because these variables are significantly linked both with one another and with the Total sum, a detailed explanation of the results will not be given. In all cases, the main effects and two way interactions on each of these variables were similar to the ones encountered for the Total Scores. One additional main effect on the classification variable, sex, was significant on a rating of therapist positive regard, $\underline{F}$ (1, 176) = 4.77, $\underline{p} < .05$. Females rated the therapist significantly higher on an assessment of positive regard than did males. The mean rating for females was 23.24 and for males it was 19.34.

TABLE III

CORRELATION COEFFICIENTS FOR EACH OF THE DEPENDENT VARIABLES

	Total	Regard	Empathy	Congruence	Termination
Total	1.000				
Regard	.8776	1.000			
Empathy	.8515	.5930	1.000		
Congruence	.9079	.6919	.6955	1.000	
Termination	-.399	-.345	-.352	-.359	1.000

All p less than .0001

Similar to the total rating score for the therapist, there was a significant main effect on race (F (1, 176) = 16.04, p < .01), on the positive regard rating, as well as a significant introduction by minority pitch interaction (F (1, 176) = 6.96, p < .01). Interpretations of directionality and interaction are the same as those given for the Total rating score. White subjects rate a therapist more positively than blacks and an introduction or minority pitch by itself makes a difference on rating scores. In combination, no further change occurs.

On the dependent variable of empathy, there was a significant race by introduction interaction, F (1, 176) = 4.90, p < .05. In analysis of the simple main effects, the interpretation is again similar to the race by introduction interaction analyzed for the Total Score variable.

Analysis of the congruence variable showed race to be a significant main effect (F (1, 176) = 10.44, p < .01), which differentiated subject's scores. Again the directionality of the means was the same as that for the Total Score variable with blacks scoring a mean of 10.71 and whites with the higher mean of 16.45.

Evaluation of the overall analysis of variance on each of the dependent variables for therapist rating shows there to be no significant interactions, of higher order than the ones already addressed. Because of this, no further qualification of the main effects is necessary. In most cases,

main effects and interactions which approached significance in the analysis of variance on therapist trait dependent variables were the same ones which have already been analyzed as significant. Race, sex, introduction, minority pitch, and the two way interactions of race by introduction, race by minority pitch, and introduction by minority pitch were the only ones to approach significance.

Assessment of Predicted Termination

The final dependent variable of the present research was measured as the length of time subjects predicted they would stay in therapy. The hypothesis that blacks would predict termination of therapy earlier than whites was not statistically upheld although there appears to be some suggestion in the data of a trend in that direction (see Table IV). As main effects, an introduction to therapy norms and claims of minority background were not found significant. The main effect of sex was found to be significant in the overall analysis of variance (Table IV). Female subjects predicted that on the average, they would return for therapy for about six months whereas male subjects predicted on the average, a return of around three months. With regard to the actual way these selections were scaled, the mean response for females was 3.26 and the mean for males was 4.35.

One two way interaction was found to be significant on the termination variable. A race by introduction to therapy interaction (see Table IV) was further analyzed in order

TABLE IV

ANOVA OF THE EFFECTS OF SEX, RACE, INTRODUCTION, AND MINORITY PITCH ON THE PREDICTED LENGTH OF THERAPY BEFORE TERMINATION

Source	SS	df	MS	F	
A (race)	23.38	1	23.38	3.68	
B (Sex)	57.42	1	57.42	9.04	**
C (Introduction)	9.63	1	9.68	1.52	
D (Pitch)	1.17	1	1.17	0.18	
A X B	0.88	1	0.88	0.14	
A X C	41.26	1	41.26	6.49	*
B X C	18.13	1	18.13	2.05	
A X D	2.75	1	2.75	0.43	
B X D	13.55	1	13.55	2.13	
C X D	11.50	1	11.50	1.81	
A X B X C	4.38	1	4.38	0.69	
A X B X D	16.92	1	16.92	2.66	
A X C X D	6.38	1	6.38	1.00	
B X C X D	3.25	1	3.25	0.51	
A X B X C X D	1.17	1	1.17	0.18	
Error	1118.08	176	6.35		
Total	1329.87	191			

**p less than .01
*p less than .05

to assess the effect of an introduction to therapy at the two levels of race (see Figure 6.). As was discovered from the analysis, whether or not black subjects are given an introduction to therapy does not effect their predicted willingness to remain in therapy, F (1, 176) = .867, n.s. For whites on the other hand, when given an introduction to what therapy might be, they significantly decreased their predicted length of time in therapy, F (1, 176) = 7.14, $p < .01$. When given no introduction they predicted a mean length for therapy of 2.7 which is a bit over six months. When an introduction was given, the mean jumped to 4.1 which translates into approximately three months. In this case, not only was the original hypothesis that an introduction would increase the predicted length of time in therapy not upheld, but in the case of white subjects the reverse was found to be true.

Another way of looking at the two way interaction of race by introduction is shown in Figure 7. In looking at race characteristics at each level of the introduction, there is a significant mean difference between white and black subjects when no introduction is given (F (1, 176) = 9.98, $p < .01$), but none when an introduction is given (F (1, 176) = 0.20, n.s.). With no introduction to either group, black subjects predicted a briefer length of time in therapy with a mean of 4.4 than did white subjects with a mean of 2.7. In terms of months, black subjects predicted

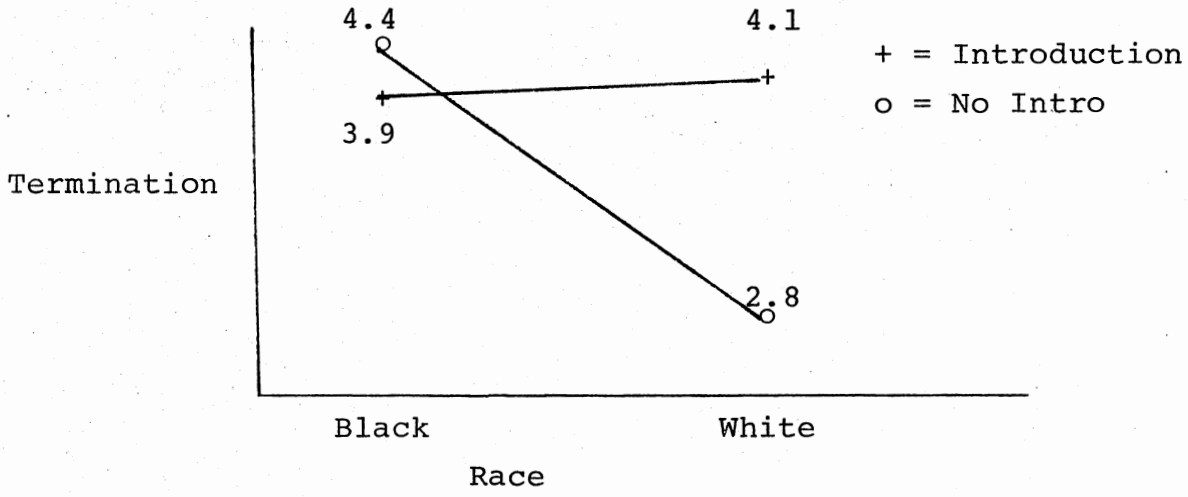

Figure 6. For Termination, Interaction Effect of an Introduction at Each Level of Race

