COUNSELING STUDENTS' RESPONSIBILITY ATTRIBUTIONS ON DIVERSE CLIENTS AND TRAUMA SURVIVORS

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AND TRAUMA SURVIVORS

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Abstract: How counseling students attribute responsibility to their clients' presenting concerns, and determine the solution to those concerns, influences the therapeutic relationship, client retention, and overall counseling efficacy (Greenleaf, Williams, & Duys, 2015). Despite the negative effects of attribution errors in counseling, little research has focused on how counseling students attribute responsibility to their clients' problems or solutions, especially within the context of diverse clients or trauma survivors. This study attempted to fill gaps in the literature by assessing counseling students' attributions of problem cause and solution for diverse clients and trauma survivors. The model of helping and coping developed by Brickman et al. (1982) was used to measure responsibility attributions for problem cause and solution by utilizing hypothetical client vignettes that varied in racial/ethnic background, or with the addition of a trauma history. A total of 217 counseling students from counseling programs around the United States participated in the study, with a total of 28 states being represented in the sample. Two separate two-way factorial ANOVA's (CRF-*32*) were conducted to determine effects of client race/ethnicity (Black/African American, Latino, or White) and the addition of a trauma history (yes or no) on counseling students' responsibility attributions of problem cause and problem solution. The interaction between these two variables was not significant for problem cause ($F(2,211) = 1.208$, $p = .301$) or problem solution ($F(2,211) = .051$, $p = .95$). The main effect of race/ethnicity was not significant for problem cause ($F(2,211) = 1.803$, $p = .167$) or solution ($F(2,211) = 1.252$, $p = .288$). The main effect of trauma history (yes or no) was significant for problem cause ($F(1,211) = 58.251$, $p < .001$) but was not significant for problem solution ($F(1,211) = .048$, $p = .827$). These findings suggest that the addition of a trauma history influences counseling students' views on their clients' presenting concerns by increasing their consideration for external factors while mitigating personal blame on the client. Implications and limitations to the study are discussed.

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INTRODUCTION

Counseling students go through an extensive amount of training to become competent mental health professionals. Clientele served by these professionals come from various backgrounds, socioeconomic classes, races, ethnicities, and cultures, with a broad range of life experiences. A counseling student is defined as someone who is currently enrolled in master's level graduate program and undergoing training to become a counselor. For counseling students, informed training is paramount for developing diagnostic and conceptualization skills that can be tailored to address diverse groups of individuals (Gauthier, Pettifor, & Ferraro, 2010). Informed training can come in a variety of different forms and modalities. Recently, researchers are endorsing enhanced theoretical and conceptual training for counseling students by having them incorporate broader contextual factors when assessing and treating clients (Conye & Cook, 2004; Greenleaf & Williams, 2009; Greenleaf, Williams, & Duys, 2015). Furthermore, researchers are calling for counseling student training to specifically focus on how a client's environment affects his or her well-being and development (Shalcross, 2013).

Counseling Student Training

One way of increasing the knowledge on these contextual factors is by training students to be aware of the traumatic experiences their clients have lived through. In addition, Educators can increase counseling student competence by teaching students how to make connections

between the presenting concerns of clients and the larger framework of their clients' environments (Williams, McMahon, & Goodman, 2015). Ideally, counseling students will learn to view clients through an environmentally sensitive lens, and develop critical thinking regarding salient historical information that contributes to presenting concerns (McMahon & Goodman, 2015). Furthermore, by drawing awareness to a client's environment, therapists identify biases related to how they perceive their clients' behaviors and increase congruence with client treatment needs (Tracey, 1988).

The American Counseling Association (ACA) Code of Ethics (2014) identifies five core professional values for practicing counselors. Concerning client diversity, core professional value number two states that counselors need to be "honoring diversity and embracing a multicultural approach in support of the worth, dignity, potential, and uniqueness of people within their social and cultural context" (p.3). Therefore, from an ethical perspective, teaching students to be aware of client diversity and environmental influences is a central focus for the development of counseling students to become competent professionals.

Vera and Speight (2003) explain that diversity training and competencies are core components of graduate level education, including case conceptualization, counselor behavior, and integration of knowledge into practice. Counseling education includes the awareness, instruction, skill development, and diagnostic knowledge to properly train therapists for providing competent services to clients from diverse backgrounds with a varied range of life experiences (Sue, Arredando, & McDavis, 1992). Further, this education is meant to train counseling students to identify a plethora of potential stressors in a client's life and prevent personal bias from negatively influencing the counseling process.

Research has shown there are disparities in mental health care for racially and ethnically diverse clients (Agency for Health Care Research and Quality, 2010; Harris, Edlund, & Larson, 2005; U.S. Surgeon General, 2001), and the lack of knowledge on environmental stressors is contributing to this disparity. Racial/ethnic minorities generally have less access to mental health care, receive lower quality treatment, and are more likely to terminate therapeutic services prematurely (Harris et al., 2005; Ojeda & McGuire, 2006). In response to this disparity, researchers have started looking at ways to increase treatment equity for diverse clients (Constantine, 2002; Gone, 2013; Huey Jr, Tilley, Jones, & Smith, 2014; Sobczak & West, 2013; Sue et al., 1992). One way of addressing this discrepancy is to improve treatment approaches and conceptualization skills for counseling students. Therefore, purposely assessing counseling students' modes of conceptualization for racially and ethnically diverse clients, serves as a viable approach to increasing quality of services (Burnett, Hamel, & Long, 2004; Greenleaf & Williams, 2009). Furthermore, addressing these dynamics can provide greater insight into how counseling students assign responsibility to their clients' problems and potential solutions (Williams, Greenleaf, & Duys, 2013).

Responsibility Attributions

Responsibility attributions are counselors' beliefs about the causes of, and solutions to, their clients' problems. These attributions directly influence both the development of the counseling process and the efficacy of therapy (i.e., symptom reduction, positive behavior change, client satisfaction, etc.) (Stepleman, Darcy, & Tracy, 2005; Wall & Hayes, 2000). More importantly, researchers state that specific responsibility attribution models influence the selection of counseling strategies, evaluation of treatment success, assessment of the presenting concerns, the counseling relationship, and overall quality of services delivered (Brickman et al.,

1982; Hayes & Wall, 1998; Jackson, Holt, & Nelson, 2005; Kernes & McWhirter, 2001; Murdock & Fremont, 1989; Stepleman et al., 2005; Tracy, 1988; Worthington & Atkinson, 1993; Zinnbauer & Pargament, 2000). However, despite the influential role of responsibility attributions on therapy outcomes, the topic is relatively understudied for counseling students in training (Williams et al., 2013).

When individuals help themselves or others, their behavior is influenced by fundamental beliefs about blame and control (Brickman et al., 1982; Mitchlitsch & Frankel, 1989). For counselors, attributing responsibility for problems and solutions can be mapped onto where they place blame. For example, counseling students may emphasize the clients' external environment, or conversely, the internal disposition of the client, as the cause of the presenting concerns (Morrow & Deidan, 1992). In other words, counselors have to decide to what extent a client's character contributes to his/her psychological distress versus the environmental constraints and pressures in which he/she lives (Batson, 1972; Berry & Frederickson, 2015; Conyne & Cook, 2004).

Brickman and colleagues (1982) developed the most widely researched theoretical framework on responsibility attributions in the helping professions. The attribution model (Figure 1) created by Brickman and colleagues is built on a 2-dimensional structure (Stepleman et al., 2005). One dimension reflects responsibility for problem cause, the other for problem solution. Brickman et al. (1982) developed a theory to assist with measuring the behavior of people who help others. Additionally, they believed that attributional bias for the development of a problem, and the solution to that problem, could be measured.

To develop this theory, Brickman et al. (1982) established four responsibility attribution models that are based on fundamental beliefs of how individuals (i.e., counselors) go about

helping those in need. In the end, the researchers found that the majority of helping models can be delineated into four distinct models. They named these orientations the moral, medical, enlightenment, and compensatory models (Figure 1).

Figure 1
Consequences of Attribution of Responsibility in Four Models of Helping and Coping

Attribution to self of responsibility for problem	Attribution to self of responsibility for solution: **High**	Attribution to self of responsibility for solution: **Low**
High	**Moral Model**	**Enlightenment Model**
Perception of self	Lazy	Guilty
Actions expected of self	Striving	Submission
Others who must act	Peers	Authorities
Actions expected of others	Exhortation	Discipline
Implicit view of human nature	Strong	Bad
Low	**Compensatory Model**	**Medical Model**
Perception of self	Deprived	Ill
Actions expected of self	Assertion	Acceptance
Others who must act	Subordinates	Experts
Actions expected of others	Mobilization	Treatment
Implicit view of human nature	Good	Weak

Note. Adapted from "Models of Helping and Coping" by P. Brickman, V.C. Rabinowitz, J. Karuza, D. Coates, E. Cohn, and Kidder, 1982, *American Psychologist*, *37*, p. 370.

The four models of attribution have been applied to numerous areas of research including alcohol and drug abuse (Bennet, 1995; West & Power, 1995), suicidal behavior (Jack & Williams, 1991), reactions to unemployment (Heubeck, Tausch, & Mayer, 1995), counseling elderly and minority clients (Karuza, Zevon, Gleason, Karuza, & Nash, 1990; Young & Marks, 1986), and cancer treatments (Avants, Margolin, & Singer, 1993). Despite the wide range of research, there has been a call for more research that evaluates how inexperienced counselors' therapy is influenced by the responsibility attributions they use with clients (Hayes & Wall, 1998; Kerns & McWhirter, 2001; Murdock & Fremont, 1989; Tracey, 1988).

The four responsibility attributions comprise viewpoints on assigning responsibility to clients' problems (i.e., external vs. internal forces) and their solutions (i.e., external vs. internal solutions). More importantly, not all of the responsibility attribution models are seen as helpful, especially in the context of counseling. In fact, some attributions on presenting concerns can undermine the value of the helping relationship and effectiveness of treatment (Jackson et al., 2005). Therefore, assessing attributions used by counselors when treating sensitive populations with multicultural backgrounds or traumatic experiences can provide valuable information on increasing counseling students' competencies as professionals.

Moral Model. In the moral model, people are seen as responsible for creating the problems in their lives, while also being held responsible for solving these problems (Brickman et al., 1982; Jackson et al., 2005). The name for this model is derived from the idea that individuals' problems are of their own making, and therefore they are *morally* responsible for helping themselves (Karuza, Zevon, Gleason, Karuza, & Nash, 1990).

Counselors who endorse this model of attribution view their clients' problems as a function of the clients' laziness, stubbornness, or lack of persistence. Counselors who support this model believe that change comes from clients enduring the problem and finding a way to solve the issue on their own (Karuza et al., 1990). Furthermore, this model emphasizes the construct of free will and clients' responsibility for their own treatment outcomes. However, counselors proactively take the role of encouragers who help motivate their clients to find the solutions to the problems they created (Worthington & Atkinson, 1993).

The primary advantage of the moral model in counseling is that clients are viewed as having the potential to solve their own problems (Jackson et al., 2005). However, a weakness of this model is that it minimizes the influence the environment has on clients' presenting concerns.

Therefore, racial/ethnic minority clients may be incongruently assigned blame for the psychological distress they bring to therapy, when discriminatory, traumatic, or oppressive environments better explain the development of their distress (Hayes, Owen, & Bieschke, 2015). Further, if societal pressures related to non-White racial or ethnic minority identity are not considered, there may be dissatisfaction in the therapeutic process due to clients feeling a lack of empathy from their therapist (Kernes & McWhirter, 2001). For example, if clients were exposed to traumatic experiences, they may not be receptive to being held responsible for creating the psychological distress in their life (Suarez & Gadalla, 2010).

Enlightenment Model. The enlightenment model holds clients responsible for causing their problems but does not hold them responsible for finding the solution to those problems (Brickman et al., 1982). Individuals conceptualized through this model are viewed as having the inability to solve their own problems (e.g., Alcoholics Anonymous, 12-step programs, etc.) (Kernes & McWhirter, 2001). Therefore, they need to be "enlightened" to see the true nature of their problem(s). Generally, clients are expected to be submissive and allow the professional in the helping relationship take responsibility for solving the distress while being complicit in the process (Hayes & Wall, 1998).

The benefits of the enlightenment model are that it may provide clients with relief that their problems are out of their control, which can be validating to hear (Michlitsch & Frankel, 1989). However, the implicit view of clients is negative, powerless, and dependent on the help of professionals to achieve solutions to presenting concerns. Furthermore, counselors who conceptualize their clients using an enlightenment model may be seen as authoritarian and dominating. While some clients may prefer this approach, it creates a clear power differential and reduces mutual collaboration amongst counselor and client (Stratton, 2003). More

importantly, clients who come from racially/ethnically diverse backgrounds may lack trust if the therapist is coming from an authority position and blaming them for presenting concerns. These clients will feel their therapist lacks understanding in the development of psychological distress, which leads to poor therapeutic outcomes (Williams et al., 2013).

Medical Model. The medical model views client mental health treatment in a parallel fashion to medical treatment. Clients are not considered the cause of their problems, nor are they seen as the solution to their problems (Worthington & Atkinson, 1993). With this model, the implicit view of human nature is that clients are sick, lack knowledge, and need the advice of a professional to diagnose and solve the issue (Brickman et al., 1982). Counselors using this model are heavily focused on manual-based treatment and work with clients from a position of expert opinion (Kernes & McWhirter, 2001). Client behaviors are seen as a result of being sick, with medication based treatments being emphasized.

The medical model allows clients to accept help without feeling responsible for the problems they bring into therapy (Kleinke & Kane, 1998). However, a deficit of the medical model is that clients and professionals have an inherent view of presenting concerns as a result of people being ill or incapacitated (Brickman et al., 1982; Young & Marks, 1986). While this approach is suitable for clients with high acuity disorders (i.e, psychotic disorders) or organic brain issues (i.e., neurocognitive disorders), it's not ideal for counselors. In counseling, this approach fosters dependence on others to solve problems and reduces client driven empowerment to solve their own problems (Dollinger, 2008). Furthermore, the therapeutic process can perpetuate the idea of client weakness and increase the power differential between client and therapist (Jackson et al., 2005).

Compensatory Model. Under the compensatory model, people are not viewed as responsible for problems they face in their lives. However, it is their responsibility to work on making their situations better (Brickman et al., 1982). Counselors who use the compensatory model expect individuals to put forth effort, ingenuity, and collaborate with others to work through the problems they are faced with (Sharf & Bishop, 1979).

Counselors who endorse this model of attribution view themselves as a "compensating" factor for clients, or a tool for clients to utilize in working towards living a healthier life (Tracey, 1988). Counselors attribute their clients' presenting concerns to a shortage of resources or opportunities for positive growth and change. Advocating for clients in order to foster change and create an egalitarian relationship as a central part of therapy (Williams et al., 2013). Moreover, clients are educated on how the environment and factors outside of the clients' control exacerbate psychological distress (e.g., discrimination, oppression, trauma, etc.) (Young & Marks, 1986).

Clients who have experienced trauma, prejudice, cultural oppression, or societal discrimination will benefit the most from therapy that is oriented towards the compensatory attribution model (Boden et al., 2012; Bloom & Sreedhar, 2008; Kleinke & Kane, 1998). Clients who have been through traumatic events in their lives, or clients who come from racially or ethnically diverse backgrounds, benefit from this model because it emphasizes inner control and empowerment for change (Henley & Furnham, 1988; Karuza et al., 1990; Kleinke & Kane, 1998; Knapp & Delprato, 1980; Williams et al., 2013; Worthington & Atkinson, 1993). Additionally, the compensatory approach is effective because it encourages clients to direct their energy outward while mitigating the client's feelings of personal guilt or blame.

A potential deficit of the compensatory model is that clients may feel they have to come up with solutions to problems they had no part in creating (Avants, Margolin, & Singer, 1993). However, when counselors utilize the compensatory model in their conceptualization of clients, despite the onus of change largely coming from the client, there are higher levels of client/therapist congruence in understanding problem etiology (Claiborn, Ward, & Strong, 1981; Hayes & Wall, 1998). The shared understanding of client concerns facilitates a greater level of empathy, and helps the client realize potential for growth and change (Bloom & Sreedhar, 2008; Boden et al., 2012).

