BIAS IN PSYCHOTHERAPY AS IT RELATES TO THE CLIENT'S ACCENT AND COUNSELORS' RACIAL IDENTITY DEVELOPMENT AND UNIVERSALITY-DIVERSITY ORIENTATION

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Submitted to the Faculty of the
Graduate College of the
Oklahoma State University
in partial fulfillment of
the requirements for
the Degree of
DOCTOR OF PHILOSOPHY
July, 2000

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Dissertation Approved:

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ACKNOWLEDGMENTS

I would like to thank my dissertation director and chair of my dissertation committee, John Romans, and each of my committee members: Carrie Winterowd, Don Boswell, Marie Miville, and Larry Mullins for their patience and guidance through this arduous task. Additionally, I am grateful to all of my family and friends who made the completion of this dissertation possible.

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Chapter 1

Introduction

The problems with ethnic group utilization of mental health services in the United States center around issues such as under-utilization of services, availability of services, invalid assessments, high premature termination rates, ineffectiveness of traditional modes of therapy, and discriminatory forms of treatment. Mental health services for ethnic populations has recently received much attention in the psychological literature. For example, Sue (1988) reviewed ethnic/racial match between therapists and clients. Sue, Fujino, Hu, Takeuchi, and Zane (1991) and Hough, Landsverk, Karno, Burnam, Timbers, Escobar, and Regier (1987) examined service related variables such as length of treatment and outcomes of Asian-American, African-American, Mexican-American, and White clients using outpatient services in Los Angeles County. O'Sullivan, Peterson, Cox, and Kirkeby (1989) investigated the dropout rates and number of services received by Asian-American, African-American, Hispanic-American, and Native American clients in the Washington Mental health Information System in the Seattle-King County area. Snowden and Cheung (1990) examined differences among several minority groups regarding admissions, lengths of treatment, and diagnoses.

While interest in mental health services for ethnic groups has been steady in the 1990s as evidenced by recent studies, (Atkinson, Brown, Parham, Mathews, Landrum-Brown & Kim; 1996, Arroyo, 1995; Arroyo; 1996), much has yet to be learned about the effects of race and ethnicity and how it affects therapist variables such as their preference for racial/ethnic match of a therapist, and client variables such as diagnosis, severity of problems, and prognosis.

Bias in psychotherapy is one area of research that has focused on the therapeutic relationship between psychotherapists and ethnically/racially different clients. Research on bias in psychotherapy is a broad area of investigation that encompasses bias as it relates to gender, race/ethnicity, social class, sexual orientation, religion, age, and disability.

My current interest on the topic of bias in psychotherapy centers around two areas. The first area focuses on clients' race/ethnicity and how this affects psychotherapists' perceptions of problem severity, prognosis, and ability to empathize with their clients. More specifically, I will be examining how accent is related to severity of problems, prognosis and empathy. Although the topic of race/ethnicity and bias was examined fairly extensively in the period between 1960 and 1985

(Lopez, 1989; Atkinson, 1985), certain gaps in the literature prompted further exploration. I will briefly discuss broad themes in the race/ethnicity bias literature in Chapter One; however, a more substantial exploration of the relevant literature and its trends can be found in the second chapter of this paper.

The second area concentrates on therapist characteristics. These will include the effects that a White counselor's racial identity development has on her/his bias towards clients of color, and the effects that the counselor's universal-diverse orientation has on his/her perceptions of the client. Several studies exist that investigate how the racial identities and univeral-diverse orientation of the counselor or client can affect the counseling process (Ottavi, & Pope-Davis, 1994; Sahnani, Ponterotto, and Borodovsky, 1991). In Chapter 2, I will review of the literature regarding White racial identity, univeral-diverse orientation, and racism.

With the continual expansion of culturally different groups in the United States, the study of multicultural psychology becomes increasingly important. Examining cultural bias in particular is significant for mainly two reasons. First, I believe that multicultural competence is a critical component of training in applied psychology.

Multicultural competence includes awareness of racial/ethnic oppression, awareness of one's own attitudes, beliefs, and biases regarding different cultural groups, having knowledge of general differences between cultures with a respect for individual differences within a culture, and having knowledge of which therapeutic techniques work, in a broad sense, with different cultural groups. Research on bias in psychotherapy also increases the knowledge base from which students and educators can draw upon to develop their multicultural competence.