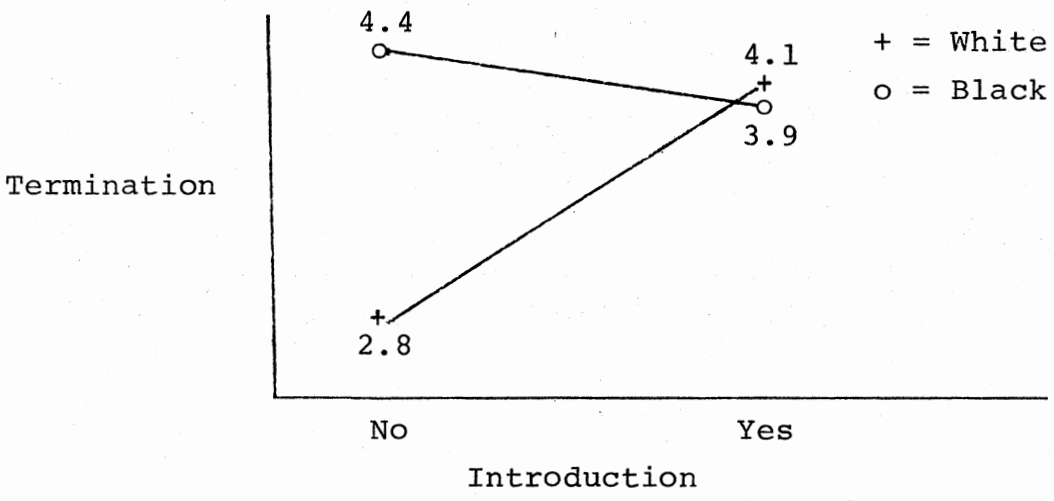

Figure 7. For Termination, Interaction Effect of Race at Each Level of an Introduction

continuation in therapy for approximately three months, and whites, longer than six months. With an introduction, both groups predicted the length of time in therapy to be around three months. In this case, the hypothesis that a non-majority group would terminate therapy earlier than a majority group was upheld, but only when both groups were given no explicit introduction to the format of therapy.

CHAPTER V

DISCUSSION

The issue of both therapeutic outcome and training of therapists to conduct psychotherapy continues to be relevant at a time when the federal government is making decisions concerning funding for delivery of mental health services to specific groups, and for types of mental health training programs. The present research arose from questions raised by majority and minority researchers claiming that therapeutic processes are measureable and manipulable and different with respect to sociocultural status. Results from the present research lend support to the work of such researchers as Olmedo and Lopez (1977) who view minority persons as responding differently to therapy than do majority persons. Because the racial groups in this study were also different in terms of occupational status, minority status and/or race imply potential differences specific to, or including, sociocultural status. Within the present study, race alone was found to differentiate the subject pool on overall rating of a therapist as well as on the specific variables of positive regard and empathy. This suggests that white subjects, to a greater degree than black subjects, believed a

white therapist felt positively toward them. This occurred regardless of how the therapist structured pre-therapy exposure of himself. White subjects also perceived the therapist as more psychologically at ease with them than did a group of black subjects.

Other differences also occurred within the context of an interaction of race and an introduction to therapy. One implication from the results is that under conditions in which a white therapist is scheduled to see a black client, the therapist may assume that a reciprocated level of acceptance by the client may not be as high as in situations where the client is of the same race. This assumption may lend credence to the ideas of Wolkon et al. (1973) and Thompson and Cimbolic (1978) who suggest it is best to match similar race therapists and clients. Before this statement could be accepted as a generalization, however, it would be important to include in an expanded research paradigm, the situation in which blacks and whites are given an opportunity to rate a black therapist. Perhaps it is simply the case that on the scale utilized in this study, blacks in general would rate therapists of any race, lower than would a group of white subjects.

With respect to the ongoing question of whether an introduction to therapy is beneficial to the client, the present research offers no conclusive answer. In and of itself, the fact that subjects were told what therapy

consisted of and what things they might expect did not create an automatic increase in a subject's positive evaluation of a therapy situation. It is true, however, that explaining therapy to black clients did effect a change in the direction of more positive ratings of a therapist. It did not influence the determination of how long they would remain in therapy. For white subjects, an introduction did not change their ratings of a therapist. One suggestion from looking at this result is to recognize that using an introduction to combat lack of knowledge is likely to effect change only in the situation where in fact there is lack of knowledge. Even though Lorion (1972) and Garfield (1971) assumed from evaluations of their sample population, that all prospective clients regardless of race were unfamiliar with the structure of therapy, perhaps this is not always so. It may be the white subjects used in the present research had a fairly realistic understanding of what therapy consisted of whereas the black subjects did not. Such learning could have occurred through university courses in psychology and other personal experience. In this case, for white subjects to be given redundant information would not be expected to change how they viewed a therapist.

A more sophisticated research design might have included a means to actually measure expectations prior to therapy, and allowed for comments to be made as to the similarity or differences between white and black subjects. At

any rate, when blacks were told about the process and procedure of therapy, they rated a therapist more positively. In fact there was no significant difference on therapist rating when black and white subjects were provided opportunity for at least a temporarily similar understanding of what psychotherapy consisted of. Under the particular conditions of the present research, therapist ratings did not significantly decrease when therapy was explained to either black or white subjects. This finding suggests that no harm is elicited by introducing a clientele to therapy even in situations where it does not necessarily benefit them. Further significance in such a finding may lie in the possibility that if black clients are extended knowledge concerning psychotherapy, they may feel as positively towards any given therapist as would a white client. Consequently, the informed black client may be less prone to terminate therapy after the first session. A similar notion was described in the work of Frank (1961).

Another way of viewing this result is to assume that since both racial samples of subjects were drawn from psychology courses, although in many cases, different universities, there is really no difference in the amount of knowledge each group had about psychotherapy. If this were the case, then it could be assumed that black subjects when forced to relate with a white therapist just simply have less positive feelings for the therapist. Even in this

approach, however, a distinct advantage is gained by attempts to confront incorrect expectations or percepts in a black group of potential clients.