Attribution Errors and Bias

Counselor awareness of bias is considered fundamental to counseling individuals who come from diverse backgrounds and experiences (Sue & Sue, 2003). Identification of counselor bias related to attribution of client behavior is well researched and documented (Burkard & Knox, 2004; Chen, Froehle, & Morran, 1997; Dollinger, 2008; Hayes & Derkis, 2000; Morrow & Deidan, 1992; Pfeiffer, Whelan, & Martin, 2000; Rosenthal, 2004; Snider, 2000; Strohmer & Shivy, 1994). Helping counseling students gain insight into their biases is an essential part of professional development because bias can lead to misdiagnosis, ineffective interventions, or worse, harm the client (Morrow & Deidan, 1992). Furthermore, the process of selecting therapeutic interventions directly relates to responsibility attributions for the events in another person's life. When an attributional error is made (e.g., wrongfully assigning blame for behavior), a discrepancy between people evaluating an event and the people involved in the event develops (Jones & Nisbett, 1971). Social psychology refers to this cognitive phenomenon as the Fundamental Attribution Error (FAE), which is also seen in the counseling process (Batson, 1975; Bishop & Richards, 1984).

With attribution errors, behavior tends to become the focal point when applying judgment to the actions of another person. If an individual's behavior makes them standout against a situational background (e.g., being late to work), the observed behavior becomes more salient than the greater context of the situation (Gilbert & Jones, 1986). In a clinical situation, a client that is refusing to seek employment may be viewed as an unmotivated or lazy client. However without considering the larger context of environmental constraints, judgment of the behavior may be inaccurate. Additionally, attribution errors are the result of a motivational bias where our perceptions look for control and predictive situations (Batson, 1975). In other words, it is comforting to feel that negative things happen to people whose dispositions have warranted negative outcomes (i.e., someone late for work is just an irresponsible person) (Vonk, 1999). Therefore, it is common to compartmentalize behavior with negative dispositional attributions, because it is justified as reasonably accurate (Berry, 2015). However, these attributions may be overemphasized, leading to misplaced judgment and biases, which place more designation on disposition and less consideration for environmental influence on behavior (Bishop & Richards, 1984). For counselors, these attribution errors are damaging to therapeutic relationships with clients from racially/ethnically diverse backgrounds, or with clients who have endured trauma, because the assignment of blame is inaccurate.

The potency of behavioral outcomes and how they are perceived has implications beyond just judgments. Gilvovich, Keltner, Chen, & Nisbett (2013) explain that attribution errors can have substantial implications both in short-term and long-term consequences. For example, intake-counseling sessions utilize 60-120-minute interviews to make decisions about the appropriate level of care and directions for treatment, with long-term implications for the success of client therapy (Freund, Russell, & Schweitzer,

1991). These initial consults are constructed on an assumption that accurate assessments can be made about an individual's disposition from a brief interaction (Nakash & Alegria, 2013). However, research indicates that accurate information related to clients' environmental constraints, trauma history, and past experiences is essential for truthful conceptualization of clients' presenting concerns (Cusack, Grubaugh, Knapp, & Frueh, 2006; Morrow & Deidan, 1992; Strohmer & Shivy, 1994). Unfortunately, additional information such as a full trauma history of the client is not always incorporated into the counseling process.

Attribution errors in counseling. Counseling students' attribution errors have significant implications for the conceptualization of clients' presenting concerns (Morrow & Deidan, 1992; Williams et al., 2013). Notably, counseling students are particularly vulnerable to committing attribution errors because they have not had sufficient training on recognizing the impact of environment on client stressors (Chen, Froehle, & Morran, 1997; Greenleaf & Williams, 2009). Novel counseling students generally give greater weight to their own perspectives while minimizing the perspectives of their clients (Arnoult & Anderson, 1988). This form of bias can be detrimental to treatment outcomes because clients will align with therapists' views in order to avoid disagreement on treatment focus, or conversely, outright disagree with the counselors' conceptualizations (Batson, 1975; Fazio, Effrein, & Falender, 1981; Rosenthal, 1974).

Counselor biases toward diverse clients. Counseling students of the majority culture (i.e., White) are more likely to have biased perceptions when making behavioral attributions toward racially or ethnically diverse clients (e.g., Black/African American or Latino) (Burkard & Knox, 2004). Clients who come from diverse backgrounds are more likely subjected to cultural,

racial, legal, or systemic oppression (Constantine, 2002). Therefore, counseling students need to be aware of the responsibility attributions they use with racial or ethnic minority clients, and be considerate of negative environmental experiences. For example, if a counselor is using either the moral or enlightenment model of attribution with a minority client, they may be assigning problem cause to client disposition, when realistically, the environmental influences are more responsible for causing mental health distress (Constantine & Gushue, 2003).

Trauma and Attribution

In counseling and other human service fields, traumatic experiences are starting to get more consideration for their contribution to mental health distress (Bloom & Sreedhar, 2008; Courtois, 2004; Courtois & Gold, 2012; Freidman, Keane, & Resick, 2007; Levers, 2009). Trauma is defined as, "an experience that creates a sense of fear, helplessness, or horror, and overwhelms a person's resources for coping" (Hopper, Bassuk, & Olivet, 2009, p. 80). Trauma is linked to a host of mental health disorders/distress including substance abuse, depression, anxiety, emotional instability, self-harm, suicide, psychosis, dissociation, anger, sleep deprivation, appetite change, negative self-identity, internalized guilt, shame, and attentional deficits (Benoit, Bouthillier, Moss, Rousseau, & Brunet, 2010; Bloom & Sreedhar, 2008; Briere, 2006; Bryant & Panasetis, 2001; Courtois, 2004; Courtios & Gold, 2012; Freidman et al., 2007; Gil-Rivas, Prause, Grella, 2009; Harrison & Fowler, 2004; Landre, Poppe, Davis, Schmaus, & Hobbs, 2006; Moser, Hajcak, Simons, & Foa, 2007). In the past, therapists would treat these various mental health stressors with a behavior specific approach that did not include incorporation of a trauma history (Bloom & Sreedhar, 2008). Unfortunately, this meant that clients were being inordinately blamed for the development of problems, which meant therapists

would focus on client disposition instead of assessing traumatic experiences (Elliot, Bjelajac, Fallot, Markoff, & Reed, 2005; Goodman, 2014; Harris & Fallot, 2001; Herman, 1997).

Trauma related to race and ethnicity. Despite the recent advancements in understanding trauma-related symptoms, there are still considerable gaps in the literature on how trauma is to be addressed through counseling (Norman, 2015). For example, there is a need for understanding trauma that is culturally, contextually, inter-generationally, or discrimination based (Dass-Brailsford, 2007; Goodman & West-Olatunji, 2008; Kira, 2010). Currently, race or ethnicity-based variables are not considered within the criteria for severe stress or trauma related disorders in the Diagnostic and Statistical Manual 5th Edition (American Psychiatric Association, 2013). The exclusion of race or ethnicity-based variables is problematic because evidence supports that racial and ethnic minorities exhibit higher rates of PTSD than the racial majority (i.e., White) (Pieterse, Carter, Evans, & Walter, 2010). Furthermore, meta-analysis studies have drawn a link between psychological distress connected to racial and ethnic discrimination (Williams, Neighbors, & Jackson, 2003), which directly relates to the exposure of traumatic experiences.

The literature on trauma focuses primarily on a universal understanding of problem cause and manifestation across racial/ethnic groups. However, some researchers have argued that it is important to recognize that some racial and ethnic minority groups are inclined to encounter persistent traumatic circumstances at greater rates than the majority population (Marsella, 2010). Under these circumstances, people are more likely to be living in conditions of deprivation, anger, and hopelessness brought on by oppression, insecurity, political subjugation and societal discrimination (Carter, 2007; Kira, 2010; Marsella, 2010; Pieterse, et al., 2010; Williams, Neighbors, & Jackson, 2003). Therefore, recognizing the larger environmental context of clients

from racial or ethnic minority backgrounds has significant implications for client conceptualization in therapy.

When counselors fail to understand the emotional/psychological/physical effects of race/ethnic based trauma, clients may feel discriminated against, which negatively influences their experiences with mental health services (Carter, 2007). Research indicates there is resistance on the part of mental health professionals to accept racial or ethnic oppression as a form of traumatic stress (Butts, 2002; Feagin & McKinney, 2003). Therefore, clients from oppressed or marginalized racial/ethnic groups, who are presenting with trauma symptoms, will be at higher risk for attribution errors by their therapists.

Current Study

Attributions that counseling students utilize to conceptualize the causes and solutions to their clients' problems, have direct influence on the counseling process and efficacy of treatment. The efficacy of treatment includes symptom reduction, positive behavior change, or improving the quality of life (Stepleman, Darcy, Tracy, 2005; Wall & Hayes, 2000). Additionally, researchers have indicated that the attribution models counselors use with clients have a direct effect on counseling strategies, treatment success, assessment of presenting concerns, counseling relationship, and quality of service (Brickman et al., 1982; Hayes & Wall, 1998; Jackson, Holt, & Nelson, 2005; Kernes & McWhirter, 2001; Murdock & Fremont, 1989; Stepleman et al., 2005; Tracy, 1988; Worthington & Atkinson, 1993; Zinnbauer & Pargament, 2000). However, despite the influential role counselor attributions have on therapeutic success, the topic is relatively understudied in counseling students (Williams et al., 2013).

Attribution errors have significant negative implications for the conceptualization of clients' presenting concerns (Williams et al., 2013; Morrow & Deidan, 1992). Beginning level

therapists are particularly vulnerable to committing attribution errors because they have not had sufficient training on recognizing the impact of environment on client presenting concerns (Chen, Froehle, & Morran, 1997; Greenleaf & Williams, 2009). In addition, counseling students generally give greater weight to their own perspectives while minimizing the perspectives of their clients (Arnoult & Anderson, 1988). This form of bias can be detrimental to treatment outcomes with diverse or trauma afflicted clients, because empathy for clients is reduced when internal client factors are considered the sole cause of problems (Batson, 1975; Fazio, Effrein, & Falender, 1981; Rosenthal, 1974). Additionally, counseling students gain patience, increase empathy, show greater understanding, and provide accurate conceptualizations when they consider the influence of environment and/or traumatic experiences (Boden et al., 2012).

The first objective of this study was to investigate if counseling students use different responsibility attributions for clients from different racial/ethnic backgrounds when presented with or without an additional client trauma history. The second objective of this study was to assess if counseling students use significantly different responsibility attributions based on the client race/ethnicity alone. The final research objective of this study was to assess if responsibility attributions used by counseling students were significantly different when a trauma history was presented in addition with the original case scenario. In order to follow the procedure of a completely randomized factorial design, research questions two and three were only assessed after finding the interaction of the two independent variables (i.e., race/ethnicity and trauma history) was not significant (See figure 2).

Research Questions

Q1 Is there an interaction between race/ethnicity (White, Latino, Black/African American) and history of trauma (yes or no) on counseling students' responsibility

attributions for problem cause based on a client case scenario?

Hypothesis: There will not be an interaction between race/ethnicity (White, Latino, or Black/African American) and history of trauma (yes or no) on counseling students' responsibility attributions for problem cause based on a client case scenario.

Q1.1 Are responsibility attributions used by counseling students for client problem cause, significantly different for clients with different racial/ethnic backgrounds (i.e., White, Latino, Black/African American)?

Hypothesis: Responsibility attributions used by counseling students for client problem cause will be significantly different for clients with different racial/ethnic backgrounds (i.e., White, Latino, Black/African American).

Q1.2 Are responsibility attributions used by counseling students for client problem cause, significantly different for clients with an additional trauma history (i.e., yes or no)?

Hypothesis: Responsibility attributions of client problem cause used by counseling students will be significantly different for clients with different racial/ethnic backgrounds (i.e., White, Latino, or Black/African American).

Q2 Is there an interaction between race/ethnicity (White, Latino, Black/African American) and history of trauma (yes or no) on counseling students' responsibility attributions of problem solution based on a client case scenario?

Hypothesis: There will not be an interaction between race/ethnicity (White, Latino, or Black/African American) and history of trauma (yes or no) on counseling students' responsibility attributions for problem solution based on a client case scenario.

Q2.1 Are responsibility attributions used by counseling students for client problem solution, significantly different for clients with different racial/ethnic backgrounds (i.e.,

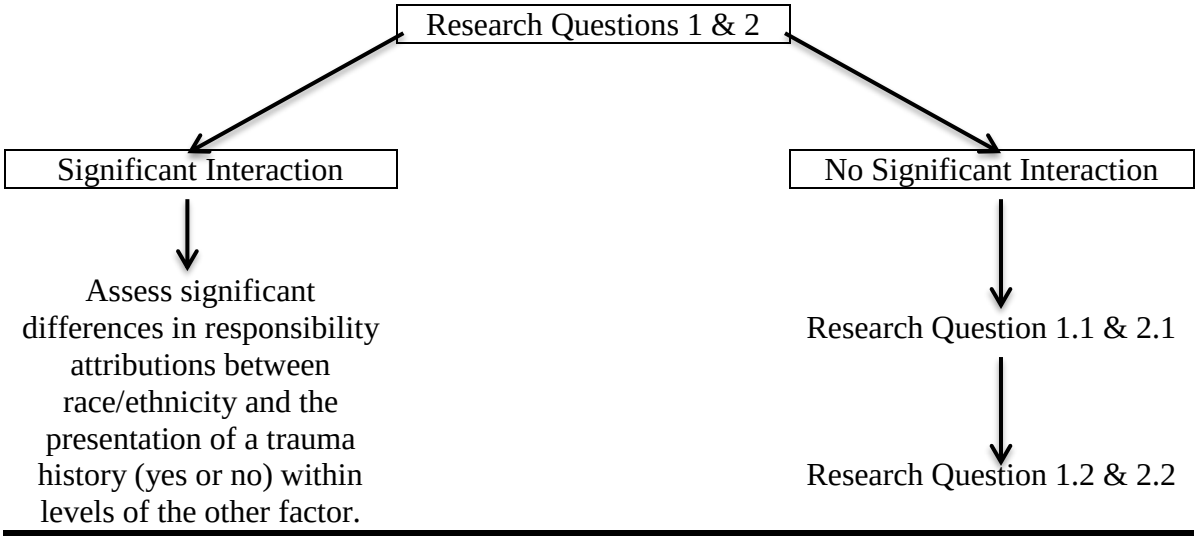
White, Latino, Black/African American)?

Hypothesis: Responsibility attributions used by counseling students for client problem solution will be significantly different for clients with different racial/ethnic backgrounds (i.e., White, Latino, Black/African American).

Q2.2 Are responsibility attributions used by counseling students for client problem solution, significantly different for clients with an additional trauma history (i.e., yes or no)?

Hypothesis: Responsibility attributions of client problem solution used by counseling students will be significantly different for clients with different racial/ethnic backgrounds (i.e., White, Latino, or Black/African American).

Figure 2
Representation of Analysis Process



CHAPTER II

METHODOLOGY

Participants

The sample consisted of 217 graduate students who were currently enrolled in master's programs for counseling in the U.S. Age of participants varied with ages 20-29 (79.3%, n = 172) being the majority, while the remainder of the participants were ages 30-39 (12.4%, n = 27), 40-55 (7.8%, n = 17), and 55+ (.45%, n = 1). Participants were purposively sampled from counseling programs from different geographic regions in the United States in order to recruit a sample that is representative of the larger population being studied. In total, 28 states were represented in the sample of participants (Table 1).

The majority of the participants identified as White (78.3%, n = 170), while the remainder of the sample was comprised of individuals who identified as Black/African American (5.5%, n = 12), Asian (7.4%, n = 16), biracial/multiracial/mixed (7.8%, n = 17), and American Indian/Alaskan Native (.9%, n = 2). In addition, the majority of the sample identified as not Hispanic/Latino(a) (87.6%, n = 190) with 27 (12.4%, n = 27) identifying as Hispanic/Latino(a). The majority of the sample identified as heterosexual/straight (84.8%, n = 184), with the remainder of the sample identifying as gay/lesbian/bisexual (12.9%, n = 28), pansexual (.9%, n = 2), asexual (.9%, n = 2) and abstinent (.45%, n = 1). In terms of gender identity, the sample was largely female (84.3%, n = 183) with males (14.7%, n = 32) and transgender (.9%, n = 2) individuals making up the rest of the participants. Notably, in terms of gender and counseling

students, this sample is representative of the counseling field in general where female counselors make up around 75% of the field (Ray, Huffman, Christian, & Wilson, 2016).