Second, and most importantly, examining bias in psychotherapy can improve mental health service delivery to underserved populations. Research has indicated that racial minority groups underutilize mental health services in the United States (Sue, et al., 1991; O'Sullivan, et al., 1989; Hough, et al., 1987; Snowden & Cheung; 1990, Sue. 1977). Delineating the variables that account for racial/ethnic bias by clinicians may help improve services to minorities which, in turn, may decrease attrition and increase utilization of services.

Theoretical Perspective

Social cognition theory has been a major theory in the literature for explaining bias. This theory will be the focus of discussion (Lopez, 1989; Arroyo; 1995; Arroyo,

1996; Hamilton, 1981; Murray & Abramson, 1985). The current research will be conceptualized within a social cognition theoretical framework. If it is indeed the aim of psychology to uncover general laws that explain behavior, it is fundamentally important to develop theories that can guide our inquiries. I will review social cognition theory in more detail in Chapter 2.

Given the gaps in the bias in psychotherapy literature that I have discussed, and the paucity of research examining racial identity development regarding bias in psychotherapy, it became clear that a study should be developed that addresses these areas. The next section delineates the specific research questions that the current research will answer.

Research Questions

The specific research questions that this study will address are: 1) Does a counselor perceive a client differently who does not speak English as a native language (i.e., non-standard American English); 2) Is a counselor's perception of a client who speaks non-standard American English related to the counselor's own racial identity development?; and 3) Is a counselor's reaction to a client who speaks non-standard American English related to his or her universal-diverse orientation?

Chapter 2

Literature Review

This literature review addresses mainly three areas. First, social cognition theory, which is the theoretical framework within which this study will be conceptualized, is discussed. Second, research that addresses racial identity and univeral-diverse orientation as it relates to bias is examined. Finally, research studies that examine racial/ethnic bias in psychotherapy are reviewed. The review of this particular topic is roughly divided into mainly two areas. First, racial/ethnic bias research in which client characteristics serve as the independent variables and a counselor effect(s) is measured, and studies in which the counselor's characteristics are independent variables and a client effect(s) is measured will be reviewed. Second, research that investigates how language bias can influence raters' perceptions of an individual will be examined.

Social Cognition Theory

Social cognition theory has been a major contributor to applied to research on bias in psychotherapy. Several definitions of social cognition are offered in the literature. Hamilton (1981) defines social cognition as "a consideration of all factors influencing the acquisition,

representation, and retrieval of person information, as well as the relationship of these processes to judgments made by the perceiver" (p. 136). Isen and Hastorf (1982) define it as "an approach that stresses understanding of cognitive processes as a key to understanding complex, purposive, social behavior" (p. 2). Forgas (1981a) views social cognition "as not merely the information-processing analysis of social domains, but as a field genuinely devoted to the study of everyday knowledge and understanding" (p. 259).

Several concepts of social cognition theory that are important to the current research will be discussed next. These concepts include attribution theory and schemata. According to attribution theory, people are motivated to make sense of their own and others' behavior (Ross & Fletcher, 1985). Two types of attribution are generally discussed in social cognition theory: situational attribution and dispositional attribution. Situational attribution refers to causes of behavior that are assigned to the environment (Wade & Tavris, 1990). For example, "the employee is being rude because he was forced to work on a holiday" is a situational attribution because the cause of the behavior is outside of the person. Dispositional attribution refers to causes of behavior that

are identified as coming from within a person (Wade & Tavris, 1990). "The employee is being rude because he is a mean person" is a dispositional attribution. Overestimating personality characteristics and underestimating the influence of the environment is known as the fundamental attribution error (Wade & Tavris, 1990).

A schema is a type of information processing that can be defined as "a data structure for representing the generic concepts stored in memory" (Rumelhart, 1984). Hamilton (1981) defines schemata as "cognitive structures that contain a person's knowledge and beliefs pertaining to some domain of content." We have schemata that represent all facets of life including social situations, objects, and events. Rumelhart (1984) asserts that our schemata of people are determined in much the same way as our perception of objects are. Schemata are developed by observing a person's characteristics. On the basis of those characteristics, we develop schemata that make predictions about the person's motivation for his/her actions. Once we develop a schema about a person's behavior, we tend to ignore other explanations that might account for the behavior. Therefore, we assume that people have certain motivations for their actions even though we do not know the motivations for certain (Hamilton, 1981).