Even though blacks increased their rating of a therapist when told what to expect in therapy, they remained stable in their prediction of length of time they would remain in therapy. The average amount of time the black sample predicted for remaining in therapy was about three months, whether or not their perceptions of therapy were manipulated. The work of Jacobs et al. (1972) and Rickels and Anderson (1969) was not supported in this case. It may be important to note, however, that one of the generally accepted notions that most clients only remain in therapy for 3 to 13 sessions (Dodd,1971; Brown & Kosterlitz, 1964; Affleck & Garfield, 1961) was supported empirically in this study when looked at from the point of prediction. The actual dropout rate after about three months may be a message to psychotherapists that, for many people, an average of three months is approximately the amount of time they have to work with any given client. It may be significant that black subjects believed mental health problems could be effectively dealt with in three months regardless of their understanding of therapy. With more positive feelings towards a therapist resulting from a better understanding of therapy, more effective work could possibly take place. If this is the case, perceptions of the dropout-from-therapy

doing more poorly in life (Baekeland & Lundwall, 1975) may have to be tempered by the hypothesis that this is more likely in the case where the client drops out of therapy following the initial interview. If the hypothesis of Boulware and Holmes (1970) is correct, it may be true that the most important determinant of a successful therapy outcome once the client has decided to attend for three months, is the degree to which positive attitudes exist between therapist and client.

It is also interesting to note that even though white subjects given no introduction to therapy predicted a return to therapy for approximately six months, when given a specific structure within which to think about therapy, they too lowered their predicted time spent in therapy to three months. One explanation of this phenomenon is that when given a realistic view of the psychotherapeutic process, they changed their thinking to a more realistic sense of how long it would take to deal with a particular problem. In this paradigm the suggestion would follow that black subjects more accurately assessed the therapy requirements as necessitating three months' work and the white subjects acquired this understanding when the actual therapy norms were explained to them. It might also be that when subjects' perceptions of the mystique of psychotherapy were confronted with an explanation of therapy, white subjects gave up their stereotypic view that psychotherapy is a long

term process and began to view it in a more realistic fashion along with choosing to resolve their therapeutic issue in less time.

Another explanation might be that when white subjects discovered the personal responsibility they have in working through their therapeutic issue, they felt less willing to struggle towards resolution over an extended amount of time. If this were the case, the present results may reflect the fact that the stimulus transcript used in the research involved a depressed individual whose problems could be very easily viewed as situationally transient. With a depiction of more severe pathology, there is some chance subjects may have predicted a longer period of time as being necessary for resolution.

One final explanation may be related to the actual introductory transcript used. At some perceptual level, white subjects may have responded to an implicit suggestion from the introduction, which caused them to believe such therapy could be successfully completed in 12 sessions. Blacks may have correctly guessed this implicit message prior to the introduction and thus found it unnecessary to change their predictions following the introduction.

A post hoc comment of the sex difference on therapy termination can be addressed here. Regardless of race differences or experimental manipulation, females were found to predict longer periods of time in therapy than did their

male counterparts. This sex difference did not change as subjects were introduced to therapy or the therapist. Within the limits of this study, a therapist can expect females to be open to remaining in therapy for an average of six months and males for an average of three months. These results must be tempered, however, by the reported results of Baekeland and Lundwall (1975) who report that in actual practice, females tend to drop out of therapy sooner than males. Although this may not hold true for the present group of females, it is at least noteworthy the females began with longer therapy intentions than males. In order to promote more extended use of therapy, researchers must find ways to capitalize on these kind of intentions.

One final result which stems directly from the data is the interaction effect of an introduction to therapy and claims by a therapist to have training in minority issues. Looking at the results at each level of the introduction variable, a theory can be forwarded that when no introduction is given, the effect of a therapist claiming minority experience elicits a type of empathy or sympathy on the part of the client which causes him or her to think more positively of the therapist. Such an interpretation is similar to the interpretation given by Brabham and Thoreson (1973) when they stated a disabled therapist was preferred by patients, over a normal therapist. Within this framework it is not impossible to think that in such a case, clients may

meet some of their reciprocal needs by not only receiving aid but also giving it to someone they feel is in some ways, less fortunate than themselves. It follows then, a consequence of giving an explanation of therapy to a person is that he or she may begin to understand the non-reciprocal nature of the psychotherapy relationship and be less prone to perceive the therapist as requiring aid in return. For this reason, positive ratings of a therapist are not likely to increase although they will not decrease due to the effect of the introduction causing equally positive ratings.

To gain perhaps a slightly better understanding of the possible dynamics behind the empathic draw for reciprocity, it may be helpful to explore a trend found in the race by minority pitch interaction for the Total rating variable. When this interaction was analyzed for the simple main effect at each level of race, blacks did not show change when the therapist claimed training and a background in minority issues. It is difficult to say whether this was because they did not believe the therapist or whether it simply means from their perceptual standpoint, it was inconsequential. In this respect it is probably noteworthy that a non-majority clientele responded better to a therapy introduction, than claims by a therapist to be somewhat similar to them.

Remaining aware of the theory of reciprocity, it is interesting to note that when white subjects heard a

therapist, claim to be disadvantaged and aware of minority issues, they tended to rate the therapist significantly higher than in those situations where they were led to believe he was identifiably majority culture and majority trained. This finding is in support of similar evidence found by Acosta et al. (1976). These researchers hypothesized that disadvantaged therapists elicit greater credibility with their empathic statements than those therapists who do not so extrinsically demonstrate possible human suffering. It seems equally possible that in the present case, white college students felt some draw on their basic altruism and thus rated a therapist more positively because of feeling sympathy for him and because of feeling fortunate they could reciprocate the help being given. Of course the possibility always exists, that white subject's response to claims of minority training simply signified recognition of the "more is better" theory. Therapists who have gone out of their way to pick up specialty training in addition to standard training may have been perceived as more motivated, expert, and likeable due to their extra effort in training.

Continuing the discussion of the introduction by pitch interaction on the therapist Total Score rating, it is apparent that in either situation where an introduction or a minority pitch is not given, there may be some advantage to the therapist in spending time talking about therapy or building himself up as having a specialty in minority

issues. When no introduction to therapy was given, a therapist elicited more positive feelings from the client when he claimed a minority background than when he did not. When an introduction was given and the client presumably understood the format of psychotherapy, no greater advantage was gained by also introducing the therapist as trained in minority issues.

In a similar manner, an introduction to therapy was beneficial to therapist ratings in the absence of talk about minority issues. When the therapist made an effort to let the client know about his training in minority issues, once again there was no increase in therapist ratings when an introduction to therapy was given.

An introduction to therapy, to demystify therapy and provide an outline of format and structure, was found to be consistently advantageous to more positive therapist ratings. A minority pitch, on the other hand, was advantageous only when no introduction was given. In the one case where there seemed to be some trend in the data of an interaction between minority pitch and race, the minority pitch was not specifically influential in changing a non-majority clientele's feelings about therapy. At the same time, the minority pitch was influential in the white subjects feeling more positively towards therapy - even though this may not have much practical value in the case of most white therapists. It may also be important to realize that even though white

subjects in general rated a therapist more positively than blacks, when both groups were subjected to clarification of their therapy expectations, both groups rated the therapist essentially equal.