In regards to graduate degree type, students pursuing a Master of Arts degree was most common (47.5%, n = 103) with a Master of Science degree being the second most common (38.2%, n = 83), and a smaller proportion of the sample acquiring a Master of Education degree (14.3%, n = 31). Of the 217 participants, the majority reported they were attending a program that was accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP) (77.9%, n = 169) with the rest of the participants (22.1%, n = 48) attending a non-CACREP accredited program. Participants in their first year (38.2%, n = 83), second year (41.9%, n = 91), and third year (15.11%, n = 34) made up the majority of the sample. Out of the 217 participants, the majority had already taken a multicultural class (79%, n = 172) with the remainder reporting they had never taken a class in multicultural studies (21%, n = 45).

In addition to basic demographic information, participants were asked to report any history of previous trauma in their lives. In total, the majority of the participants reported experiencing at least one form of trauma in their lives (71%, n = 154).

Participants reported emotional trauma as the most common experience (31.8%, n = 69) and sexual trauma as the second most common (12.9%, n = 28). Some participants reported psychological trauma (11%, n = 24) or physical trauma (6.5%, n = 14) in their past. A significant portion of participants reported they had not endured any trauma (29%, n = 63), while other participants reported they endured a combination of the traumatic experiences listed (8.8%, n = 19).

Table 1
Demographic Information of Participants (N = 217)

Characteristic		n	%
Gender			
	Female	183	84.3
	Male	32	14.7
	Transgender	2	.9
Race			
	American Indian/Alaska Native	2	.9
	Asian	16	7.4
	Black/African American	12	5.5
	White	170	78.3
	Biracial/Multiracial/Mixed	17	7.8
Ethnicity			
	Hispanic/Latino(a)	27	12.4
	Not Hispanic/Latino(a)	190	87.6
Sexual Orientation			
	Heterosexual/Straight	184	84.8
	Gay/Lesbian/Bisexual	28	12.9
	Pansexual	2	.9
	Asexual	2	.9
	Abstinent	1	.5
Age			
	20-29	172	79.3
	30-39	27	12.4
	40-55	17	7.8
	55+	1	.5
Degree			
	M.A.	103	47.5
	M.Ed.	31	14.3
	M.S.	83	38.2
School Accreditation			

	CACREP	169	77.9
	Non-CACREP	48	22.1
Trauma			
	Emotional	69	31.8
	Sexual	28	12.9
	Physical	14	6.5
	Psychological	24	11
	Combination	19	8.8
	None	63	29
State			
	Alabama	1	.5
	Alaska	5	2.3
	Arizona	12	5.5
	Arkansas	6	2.8
	Colorado	24	11.1
	District of Columbia	1	.5
	Florida	18	8.3
	Idaho	1	.5
	Indiana	6	2.8
	Kansas	1	.5
	Kentucky	3	1.4
	Massachusetts	1	.5
	Minnesota	25	11.5
	Missouri	6	2.8
	Nebraska	1	.5
	New Jersey	1	.5
	New Mexico	1	.5
	New York	9	4.1
	Oklahoma	27	12.4
	Oregon	9	4.1
	Pennsylvania	13	6
	South Carolina	6	2.8
	Tennessee	9	4.1
	Texas	4	1.8
	Virginia	2	.9
	Washington	14	6.5
	West Virginia	9	4.1

Instruments

Demographic form. Participants completed a demographic questionnaire, which included questions regarding age, gender identity, sexual orientation, race, ethnicity, degree type, year in program, past trauma (i.e., sexual, physical, emotional, psychological, none), completion of a multicultural class, and program accreditation. See Appendix E for a complete list of demographic questions.

Client Vignettes. Participants were provided with a case study vignette of a client depicting common presenting concerns (i.e., anxiety/depression symptoms) with behavioral descriptors of the symptomology. The vignettes utilized in the study depicted a male client of White, Latino, or Black/African American racial/ethnic background. The vignettes had identical descriptors of presenting concerns except for the change in race/ethnicity of the client.

Additionally, some participants were presented with the aforementioned vignettes and an additional trauma history. The addition of the trauma history was randomly assigned to research participants utilizing a randomizer algorithm in the online survey software. Through this randomization process, the researcher was able to assess the changes in responsibility attributions when a client trauma history was provided to the counselor in addition to the initial case study. Furthermore, the combination of the two dependent variables, problem cause and problem solution, allowed the researcher to assess the interaction of race/ethnicity and trauma history as it relates to counseling students' attributions for problem cause and solution.

The Attribution of Problem Cause and Solution Scale (APCSS). The APCSS was created by Stepleman, Darcy, and Tracy (2005). The measure was specifically designed to be used in the counseling process and was formulated on the theoretical framework created by Brickman and colleagues (1982) (Figure 1). The measure loads participant responses into four

distinct categories of responsibility attributions for a client's problem cause and problem solution using a 7-point Likert-type scale (1 = very strongly disagree, 2 = strongly disagree, 3 = disagree, 4 = neutral, 5 = agree, 6 = strongly agree, and 7 = very strongly agree).

Stepleman and colleagues (1982) normed the APCSS on 202 undergraduate psychology students at a large Midwestern university. The authors created 55 initial items to represent the four different attribution orientations and align with the problem cause and solution attributions based on internal and external responsibility. Of the original 55 items, four did not demonstrate pattern coefficients in excess of .4 on any dimension, and seven items demonstrated pattern coefficients in a manner contrary to that projected by the theory. These items were dropped from the scale. Four additional items showed pattern coefficients in excess of .4 on both factors and were preserved as instrument items. The five items that had pattern coefficients in excess of .4 on both factors were preserved. This final pool of 44 items was again subjected to a principal axis analysis, which resulted in two clear factors. Thus, the APCSS measure is a 44-item scale, with 24 items measuring responsibility for problem cause (11 external, 13 internal) and 20 items measuring responsibility for problem solution (16 external, 4 internal). The internal consistency for the cause and solution scales is high, with Cronbach's values of .95 (cause) and .92 (solution).

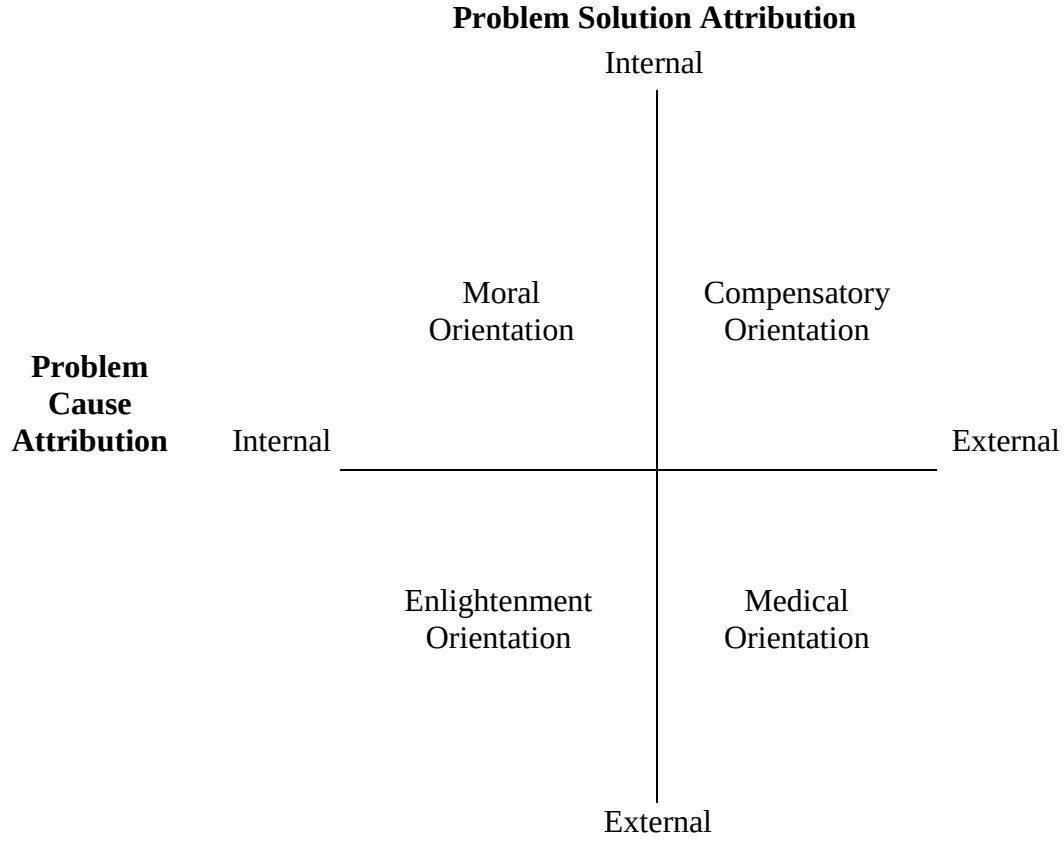
This measure asks counseling students to answer questions about clients broadly, and categorizes the responses into internal cause, external cause, and internal solution, external solution (See Figure 3). For the current study, the measure was slightly altered so that questions refer specifically to the "client" in the case vignette. Prior to administering the survey, the researcher was given permission from Dr. Stepleman to alter the survey to align with the current study. The researcher and research advisor collaborated to create the altered survey questions to

match client vignettes. For example, on external cause items, the original survey asked, "Other people are the cause of my problems," which was altered to "Other people are the cause of the client's problems." For problem cause items, the original survey asked, "I am responsible for the cause of my problems," which was changed to "The client is responsible for the cause of his problems?" For internal problem solution items, the original survey asked, "My own capabilities should be used to solve the problems," which was altered to "The client's own capabilities should be used to solve the problems." Lastly, external problem solution questions were also altered. The original survey asked, "Solving this problem is my responsibility" was changed to "Solving this problem is the client's responsibility."

In this study, factor and item analysis were conducted to assess if the altered items on the survey continued to load onto the two dimensions of the original theoretical model proposed by Brickman et al. (1982). Items were factor analyzed using the principal-axis factor analysis with varimax rotation to see if the structure held. Similar to the analysis conducted by Stepleman et al. (2005), varimax rotation was chosen given that Brickman et al. (1982) hypothesized that attributions for problem cause and attributions for problem solution were independent of each other and functioned in a different fashion. The altered survey demonstrated loading of items onto two separate categories with no items demonstrating pattern coefficients of less than .4 or displaying pattern coefficients contrary to prediction as per the original theory. Therefore, the 44-item scale did not require any items to be removed from the measure. The internal consistency for the cause and solution scales demonstrated a marginal decrease from Stepleman et al. (2005), which originally reported Cronbach's α values of .95 (cause) and .92 (solution). However, the internal consistency for the cause and solution scales from this study remained high, with Cronbach's α values of .89 (cause) and .76 (solution) (Streiner, 2003).

Figure 3

Structure of Helping and Coping Attributions



Note. Adapted from "Helping and Coping Attributions: Development of the Attribution of Problem Cause and Solution Scale" by L. M. Stepleman, M. Darcy, and T. Tracey, 2005, *Educational and Psychological Measurement, 65*, p. 527.

Procedure

Participants were identified by utilizing the online database of counseling programs listed on www.CACREP.org, counseling student Facebook pages, and from purposive recruitment emails to counseling faculty at other universities from counseling faculty at Oklahoma State University. The majority of students were recruited through graduate school-assigned email addresses by a training director, program coordinator, or counseling faculty from their respective university. The training directors, program coordinators, and faculty were identified through

university counseling homepages listed on www.CACREP.org. Emails requesting participation in the study were sent out to these individuals asking for voluntary assistance in disseminating a recruitment email. Faculty that consented to help received the recruitment email, which they sent out to their students. The recruitment email contained information regarding the study, eligibility, and the link to the survey. In addition, counseling student Facebook pages were utilized to recruit participants to the study. Pages that allowed research survey postings were identified, and the researcher posted a research participant request, which contained information related to the study and the survey link. To increase student participation, the researcher provided a random drawing for three 50-dollar gift cards that were mailed out to randomly selected participants after the completion of data collection.

Research participants who volunteered to participate in the study utilized an online link that directed them to the informed consent document (Appendix D). The link for the study was provided at www.tinyurl.com/kevdiss and the online questionnaire was administered through the researcher's online Qualtrics account. Eligible participants read the informed consent document and were asked to confirm if they understood the purpose of the study and the extent of their involvement. The informed consent document concluded by stating, "I have been fully informed about the procedures listed above. I am aware of what I am being asked to do and of the benefits of participation. If you consent to participate in this study, click yes, if you do not consent to participate in this study click no." Students who clicked "yes" were directed to the demographic questionnaire, client vignette, and research survey. Students who clicked "no" were directed out of the survey.

After completing the demographic questionnaire the participants were prompted to click "continue" and were presented with a random hypothetical client vignette. The hypothetical

client vignette was manipulated by race/ethnicity (Latino, White, Black/African American) and by the addition of a trauma history narrative (included or not included). The vignettes were randomly assigned to participants by incorporating a "randomizer" algorithm via the survey flow module in the Qualtrics program software. Therefore, research participants were randomly assigned to one of six different groups based on the client's race/ethnicity and the inclusion of an additional trauma history. Participants read the randomly assigned vignette and were prompted to continue to the research survey to answer questions regarding their beliefs about who is responsible for causing the client's problems (i.e., internal vs. external) and who is responsible for solving those problems (i.e., internal vs. external). Following completion of the research survey, participants were provided with an additional link to add their email address for drawing of the gift cards. The additional link allowed the researcher to maintain anonymity of responses from the participants and did not pair any identifying information with their survey responses. This completed the subjects' participation in the study.

CHAPTER III

RESULTS

Statistical Design

To measure the significance of the effect of the independent variables, race/ethnicity and trauma history, the researcher analyzed the data with multiple two-way analyses of variance (ANOVA) omnibus F-tests, one for problem cause and one for problem solution. The researcher used a completely randomized factorial design (CRF-*32*) with tests of between-subjects effects (Table 2). This design is utilized when a researcher wants to test whether the population means across levels of groups A (i.e., race/ethnicity) and groups B (i.e., trauma history) are equal. Additionally, if the interaction is not significant then the researcher can test the null hypothesis that (1) the population means of group A (i.e., race/ethnicity) are equal, and (2) the population means of group B (i.e., trauma history) are equal (Kirk, 2013). Further, a completely randomized factorial design requires two or more levels in each independent variable. The study of two racial and one ethnic group (three levels) in one independent variable, as well as the manipulation of a trauma history (two levels) in the other independent variable, is represented as CRF-*32*.

In order to maximize the conclusion validity of the CRF-*32* design, the researcher recruited a sample of n = 217 counseling students, which allowed for greater than 30 students per block (Van Voorhis & Morgan, 2007) (Table 2). Each block represents the six different conditions that counseling students were randomly presented with different client vignettes

varying by race/ethnicity and trauma history (Table 2). By sampling enough students to achieve 30 subjects per block, the researcher increased the veracity of the statistical findings by achieving statistical power greater than 80% (Van Voorhis & Morgan, 2007).

Table 2
Sample Sizes of the Six Groups in the CRF-32 Design

	Race/Ethnicity of Client in Vignette		
Trauma History	White	African American/Black	Latino
Included	N=36	N=42	N=32
Not Included	N=36	N=32	N=39

Additionally, CRF-*32* assumptions were evaluated in order for the analysis to be valid (Kirk, 2013). Therefore, the researcher ran a Shapiro-Wilks statistical test to ensure normality of distribution within group combinations (Field, 2013). Random assignment of all independent variables and levels was achieved through the "randomizer" option available in the Qualtrics software for independence of observations (Kirk, 2013). Additionally, the researcher conducted a Levene's statistical test to assess the homogeneity of variance with the different groups (Field, 2013).

Statistical Assumptions and Preliminary Analyses

Data screening. The data was manually screened to determine if participant demographics and the number of items completed met criteria for inclusion in the study (counseling student, age, currently enrolled, etc.). All participants who failed to complete the items of the demographic questionnaire or research survey were not used in data analysis. The survey was designed with forced choice responses, therefore if a research subject did not answer a question of the survey, he/she was prevented from moving on the next question of the survey.

Incomplete surveys were rejected from the data analysis process. Of the 254 surveys recorded, 217 met criteria for inclusion in the study.