Schemata can contribute to prejudice in that a person can develop a schema regarding a group of people based on the characteristics of one person (Hamilton, 1979). When perceived information is congruent with a schema that is already in place, the information is more likely to be attended to, comprehended, and represented in memory (Hamilton, 1981). When the information does not match a schema that is already established, this conflicting information is largely ignored. In essence, this represents an error in information processing because a person can believe a certain notion even though conflicting evidence is concurrently observed.

Lopez (1989) offers a thorough review of social cognition theory and how it relates to bias in psychotherapy. He discusses bias as it relates to certain cognitive processes such as attribution, base rates, memory, and hypothesis testing. As noted earlier, attribution is "the process of explaining the causes of people's behavior, our own and other people's." Research indicates that client variables such as race or gender can influence attributions about behavior (Duncan, 1976; Taylor & Jaggi, 1974). Base rates refer to participantive probabilities that clinicians hold about specific populations having certain symptoms or disorders (Lopez,

1989). Several studies have confirmed that base rate biases are operating (Lopez, 1983a; Wolkenstein & Lopez, 1988). For example, the belief that schizophrenia is more prevalent among lower socioeconomic groups is a base rate assumption.

Memory is important in social cognition theory and in clinical judgment because a therapist's recollection of a client's attributes such as gender, race, or social class can affect his/her perception of the client (Lopez, 1989). Patient variables such as gender, ethnicity, and sexual orientation have been found to affect clinicians' recall of the client (Buczek, 1981; Casas, Brady, & Ponterotto, 1983). Finally, hypothesis testing refers to a confirmatory bias that a clinician might have regarding a case. Research has suggested that clinicians might more readily accept information that confirms their theory and devalue facts that contradict it (Perlick & Atkins; 1988; Wolkenstein & Lopez; 1988).

Social cognition theory will serve as a framework for this study. Conclusions and discussions will be described in terms of social cognition in order to help develop a theoretical explanation of racial/ethnic bias in psychotherapy.

<u>Racial Identity, Universality-Diversity, and Racism</u>

The investigation of the relationship between racial identity and racism began only recently. No studies existed on this topic prior to 1990. Consequently, very few studies have addressed how racial identity affects both racism and clinical judgments such as prognosis and severity of clinical symptoms.

Carter (1990) examined the relationship between racism and racial identity among White undergraduate college students. One hundred students completed the White Racial Identity Inventory and the New Racism Scale. The results suggest that both the male and female students in the sample hold racist beliefs but express them in different ways. Male students appeared to hold racist attitudes at all levels of racial identity development, while female students tended to be racist only when their racial identity development was low.

Pope-Davis and Ottavi (1992) investigated White racial identity and racism among college faculty members. Eighty seven male and eighty three female White college faculty completed the White Racial Identity Scale and the New Racism Scale. The results of the study indicate that racial identity attitudes were predictive of racism with men displaying higher levels of Disintegration. Disintegration is a stage of Helms' (1984) White Racial

Identity Model that signifies an initial awareness of one's own White racial identity. Additionally, the racial attitudes of men in the Reintegration stage also were predictive of racism. Reintegration represents the idealization of Whites and the denigration of Blacks.

Pope-Davis and Ottavi (1994) conducted a replication of Carter's (1990) study. Pope-Davis (1994) surveyed 104 male and 130 female undergraduate students to examine the relationship between racism and racial identity development. Each participant completed the White Racial Identity Scale and the New Racism Scale. The study replicated Carter's (1990) findings with racial identity attitudes being predictive of racism. Additionally, similar to the findings of Pope-Davis (1992), men had higher levels of Disintegration and Reintegration attitudes.

Ottavi, Pope-Davis, and Dings (1994) investigated the relationship between White racial identity attitudes and self-reported multicultural counseling competencies. One hundred twenty eight counseling graduate students completed the White Racial Identity Attitude Scale and an instrument measuring self-reported multicultural counseling competencies. The results suggest that, when demographic information, educational level, and clinical experience

were controlled for, racial identity attitudes explained the variability in self-reported multicultural competencies.

The studies reviewed here have suggested that racial identity development is indeed related to racist attitudes. The current study will explore whether this same trend can be generalized to the relationship between counselors' racial identity development and their racist attitudes.