Although the results from this study cannot be generalized to the entire academic or therapeutic community, they may have implications for training and for practice. If a therapist assumes, as do Truax and Carkhuff (1967), that better therapeutic progress can be obtained when the client feels most positively towards him or her, it may be advantageous to give the client, prior to therapy, some idea of what he or she can expect. In the case of non-majority clients--even if unidentifiable as such, this may result in more positive feelings towards the therapist. With any given sample, more positive feelings may be engendered by such an introduction, especially in the absence of a therapist claiming a specialty background with minority training. Since few majority psychotherapists are trained in minority issues, this condition may be rather common. As a means of seriously confronting black/white subject differences in their utility of psychotherapy, a pre-therapy introduction may help equalize majority and non-majority therapeutic status.

Another implication from the present study is that with respect to the academic mental health training program curriculum for majority graduate students, the emphasis on

minority training may not be cost effective. It seems that a non-majority client is not automatically going to think more highly of the therapeutic qualities of a white therapist simply because he comes from a disadvantaged background and has had professional training in minority issues. Although in some cases it may positively influence a therapy client, it does not effect change greater than does an introduction explaining the psychotherapeutic structure. There may also be a tendency towards engendering change in white subjects while not affecting the cognitions or emotions of a non-majority client. In terms of training goals, there is probably little reason to make such a maneuver with reference to majority culture persons, and may create unnecessary uncertainty in majority clients. Such clients would most likely not understand why therapists would reference their minority background in their work with them.

One final implication from the present study deals with the average amount of time clients expect to be in therapy even after being told what therapy consists of. Even though such an introduction may shorten the amount of time clients expect to be in therapy, the average time clients expect to be in therapy hovers around three months. The implication follows, that even though a certain percentage of clients will continue to attend therapy for extended periods of time, therapists can be trained to realistically expect some therapy to terminate in three months. If therapists have

three months to facilitate resolution of problems or issues, they might spend at least a significant amount of their time during training learning therapeutic procedures geared towards short term therapy for both majority and non-majority clients. Realistic perceptions may include the knowledge that females in general anticipate staying in therapy longer than males and that most black and white subjects, when told what to expect, remain in therapy for approximately three months. Through sensitivity to these issues, a therapist may have a better means of evaluating his or her own effectiveness.

As often occurs with research, more questions are raised than answered. Because of the necessary limitations of the present design, comments with regard to training and application must be very tentative indeed. Much of the past research which has dealt with patient/therapist similarity cannot be addressed since for all sample groups, only a white male therapist was used. Perhaps differences in therapist ratings would be discovered if blacks were given same race and sex therapists. Further research efforts will need to determine whether introductory statements and expressed training in minority issues, by a therapist, benefits the therapeutic process when the therapist is the same sex and race as the client. It may also be true that a black clientele would feel more positively about a white female therapist than a male therapist. Many different combination

possibilities exist not only in therapist/client match-ups but also in the type of mental health issues portrayed.

One criticism professionals attempting to apply the present research to practice may have, is that responses by subjects to the therapy conditions were made with a reliance on projective theory. The therapy situation was only a simulation and actual client-therapist interaction did not take place. Subjects were essentially required to use projection in order to complete the rating forms. In the same way that one cannot always go directly from a Rorschach protocol interpretation to specific interpersonal behavior, one may not be able to draw specific conclusions about therapy behavior from the projective responses in the study presented. In response to this comment and as a summary statement concerning the research, the following acknowledgement is made. Even though there is possibly little relationship between subjects identifying with an analogue therapy session, and their actual involvement in therapy, the present research partially dealt with and confronted two issues which require further study. The issue of whether clients benefit from knowing what to expect in therapy is an important ongoing question. The present research suggests an affirmative answer, especially in the context of a minority clientele. Because one cannot always recognize the minority client, it may be important to consistently explain therapy to a client. On the topic of minority issues

training, the present research at least suggests that further evaluation of such training be considered. It is difficult to determine whether such training would be perceived by a minority client in the presence or absence of such credentials if the therapist made no mention of it. If, when such credentials are claimed, there is questionable benefit gained either for the client or therapist, such training may be suspect.

Perhaps before graduate programs are required to train their majority culture students in minority issues, the efficacy of such a curriculum needs to be further evaluated. Perhaps it is the overall understanding of cultural aspects as they impact on human beings rather than "minority issues" which should be brought into training and experience discussions. In the long run, this understanding may create a beneficial climate within which therapists and clients can grow together.

SELECTED BIBLIOGRAPHY

Abad, V., Ramos, I., & Boyce, E. A model for delivery of mental health services to Spanish speaking minorities. American Journal of Orthopsychiatry, 1974, 44, 584-595.

Acosta, F., & Sheehan, J. Preferences toward Mexican American and Anglo American psychotherapists. Journal of Consulting and Clinical Psychology, 1976, 44, 272-279.

Affleck, D. C., & Garfield, S. Predictive judgments of therapists and duration of stay in psychotherapy. Journal of Clinical Psychology, 1961, 17, 134-137.

Albronda, H. F., Dean, R. L., & Starkweather, J. A. Social class and psychotherapy. Archives of General Psychiatry, 1964, 10, 276-283.

Aronson, H., & Overall, B. Treatment expectations of patients in two social classes. Social Work, 1966, 11, 35-41.

Atkinson, D. R., Maruyama, M., & Matsui, S. Effects of counselor race and counseling approach on Asian Americans' perceptions of counselor credibility and utility. Journal of Counseling Psychology, 1978, 25, 76-83.

Babcock, C., & Caudill, W. Personal and cultural factors in treating a Nisei man. Dr. G. Steward, (Ed.), Clinical studies in culture conflict. New York: Ronald Press, 1958.

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

Banks, W. The black client and the helping professionals. In R. I. Jones (Ed.), Black psychology. New York: Harper and Row, 1972.

Banks, G., Berenson, B., & Carkhuff, R. The effects of counselor race and training upon counseling process with Negro clients in initial interviews. Journal of Clinical Psychology, 1967, 23, 70-72.

Barrett-Lennard, G. T. Dimensions of therapist response as causal factors in therapeutic change. Psychological Monographs, 1962, 76, (43, Whole No. 562).

Barton, H. H. (Ed.) Brief therapies. New York: Behavioral Publications, 1971.

Baum, O., & Felzer, S. Activity in initial interviews with lower-class patients. Archives of General Psychiatry, 1964, 10, 345-353.

Baum, O., Felzer, S., D'Zmura, T., & Shumaker, E. Psychotherapy, dropouts and lower socioeconomic patients. American Journal of Orthopsychiatry, 1966, 36, 629-635.

Berman, J. Counseling skills used by black and white male and female counselors. Journal of Counseling Psychology, 1979, 26, 81-84.

Boulware, D. W., & Holmes, D. S. Preferences for therapists and related expectancies. Journal of Consulting and Clinical Psychology, 1970, 35, 269-277.

Brabham, R. E., & Thoreson, R. Relationship of client preferences and counselor's physical disability. Journal of Counseling Psychology, 1973, 20, 10-15.