Data coding. The four sub-domains of the model (i.e., problem cause internal/external and problem solution internal/external) were combined to create an overall problem cause score and problem solution score. For problem cause, items 1-11 were scored normally while items 12-24 were reverse coded to combine the two subdomains (i.e., external and internal cause attributions) into one domain. Likewise, for problem solution, items 25-28 were normally scored, while items 29-44 were reverse coded to once again combine the two sub-domains (internal and external solution attributions) into one domain. The reverse coding of the items allowed the researcher to determine a mean score for problem cause and a mean score for problem solution from each respondent. The minimum mean score for problem cause was (m = 1.73) and the maximum mean score was (m = 5.74). The minimum mean score for problem solution was (m = 2.97) and the maximum mean score was (m = 6.09). The lower the mean score for problem cause corresponded to the respondent giving more responsibility to external variables for the development of the cause, whereas a higher the mean score corresponded to the respondent giving more responsibility to the client's internal variables for the development of the cause. For problem solution, the lower the mean score for problem solution, the more responsibility placed on external assistance to fix the client's problem, whereas the higher the mean score, the more responsibility placed on the individual to solve his/her own problems. The means of the scores were then used for comparative analysis of the variables (i.e., race/ethnicity and trauma history).

Statistical assumptions. Prior to conducting the two-way factorial ANOVA, the statistical assumptions for the completely randomized factorial design (CRF-32) were assessed. The data was tested for violation of normality at a .05 level of significance using the Shapiro

Wilks normality test. The data within each cell demonstrated normality of distribution ($p > .05$). Therefore, normality was held for problem cause and problem solution scores across all levels of the factorial model. Random assignment of the independent variables was maintained through the Qualtrics online software with the client vignettes and additional trauma history being randomly assigned to participants. Lastly, the data demonstrated homogeneity of variance within the combination of variables for problem cause ($p > .05$) and problem solution ($p > .05$). Therefore, all statistical assumptions for the completely randomized factorial design (CRF-*32*) were met.

Findings

Problem cause. A two-way factorial ANOVA assessed the effect of client race/ethnicity (Black African/American, Latino, and White) and the addition of a trauma history (included or not included) on the responsibility attributions for problem cause by counseling students. The responsibility attributions of the interaction of race/ethnicity and trauma history was not significant ($F(2,211) = 1.235$, $p = .293$). Following the statistical procedure of the completely randomized factorial design, main effects were investigated to look for significant differences between race/ethnicity groups and trauma history groups independently (Kirk, 2013). The one way ANOVA for race/ethnicity groups was not significant ($F(2,211) = 1.862$, $p = .158$). However, for trauma history, the ANOVA ($F(1,211) = 60.202$, $p < .001$) confirmed significant differences existed between the responsibility attributions used when an additional trauma history was provided with the original client vignette. The ANOVA had a medium effect size ($\eta^2 = 0.22$) and power analysis conducted via G*Power 3.1.9.2 software determined Power = .89. A post hoc test was not performed for trauma history because there were fewer than two groups. However, the observation of means for trauma ($m = 3.27$) and no trauma ($m = 3.93$) indicated

that counseling students presented with an additional trauma history were more likely to attribute responsibility of the client's problems to external causes. Counseling students that were not provided the additional trauma narrative were more likely to attribute responsibility of the client's problems to internal causes.

Table 3
Analysis of Variance (ANOVA) Tests of Between-Subjects Effects for Problem Cause

	df	*SS*	*MS*	*F*	*p*	η^2
Race/Ethnicity &Trauma History Interaction	2	.955	.477	1.235	.293	.012
Race/Ethnicity	2	1.439	.720	1.862	.158	.017
Trauma History	1	23.271	23.271	60.202	.000**	.222

Note: *$p < .05$; **$p < .01$

Problem solution. The researcher utilized a two-way factorial ANOVA to determine the effect of client race/ethnicity (Black African/American, Latino, and White) and the addition of a trauma history (included or not included) on the responsibility attributions for problem solution by counseling students. The differences in responsibility attributions for the interaction between the two variables (i.e., race/ethnicity and trauma history) was not significant ($F(2,211) = .451$, $p = .637$). Following the statistical procedure of the completely randomized factorial design, main effects were observed to look for significant differences between race/ethnicity groups and trauma history groups independently (Kirk, 2013). The responsibility attributions used by counseling students for problem solution across racial/ethnic groups was not significant ($F(2,211) = .148$, $p = .863$). Similarly, the responsibility attributions used by counseling students for problem solution when presented with an additional trauma history was not significant

($F(1,211) = .002$, $p = .969$).

Table 4
Analysis of Variance (ANOVA) Tests of Between-Subjects Effects for Problem Solution

	df	*SS*	*MS*	*F*	*p*	η^2
Race/Ethnicity &Trauma History Interaction	2	.306	.153	.451	.637	.000
Race/Ethnicity	2	.100	.050	.148	.863	.012
Trauma History	1	.001	.001	.002	.969	.000

Note: *$p < .05$ level; **$p < .01$

Exploratory analysis. In addition to analyzing the responsibility attributions outlined in the research questions, the researcher also conducted exploratory analysis to rule out potential confounding variables in the data. Independent samples t-tests were conducted to assess the differences in responsibility attributions for participants based on their gender, race/ethnicity, program accreditation, whether they took a multicultural class, and past experience of trauma.

The research participants' responsibility attributions for problem cause were not significantly different between males ($M = 3.537$, $SD = 8.023$, $N = 32$) or females ($M = 3.621$, $SD = .689$, $N = 183$); t(213) = -.629, $p = .530$). Likewise, responsibility attributions for assessing problem solution were not significantly different between males ($M = 4.636$, $SD = .512$, $N = 32$) or females ($M = 4.614$, $SD = .587$, $N = 183$); $t(213) = .198$, $p = .843$).

Students who attended CACREP programs ($M = 3.620$, $SD = .691$, $N = 169$) did not have significantly different responsibility attributions for problem cause when compared to students from non-CACREP programs ($M = 3.553$, $SD = .749$, $N = 48$); $t(215) = .586$, $p = .559$. Similarly, students who attended CACREP programs ($M = 4.636$, $SD = .589$, $N = 169$) did not have

significantly different responsibility attributions for problem solution when compared to students from non-CACREP programs (M = 4.546, SD = .535, N = 48); t(215) = .960, p = .338.

Students who completed a multicultural class prior to taking the survey (M = 3.567, SD = .734, N = 170) did not have significantly different responsibility attributions for problem cause when compared to students who had not taken a multicultural class (M = 3.745, SD = .562, N = 47); t(215) = -1.540, p = .125. Similarly, students who completed a multicultural class prior to taking the survey (M = 4.615, SD = .589, N = 170) did not have significantly different responsibility attributions for problem solution when compared to students who had not taken a multicultural class (M = 4.619, SD = .538, N = 47); t(215) = -.037, p = .970.

The responsibility attributions for problem cause were not significantly different for White students (M = 3.576, SD = .727, N = 170) when compared to non-White students (M = .604, SD = .604, N = 47); t(215) = 1.170, p = .243. Likewise, the responsibility attributions for problem solution were not significantly different for White students (M = 4.663, SD = .571, N = 170) when compared to non-White students (M = 4.447, SD = .575, N = 47) t(215) = -2.295, p = .785.

Lastly, the responsibility attributions for problem cause were not significantly different for students who reported previous experiences of trauma (M = 3.559, SD = .741, N = 157) when compared to students who did not report any experiences of previous trauma (M = 3.726, SD = .581, N = 60); t(215) = 1.741, p = .084. In addition, the responsibility attributions for problem solution were not significantly different for students who reported previous experiences of trauma (M = 4.627, SD = .613, N = 157) when compared to students who did not report any previous experiences of trauma (M = 4.588, SD = .477, N = 60); t(215) = -.496, p = .621

CHAPTER IV

DISCUSSION

The United States Department of Labor Bureau (2017) indicates there are around 552,000 mental health professionals providing treatment and mental health services in the United States, and 365,600 of these professionals can be categorized as master's level counselors. Therefore, master's level counselors are conducting the majority of mental health services provided to the public. However, little is known about how these professionals conceptualize the cause of their clients' problems or the responsibility they assign to fix these problems. Furthermore, effective treatment with diverse clients and trauma survivors is heavily influenced by the responsibility attributions utilized by their counselors. Therefore, this study attempted to address a gap in the literature by assessing the responsibility attributions of master's level counselors for diverse and trauma afflicted clients. To date, no other research study exists that addresses these important questions empirically.

Hypothesis

The first hypotheses under investigation was: The interaction between race/ethnicity and the addition of a trauma history of a client will not significantly change the responsibility attributions utilized by counseling students when conceptualizing problem cause and problem solution. These hypotheses were supported for both the problem cause and the problem solution. The second hypotheses under investigation were: The race/ethnicity of the client will

significantly change the responsibility attributions utilized by counseling students for a) problem cause and b) problem solution. Neither of these hypotheses was supported. The third hypotheses under investigation were: Additional knowledge of a trauma history will significantly change the responsibility attributions utilized by counseling students when conceptualizing problem cause and problem solution. The hypothesis was supported for the responsibility attributions on client problem cause, but was not supported for responsibility attributions of client problem solution.

Responsibility Attributions and Diverse Clients

Two separate two-way factorial ANOVA's revealed that the race/ethnicity of the client portrayed in the survey vignette did not significantly change the responsibility attributions utilized by counseling students for problem cause or problem solution. Previous research on responsibility attributions and problem cause where race/ethnicity was manipulated, found that African American clients were held more personally responsible for the problems they were presenting with, while White clients were given greater consideration for environment causing the problems (Rosenthal, 2004). The findings from this study, however, did not find a significant difference in the counseling students' perception of problem cause amongst the diverse clients represented. There may be several reasons why this study did not find a similar result as previous research. One reason may be the increase in multicultural sensitive training counselor education programs now employ (Bezrukova, Spell, Perry, & Jehn, 2016). The focus on multiculturalism and bias awareness is becoming more integrated into counselor education training at all levels, which could explain the similar perceptions of diverse clients in terms of the development of problems and the solutions to those problems. Furthermore, students who previously completed a multicultural course did not have significantly different responsibility attributions from students who did not complete multicultural course. Therefore, the integrated model of multicultural

training appears to be increasing students' sensitivity when working with diverse clients even when they have not taken a specific course in multicultural training.

Another possible explanation for the findings relates to social desirability amongst counseling students. Burkard and Knox (2004) found that when mental health professionals from the majority population (i.e. White) were assessed on their beliefs about clients from varying racial/ethnic backgrounds, they tended to provide socially desirable answers that would not indicate any sort of discriminatory beliefs. It may be that the structure of the survey items and specific questions about placing fault on the client (i.e., internal cause) prompted the counseling students to answer questions that would seem socially desirable. Therefore, it is plausible the research participants, especially those from the majority population (i.e., White), were being cautious to not assign personal blame in the vignettes depicting diverse clients (Black/African American and Latino).

Furthermore, the sample of participants was predominately White (n = 170, 78.3%), so assigning personal blame to clients that are from different racial/ethnic backgrounds could also engender feelings of white guilt (Helms, 1990). Collective guilt research demonstrates that individuals from the majority group will overcompensate by demonstrating additional empathy and caring for individuals from minority groups (Ferguson & Branscombe, 2014). However, it is important to note that the responses from the counseling students did not indicate any racial/ethnic bias or overcompensation for any of the racial/ethnic group represented in the vignettes.

The responsibility attributions for problem solution were also not significantly different across the diverse clients represented in the vignettes. Similar to the study's findings on problem cause attributions, these findings are not consistent with previous studies. For example, Burkard

and Knox (2004) found that African Americans were more likely to be held personally responsible for solving their problems when compared to Whites. There are several possible reasons why this study did not find differences in responsibility attributions for problem solution across diverse clients. First, similar to the attributions on problem cause, the increase in diversity training would increase the sensitivity to race/ethnicity and help counseling students reduce implicit bias towards clients from racial/ethnic minority status (Bezrukova et al., 2016). It may also be conceivable that the short amount of time the counseling students have in actually conducting therapy influences their confidence on assigning responsibility for the solutions to their clients' problems. For example, Kurtyilmaz (2015) found that counseling students in general exhibit a high level of anxiety related to their competence in helping clients solve problems. Therefore, it may be that the counseling students were not able to be decisive about assigning responsibility for solving their clients' problems.

In addition, the development of a counselor's theoretical orientation takes time and practice before it can be utilized in a structured format in therapy (Kurtyilmaz, 2015). Therefore, counseling students will not have been practicing long enough in the field to be proficient at using evidenced based treatment or feel purposeful when structuring the solutions to their clients' problems. This lack of experience may better explain the wide variability in the attributions for problem solution amongst the research participants.

Responsibility Attributions and Trauma Survivors

A two-way factorial ANOVA revealed significant differences in responsibility attributions for problem cause when the clients' trauma history was made known. The data from the study indicates that when counseling students were presented with an additional trauma history in conjunction with a case report, they were more likely to give greater consideration to

external variables when conceptualizing problem cause of their clients. This finding demonstrates the importance of specifically focusing on the traumatic experiences of clients because it mitigates the personal blame placed on clients when conceptualizing problem cause. As Marsella (2010) stated, "traumatic events are a universal part of human experience" (p. 8). In addition, five out of every six clients in mental health clinics are trauma survivors that require specialized knowledge on behalf of counselors for treatment (Jones & Cureton, 2014).

Courtois and Gold (2009) reported that despite the establishment of scientific literature on trauma, counseling graduate programs have resisted making trauma training a core curriculum component. The data from this study demonstrates the importance of training students on identifying the types of trauma their clients have lived through. Gaining knowledge on past traumas, as evidenced by the data from this study, provides greater historical context for counseling students when conceptualizing the problems their clients are presenting with. More importantly, the greater the consideration of external variables for trauma afflicted clients, the more likely a counselor will demonstrate patience, empathy, and understanding of their clients' problems (Elliot et al., 2005; Ford & Russo, 2006; Goodman, 2015; Goodman & West-Olatunji, 2008). Therefore, graduate programs responsible for training counselors should begin to incorporate specific training on gathering trauma histories, not only for the benefit of the clients, but also for the benefit of the counselor. As Bloom and Sreedhar (2008) noted, when a counselor asks, "What happened to you?" instead of "What's wrong with you?" (p. 50) a shift in blame immediately takes place and makes counselors more empathic while simultaneously increasing their understanding of client etiology.

A two-way factorial ANOVA did not demonstrate differences in responsibility attributions for problem solution when the clients' trauma history was made known. There are

several possible reasons for this finding. First, as mentioned above, trauma informed training is not a widespread focus for graduate training programs. Therefore, it is conceivable that the participants in the study had not been trained on evidence-based models for treating trauma-afflicted clients. Ideally, if the counseling students had been exposed to trauma informed treatment models, the data would have indicated the responsibility of problem solution being greater for the client and not the counselor. For example, Seeking Safety, a well-researched treatment model for clients suffering from PTSD, utilizes client empowerment to create solutions to presenting concerns (Boden et al., 2011; Najavits, 2005). In addition, Cognitive Processing Therapy (CPT), another empirically supported treatment for trauma survivors, places the responsibility for change on the client, while recognizing the role that past trauma plays in problem development (Finlay, 2015). With both treatment models, the focus of treatment is future oriented with the counselor acknowledging the trauma of the past. Therefore, presenting concerns are not considered to be the fault of the client, but the solutions to the concerns are largely placed in the client (i.e., compensatory model). More importantly, the recognition of past trauma and emphasizing personal client empowerment is effective because it stresses inner control and a future emphasis for change (Henley & Furnham, 1988; Karuza et al., 1990; Kleinke & Kane, 1998; Knapp & Delprato, 1980; Williams et al., 2013; Worthington & Atkinson, 1993). Additionally, this approach is effective because it encourages clients to direct their energy outward while mitigating their feelings of personal guilt or blame.

Unfortunately, in terms of the data from this study, there was no defined attribution for problem solution. This indicates there is a need for evidence based trauma training for counseling students. However, as mentioned above, the lack of counseling experience and application of theoretical counseling models may better explain the variations in responsibility

attributions for problem solution of trauma-afflicted clients. Despite the research literature on treating clients with trauma not aligning with the data from this study, the counseling students gave similar consideration to external and internal variables for problem solution. This indicates that the counseling students gave similar consideration to who is responsible for solving the presenting concerns (counselor or client). Optimistically, this is not necessarily a negative finding. For example, even though trauma informed models typically place greater responsibility on the client for problem solution, counselor intervention and support is still an integral part of treatment success (Bloom & Sreedhar, 2008; Hensel, Ruiz, Finney, & Dewa, 2015). Therefore, responsibility for solving a client's problems includes professional intervention at some level in order for the client to receive effective treatment.