Racial/Ethnic Bias in Psychotherapy

The focus of this review will now turn to research that emphasizes clients' preferences for certain types of counselors. Most of the research in this area has examined ethnic matching between clients and their counselors. Haviland, Horswill, O'Connell, and Dynneson (1983) surveyed 39 female and 23 male Native American college students and asked them state their preference regarding the counselor with whom they would most like to work. After reading two hypothetical presenting problem situations, the students were asked to rank order four potential counselors that they might see for counseling at the university counseling center. The counselors that they chose from included a Native American female, a Native American male, a White female, and a White male. The students expressed a strong preference for Native American counselors. Additionally,

the likelihood that the students would use the counseling center on campus increased if they could be seen by a counselor of the same race. Pinchot, Riccio, and Peters (1975) examined the counselor preference of 180 sixth-grade students and their parents. Both the parents and the students completed a demographics questionnaire, while only the students completed the demographics questionnaire as well as the California Test of Personality. The personality test was administered to assess the effect of personality variables on counselor preference. The results indicated that both African-American an White students and parents preferred counselors of their own race.

Thompson and Cimbolic (1978) surveyed 42 female and 33 male Black college students regarding their counselor preference. The students were presented with a hypothetical situation in which they were asked to picture themselves. The hypothetical situation described a college student having personal problems that centered around inadequacy feelings and depression. The students had a choice to see one of four different counselors at the university counseling center. Their choices included a Black female, a Black male, a White female, and a White male. They were then instructed to rank order the counselors form least preferred to most preferred. The

results indicated that the students preferred African-American counselors for both personal and educational-vocational problems. Additionally, the likelihood of the participants seeking counseling at the university's counseling center increased if a Black counselor was available.

Proctor and Rosen (1981) asked 26 White and eight African-American male veterans who received individual outpatient counseling to express their preference for counselor race prior to their initial intake session. The results indicated that the race of the client was associated with their preference of the counselor's race. Of the clients who preferred a specific counselor race, the majority preferred a counselor of their own race. A limitation of this study appears to be the small sample of African-American clients. Parham and Helms (1981) had 92 Black undergraduate college students complete a racial identity scale and a counselor preference scale. The authors found that different stages of racial identity development were associated with preferences of same-race or different-race counselor. Specifically, of the four types of racial attitudes measured (preencounter, encounter, immersion-emersion, and internalization), preencounter were most strongly associated with preferences

for White counselors and a nonacceptance of Black counselors. Apparently, the participants in this study who were at the preencounter stage of racial identity development, that is, participants who totally accept White culture and reject Black culture (Cross, 1971), preferred White counselors to Black counselors.

More recently, several studies have been conducted that address clients' preferences for a counselor's race. Atkinson and Matsuchita (1991) had 68 Japanese-Americans complete an acculturation scale, a counselor rating scale, and then listen to a simulated counseling session of a directive and a nondirective counselor. The authors hypothesized that Japanese-American clients prefer structure in a counseling session. Therefore, they proposed that the Japanese-American participants would prefer the directive counseling style over the nondirective style. The participants rated the Japanese-American counselor as more attractive than the White counselor when portraying a directive counseling style. Additionally, the participants were more willing to see a directive Japanese-American counselor for therapy. Kenney (1994) examined preference for counselor ethnicity among 69 Asian-International, African-American, and White students using the Expectations About Counseling-Brief Form. The results

of the study indicated that the students preferred to see a counselor of the same ethnicity.

The findings of the research on client preference of counselor race/ethnicity appear to be convincing. The studies reviewed here all suggest that ethnic/racial matching of counselors and clients may indeed be prudent. At the very least, a counselor should be aware that clients may have expectations or preferences regarding their counselor's race/ethnicity and may wish to explore this topic with their clients.