Brown, J., & Kosterlitz, N. Selection and treatment of psychiatric outpatients. Archives of General Psychiatry, 1964, 11, 425-438.

Brown, T., Stein, K., Huang, K., & Harris, O. Mental illness and the role of mental health facilities in Chinatown. In S. Sue and N. Wagner (Eds.), Asian-American: Psychological perspectives. Palo Alto: Science and Behavioral Books, 1973.

Carkhuff, R., & Pierce, R. Differential effects of therapist race and social class upon patient depth of self-exploration in the initial interview. Journal of Consulting Psychology, 1967, 31, 632-634.

Clemes, S., & D'Andrea, V. Patient's anxiety as a function of expectation and degree of initial interview ambiguity. Journal of Consulting Psychology, 1965, 29, 397-404.

Cousins, M. The mysterious placebo: How mind helps medicine work. Saturday Review, 1977, 5, 8-16.

Danish, S. J., & D'Augelli, A. R. Rationale and implementation of a training program for paraprofessionals. Professional Psychology, 1976, 7, 38-46.

Devine, D. A., & Fernald, P. S. Outcome effects of receiving a preferred, randomly assigned, or nonpreferred therapy. Journal of Counseling and Clinical Psychology, 1973, 41, 104-107.

Dibner, A., Palmer, R., Cohen, B., & Gofstein, A. The use of an open-ended group in the intake procedure of a mental hygiene unit. Journal of Consulting Psychology, 1963, 27, 83-88.

Dodd, J. A retrospective analysis of variables related to duration of treatment in a university psychiatric clinic. Journal of Nervous and Mental Disease, 1971, 151, 75-85.

Duckro, P., Beal, D., & George, C. Research on the effect of disconfirmed client role expectations in psychotherapy: A critical review. Psychological Bulletin, 1979, 86(2), 260-275.

Fisher, E. H., & Cohen, S. Demographic correlates of attitudes toward seeking professional psychological help. Journal of Consulting and Clinical Psychology, 1972, 39, 20-24.

Fisher, E. H., & Turner, J. Orientations to seeking professional help: Development and research utility of an attitude scale. Journal of Consulting and Clinical Psychology, 1970, 35, 75-90.

Frank, J. D., Hoehn-Saric, R., Imber, S., Liberman, B., & Stone, A. Effective ingredients of successful psychotherapy. New York: Brunner/Mazel, 1978.

Frank, J. D. Pervasion and healing. Baltimore: John Hopkins Press, 1961.

Frank, J. Effective ingredient of successful psychotherapy. New York: Brunner/Mazel, 1978.

Freedman, N., Engelhardt, D., Hankoff, L., Glick, B., Kaze, H., Buchwald, J., & Stark, P. Drop-out from outpatient psychiatric treatment. American Medical Association Archives of Neurology and Psychiatry, 1958, 80, 657.

Fujii, S. M. Elderly Asian Americans and use of public services. Social Casework, 1976, 57, 202-207.

Garfield, S. L. Research on client variables in psychotherapy. In A. E. Bergin and S. L. Garfield (Eds.), Handbook of psychotherapy and behavior change. New York: Wiley, 1971.

Garfield, S., Affleck, D., & Muffly, R. A study of psychotherapy interaction and continuation of psychotherapy. Journal of Clinical Psychology, 1963, 19, 473-478.

Goin, M., Yamamoto, J., & Silverman, J. Therapy congruent with class-linked expectations. Archives of General Psychiatry, 1965, 13, 133-137.

Goldstein, A. P. Therapist and client expectation of personality change in psychotherapy. Journal of Counseling Psychology, 1960, 7, 180-184.

Goldstein, A., Heller, K., & Sechrest, L. Psychotherapy and the psychology of behavior change. New York: Wiley, 1966.

Gould, R. E. Dr. Strangeclass: Or how I stopped worrying about the therapy and began treating the blue-collar worker. American Journal of Orthopsychiatry, 1967, 37, 78-86.

Green, R. L. The social responsibility of psychology. The Journal of Black Psychology, 1974, 1, 25-30.

Greenberg, R. P. Effects of presession information on perception of the therapist and receptivity to influence in a psychotherapy analogue. Journal of Consulting and Clinical Psychology, 1969, 33, 425-429.

Greenberg, R., Goldstein, A., & Gable, R. Influence of background similarity and trait structure on the perception of a taped therapist. Journal of Consulting and Clinical Psychology, 1971, 37, 423-427.

Greenberg, R., Goldstein, A., & Perry, M. The influence of referral information upon patient perception in a psychotherapy analogue. Journal of Nervous and Mental Disease, 1970, 150, 31-36.

Greenwald, A., & Bartemeier, L. Psychiatric discharges against medical advice. I. Origin and prevention. Archives of General Psychiatry, 1963, 8, 117-119.

Heine, R. W., & Trosman, H. Initial expectations of the doctor-patient interaction as a factor in continuance in psychotherapy. Psychiatry, 1960, 23, 275-278.

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

Heitler, J. Preparation of lower-class patients for expressive group psychotherapy. Journal of Consulting and Clinical Psychology, 1973, 41, 251-260.

Heller, K. Effects of modeling procedures in helping relationships. Journal of Consulting and Clinical Psychology, 1969, 33, 522-526.

Ho, M. K. Social work with Asian Americans. Social Casework, 1976, 57, 195-201.

Hoehn-Saric, R., Frank, J. D., Imber, S. C., Nash, E. H., Stone, A. R., & Battle, C. C. Systematic preparation of patients for psychotherapy: 1. Effects of therapy behavior and outcome. Journal of Psychiatric Research, 1964, 2, 267-281.

Holliday, P. B. Effects of preparation for therapy on client expectations and participation (Doctoral dissertation, University of Georgia, 1978). Dissertation Abstracts International, 1979, 39, 3517B. (University Microfilms No. 7901646)

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

Hornstra, R., Lubin, B., Lewis, R., & Willis, B. Worlds apart: Patients and professionals. Archives of General Psychiatry, 1972, 27, 553-557.

Hunt, L. L., & Cushing, R. G. Status discrepancy, interpersonal attachment and right-wing extremism. Social Science Quarterly, 1970, 51, 587-601.

Imber, S., Nash, E., Jr., & Stone, A. Social class and duration of psychotherapy. Journal of Clinical Psychology, 1955, 11, 281-284.

Jackson, M., & Thompson, C. Effective counselor: Characteristics and attitudes. Journal of Counseling Psychology, 1971, 18, 249-254.

Jacobs, D., Charles, E., Jacobs, T., Weinstein, H., & Mann, D. Preparation for treatment of the disadvantaged patient: Effects on disposition and outcome. American Journal of Orthopsychiatry, 1972, 42, 666-674.

Jurich, J. A. Variables related to dropping out of therapy (Doctoral dissertation, Kansas State University, 1978). Dissertation Abstracts International, 1979, 39, 5071B. (University Microfilms No. 7906786)

Kadushin, C. Why people go to psychiatrists. New York: Atherton, 1969.