Implication of Findings

The findings of this study have several implications. First, this study adds novel information to the field of responsibility attributions for diverse clients and trauma survivors. Past research has largely focused on the responsibility attributions related to clients of White or Black/African American racial backgrounds. This study attempted to incorporate additional racial/ethnic variables as well as the addition of a trauma history. To date, no other study has looked at counseling students' perceptions on trauma related to diverse clients. Therefore, the goal of this study was to fill a gap in the current literature, while also assessing for potential errors in counseling student conceptualizations for sensitive populations of clients (diverse clients and trauma survivors).

Research shows that the compensatory model of attribution for problem cause and solution is the most beneficial for working with clients who have either a diverse racial/ethnic background or who have experienced trauma (Bloom & Sreedhar, 2008; Constantine, 2002;

Dass-Brailsford, 2007; Greenleaf & Williams, 2014; Huey et al., 2014; Suarez & Gadalla, 2010; Williams et al., 2013). However, the data from this study did not reflect a defined orientation model for counseling students when conceptualizing diverse clients or trauma survivors. Although the attribution models were not clear, the incorporation of a trauma narrative demonstrated attributions closely aligned with the moral and compensatory models. What this indicates is that counseling students were able to suspend personal blame for the cause of the clients' problems when the trauma narrative was provided, which is consistent with the compensatory and moral attribution models. However, regardless of race/ethnicity or trauma, solutions to the presenting concerns (client responsibility vs. counselor responsibility) were undefined. These findings demonstrate the importance for increasing counseling student knowledge on strength based counseling, client empowerment, and solution focused therapy models. As mentioned above, evidence based models for racially/ethnically diverse clients and trauma survivors emphasize the responsibility of the client to engage in action oriented solutions to their problems (i.e., compensatory model) (Boden et al., 2011; Finlay, 2015; Najavits, 2005). Therefore, if a counseling student is working with diverse client, or if he/she is aware of a client's trauma history, the student needs to be cautious of taking too much personal responsibility for solving the client's problems. Furthermore, if counseling students over function for their clients, they are at risk for fostering clinical dependence for client solutions, as well as feeling overwhelmed with responsibility, which can lead to burnout (Gutierrez & Mullen, 2016). Notably, the data did not definitively reach this conclusion in terms of attributions for problem solution; however, the variation in responses indicates that a significant number of the respondents were reporting high levels of personal responsibility for solving the client's problems, which can lead to problematic boundary issues with clients (Herlihy & Corey, 2014).

Additionally, this study provides valuable information for graduate programs responsible for training counseling students. The importance of emphasizing trauma related symptoms during clinical training cannot be understated. The data from this study demonstrated a significant perception change related to presenting concerns by simply adding an additional trauma history to the psychosocial narrative. The addition of a trauma history provided greater contextual information for respondents to conceptualize their client, and more importantly, current literature emphasizes why this is important for effective counseling student training (Conye & Cook, 2004; Greenleaf & Williams, 2009; Greenleaf, Williams, & Duys, 2015). In addition, when greater environmental context is provided (i.e., trauma history), counseling students are able to recognize the development of mental health distress in their clients without attributing personal blame. Therefore, this additional knowledge can help increase counselor empathy, patience, and increase client retention rates (Cusack, et al., 2006; Morrow & Deidan, 1992; Strohmer & Shivy, 1994). Furthermore, counseling students equipped with this knowledge will know how to conceptualize difficult behaviors (i.e., drug abuse, anger/irritability, hypervigilance, etc.) while being more sensitive to their clients.

The data from this study also has broader implications for counseling practice in general. For example, the results from this study provide encouragement for counseling clinics, hospitals, residential treatment centers, schools, etc., to start adopting a trauma sensitive approach when conducting therapy. In this study, clients portrayed in the vignettes without a trauma narrative received significantly higher rates of internal attributions for problem cause. Therefore, these clients were being conceptualized with a higher level of personal blame for the development of their psychological distress. As previous research has shown, clients from diverse racial/ethnic backgrounds, and clients with traumatic histories, are especially sensitive to personal blame for

problem cause development (Elliot, et al., 2005; Goodman, 2014). Moreover, personal blame for clients' problem cause can even be detrimental to their recovery (Burkard & Knox, 2004; Harris & Fallot, 2001). Therefore, subtle systematic changes in approaching conceptualization with clientele can have large ramifications for treatment success. It is conceivable that a widespread adoption of trauma sensitive counseling could improve the quality of mental health care in the United States, especially for diverse clients, who receive lower quality health care on average, and are less likely to use counseling services in the first place (Harris et al., 2005; Ojeda & McGuire, 2006).

Future Directions

Although this study provides preliminary information on counseling students' responsibility attributions for diverse clients and trauma survivors, additional research is warranted on this topic. The client vignettes depicted only male clients; therefore future research may want to manipulate the variables of race/ethnicity and trauma for female clients. In addition, the racial/ethnic categories in this study represented the three most prevalent racial/ethnic groups in the United State (White, Black/African American, and Latino(a)), however responsibility attributions for other racial and ethnic groups should be studied as well. For example, research indicates that American Indians and Alaska Natives experience substantially higher rates of Post-Traumatic Stress Disorder than U.S. Whites do (Bassett, Buchwald, & Manson, 2014). This population also has significantly higher rates of substance abuse, domestic violence, pathological gambling, and general health problems, all of which can be best explained by traumatic experiences (Courtois, 2004; Courtios & Gold, 2012; Freidman et al., 2007; Gil-Rivas, Prause, Grella, 2009; Harrison & Fowler, 2004). Therefore, assessing the responsibility attributions

applied to various other racial/ethnic groups will provide a deeper understanding of whether biased counseling is more likely with one population of clients over the other.

Future research may also want to utilize a more salient manipulation of racial/ethnic variables. In this study, the client vignettes provided multiple race/ethnic identifiers for the respondents. It is conceivable, however, that the responsibility attributions were not significantly different across the different racial/ethnic presentations because the manipulation of the variable did not provide powerful enough stimuli to demonstrate racial/ethnic bias. Past research shows that racial/ethnic minorities experience higher levels of bias when compared to the racial majority (i.e. White) (Burkard & Knox, 2004; Constantine, 2002). However, the data from this study indicated that all racial/ethnic groups were being conceptualized similarly, which may reflect progress in counseling student training. Conversely, the bias observed by previous researchers may still be present in counseling environments, so future research should look at continuing to assess the responsibility attributions related to diverse clients to add additional empirical support for racial/ethnic sensitive counseling.

Limitations

The proposed study should be interpreted within the context of its limitations. The survey was distributed to universities throughout the United States. However, the sample may not be representative of all masters' level counseling students in training, which limits generalizability. Additionally, the survey vignettes depicted only male clients in order to lower the number of respondents needed to maintain a significant level of power and increase feasibility of the study (Van Voorhis & Morgan, 2007). By representing a client of one gender, the generalizability of the data is also limited. Future research will want to utilize vignettes that depict a female client, especially when considering that more females engage in therapy than do males. In addition, the

trauma narrative included sexual abuse of a male client, which represents a rarely disclosed form of trauma in male clients (Easton, Saltzman, & Willis, 2014). Therefore it is conceivable the findings related to the trauma history were influenced by a social bias for men and sexual abuse.

Another potential limitation was the survey-based format of the study. Survey research is efficient in time management and cost, but presents weaknesses including incomplete responses, unacceptable responses, multiple submissions, and invalid responses (King, Murray, Salomon, & Tandon, 2003; Schmidt, 1997). In total, 37 surveys were unable to be recorded and were not included due to incomplete responses. Lastly, the survey method of research does not allow conclusions about cause and effect. However, the significant findings from the trauma history still provide valuable insight into counseling students' perceptions when provided with additional client background information.

Conclusion

The assessment of counseling students' responsibility attributions is a novel area of research. This study provides valuable information about conceptualizing clients from diverse backgrounds as well as clients presenting with trauma. When counseling students were presented with a case scenario without knowledge of the client's prior trauma, they were more likely to assign personal blame for the client's problems. Conversely, when the counseling students were provided with the same case scenario and an additional trauma narrative, they were more likely to consider environmental influences for the development of the client's problems. These findings demonstrate the importance of teaching students to inquire, assess, and utilize trauma histories when conceptualizing their clients' presenting concerns. With the inclusion of a trauma history, counseling students can learn to be more empathic, patient, and provide accurate diagnoses when working with future clients. In addition, information related to client trauma has

broader implications beyond just counseling students. Any setting where clients are being treated for mental health services can benefit from the inclusion of trauma history narratives. The current study demonstrates that perceptions of clients can be drastically altered in a positive way by adding a simple assessment of past trauma, which in turn, can improve the mental health treatment in the general population in whole.

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APPENDICES

Appendix A

Extended Review of the Literature

Counseling students go through a gamut of edification in order to develop competent therapy skills. Clientele served by these professionals come from various backgrounds, socioeconomic classes, races, ethnicities, and cultures, with a wide range of life experiences. For counseling students, informed training is paramount for developing diagnostic and conceptualization skills for working with diverse groups of clients (Gauthier, Pettifor, & Ferraro, 2010). Informed training can come in a variety of different forms and modalities. Recently, researchers have started to endorse enhanced theoretical and conceptual training for master's level counseling students. For example, researchers indicate that counseling students need to incorporate broader contextual factors to appropriately assess and treat clients, especially amongst clients from racially/ethnically diverse backgrounds (Conye & Cook, 2004; Greenleaf & Williams, 2009; Williams, Greenleaf, & Duys, 2015). Furthermore, this emphasis on enhanced didactics recommends counseling students be specifically taught to assess how a client's environment affects his or her well-being and development (Shalcross, 2013), while implementing interventions that move beyond exclusively focusing on the individual.

Educators can increase counselor competence by teaching students to draw connections between the presenting concerns of clients and the larger framework of their environments

(Williams, McMahon, & Goodman, 2015). Additionally, counseling students should learn to view their clients' through an environmentally sensitive lens, and develop critical thinking in regards to contextual conditions that contribute to presenting concerns (McMahon & Goodman, 2015). Putting emphasis on clients' environments can help therapists identify their own biases related to clients' behaviors and increase treatment congruence (e.g., treatment plan, relationship, or cause of problem) (Tracey, 1988).

Diversity Training

The American Psychological Association (APA) signifies that psychologists are to provide therapy with the absence of prejudice and understanding of client diversity (APA, 2010). Therapists are to incorporate a wide range of client information in order to perform effective treatment when practicing. Specifically, Principle E: Respect for People's Rights and Dignity States:

> …Psychologists are aware of and respect cultural, individual, and role differences, including those based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status and consider these factors when working with members of such groups. Psychologists try to eliminate the effect on their work of biases based on those factors, and they do not knowingly participate in or condone activities of others based upon such prejudices (p.4).

Further, the American Counseling Association (ACA) Code of Ethics identifies five core professional values for practicing counselors. Core professional value number two states that counseling students need to be "honoring diversity and embracing a multicultural approach in support of the worth, dignity, potential, and uniqueness of people within their social and cultural

context" (p.3). Therefore, regardless of the accrediting body a counselor or psychologist is adhering to, awareness of client diversity and environmental influences are crucial for development of competent professionals.

Vera and Speight (2003) explain that diversity training and competencies are core components of graduate training and include, case conceptualization, counselor behavior, and integration of knowledge into practice. Counseling education includes the awareness, instruction, skill development, and diagnostic knowledge to properly train therapists for competent practice with clients from diverse backgrounds and a wide range of experiences (Sue, Arredando, & McDavis, 1992). Further, this education trains counseling students to identify a plethora of client stressors and prevent bias from negatively influencing the counseling process.

Effective implementation of these constructs through education is essential given that counseling students can expect to work with a wide range of racially and ethnically diverse clients. In the United States, counseling students can expect to work with clients who are American Indian/Alaska Native, Asian, White, Black/African, Native Hawaiian/Pacific Islander, and White Hispanic/Latino(a) or non-White Hispanic/Latino(a) (Arredondo et al., 1996).

While the aforementioned ethnic/racial groups do not make up the total diversification of the United States population, they embody the majority of citizens throughout the population. However, it's important to note that in terms of race or ethnicity, multiple nationalities may be incorporated into one category, minimizing the identification of diverse backgrounds in the United States (Vera & Speight, 2003). Therefore, counseling students need to gather adequate information on the historical backgrounds of their clients in order to understand environmental influences or additional stressors they have experienced (Toporek & Pope-Davis, 2005).

The United States Census Bureau (2015) reports the percentage of racial/ethnic variability in the United States population as White/European (62%), African/Black (12%), American Indian or other indigenous groups (1%), Asian (6%), Latino(a) (18%), and two or more combined races (2%). Counselor awareness and competency with diverse clients is critical given the United States census data indicates a transition from the majority of citizens identifying as White, to more varied racial/ethnic identification. Further, the United States Census Bureau (2015) predicts this trend of citizen diversification to continue, signifying that ethnic groups that are not a part of the majority culture (i.e., White) will continue to become more prevalent in the United States population.

Research shows there are disparities in mental health care for racially and ethnically diverse clients (Agency for Health Care Research and Quality, 2010; Harris, Edlund, & Larson, 2005; U.S. Surgeon General, 2001). Racial/ethnic minorities have less access to mental health care, receive lower quality treatment, and are more likely to terminate therapeutic services prematurely (Harris, et al., 2005; Ojeda & McGuire, 2006). While there are numerous explanations for why this disparity exists, researchers identified ways to increase therapeutic treatment equity for diverse clients (Carey, Reinat, & Fontes, 1990; Constantine, 2002; Gone, 2013; D'Andrea, Daniels, & Heck, 1991; Huey Jr, Tilley, Jones, & Smith, 2014; Sobczak & West, 2013; Sue et al., 1992). One-way of addressing this discrepancy is to assess how counseling students conceptualize problem cause and solution of diverse clients (Williams, Greenleaf, & Duys, 2013).

In the past (i.e., 1950's and 1960's), as little as one percent of graduate students had training that focused specifically on counseling clients with diverse backgrounds (Ponterotto & Casas, 1987). During the 1960's and 1970's, a transformation in counselor education started to

address the lack of training in multicultural practice. The American Psychological Association (APA) brought attention to this need at the Vail Conference of 1973 (Korman, 1974). The conference signified a change in multicultural focused therapy and led to the creation of the Board of Ethnic Minority Affairs (BEMA) in 1979 (Sagun, 2014). The creation of BEMA played an integral part in changing educational guidelines and required that multicultural training be one of seven criteria for accreditation of doctoral education and training programs (APA, 1979). Following the change in APA guidelines for accreditation, other counselor training programs started to follow suit throughout the 1980's, and major breakthroughs in training requirements, empirically supported practice, theoretical development, and future research began taking hold (Ponterotto, 2008).

From 2000-2015 significant progress on the implementation of multicultural training in psychology and counseling related graduate programs has been made (Sagun, 2014). Counseling students now get more exposure with clinical training, research, supervision, conferences, theoretical expansion, client conceptualization and diagnostics (Toporek & Pope-Davis, 2005; Tori & Ducker, 2004). The integration and expansion of multicultural training increased knowledge and empirical literature on multicultural counseling, however, the level and depth of training still leaves a lot to be desired (Dickson, Argus-Calvo, & Tafoya, 2010).

Research indicates that many trainees still do not feel confident in working with diverse racial/ethnic clients, even after completing multicultural training in their graduate programs (Burnett, Hamel, & Long, 2004; Dickson, Argus-Calvo, & Tafoya, 2010; Thomlinson-Clarke, 2000). Therefore, increased research on client conceptualization and counselor attributions can guide future training, while informing students on empirically supported therapeutic approaches.