The focus will now turn to research that is more closely related to the present study. This section presents a chronology of research on racial/ethnic bias in psychotherapy in which clients are rated on client characteristics. Researchers began extensively examining racial/ethnic variables in psychotherapy during the 1960s and 1970s. Many of the studies focused only on African-American clients. Blake (1971) examined psychiatric residents' ratings of a clinical vignette along different dimensions of clinical impressions for African-American and White patients. Seventeen psychiatric residents in their first year of training at a New York metropolitan hospital participated in the study. The results reveled no statistical difference between the residents' ratings of

African-Americans and Whites on judgments such as prognosis, need for hospitalization, and willingness to participate in treatment. Merluzzi and Merluzzi (1978) examined how stereotypes affect counselors' assessments of clients. Eighty-six graduate students in counseling programs evaluated one of eight clinical vignettes. The participants rated the fictitious clients on their personal characteristics, orientation toward counseling and counseling readiness, and predicted outcome of counseling. To the researchers' surprise, the results suggested that the counselors assessed the African-American clients more favorably than the White clients. The counselors actually displayed a reverse bias. The authors hypothesized that the participants, in an attempt to appear non-biased, consciously rated the African-American clients more favorably (Merluzzi & Merluzzi, 1978). In another study by Umbenhauser and Dewitte (1978), 527 mental health professionals evaluated patient protocols. The participants made several clinical decisions regarding the protocols such as motivation for change and degree of disturbance. The researchers did not uncover a negative race bias; however, like the Merluzzi and Merluzzi (1978) study mentioned above, a reverse bias was detected. The results suggested that the participants rated the African-

American clients as significantly more motivated for change than their White counterparts. Bloch, Weitz and Abramowitz (1980) used an analogue study to examine White counselors' bias against African-American clients. Thirty-four White mental health professionals and 15 White students read a case profile of a young male Black outpatient. Again, the researchers were unable to detect a race bias towards the Black clients. In another analogue study, Luepnitz, Randolph, and Gutsch (1982) investigated racial and social class bias in the diagnosis of alcoholism. Forty graduate psychology students reviewed one of four videotaped intake interviews with alcoholic clients. The four tapes reflected different race and socioeconomic conditions. The participants were then asked to make a diagnosis. The results revealed significant differences for the race variable. African-American clients were more accurately diagnosed with alcoholism than White clients.

Roughly beginning in the 1980s, researchers began to expand their focus to include different races/ethnicity in their research. Warner (1979) examined race related bias in psychiatric diagnoses. One hundred seventy five mental health professionals were asked to make clinical judgments regarding a patient's profile. The participants were asked to choose one of eight possible diagnoses which included:

drug dependence, alcoholism, hysterical, antisocial, paranoid, anxiety neurosis, and schizophrenia (simple or paranoid type). Each profile differed on race and gender variables. The results suggested that the clinicians displayed minimal race bias along the dimensions of diagnosis.

Norman and Martinez (1978) investigated how social class and race affects clinical judgments. Ninety two undergraduate students evaluated clinical vignettes that differed on ethnicity, behavior, and social class. The students evaluated the clients in the vignettes along several clinical dimensions such as candidacy for psychotherapy and need for medication. The results of the study suggest that Mexican-American clients were viewed as in more need of hospitalization than Anglo clients when rated by Anglo participants. Utilizing an undergraduate college population and asking them to make clinical judgments appears to be a limitation of this study. McLaughlin and Balch (1980) examined clinical judgments of Hispanic and White counselors as they related to Hispanic and White clients. Participants in the study were 98 Mexican-American and White social workers and graduate students in social work. The participants read one of four clinical vignettes that represented different types of

psychopathology. The participants then rated the client along dimensions such as prognosis, length of treatment, and the type of treatment that is most appropriate. The findings of this study suggest that the participants in the sample were not race biased on prognosis, length of treatment, and the type of treatment.

Mukherjee, Shukla, Woodle, Rosen, and Olarte (1983) investigated the misdiagnosis of schizophrenia in patients with bipolar disorder. The authors examined the records of 76 Hispanic, Black, and White bipolar patients from an outpatient unit of an inner-city hospital for histories of previous misdiagnoses of schizophrenia. The results indicated that ethnicity was significantly correlated with the misdiagnosis of bipolar patients as schizophrenic. Additionally, both Black and Hispanic clients with bipolar disorder were more often misdiagnosed as having schizophrenia than White clients who also had bipolar disorder.