Kamin, I., & Caughlin, J. Subjective experiences of outpatient psychotherapy. American Journal of Psychotherapy, 1963, 17, 660-668.

Kim, B. L. C. Asian-Americans: No model minority. Social Work, 1973, 18, 44-53.

Korchin, S. Clinical psychology and minority problems. American Psychologist, 1980, 35, 262-269.

Leonard, J., & Bernstein, A. The anatomy of psychotherapy. New York: Columbia University Press, 1960.

Levitt, E. E. Psychotherapy research and the expectation-reality discrepancy. Psychotherapy: Theory, Research, and Practice, 1966, 3, 163-166.

Long, T. J. The effects of pretraining procedures on client behavior during initial counseling interviews. Dissertation Abstracts, 1968, 29, 1784A. (University Microfilms No. 68-15, 007)

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

Lorion, R. P. Social class differences in treatment attitudes and expectations. Unpublished doctoral dissertation, University of Rochester, 1972.

Lorr, M., & McNair, D. Correlate of length of psychotherapy. Journal of Clinical Psychology, 1964, 20, 497-504.

Luborsky, L., Chandler, M., Auerbach, A., Cohen, J., & Bachrach, H. Factors influencing the outcome of psychotherapy: A review of quantitative research. Psychological Bulletin, 1971, 75, 145-186.

Mann, J. Time-limited psychotherapy. Cambridge, Mass.: Harvard University Press, 1973.

Mason, R., Clark, G., Reeves, R., & Wagner, B. Acceptance and healing. Journal of Religion and Health, 1969, 8, 123-142.

McNair, D., Lorr, M., & Callahan, D. Patient and therapist influences on quitting psychotherapy. Journal of Consulting Psychology, 1963, 27, 10-17.

Minority graduate enrollments. APA Monitor, January 1977, p. 16.

Olmedo, E., & Lopez, S. (Eds.). Hispanic mental health professional. Los Angeles: Spanish Speaking Mental Health Research Center, 1977.

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

Osako, M. Intergenerational relations as an aspect of assimilation: The case of Japanese Americans. Sociological Inquiry, 1976, 46, 67-72.

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

Padilla, A., Ruiz, R., & Alvarez, R. Community mental health services for the Spanish-speaking/surnamed population. American Psychologist, 1975, 30, 892-897.

Poser, E. The effect of therapists' training on group therapeutic outcome. Journal of Consulting Psychology, 1966, 30, 283-389.

Redlich, F., Hollingshead, A., & Bellis, E. Social class differences in attitudes towards psychiatry. American Journal of Ortho-psychiatry, 1955, 25, 60-70.

Rickels, K. Non-specific factors in drug therapy of neurotic patients. In K. Rickels (Ed.), Non-specific factors in drug therapy. Springfield, Ill.: Charles C. Thomas, 1968.

Rickels, K., & Anderson, J. The low socio-economic psychiatric out-patient. Diseases of the Nervous System, 1969, 30, 322-327.

Riessman, F., & Scribner, S. The underutilization of mental health services by workers and low income groups: Causes and cures. American Journal of Psychiatry, 1965, 121, 798-801.

Schonfield, J., Stone, A. R., Hoehn-Saric, R., Imber, S. R., & Pande, S. K. Patient-therapist convergence and measures of improvement in short-term psychotherapy. Psychotherapy: Theory, Research, and Practice, 1969, 6, 267-272.

Siegel, J. A brief review of the effects of race in clinical service interactions. American Journal of Orthopsychiatry, 1974, 44(4), 555-562.

Singer, T. J. Patient expectations and continuation in psychotherapy (Doctoral dissertation, Yale University, 1977). Dissertation Abstracts International, 1978, 39, 1969B. (University Microfilms No. 7818098)

Sloane, R. B., Cristol, A., Peppernik, M., & Staples, F. Role preparation and expectation of improvement in psychotherapy. Journal of Nervous and Mental Diseases, 1970, 150, 18-26.

Smith, W., Burlew, A., Mosley, M., & Whitney, W. Minority issues in mental health. Massachusetts: Addison-Wesley, 1978.

Snelbecker, G. E. Influence of therapeutic techniques on college students' perceptions of therapists. Journal of Consulting Psychology, 1967, 31, 614-618.

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

Sue, D. W. Ethnic identity: The impact of two cultures on the psychological development of Asians in America. In S. Sue and N. N. Wagner (Eds.), Asian Americans: Psychological perspectives. Palo Alto, Cal.: Science and Behavior Books, 1973.

Sue, D. W. Eliminating cultural oppression in counseling: Toward a general theory. Journal of Counseling Psychology, 1978, 25(5), 419-428.

Sue, S. Community mental health services to minority groups. American Psychologist, 1977, 32, 616-624.

Sue, S. Training of third "world" students to function as counselors. Journal of Counseling Psychology, 1973, 20(1), 73-78.

Tanaka-Matsumi, J., & Marsella, A. Cross-cultural variations in the phenomenological experience of depression: World association studies. Journal of Cross-Cultural Psychology, 1976, 7, 379-396.

Thompson, R., & Cimbolic, P. Black students' counselor preference and attitude toward counseling center use. Journal of Counseling Psychology, 1978, 25(6), 570-575.

Traux, C., & Carkhuff, R. Toward effective counseling and psychotherapy. Chicago: Aldme, 1967.

Traux, C., & Wargo, D. Effects of vicarious therapy pretraining and alternate sessions on outcome of group psychotherapy with outpatients. Journal of Consulting and Clinical Psychology, 1969, 33, 509-521.

Vontress, C. E. Racial differences: Impediments to rapport. Journal of Counseling Psychology, 1971, 18(1), 7-13.

Whalen, C. Effects of a model and instructions on group verbal behavior. Journal of Consulting and Clinical Psychology, 1969, 33, 509-521.

White, A., Fichtenbaum, L., & Dollard, J. Evaluation of silence in initial interviews with psychiatric clinic patients. Journal of Nervous and Mental Diseases, 1964, 139, 550-557.

Wilkins W. Expectancy of therapeutic gain: An empirical and conceptual critique. Journal of Counseling and Clinical Psychology, 1973, 40, 69-77.

Williams, R. L., & Kirkland, J. The white counselor and black client. Counseling Psychologist, 1971, 4, 114-117.

Williams, H., Lipman, R., Uhlenhuth, E., Rickels, K., Covi, L., & Mock, J. Some factors influencing the treatment expectations of anxious neurotic outpatients. Journal of Nervous and Mental Disease, 1967, 145, 208-220.

Wolkon, G., Mori aki, S., & Williams, K. Race and social class as factors in the orientation toward psychotherapy. Journal of Counseling Psychology, 1973, 20, 312-316.

Yamamoto, J., James, Q., Palley, N. Cultural problems in psychiatric therapy. Archives of General Psychiatry, 1968, 19, 45-49.