Coursework. The most widely accepted form of counselor training comes in the form of coursework while enrolled in a graduate program (Abreu, Chung, & Atkinson, 2000; Pieterse, Evans, Risner-Butner, Collins, & Mason, 2008). Students study topics including sociopolitical history, culture, traditions, and values related to belief systems (Abreu, 2000). The combination of bias awareness and topical discussion informs students on the nuanced aspects of providing therapy to clients with diverse backgrounds. However, while this is an important aspect of graduate education in counseling, most programs only utilize a separate course format where a single class is added to existing curriculum to meet accreditation standards (Pieterse et al, 2008). A more effective approach to training counselors' treatment with diverse clients is to utilize a format where multicultural education is infused throughout most of the general graduate classes (Copeland, 1982). Therefore, research on counselor conceptualization of clients serves as a viable resource for counselor training in terms of diversity and understanding the development of client problems.

Responsibility Attributions

The attributions that counselors make about the cause, and solutions to, clients' problems directly influence the counseling process and efficacy of the treatment (e.g., symptom reduction, behavior change, or improving quality of life) (Stepleman, Darcy, Tracy, 2005; Wall & Hayes, 2000). Researchers state that counselors' attributions of clients' problems have a direct effect on the selection of counseling strategies, treatment success, assessment of problems, development of the counseling relationship, and the quality of service delivered (Brickman et al., 1982; Hayes & Wall, 1998; Jackson, Holt, & Nelson, 2005; Kernes & McWhirter, 2001; Murdock & Fremont, 1989; Stepleman et al., 2005; Tracy, 1988; Worthington & Atkinson, 1993; Zinnbauer &

Pargament, 2000). However, despite the influential role attributions have on therapeutic success, the topic is relatively understudied in counselor training (Williams, Greenleaf, & Duys, 2013).

When individuals help themselves or others, their behavior is influenced by fundamental beliefs about blame and control (Mitchlitsch & Frankel, 1989; Brickman et al., 1982). For counselors, attributing responsibility for problems and solutions is embedded in how blame and responsibility are assigned to either the situation or the person. In other words, to what extent does a person's character contribute to their psychological distress versus the environmental constraints and pressures the individual is living in?

Brickman and colleagues (1982) are credited with developing the most researched theoretical framework on responsibility attributions. Together, they created four models, the moral, medical, enlightenment, and compensatory models. Brickman stated:

> It is our belief that (1) a general theory of helping and coping must build a bridge between two literatures… (2) the form people's behavior takes once they decide to help; and (3) the critical determinants of the form of their behavior are their attributions of responsibility for problems and solutions (Brickman, 1982, p. 368).

The four models of attribution are applicable to a wide range of helping occupations, but most importantly, counseling. They have been applied to numerous areas of research including alcohol and drug abuse (Bennet, 1995; West & Power, 1995), suicidal behavior (Jack & Williams, 1991), reactions to unemployment (Heubeck, Tausch, & Mayer, 1995), counseling elderly and minority clients (Karuza, Zevon, Gleason, Karuza, & Nash, 1990; Young & Marks, 1986), and cancer treatments (Avants, Margolin, & Singer, 1993). Despite the wide range of research, little research has evaluated how counseling students' therapy is guided by the responsibility attributions they use with clients (Hayes & Wall, 1998; Kerns & McWhirter, 2001;

Murdock & Fremont, 1989; Tracey, 1988). Further, no research has been conducted on counseling students responsibility attributions related to diverse clients or trauma survivors.

The four responsibility attributions comprise how a counselor might assign responsibility to clients' problems (i.e., the environment or client disposition) and their solutions (i.e., professional or client). Brickman et al., (1982) elaborated further:

> Whether or not people are responsible for causing their problems and whether or not they are responsible for solving these problems are the factors determining four fundamentally different orientations to the world, each internally coherent, each in some measure, incompatible with the other three. (p. 369)

More importantly, the effectiveness of the helping relationship and the effectiveness of treatment in general is influenced by the type of attributions a counselor makes about their clients (Jackson et al., 2005). Therefore, analyzing these models in relation to counselor training can add insight into counselor conceptualization, and whether or not they are beneficial in treating clients who have multicultural backgrounds or traumatic experiences.

Moral model. In the moral model, a person's disposition is the reason for psychological distress, and therefore, the individual is responsible for solving the concerns themselves (Brickman et al., 1982; Jackson et al., 2005). The name for this model is related to the conceptual framework it uses for viewing human behavior. Because individuals' problems are from their own making, they are "morally" responsible to help themselves (Karuza, Zevon, Gleason, Karuza, & Nash, 1990).

Counselors that endorse this model of attribution typically view their clients' problems as a function of laziness, stubbornness, or lack of persistence. Change is facilitated through the clients enduring the problem and finding their own way of solving the issue (Karuza et al.,

1990). Counselors emphasize the construct of free will, and client responsibility for their own fate. Additionally, counselors take the role of encouragers who help motivate their clients to finding their own solutions to the problems they created (Worthington & Atkinson, 1993).

The primary advantage of the moral model is that clients' possess the potential to solve their own problems (Jackson et al., 2005). However, a weakness of this model is that it minimizes the influence the environment has on clients' presenting concerns. Resultantly, clients that are not a part of the majority population may be spuriously assigned blame for psychological distress they bring to therapy. Furthermore, if societal discrimination related to non-white racial or ethnic identity is not taken into consideration, counseling may lead to dissatisfaction due to clients feeling a lack of empathy from their therapist (Kernes & McWhirter, 2001).

Additionally, if a client has lived through traumatic experiences they may not be receptive to the idea that they are responsible for creating the psychological distress in their life. Often times, traumatic experiences occur where the individual has no control over the traumatic event (Bloom & Sreedhar, 2008). For example, blaming a rape victim for being responsible for depressive symptoms would be incongruent with the client's feelings, and potentially cause additional harm to the client (Suarez & Gadalla, 2010).

Enlightenment model. The enlightenment model holds clients responsible for causing their problems, but does not hold them responsible for finding the solution to those problems (Brickman et al., 1982). Individuals conceptualized through this model are not knowledgeable on solving their problems, and may even be viewed as out of control (Kernes & McWhirter, 2001). Therefore people need to be "enlightened" in order to see the true nature of their problem(s).

In counseling, clients are expected to be submissive and allow the professional in the helping relationship take responsibility for solving problems while being complicit in the process

(Hayes & Wall, 1998). Many Alcoholics Anonymous (AA) groups demonstrate this model by having group members admit they are powerless over their addiction and therefore must submit to a higher power to solve their affliction (Brickman, et al., 1982).

The benefits of the enlightenment model is that it may provide clients with relief that their problems in life are out of their control, which can be validating for clients to hear (Michlitsch & Frankel, 1989). However, the implicit view of clients in this model is negative, powerless, and dependent on the help of professionals in order to achieve solutions to presenting concerns. Additionally, this attribution model can influence clients to construct their entire lives around authority, which limits their personal empowerment (Kernes & Mcwhirter, 2001). Counselors who conceptualize clients using an enlightenment model may be seen as authoritarian or dominating. While some clients may prefer this approach, it runs the risk of creating a power differential in the counseling relationship. Therefore, the counselor takes responsibility for solving problems and reduces mutual collaboration (Stratton, 2003).

Clients that identify with racially/ethnically diverse backgrounds may lack trust in the counseling process if the therapist is coming from an authority position while blaming them for presenting concerns (Williams, et al., 2013). Similar to the moral model, clients with psychological distress resulting from their environment (e.g., trauma, discrimination, oppression, etc.) may not feel the therapist understands the development of their problems, which leads to poor therapeutic outcomes (Williams et al., 2013).

Medical model. The medical model views client treatment in a parallel fashion to medical treatment. Clients are not considered the cause of their problems nor are they the solution to the problem(s) (Worthington & Atkinson, 1993). The medical model sees individuals as ill who must seek professional help to have a knowledgeable individual cure them of their

problem (Brickman et al., 1982). The implicit view of human nature is that clients are weak and need to comply with the advice of a professional who knows better (Brickman et al., 1982).

Counselors using this model are heavily focused on manual focused treatment and working with clients from an expert position, which is common in psychiatric care (Kernes & McWhirter, 2001). The emphasis on professional guidance fosters client acceptance of their problems and also emphasizes that professional authorities know what is best.

The medical model is beneficial because it allows clients to accept help without being blamed for the problems they present in therapy. Clients seek help while being treated by a knowledgeable individual that can help them overcome their presenting concerns (Kleinke & Kane, 1998). Inpatient psychiatric units utilize this model because it is centered around specialized knowledge for severe mental illness, which relies on medication-based interventions. However, a deficit of the medical model is that professionals, who provide services, have an inherent view of presenting concerns as a result of people being ill or incapacitated (Brickman et al., 1982; Young & Marks, 1986). For hospitalization this may be an appropriate approach, for counselors providing outpatient services, it fosters dependence on others to solve problems (Gil-Rivas, Prause, & Grella, 2009). Dependence on others, resultantly, negatively reduces client driven empowerment to solve their problems (Dollinger, 2008). Furthermore, counselors using the medical model will perpetuate client weakness and increase the power differential between client and therapist (Jackson et al., 2005). If clients are faced with a problem that is best suited for them to overcome on their own, they will be reluctant to engage because change is considered the responsibility of the professional (Lipman & Sterne, 1969).

Compensatory model. Under the compensatory model, people are not viewed as responsible for problems they face in their lives; however it is still their responsibility to work on

making their situation better. Counselors who use the compensatory model expect individuals to put forth effort, ingenuity, and collaborate with others in order to work through problems (Sharf & Bishop, 1979).

Counselors' who endorse this model of attribution view themselves as a "compensating" factor for clients, or an additional tool to utilize while working towards living a healthier life (Tracey, 1988). Counselors attribute presenting concerns to a shortage of resources or opportunities for positive growth and change. Moreover, counselors advocate on behalf of clients to foster change and create an egalitarian relationship. Mutual understanding of client environment and resources for change is a central part of therapy in the compensatory model (Williams et al., 2013). Likewise, through the therapeutic relationship, clients learn to accept that presenting concerns may stem from the things outside of their control (i.e., discrimination, trauma, oppression). However client strengths are highlighted and utilized to create positive growth and change (Young & Marks, 1986). This type of therapeutic approach provides empowerment to the client while not blaming them for things they cannot control.

Client's that come to therapy with traumatic or oppressive histories as a result of prejudicial experiences, cultural oppression, or systematic discrimination, will benefit the most from a compensatory attribution model (Kleinke & Kane, 1998). The therapeutic dynamics of inner control and contextual understanding increase counselor empathy while promoting clients beliefs about overcoming adversity through strengths (Karuza et al., 1990; Kleinke & Kane, 1998).

Research shows that internalized client empowerment; combined with understanding that client concerns may result from situations outside of their control, provides effective treatment for a wide range of mental health concerns (Henley & Furnham, 1988; Knapp & Delprato;

Williams et al., 2013; Worthington & Atkinson, 1993). The compensatory approach promotes these constructs because it encourages clients to direct energy outward, while minimizing the client's feelings of personal guilt or blame. Energy and focus are dedicated to finding solutions, not perseverating on things that the client cannot change (Bloom & Sreedhar, 2008; Brickman et al., 1982; Worthington & Atkinson, 1993).

A potential deficit of the compensatory model is that clients may feel they have to come up with solutions to problems they had no part in creating. Therefore, if clients are not reinforced for successful problem solving, they may endorse a negative worldview and lose motivation to continue looking for solutions (Avants, Margolin, & Singer, 1993). However, counselors who utilize the compensatory model in conceptualization of clients, despite the onus of change being on the client, find higher levels of client/therapist agreement when it comes to understanding the development of client problems (Hayes & Wall, 1998; Claiborn, Ward, & Strong, 1981). Further, the more a therapist and client align on responsibility for presenting concerns, the more likely the client is to benefit from the therapeutic relationship (Hayes & Wall, 1998). Therefore, therapists are more likely to respond to their clients with empathic understanding while controlling for their own biases related to client presentation (Williams et al., 2013).

Attribution Errors and Bias

Counselor awareness of oppression and bias are considered fundamental to counseling individuals that come from diverse backgrounds and experiences (Sue & Sue, 2003). Bias related to attribution of client behavior has been well researched and documented (Burkard & Knox, 2004; Chen, Froehle, & Morran, 1997; Dollinger, 2008; Hayes & Derkis, 2000; Morrow & Deidan, 1992; Pfeiffer, Whelan, & Martin, 2000; Rosenthal, 2004; Snider, 2000; Strohmer & Shivy, 1994). Helping counselors' gain insight into their biases is an essential part of

professional development because bias can lead to misdiagnosis or improper interventions (Morrow & Deidan, 1992). Furthermore, the process of selecting therapeutic interventions directly relates to assigning responsibility for events in another person's life; however there often exists discrepancy between people who evaluate an event and the people actually involved in the event (Jones & Nisbett, 1971). Social psychology refers to this cognitive phenomenon as the Fundamental Attribution Error (FAE), and has it takes place in the counseling process (Batson, 1975; Bishop & Richards, 1984).

The Fundamental Attribution Error (FAE). The fundamental attribution error (FAE) proposed by Heider (1958) is defined as "the tendency to attribute another person's behavior to their dispositional qualities, rather than situational factors" (Landridge & Butt, 2004, p. 359). This construct is a fundamental error in cognition where people underestimate the influence the environment has on the behavior of others.

Behavior tends to become the focal point when applying judgment to the disposition of another person. If an individual's behavior makes them standout against a situational background (e.g., being late to work), the behavior becomes more salient than the context of why the person was late to work in the first place (Gilbert & Jones, 1986). In a clinical context for example, a client that is refusing to seek employment may be conceptualized as an unmotivated client (i.e., moral model), however without considering the context of the environmental constraints, rationale for the behavior may be inaccurate. Additionally, the FAE is viewed as a motivational bias where our perceptions look for control and predictive situations based on behavior (Batson, 1975). In other words, it's comforting to feel that negative things happen to people whose dispositions have warranted negative outcomes (e.g., someone late for work is just irresponsible) (Vonk, 1999). Therefore, it's not uncommon to compartmentalize behavior with negative

dispositional attributions, because it is justified as reasonably accurate (Berry, 2015). However, these attributions may be overemphasized, leading to misplaced judgment and biases, which place more designation on disposition and less consideration for environmental influence on behavior (Bishop & Richards, 1984).

Underlying functions of the FAE. People are more potent as a figure than their environment or situations (Berry, 2015; Riggio & Garcia, 2009; Trope, 1986). Given that we can observe a person directly, but not fully identify or acknowledge the context of their environmental situation, we are more likely to make attributions about behavior by what we can observe at face value. Furthermore, it is easier to attribute an individual's behavior to their dispositional characteristics than it is to factor in their situational constraints because it requires less complex cognitive processing (Berry, 2015). Moreover, when we are faced with processing information related to another individual's behavior, it's a natural human proclivity to parcel out what dispositional attributes could be the determiners of behavior (Burger, 1981).

The FAE has negative impacts on interpersonal relationships as well. The overestimation of dispositional characteristics, impacts how we interact given our conclusions made about other people's behavior (Harvey, Town, & Yarkin, 1981). Our conclusions related to behavioral outcomes might lead to victimization, marginalization, or biased views of other individuals.

Social psychologists explain how people are sensitive to behavioral outcomes and judgments based in dispositional attributions. Alisson, Mackie, and Messick (1996) explained:

> Outcomes appear to bias our judgments about their origins and causes, influence our evaluations of the individuals who produce them, affect our estimates of how frequently others produce them, bias our assessments about who is responsible for them, influence our estimates of how foreseeable they should have been, affect

> our beliefs about how likely they are to occur in the future, bias our perceptions of how much they were deserved, influence our beliefs about how controllable and preventable they were, and affect how satisfied we are with them in comparison to other possible outcomes. (p. 56)

Additionally, the potency of behavioral outcomes and how they are perceived has implications beyond just judgments. Gilvovich, Keltner, Chen, & Nisbett (2013) explained that attribution errors can have substantial implications both in short-term and long-term consequences. For example, intake-counseling sessions utilize 60-120-minute interviews to make decisions about the appropriate level of care and directions for treatment, with long-term implications for the well-being of the client (Freund, Russell, & Schweitzer, 1991). These initial consults are constructed on an assumption that accurate assessments can be made about an individual's disposition from a preliminary interaction (Nakash & Alegria, 2013). However, research indicates that additional information related to clients environmental constraints, trauma history, and phenomenology is essential for accurate conceptualization of clients' presenting concerns (Cusack, Grubaugh, Knapp, & Frueh, 2006; Morrow & Deidan, 1992; Strohmer & Shivy, 1994).