During the 1990s few studies have focused on racial/ethnic bias in psychotherapy. Littlewood (1992) surveyed 339 British psychiatrists regarding racial bias in psychiatric diagnoses. The participants reviewed one of two patient vignettes that differed only on racial content. In one vignette, the patient was "born locally", and in the

other vignette, the patient was described as born "to Jamaican parents." The participants were asked to select from among these six diagnoses: manic-depressive psychosis, major depressive disorder, paranoid psychosis, schizophrenia, personality disorder, and neurotic-stress reaction. The authors concluded that their study did not demonstrate any diagnostic bias. They found that ethnicity was not linked to any certain psychiatric diagnosis. Arroyo (1995) examined racial bias of Hispanic clients via the clinical analogue. One hundred eighty nine undergraduate college students participated in the study. The participants viewed one of four videotapes that were depictions of a client intake that differed only on racial/ethnic characteristics including accent. The participants then rated the client on such things as severity of their problem, prognosis, and candidacy for treatment. The results of the study indicated that the client's Hispanic accent in the videos influenced the participant's ratings of the client's educational level, socioeconomic status, and cultural and linguistic background. Additionally, the participants rated the client in the Hispanic guise (Hispanic accent and dark skin color) as more pathological and in more need of treatment. Another study by Arroyo (1996) investigated ethnic bias in

a sample of 56 non-Hispanic White psychologists. The psychologists were presented with one of two videotaped depictions of intake sessions. In one video, the client was portrayed as a non-Hispanic White woman; while in the other video her appearance was changed to resemble a dark-skinned Hispanic. The participants evaluated the client on diagnosis, prognosis, level of disturbance, and candidacy for treatment. Additionally, the participants rated their own ability to empathize with the client and their level of desire to help the client. The participants made their evaluations by completing the Clinical Ratings Questionnaire and the Brief psychiatric Rating Scale. The results indicated that participants rated the dark-skinned Hispanic client as having a poorer prognosis. Additionally, the participants perceived less ability to empathize with the Hispanic client.

Language Bias

It has long been established that one's perceptions can be influenced by an individual's use of language (Lambert, 1967; Giles, Scherer, & Taylor, 1979; Giles & Powesland, 1975; Giles & St. Clair, 1979; Ryan & Giles, 1982). Lambert (1967) performed much of the pioneering research on the topic of language and bias. Lambert, Hodgson, Gardner and Fillenbaum (1960) examined Canadian

college students' ratings of taped two minute speeches by French-Canadian (FC) and English-Canadian (EC) political leaders. Apparently, in the community in which this study was conducted, FC citizens are viewed as inferior to ECs. The results of the study reflected the community's opinions regarding the FCs. The participants rated the FCs as being less intelligent, less dependable, less likable, and as having less character.

More recently, Stewart, Ryan and Giles (1985) presented 60 American college students either audiotaped standard British or standard American English speakers. British speakers were rated by the participants as possessing higher status than the American English speakers. The authors attribute this bias to the tradition that a British accent is usually associated in American society with dignity, culture, and etiquette. Giles (1971) presented 17-year-old students with a speaker using six different regional accents. The students rated the speaker on pleasantness, social prestige of the voice, and their own comfort level if they were to interact with the speaker. The results suggested that the students were less tolerant of non-standard speech as indicated by their less favorable evaluations of the speaker on all three dimensions mentioned above.

More specifically, research has pointed out that speakers using an Hispanic accent are evaluated less favorably than when no accent is present. Brennen and Brennan (1981) examined the relationship between accent and perceived status of audio-taped Mexican-American readers. Eighty high school students served as participants in the study. The students listened to different tapes, which represented different degrees of "accentedness", and rated the speaker on several dimensions that included status. The results suggest that the students rated speakers with stronger Hispanic accents as significantly lower in status. Rey (1977) investigated the attitudes of employers listening to taped speakers who had an Hispanic accent. The participants in the study comprised of 20 White-Americans, 11 African-Americans, and 12 Cuban Nationals. The findings of the study indicated that the judges evaluated the speakers who possessed the strongest accent as the least desirable job candidates. Ryan and Sebastian (1980) presented 80 undergraduates with audiotaped male speakers of either Hispanic-accented English or standard English. The students rated the speaker on status, solidarity, stereotype, speech characteristics, and also made social distance judgments. Overall, accented speakers were perceived as less favorable on all measures. In a

similar study, Ryan and Carranza (1975) had 63 Hispanic, African-American, and White adolescent female participants rate the personalities of male speakers of Hispanic-accented speech and standard English. The results indicate that the participants rated the non-standard English speakers as less favorable. Arthur, Farrar, and Bradford (1974) examined the bias of 48 UCLA students regarding different dialects of English of Los Angeles Hispanics. The students, who rated the speakers on variables related to success, ability, and social awareness, negatively evaluated speakers who spoke non-standard English.