Zaro, J., Barach, R., Nedelman, D., Dreiblatt, I. A guide for beginning psychotherapists. New York: Cambridge, 1977.

Ziemalis, A. Effects of client preference and expectancy upon the initial interview. Journal of Counseling Psychology, 1974, 21, 23-30.

APPENDIX A

TRANSCRIPT OF AN INITIAL INTERVIEW

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Therapist: Before you begin talking about what brings you here today, I want to intruduce myself to you. By the way, what name would you prefer to go by in our time together?

Client: Pat

T: Pat, good. You may call me Jon. To start with I should mention I'm a graduate student in clinical psychology. I am directly supervised by a licensed psychologist which simply means someone is available to act as a guide and consultant to me as I work in therapy with people.

(Condition I) My training is the standard training all psychotherapists receive, who call themselves clinical psychologists. I have received training which has taught me to understand a wide variety of problems which people face in life. Because of this training and various other work experiences, I feel qualified to work with most people seeking help.

(Condition II) Along with my work in this clinic I've received specialized training in working with all types of individuals from various racial and cultural backgrounds. I've had numerous difficult situations to face in life and because of my own underprivileged background, as well as my present training in both majority and minority issues, I feel qualified to work with a wide variety of persons seeking help.

However, because my life experience will obviously have been somewhat different from your own, you may at times need to make sure I understand your ideas and feelings correctly. Umm, anything else -- oh yes, I also have access to a psychiatrist who is qualified to prescribe medication if that becomes necessary, for psychological reasons. I want to say, too, that nothing you say in our time together will be told to anyone else unless you agree to that and sign a release of information form. I use a tape recorder to help me when reviewing the session and in preparation for following sessions. Umm, - I guess that's about it. Do you have any questions, Pat?

C: Umm, not that I can think of right now.

T: Ok, if you have any later, feel free to bring them up. Perhaps you would spend some time then, talking about why you are here today.

C: Well, to be honest, I almost didn't come. When I called the other day I was feeling really down and felt like maybe coming here would help. I broke up about two and a half months ago and that was still on my mind. The weekend before last I had one bad headache through the whole weekend and after I got over that, I've just felt real depressed. It's probably stupid for me to even have come - - - Since I made the appointment though, I thought I might as well come and check the place out.

T: Sounds like you've noticed some unacceptable differences in yourself these last couple weeks.

C: That's for sure - - I've just been staying in my room and sleeping alot. I haven't had much of an appetite for the last two months now. I think I've lost four pounds. The worst though, is just not having any energy. I said I sleep alot but I still feel tired. Just thinking about going to classes makes me depressed, plus I probably wouldn't be able to pay attention anyway.

T: You don't have much motivation for doing things.

C: Not lately I don't. I hate to leave my room even, to go eat or go up town.

T: From some of the things you've said, it seems as though you had a painful experience with another person recently. Could it be that the way you are feeling is related to that event?

C: Oh, I don't know - - I'm just sick of dating. People are so shallow - about the time I start feeling a little close, then everything goes to pieces. I'm seriously starting to think about just staying single. It sure would save me a lot of grief. Just thinking about this gets me so mad - sometimes I just think everyone is locked away into their own little closet and couldn't care less about anyone else. I remember as a little child, I used to go to the store with mom and I would say hi to people I met on the street. They would nearly always say hi in return - although mom would tell me it wasn't polite to bother other people that way. Children can do things older people can't, I guess.

T: You guess - - - say more about what you mean when you say children can do things older people can't.

C: Oh, I don't know why I said that. I just remember that as a child it never seemed such a big deal to run into people I could get along with. Kids don't hide behind their clothes, or what car they drive, or what major they're in.

T: Some of the things you've said about having difficulty feeling comfortable around people makes me think it hurts alot when people act like they don't care about you - especially after you've gotten to know them some.

C: Ya, well maybe that's what I need - to learn how not to care - all that will take care of itself if I just stay away from people.

T: Hmmm, But you've come here today because you've learned that really doesn't seem to be the answer.

C: Well, I'm afraid there probably aren't any answers. I doubt if this would make sense to anyone, anyway.

T: Hmmm. Maybe this is one of those moments where you feel I'm so different than you that I won't understand you. Perhaps you could help me better understand you by talking some about your years growing up.

C: (Mumbling) I don't know what this has to do with my depression - but, anyway - I'm the oldest child. I've got one younger sister and one younger brother. My sister will maybe go to college but my brother will probably never make it at anything. He's so lazy. Mom used to let him get away with everything. Dad wasn't around much and when he did get home he was always grumpy and pretty much wanted to be left alone. (Pause) Oh, by the way, my parents separated when I was three years old. I went to live with my dad because apparently mom needed some time to figure out some things. Actually I lived most of the next year with my grandparents and baby sitters. My parents got back together a year later and things got back to normal. My sister was born within that next year. I remember that it took awhile before I really let myself trust that my parents would stay together. Everytime mom got upset I worried that she'd leave again.

T: Before you were able to trust her, you probably needed a lot of reassurance from your mom, that she still cared about you.

C: Oh, I know she cared about me. She made sure that I would be ok in life by giving me all kinds of advice. My mom was always going on how the only way to compete in this world is to get a college education. She got married right after high school and never made it back into academia. I'm really not sure how she knows. Of course, she never has any doubts about what she thinks she knows.

T: It seems your mother's ideas are pretty important to you, but they make you angry.

C: Oh, my mom and I get along fine. It's just that I haven't even seen my mother for several years - at least for any length of time.

T: Perhaps your mother's ideas meant alot to you as you were growing older as a child.

C: Well, all I know is that for not having gotten much schooling, she sure thought my life depended on how I did in school. She would actually cry if I got a C in grade school. She'd go into this big tirade about how I wasn't paying attention in school and how I didn't give a damn what impression people had of the family. I never saw her make such a ruckus when the other kids got C's. Plus I hardly ever got C's anyway. Sometimes I think I got B's in school just to please her.

T: Hmmm - Or you may have felt forced to do well in school to stay on the good side of her.

C: Maybe - - I have to admit though, grades became pretty important to me - just for myself. That's why it gets me so upset when my dating goes sour. I didn't have time to spend all my time with Lynn - that's the last person I dated - because I also needed to study. But noone else seems to understand that life consists of more than being together all the time. Of course, sometimes I fantasize that that might be alot of fun - it also seems pretty impractical.

T: That leaves you kind of in a bind. If you are ever to amount to anything you better not play around too much - but when you don't, you have trouble with your friends and get depressed.

C: That sounds depressing just to hear it said that way (laughs).