Attribution Errors and Counseling.

For counselors, attribution errors have significant implications for the conceptualization of clients' presenting concerns (Williams et al., 2013; Morrow & Deidan, 1992). Notably, beginning level therapists are particularly vulnerable to committing attributional errors because they have not had sufficient training to recognize the impact of environment on client problems (Chen, Froehle, & Morran, 1997; Greenleaf & Williams, 2009). Further, counselors in training

have shown to give greater weight to their own perspectives while minimizing the perspectives of their clients (Arnoult & Anderson, 1988). This form of bias can be detrimental to treatment outcomes because clients' may internalize blame as a way to stay consistent with their counselor's views (Batson, 1975; Fazio, Effrein, & Falender, 1981; Rosenthal, 1974).

Counselor biases toward diverse clients. Novel counseling students of the majority culture (i.e., White) are more likely to have biased perceptions when making behavioral attributions on racially or ethnically diverse clients (Burkard & Knox, 2004). Clients that come from a diverse background are more likely to have been subjected to cultural, racial, legal, or systemic oppression. Therefore, counseling students will effectively work with clients with these experiences unless they can communicate empathy that demonstrates understanding of personal struggles (Chung & Bemak, 2002; Kim, Zane, & Blozis, 2012; Weathorford & Spokane, 2013). Further, the level of perceived empathy by the client will affect their willingness to continue with therapy services (Kim, Zane, & Blozis, 2012).

Counseling students need to be aware of how their biases or preconceptions related to race and ethnicity guide their perceptions of client behavior. Neville, Spanierman, and Doan (2006) found that even when controlling for multicultural counseling training, counseling students still minimized the existence of racial and ethnic social differences related to oppression or discrimination. These biases are important to highlight because they indicate that counseling students are not conceptualizing clients with the incorporation of external stressors (i.e., environment), even after appropriate training (Wong, Kim, Zane, Kim, & Huang, 2003).

Counseling students may not only misinterpret clients' presenting concerns, they may also miss potential solutions. Counseling students may fail to acknowledge support systems and personal connections within the client's community, church, and family, which could be

significant in facilitating client healing (Minuchin, Colapinto, & Minuchin, 1998). Conversely, if counseling student bias is appropriately examined during training, counseling students can develop sensitivity to cultural, societal, or systemic forms of oppression:

> Counseling training programs which expose students early in their education to systemic/ecological perspective/theories of counseling would allow more time and opportunity for students to develop a broader perspective to the many social justice concerns that inhibit client growth and development. Actual training opportunities where students work directly with various diverse groups, have involvement in service-based learning experiences, and participate in unique practicum/internship situations would heighten awareness of the complexities that contribute to a client's situation. In other words, these opportunities may increase counselors-in training awareness and understanding of the oppressive and pervasive nature of a client's situation and how it may affect overall well-being (Williams et al., 2013. p. 12).

Trauma and Attribution

In counseling and other human service fields, traumatic experiences are getting more consideration in the onset of mental health distress (Courtois, 2004; Courtois & Gold, 2012; Freidman, Keane, & Resick, 2007; Levers, 2009). Trauma is defined as "an experience that creates a sense of fear, helplessness, or horror, and overwhelms a person's resources for coping" (Hopper, Bassuk, & Olivet, 2009, p. 80). 30 years ago, it was uncommon for clinicians to be trained on the relationship between trauma and mental health disorders (Goodman, 2015). Counselors were unlikely to assess clients for underlying traumatic events and the symptoms that manifested through clients' behaviors (Goodman, 2015). Today, trauma is being linked to host of

mental health disorders/distress including substance abuse, depression, anxiety, emotional instability, self-harm, suicide, psychosis, dissociation, anger, sleep deprivation, appetite change, negative self-identity, internalized guilt, shame, and attention deficits (Benoit, Bouthillier, Moss, Rousseau, & Brunet, 2010; Bryant & Panasetis, 2001; Briere, 2006; Courtois, 2004; Courtios & Gold, 2012; Freidman et al., 2007; Gil-Rivas, Prause, Grella, 2009; Harrison & Fowler, 2004; Landre, Poppe, Davis, Schmaus, & Hobbs, 2006; Moser, Hajcak, Simons, & Foa, 2007). In the past, therapists would treat these various mental health stressors with a behavioral specific approach that did not include incorporation of a trauma history (Courtois & Gold, 2012). Unfortunately, these meant clients were being blamed for the symptoms of their trauma, and not treated appropriately (Elliot, Bjelajac, Fallot, Markoff, & Reed, 2005; Goodman, 2014; Harris & Fallot, 2001; Herman, 1997).

Despite the recent advancements in understanding trauma related symptoms, there are still considerable gaps in the literature on how trauma should be addressed through counseling (Norman, 2015). For example, there is still a need for expanding and understanding trauma that is culturally, contextually, inter-generationally, or discrimination based (Dass-Brailsford, 2007; Goodman & West-Olatunji, 2008; Kira, 2010). Furthermore, research is needed on interventions that incorporate and facilitate strength-based approaches in treatment (i.e., compensatory attribution models) (Levers, 2012; Marsella, 2010).

As knowledge on the effects of trauma is being incorporated into counseling treatment, changes are being made in the attributions to clients' problem causes and solutions. Previously, counseling for trauma-afflicted clients utilized therapeutic models that were narrow in scope, biased, deficit oriented, and pathologizing (Burstow, 2003; Eriksen & Kress, 2006; Mead, Hohensil, & Kusum, 1997, White, 2002). Today, there are more effective treatments that focus

on client empowerment to overcome the symptoms of traumatic histories (Boden et al., 2012; Ford & Russo, 2006; Roberts, Roberts, Jones, & Bisson, 2015). For example, substance use disorders were historically conceptualized as a pathological interaction between an addictive substance and the disposition of the user (i.e., addictive personality). Treatment focused on the substance use disorder, which unfortunately, did not address the underlying trauma symptoms that perpetuated the substance use disorder in the first place (Cusack, Grubaugh, Knapp, & Freuh, 2006). Trauma screenings are starting to become regularly administered prior to starting treatment, and clinicians are recognizing that traumatic events are a better descriptor of the psychological distress the client is presenting with (Boden et al., 2012). Furthermore, with the inclusion of a trauma history, clinicians view their clients through a more empathic lens because they understand that clients' behaviors are a function of experiences and not client dispositions (Bloom & Seedhar, 2008; Marsella, 2010; Williams et al., 2013).

Trauma informed treatment is effective because it empowers clients to enact change through utilizing their own strengths, while not holding them responsible for the traumatic events in their lives (Bloom & Seedhar, 2008; Hopper et al., 1982). For example, Seeking Safety, a trauma informed manualized treatment for posttraumatic stress disorder (PTSD), produces higher rates of client retention, satisfaction, and reduces mental health distress at greater rates than traditional therapy (Boden et al., 2012; Najavits et al., 2005). Additionally, the Sanctuary model, which is a trauma informed treatment model that focuses on the biological, affective, cognitive, social, and existential wounds suffered by trauma survivors, has also shown promise (James, 2011). The Sanctuary model has been shown to produce lower attrition rates and aggressive outbursts, while increasing emotional control, and problem solving for clients through mutual respect and collaboration (James, 2011). Most importantly, what these treatment models have in

common is the utilization of a compensatory attribution model for client conceptualization (Brickman et al., 1982). When client behavior is viewed as a product of their environment, and not as a dispositional flaw, the efficacy in treatment increases, the therapeutic alliance strengthens, and the client/counselor alignment on treatment approach increases (Bloom & Sreedhar, 2008; Zimmerman, 1990).

Trauma related to race and ethnicity. Currently, race or ethnic-based variables are not considered within the criteria of severe stress or trauma related disorders in the Diagnostic and Statistical Manual 5th Edition (American Psychiatric Association, 2013). This is problematic, especially since there is clear evidence to support that racial and ethnic minorities exhibit higher rates of PTSD than the racial majority (i.e., White) (Pieterse, Carter, Evans, & Walter, 2010). Furthermore, meta-analysis studies have drawn a link between psychological distresses connected to discrimination (Williams, Neighbors, & Jackson, 2003), which correspond with traumatic experiences.

Literature on trauma has focused primarily on a universal understanding of problem cause and manifestation across racial/ethnic groups. However, some researchers argue that it's important to recognize racial and ethnic minority groups are more likely to encounter persistent traumatic circumstances (Marsella, 2010). Under these circumstances, diverse individuals are more likely to be living in conditions of deprivation, anger, and hopelessness brought on by oppression, insecurity, political subjugation and societal discrimination (Carter, 2007; Kira, 2010; Marsella, 2010; Pieterse, et al., 2010; Williams, Neighbors, & Jackson, 2003). Therefore, recognizing the environmental context of clients from racial or ethnic minority backgrounds has significant implications for therapy.

Racial or ethnic discrimination negatively influences mental health care services, which

is attributed to counselors' failure in understanding the emotional, psychological, and physical effects of race or ethnic based trauma (Carter, 2007). Research indicates there is resistance on the part of mental health professionals to accept racial or ethnic oppression as a form of traumatic stress (Butts, 2002; Feagin & McKinney, 2003). Therefore, clients who come from oppressed or marginalized racial/ethnic groups presenting with trauma symptoms will be at higher risk for attribution error of problem cause and solution by their therapists.

Appendix B

Tables

Table 1
Demographic Information of Participants (N = 217)

Characteristic		n	%
Gender			
	Female	183	84.3
	Male	32	14.7
	Transgender	2	.9
Race			
	American Indian/Alaska Native	2	.9
	Asian	16	7.4
	Black/African American	12	5.5
	White	170	78.3
	Biracial/Multiracial/Mixed	17	7.8
Ethnicity			
	Hispanic/Latino(a)	27	12.4
	Not Hispanic/Latino(a)	190	87.6
Sexual Orientation			
	Heterosexual/Straight	184	84.8
	Gay/Lesbian/Bisexual	28	12.9
	Pansexual	2	.9
	Asexual	2	.9
	Abstinent	1	.5
Age			
	20-29	172	79.3
	30-39	27	12.4
	40-55	17	7.8
	55+	1	.5
Degree			
	M.A.	103	47.5

	M.Ed.	31	14.3
	M.S.	83	38.2
School Accreditation			
	CACREP	169	77.9
	Non-CACREP	48	22.1
Trauma			
	Emotional	69	31.8
	Sexual	28	12.9
	Physical	14	6.5
	Psychological	24	11
	Combination	19	8.8
	None	63	29
State			
	Alabama	1	.5
	Alaska	5	2.3
	Arizona	12	5.5
	Arkansas	6	2.8
	Colorado	24	11.1
	District of Columbia	1	.5
	Florida	18	8.3
	Idaho	1	.5
	Indiana	6	2.8
	Kansas	1	.5
	Kentucky	3	1.4
	Massachusetts	1	.5
	Minnesota	25	11.5
	Missouri	6	2.8
	Nebraska	1	.5
	New Jersey	1	.5
	New Mexico	1	.5
	New York	9	4.1
	Oklahoma	27	12.4
	Oregon	9	4.1
	Pennsylvania	13	6
	South Carolina	6	2.8
	Tennessee	9	4.1
	Texas	4	1.8
	Virginia	2	.9

	Washington	14	6.5
	West Virginia	9	4.1

Table 2
Sample Sizes of the Six Groups in the CRF-32 Design

	Race/Ethnicity of Client in Vignette		
Trauma History	White	African American/Black	Latino
Included	N=36	N=42	N=32
Not Included	N=36	N=32	N=39

Table 3
Analysis of Variance (ANOVA) Tests of Between-Subjects Effects for Problem Cause

	df	*SS*	*MS*	*F*	*p*	η^2
Race/Ethnicity &Trauma History Interaction	2	.955	.477	1.235	.293	.012
Race/Ethnicity	2	1.439	.720	1.862	.158	.017
Trauma History	1	23.271	23.271	60.202	.000**	.222

Note: *$p < .05$; **$p < .01$

Table 4
Analysis of Variance (ANOVA) Tests of Between-Subjects Effects for Problem Solution

	df	*SS*	*MS*	*F*	*p*	η^2
Race/Ethnicity &Trauma History Interaction	2	.306	.153	.451	.637	.004
Race/Ethnicity	2	.100	.050	.148	.863	.001
Trauma History	1	.001	.001	.002	.969	.000

Note: **p* < .05 level; ***p* < .01

Appendix C

Figures

Figure 1
Consequences of Attribution of Responsibility in Four Models of Helping and Coping

Attribution to self of responsibility for problem	Attribution to self of responsibility for solution: **High**	Attribution to self of responsibility for solution: **Low**
High	**Moral Model**	**Enlightenment Model**
Perception of self	Lazy	Guilty
Actions expected of self	Striving	Submission
Others who must act	Peers	Authorities
Actions expected of others	Exhortation	Discipline
Implicit view of human nature	Strong	Bad
Low	**Compensatory Model**	**Medical Model**
Perception of self	Deprived	Ill
Actions expected of self	Assertion	Acceptance
Others who must act	Subordinates	Experts
Actions expected of others	Mobilization	Treatment
Implicit view of human nature	Good	Weak

Note. Adapted from "Models of Helping and Coping" by P. Brickman, V.C. Rabinowitz, J. Karuza, D. Coates, E. Cohn, and Kidder, 1982, *American Psychologist*, *37*, p. 370.

Figure 2
Representation of Analysis Process

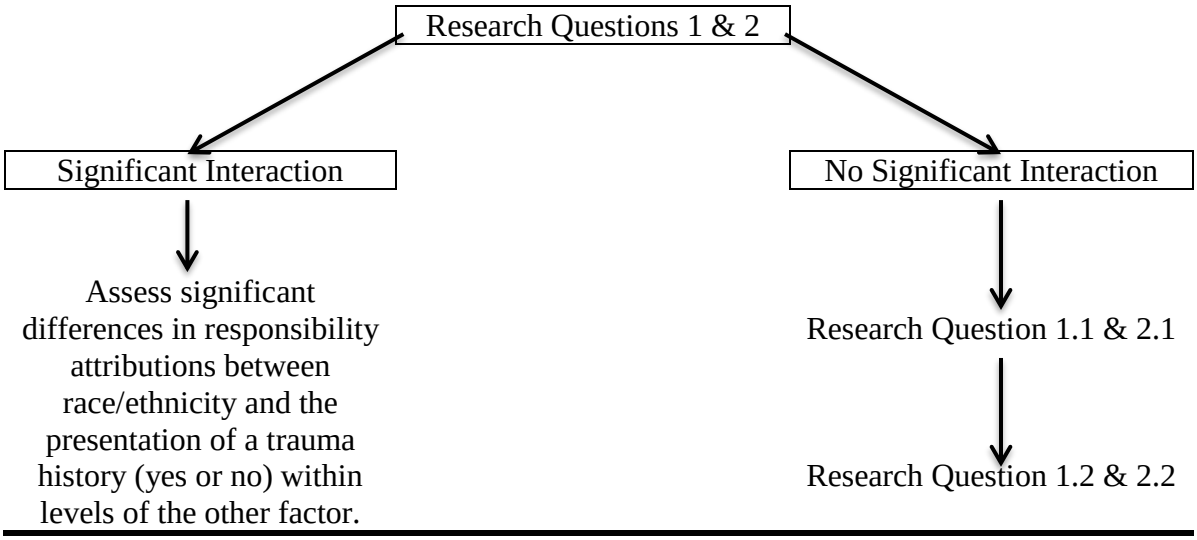
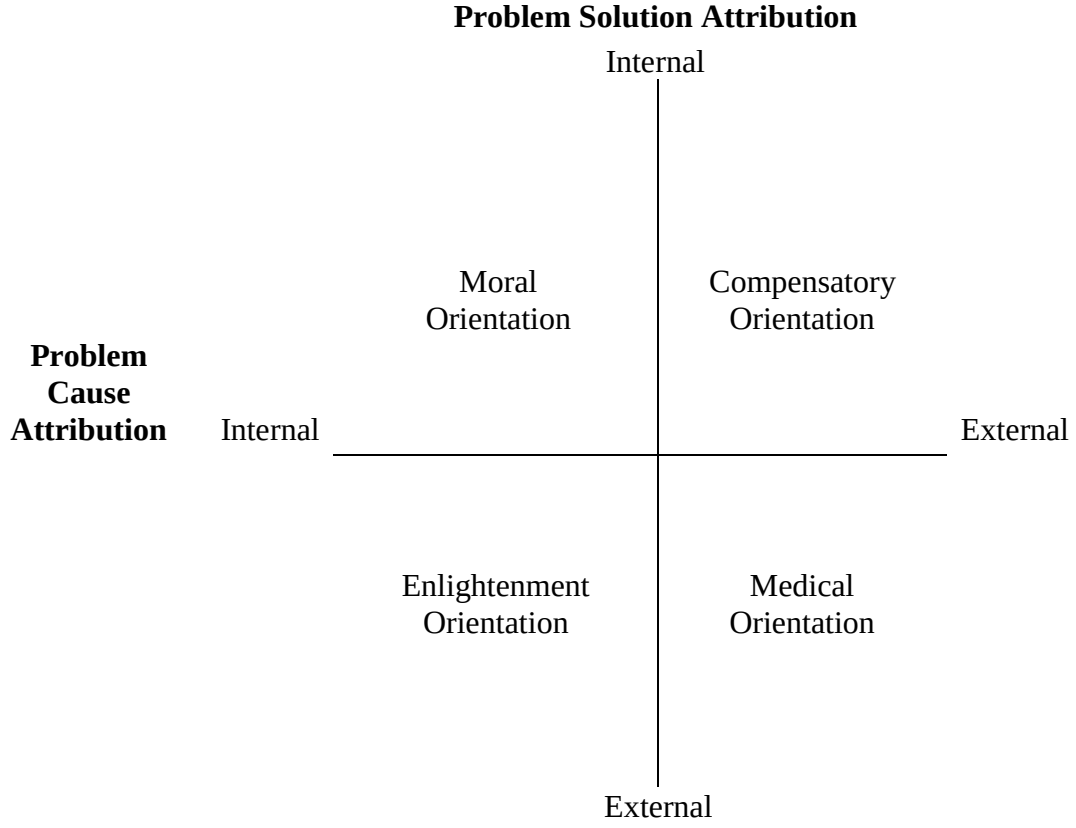


Figure 3
Structure of Helping and Coping Attributions



Note. Adapted from "Helping and Coping Attributions: Development of the Attribution of Problem Cause and Solution Scale" by L. M. Stepleman, M. Darcy, and T. Tracey, 2005, *Educational and Psychological Measurement, 65*, p. 527.