So far, this literature review has examined the racial/ethnic bias research over the past four decades, summarized the language bias literature, and reviewed social cognition theory as it pertains to the current research. The conclusions that can be drawn from racial/ethnic bias research have been equivocal. A significant portion of the studies performed on this topic have either shown no counselor bias or actually indicated a reverse bias. These ambiguous results suggest that much more research needs to be undertaken in this area to fully understand the dynamics at work in cross-cultural counseling.

The results of the research surrounding language bias

are much clearer. Very few studies in this area have failed to reveal significant effects. One might wonder what types of results would have been observed if speech cues such as accent were included in the racial/ethnic bias studies in the last 30 years. The present research will begin to answer this very question.

Universality-Diversity

The concept of universality-diversity is a relatively new one in the multicultural literature. Miville et al. (1998) define universal-diverse orientation as "an attitude that recognizes and accepts the differences and similarities among people." Being aware of both the similarities and differences among people is central to effective multicultural counseling (Vontress, 1996). This raises the question, "Are counselors who value similarities and appreciate differences among people less likely to be biased against clients who speak non-standard American English? The current research will examine this question.

Research Questions

Once again, the research questions that this study will address are: 1) Does client accent affect counselor bias on ratings of severity of clinical symptoms, ratings of prognosis, and expectations of successful treatment?; 2) Does a counselor's own racial identity development affect

his or her perceptions of a client who does not speak standard American English?; and 4) Is racial bias in psychotherapy related to the counselor's universal-diverse orientation?

Hypotheses

It is proposed that 1) a counselor will rate clients who speak non-standard American English as having more severe clinical symptoms, a poorer prognosis, and will perceive less ability to treat the client successfully when compared to their ratings of clients who speak standard American English, 2) counselors whose own racial identity is less sophisticated will rate clients who speak non-standard American English as having more severe clinical symptoms, a poorer prognosis, and will perceive less ability to treat the client successfully when compared to counselors whose racial identities are more sophisticated, and 3) counselors who display a weaker universal-diverse orientation will rate clients who speak non-standard American English as having more severe clinical symptoms, a poorer prognosis, and will perceive less ability to treat the client successfully than counselors who display stronger universal-diverse orientation.

Chapter 3

Method

Participants

One hundred eight participants were involved in this study. They consisted of graduate level counselors-in-training in counseling psychology, clinical psychology, counseling, and closely related fields. Table 1 graphically illustrates the demograhics of the participants.

Table 1

Demographics for Participants

Mean Age	30.9
Gender	
Females	77
Males	33
Racial Identity	
African-American	8
Native-American	4
Asian/Asian-American	6
Caucasian	88
Hispanic	1
Other	2
Missing	1
Degree Working Towards	
Doctorate	31
Masters	78
Missing	1
Socioeconomic Status	
Low	7
Low-Middle	18
Middle	63
High-Middle	18
High	3

Missing 1

Procedure

I contacted the instructors of graduate level courses in psychology or closely related fields by telephone to ask their permission to use their students as participants in this study and to explain the nature of the research. I selected the universities and schools to be contacted based on their proximity to my residence. It should be noted that this type of selection may limit the generalizability of this study's findings. The participants were tested in classroom settings in groups of approximately 10-20 students to maximize efficiency of data collection. I used a short script (Appendix VII) to introduce the study to the participants and had them complete a consent form (Appendix V). In previous research, Arroyo (1995, 1996) led participants to believe that the videotapes to be viewed are for training purposes. In order to avoid such a high level of deception, the participants were told in general terms the purpose of the study. The researcher told the participants that they are taking part in a study about social attitudes. Doing so helped to control the internal validity of the study. Otherwise, the participants may guess the true purpose of the study and may attempt to