T: And it's also an area that we will need to look more at. For right now though, I wonder if you would say a bit more about the kind of fantasies you have, when thinking about the perfect relationship ----

APPENDIX B

INFORMATION QUESTIONNAIRE

INFORMATION QUESTIONNAIRE

Age:_____

Sex:_____

Race:_____

Primary or First Language:_____

Secondary Language spoken:_____

Country of Citizenship:_____

Classification in school (i.e., Freshman, Sophomore, etc.):

_____

Major in school:_____

Father's present or most recent job:_____

Mother's present or most recent job:_____

Have you ever been in therapy or counseling:_____

Was it helpful:_____ Comments:

APPENDIX C

INTRODUCTION TO PSYCHOTHERAPY

INTRODUCTION TO PSYCHOTHERAPY

Persons sometimes enter therapy when they have difficulty getting along with their friends, family, or people in general. Others enter therapy because of curiosity or uncertainties about their behavior, thoughts, or feelings. Persons entering psychotherapy for the first time are often uncertain exactly what therapy is and what to expect from the therapist.

In many ways, talking with a psychotherapist is different from talking with, and being treated by, a physician. When you consult your family doctor, the usual procedure is for you to tell him or her what's wrong and for him or her to prescribe the appropriate medicine or treatment. Ordinarily, you do not discuss your emotional feelings in great detail. You concentrate on the particular thing that hurts or bothers you.

With a psychotherapist it is a little different. Rather than prescribing medication, the therapist tries to get to the root of your experience or problem by discussing the issue with you. Many clients discover they must play a very active role in dealing with their questions. Psychotherapy may take 3 months to a year, or even longer, on a once a week basis. Sessions each time generally last about 50 minutes.

Below is a list of ideas some clients found to be true, after having been in therapy for a period of time.

My therapist:

1) Wanted my opinions.
2) Expected me to do most of the talking.
3) Wanted to know what my childhood was like.
4) Believed some of my problems were emotionally based.
5) Wanted to know what kinds of things made me unhappy.
6) Was interested in hearing about my personal problems.
7) Wanted to know about my thoughts and feelings.
8) Asked questions about my personal life.
9) Wanted to know what my friends were like.
10) Did not give advice until he got to know me well.
11) Wanted to know how I got along with people.
12) Seldom if ever gave me definite rules to follow.
13) Did not necessarily tell me ways to solve my problems and/or questions.
14) Expected me to talk about my thoughts, feelings, and behavior, openly.
15) Wanted me to introduce and sustain, topics of my own choice.

Many clients discover that having a relationship of trust with another person, as well as talking about their life, helps them to deal with, overcome, and work through problems they have in living. Psychotherapy, which relies on clients talking about themselves (their thoughts, feelings, and actions), is one place persons can work on how their personality affects their life.

APPENDIX D

RELATIONSHIP INVENTORY

RELATIONSHIP INVENTORY

Below are listed a variety of ways that one person could feel or behave in relation to another person. Please consider each statement with respect to whether you think it is true or not true in the present relationship of the observed therapist and yourself acting as a client. Mark each statement in the left margin according to how strongly you feel it is true or not true with reference to the therapist you just observed. In answering, assume you are the client. Please mark every one. Write in 3, 2, 1; or -1, -2, -3, to stand for the following answers:

3: I strongly feel that it is true.
2: I feel it is true.
1: I feel that it is probably true, or more true than untrue.

-1: I feel that it is probably untrue, or more untrue than true.
-2: I feel it is not true.
-3: I strongly feel that it is not true.

* * * * * * *

_____1. He respects me.

_____2. He tries to see things through my eyes.

_____3. He pretends that he likes me or understands me more than he really does.

_____4. He disapproves of me.

_____5. He understands my words but not the way I feel.

_____6. What he says to me never conflicts with what he thinks or feels.

_____7. He is curious about "the way I tick," but not really interested in me as a person.

_____8. He is interested in knowing what my experiences mean to me.

_____9. He is disturbed whenever I talk about or ask about certain things.

____10. He likes seeing me.

____11. He nearly always knows exactly what I mean.

____12. I feel that he has unspoken feelings or concerns that are getting in the way of our relationship.

____13. He is indifferent to me.

____14. At times he jumps to the conclusion that I feel more strongly or more concerned about something than I actually do.

____15. He behaves just the way that he really is, in our relationship.

____16. He appreciates me.

____17. Sometimes he thinks that I feel a certain way, because he feels that way.

____18. I do not think that he hides anything from himself that he feels with me.

____19. He is friendly and warm toward me.

____20. He understands me.

____21. He cares about me.

____22. His own attitudes toward some of the things I say, or do, stop him from really understanding me.

____23. He does not avoid anything that is important for our relationship.

____24. He feels that I am dull and uninteresting.

____25. He understands what I say, from a detached, objective point of view.

____26. I feel that I can trust him to be honest with me.

____27. He is interested in me.

____28. He appreciates what my experiences feel like to me.

____29. He is secure and comfortable in our relationship.

____30. He just tolerates me.

____31. He is playing a role with me.

____32. He does not really care what happens to me.

____33. He does not realize how strongly I feel about some of the things we discuss.

____34. There are times when I feel that his outward response is quite different from his inner reaction to me.

____35. He seems to really value me.

____36. He responds to me mechanically.

____37. I don't think that he is being honest with himself about the way he feels toward me.

____38. He dislikes me.

____39. I feel that he is being genuine with me.

____40. He is impatient with me.

____41. Sometimes he is not at all comfortable but we go on, outwardly ignoring it.

____42. He feels deep affection for me.

____43. He usually understands all of what I say to him.

____44. He does not try to mislead me about his own thoughts or feelings.

____45. He regards me as a disagreeable person.

____46. What he says gives a false impression of his total reaction to me.

____47. At times he feels contempt for me.

____48. When I do not say what I mean at all clearly he still understands me.

____49. He tries to avoid telling me anything that might upset me.

____50. He tries to understand me from his own point of view.

____51. He can be deeply and fully aware of my most painful feelings without being distressed or burdened by them himself.

APPENDIX E

TERMINATION SCALE

TERMINATION SCALE

Most therapists believe mental health problems cannot be resolved in only one session. Oftentimes eight or more sessions are recommended. Whether a client returns for therapy is often dependent on his/her initial experience with the therapist. Following the session you just observed, this therapist recommended that the client return for further sessions on a once a week basis. From your observation of the therapy session, please make a prediction by selecting one of the following choices.

Keeping in mind that for the present experiment, I am responding as the client, I would return and remain in therapy on a once a week basis for:

____1 - as long as the therapist recommends.

____2 - a year (50 sessions), if necessary, but no longer.

____3 - six months (25 sessions), if necessary, but no longer.

____4 - three months (12 sessions), if necessary, but no longer.

____5 - two months (8 sessions), if necessary, but no longer.

____6 - one month (4 sessions), if necessary, but no longer.

____7 - one more time in order to check things out further.

____8 - I would stop therapy altogether by not returning.

Please list the reason(s) you believe yourself (the client) will or will not return for therapy.

Will return because:

Will not return because:

VITA

Ian Timothy Birky

Candidate For The Degree Of

Doctor of Philosophy

THESIS: INFLUENCE OF TREATMENT FACTORS ON THE THERAPY PERCEPTIONS OF MAJORITY AND MINORITY SUBJECTS

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