Appendix D

Informed Consent

Informed Consent Agreement

You are being invited to participate in a research study about client presenting concerns. This study is being conducted by Kevin Richard M. A. under the direction of Julie Koch, Ph.D., from the School of Applied Health and Educational Psychology at Oklahoma State University. Mr. Richard is currently a graduate student in the Counseling Psychology Ph.D. program at Oklahoma State University, and data gathered in this study will be used in his doctoral dissertation. The study will provide information that may ultimately be used to inform future counselor training in master's level graduate programs.

Participation involves completing a 44-item electronic survey related to a hypothetical client vignette. The survey will take approximately 20-30 minutes to complete. Participation is voluntary and respondents will be placed into a lottery to win one of three 50$ gift cards to Amazon.com. You may choose not to participate or discontinue participation at any time without consequence.

Procedures will be taken to protect confidentiality. To encourage honest responses, you will not be asked to provide your name or departmental affiliation. Computer IP addresses will not be collected, and any demographic information (such as your age, ethnicity, or level of education) will be presented in summary form when findings are reported. Please note that Qualtrics has specific privacy policies of its own. You should be aware that this web service may be able to link your responses to your ID in ways that are not bound by this consent form and the data confidentiality procedures used in this study, and if you have concerns you should consult these services directly. Qualtrics' privacy statement is provided at: http://qualtrics.com/privacy-statement.

The data will be password-protected, and only the researcher and individuals responsible for research oversight will have access to the records. Data collected in the study will be destroyed after 5 years.

There are no risks involved in participating in the study in excess of those you would experience in everyday life.

Your consent to participate is granted by selecting that you are over 18 years old, and by acknowledging that you have been fully informed about the procedures listed here, and you are aware of what you will be asked to do and the benefits and risks of participation. If you have any questions or concerns about this study you may contact the researcher. If you would like a copy of the results of this study, please contact the researcher and arrangements will be made.

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Advisor: Julie Koch, Ph.D.
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Oklahoma State University
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Stillwater, OK 74078
Email: Julie.Koch@okstate.edu

If you have questions about your rights as a research volunteer, you may contact the Oklahoma State University Institutional Review Board (IRB) Chair.

IRB Chair: Hugh Crethar, Ph.D.
223 Scott Hall
Oklahoma State University
Stillwater, OK 74078,
Phone: (405) 744-3377
Email: irb@okstate.edu

Thank you for your time and participation. If you would like to participate in this study, please select the link provided below:

Appendix E

Survey/Measure

Participant Demographics

Age:
20-29
30-39
40-55
55+

Gender Identity:
Male
Female
Transgender

Sexual Orientation:
Heterosexual/Straight
Gay/Lesbian/Bisexual
Category not listed: _____

Race:
American Indian/Alaska Native
Asian
Black/African American
Native Hawaiian/Pacific Islander
White
Biracial/multiracial/mixed

Ethnicity:
Hispanic/Latino(a)
Not Hispanic/Latino(a)

Degree Type:
M.A.
M.Ed.
M.S.

Master's degree in progress
Ph.D.
Psy.D.
Ed.D.
Doctorate degree in progress
Other _____

Year in Current Master's Program:
1st
2nd
3rd
4th
Other

State: _____

Have you experienced any of the following trauma in your life:
Sexual Yes No
Physical Yes No
Emotional Yes No
Psychological Yes No
Other: ____

Is your counseling program accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP)?
Yes No

Have you ever taken a multicultural class before?
Yes No

Client Vignette

John is a 32-year-old (race/ethnicity) heterosexual male seeking therapy for anxiety and depression symptoms he has been experiencing over the last 6 months. John tells you that he has been experienced these symptoms for longer than 6 months, but over the last 6 months, the severity of the symptoms have increased to the point John felt he needed to seek help through counseling. John does not currently endorse any suicidal ideation but there have been times in his life where he thought about "not having to go on anymore." John reported that over the last 6 months he has been isolating himself in his house and has little motivation to complete tasks that he normally finds enjoyment in. John explains that he was fired from his job 6 months ago due to his anger and irritability, which led to conflicts with his co-workers and supervisor. He currently remains unemployed.

John reported that he struggles with his emotions quickly changing from sad, to happy, to angry, to irritable without understanding the reason for the changes. John explained that for most of his life, he remembers becoming easily angered with family, friends, and colleagues. John stated that he hasn't been able to keep a job for longer than a year and he is no longer interested in going out and finding a new job. Additionally, John explained that his co-workers at his most recent job "were not treating him fairly," and he was fired because nobody cared about him as an employee. John also explained that he feels he was fired because he is (race/ethnicity) and his co-workers were discriminating against him.

John reported that he regularly experiences shortness of breath, racing thoughts, sweating, and feelings of losing control. John states that his symptoms have been a part of his life for "as long as he can remember" and limited his ability to build a strong support group of friends. Additionally, John explains that he has little friends because "nobody understands me" and because he is (race/ethnicity). John stated he tends to spend a majority of time by himself because his symptoms are less severe when alone. John reported that he has never been in an intimate relationship and that he doesn't have any interest in finding a significant other.

John stated that he doesn't abuse any substances and he isn't taking any medication. John explained that he has always considered himself a healthy guy, but recently he has been putting on weight due to inactivity from not leaving his house. John reports that he showers infrequently and stays at home in bed for most of the day. He attributes this to feeling "low." When John was working he was able to take care of himself, but now that he is unemployed, he has been relying on his parents to support him financially. John states that his parents are becoming increasingly impatient with his unemployment and are threatening to stop their financial support. Therefore, the combination of stressors in John's life has led him to you for treatment.

Trauma History

John disclosed that when he was 8 years old, he was the victim of sexual abuse from his uncle. He states the abuse involved both sexual penetration and repeated fondling or inappropriate touching. John explained the abuse continued for 2 years until he was 10 years old. During the time of the abuse, John states that he always felt "unsafe" and "powerless" to do anything about what was happening. He states that he reported the sexual abuse to his parents, but they refused to believe him and decided not to report it to the authorities because his lies "would devastate the family." John states that since nobody would believe him; he remained silent about the abuse. Additionally, John's parents refused to let him speak with a therapist

about the abuse because they were afraid he would say something that would lead to an investigation. Therefore, John reports he has never sought out therapy until now.

John states that two years after the abuse started, his family moved out of state away from his uncle, and that's when the abuse finally stopped. John explained that he didn't have to interact with his uncle after moving away, but he still has intrusive memories of the abuse. He stated that he still thinks about the abuse and has difficulty being alone in rooms with older men because it triggers his anxiety and racing thoughts. Additionally, John explained that he has night terrors where he dreams about the event happening and he wakes up "covered in sweat" with his heart racing. He states that he becomes angry randomly without being able to understand where it's coming from, and often feels guilt and shame after an outburst of anger.

APCSS
For the purposes of this survey, the following definitions are applicable.

Client: The individual referenced in the aforementioned client vignette.

Problems: The presenting concerns in the aforementioned client vignette.

Directions: Please choose the response that best matches how much you agree or disagree with each statement. There are no right or wrong answers. Although some of the items may look alike, it is important to us that you answer all of them.

1. **Other people are the cause of the client's problems.**

○	○	○	○	○	○	○
Very Strongly Disagree	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Very Strongly Agree

2. **The client did not cause his problems.**

○	○	○	○	○	○	○
Very Strongly Disagree	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Very Strongly Agree

3. **The client's problems were caused because he did not have as much control as he should have.**

○	○	○	○	○	○	○
Very Strongly Disagree	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Very Strongly Agree

4. **The client deserves no blame for the cause of his problems.**

○	○	○	○	○	○	○
Very Strongly Disagree	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Very Strongly Agree

5. **Forces beyond the client's control are the cause of his problems.**

○	○	○	○	○	○	○
Very Strongly Disagree	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Very Strongly Agree

6. The client's problems are caused by things external to him.

○	○	○	○	○	○	○
Very Strongly Disagree	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Very Strongly Agree

7. The client's own action had nothing to do with cause of his problems.

○	○	○	○	○	○	○
Very Strongly Disagree	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Very Strongly Agree

8. The client is an innocent victim.

○	○	○	○	○	○	○
Very Strongly Disagree	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Very Strongly Agree

9. The client is not the source of his problems.

○	○	○	○	○	○	○
Very Strongly Disagree	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Very Strongly Agree

10. It is not the client's fault.

○	○	○	○	○	○	○
Very Strongly Disagree	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Very Strongly Agree

11. The client's problems are the result of the situation he is in.

○	○	○	○	○	○	○
Very Strongly Disagree	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Very Strongly Agree

12. The client feels guilt for having caused his problems.

○	○	○	○	○	○	○
Very Strongly Disagree	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Very Strongly Agree

13. The client is responsible for the cause of his problem.

○	○	○	○	○	○	○
Very Strongly Disagree	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Very Strongly Agree

14. The client's personal qualities are what cause his problems.

○	○	○	○	○	○	○
Very Strongly Disagree	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Very Strongly Agree

15. The client's lack of willpower is what caused the problems.

○	○	○	○	○	○	○
Very Strongly Disagree	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Very Strongly Agree

16. The client should have done more to prevent his problems

○	○	○	○	○	○	○

Very Strongly Disagree	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Very Strongly Agree

17. The client's behavior caused the problems.

○ Very Strongly Disagree	○ Strongly Disagree	○ Disagree	○ Neutral	○ Agree	○ Strongly Agree	○ Very Strongly Agree

18. The client caused his problems.

○ Very Strongly Disagree	○ Strongly Disagree	○ Disagree	○ Neutral	○ Agree	○ Strongly Agree	○ Very Strongly Agree

19. The client is to be blamed for the cause of his problems.

○ Very Strongly Disagree	○ Strongly Disagree	○ Disagree	○ Neutral	○ Agree	○ Strongly Agree	○ Very Strongly Agree

20. The client blames himself.

○ Very Strongly Disagree	○ Strongly Disagree	○ Disagree	○ Neutral	○ Agree	○ Strongly Agree	○ Very Strongly Agree

21. The clients own imperfections are what caused the problems.

○ Very Strongly Disagree	○ Strongly Disagree	○ Disagree	○ Neutral	○ Agree	○ Strongly Agree	○ Very Strongly Agree

22. The client should try harder.

○	○	○	○	○	○	○
Very Strongly Disagree	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Very Strongly Agree

23. The client has these problems because he is not strong willed.

○	○	○	○	○	○	○
Very Strongly Disagree	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Very Strongly Agree

24. The client has these problems because he does not have will power.

○	○	○	○	○	○	○
Very Strongly Disagree	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Very Strongly Agree

25. Solving these problems is the client's responsibility.

○	○	○	○	○	○	○
Very Strongly Disagree	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Very Strongly Agree

26. The client's own capabilities should be used to solve the problems.

○	○	○	○	○	○	○
Very Strongly Disagree	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Very Strongly Agree

27. The client has the inner strength to solve the problems.

○	○	○	○	○	○	○
Very Strongly Disagree	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Very Strongly Agree

28. Solving the problems is more the client's responsibility.

○	○	○	○	○	○	○
Very Strongly Disagree	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Very Strongly Agree

29. Solving the problems is someone else's responsibility.

○	○	○	○	○	○	○
Very Strongly Disagree	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Very Strongly Agree

30. Others are better able to solve the client's problems than he.

○	○	○	○	○	○	○
Very Strongly Disagree	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Very Strongly Agree

31. The client needs other people to help solve his problems

○	○	○	○	○	○	○
Very Strongly Disagree	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Very Strongly Agree

32. Others should do more to help solve the client's problems.

○	○	○	○	○	○	○
Very Strongly Disagree	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Very Strongly Agree

33. Others must be more assertive in solving the client's problems.

○	○	○	○	○	○	○

Very Strongly Disagree	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Very Strongly Agree

34. Other people must change for resolution to the clients' problems.

○ Very Strongly Disagree	○ Strongly Disagree	○ Disagree	○ Neutral	○ Agree	○ Strongly Agree	○ Very Strongly Agree

35. Others are responsible for changing the situation.

○ Very Strongly Disagree	○ Strongly Disagree	○ Disagree	○ Neutral	○ Agree	○ Strongly Agree	○ Very Strongly Agree

36. The client feels dependent on others to solve his problems

○ Very Strongly Disagree	○ Strongly Disagree	○ Disagree	○ Neutral	○ Agree	○ Strongly Agree	○ Very Strongly Agree

37. The client feels he cannot solve his problems without the help of others.

○ Very Strongly Disagree	○ Strongly Disagree	○ Disagree	○ Neutral	○ Agree	○ Strongly Agree	○ Very Strongly Agree

38. Other's people assistance is necessary to solve the client's problems.

○ Very Strongly Disagree	○ Strongly Disagree	○ Disagree	○ Neutral	○ Agree	○ Strongly Agree	○ Very Strongly Agree

39. The situation prohibits the client from solving his problems.

○	○	○	○	○	○	○
Very Strongly Disagree	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Very Strongly Agree

40. The client holds others accountable for modifying his problem.

○	○	○	○	○	○	○
Very Strongly Disagree	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Very Strongly Agree

41. Others should be working to rectify the client's problems.

○	○	○	○	○	○	○
Very Strongly Disagree	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Very Strongly Agree

42. Others have an obligation to help the client.

○	○	○	○	○	○	○
Very Strongly Disagree	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Very Strongly Agree

43. The client is waiting for someone else to take action.

○	○	○	○	○	○	○
Very Strongly Disagree	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Very Strongly Agree

44. The client thinks other people are required to fix his problems.

○	○	○	○	○	○	○
Very Strongly Disagree	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Very Strongly Agree

Appendix F

Debriefing Statement

Thank you for participating in this research. In the study, the researcher studied how counseling students attribute responsibility for problem cause and problem solution when conceptualizing clients. If you would like a copy of the results of the study, please contact the researcher and arrangements will be made.

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If you have questions about your rights as a research volunteer, you may contact the Oklahoma State University Institutional Review Board (IRB) Chair.

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Thank you for participating.

VITA

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Doctor of Philosophy

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