appear socially desirable while completing the instruments. They viewed one of the two tapes which corresponds to one of the two experimental conditions. After viewing the video, the participants completed the Brief Psychiatric Rating Scale, the Clinical Ratings Questionnaire, the White Racial Identity Attitude Scale, the Universality-Diversity Scale, and a demographics questionnaire that was presented to the participants in a plain manila envelope. The only identifying information for each packet was a numbered code printed on the outside of the envelope. The participants were asked to not write their names or any other identifying information on the packets. Two different packets were used in the study. The only difference between the packets was the order in which the instruments were placed in them. Counterbalancing was achieved by randomly distributing the BPRS and the CRQ as either the first or second instrument that the participants completed. Similarly, the WRIAS and the UDS were counterbalanced. This counterbalancing hopefully distributed testing effects evenly that the instruments may have caused. Additionally, completing the WRIAS and the UDS after the BPRS and the CRQ avoided carry over effects that might have resulted from filling out the racially sensitive scales first. The packets were staggered so that individuals sitting next to

one another received different packets. The participants were instructed to complete the instruments in the order in which they were presented. When the participants finished, the researcher collected the instruments and sealed them in a large folder to ensure anonymity.

Instruments

Each participant completed the Brief Psychiatric Rating Scale (BPRS), the White Racial Identity Attitude Scale (WRIAS), the Clinical Ratings Questionnaire (CRQ), the Universality-Diversity Scale (UDS), and a demographics questionnaire developed by the author of this study (Appendix I).

The BPRS (Overall & Gorham, 1962) is a short assessment instrument that clinicians can use to rate clients along 16 different dimensions of psychological symptomotology (Appendix II). The scale is composed of 16 items. Each item describes a different symptom such as depression or anxiety and the clinician is directed to circle the descriptor on a seven-point Likert-type scale that best describes the client being observed. The entire instrument can be completed usually within five minutes.

Overall and Gorham (1962) report that the inter-rater reliabilities of the 16 different scales of the BPRS range from .56 to .87. Inter-rater reliability is the product-

moment correlation between ratings of two different individuals. Eighty three schizophrenic patients were rated by two independent judges to obtain the reliabilities reported by Overall and Gorham.

A score on the BPRS for a participant in the present study was calculated by summing the Likert-type response on each question and dividing this total by 16 (the number of items on the BPRS) to obtain an average response for that individual. A higher score indicated that the participant perceived the client in the videotaped condition as having more severe psychopathology. The opposite is true for lower scores on the BPRS. The mean score on the BPRS was used as a dependent variable in subsequent analyses (see "Analyses" section).

The White Racial Identity Scale (WRIAS) (Helms, 1990) is a measure designed to assess a White person's attitudes about his/her racial identity (Appendix III). Racial identity can be defined as "a sense of group or collective identity which is based on one's perception that he or she shares a common racial heritage with a particular racial group" (Helms, 1990, p. 3). The WRIAS consists of 50 attitudinal statements that participants respond to on a five-point Likert scale (1 = Strongly disagree, 5 = Strongly Agree). The WRIAS is scored by adding the point

values of each item to obtain a total for each subscale. Next, the subscale sum is divided by 10 to maintain the same scale metric

The WRIAS was developed to assess racial attitudes as they relate to Helms' (1984b) five stages of White racial identity development. The five stages outlined by Helms include Contact, Disintegration, Reintegration, Pseudo-Independence, and Autonomy. Contact refers to an "obliviousness to racial/cultural issues" (Helms, 1990, p. 68). Disintegration refers to a White person's awareness of the implications of race; however, there is a failure to recognize how his or her "Whiteness" may contribute to racism and how certain privileges are inherently obtained simply as a result of being White. In the Reintegration stage, there is an "idealization of everything that is White and denigration of everything thought to be Black" (Helms, 1990, p. 68). Pseudo-independence signifies an understanding of Black culture and the advantages of being White in the United States. Additionally, the capacity exists to take personal responsibility for the rectification of the consequences of racism. Finally, in the Autonomy stage, there is a "bicultural or racially transcendent world view" (Helms, 1990, p. 68). A nonracist White identity is developed that endeavors to eradicate

racial oppression.

The WRIAS is an Afrocentric instrument that addresses White racial identity development as it relates to African-Americans. Although the current study focuses on bias regarding Hispanic clients, the WRIAS was nevertheless be employed. With the permission of the author of the WRIAS, the instrument was adapted to better suit the current research. On the WRIAS, the terms "Black" or "Blacks" was changed to "Hispanic" or "Hispanics." It should be noted that no psychometric data on this modified version of the WRIAS are available. Post hoc analyses were performed once the data was collected to examine its psychometric properties. To assess the reliability of the adapted version of the WRIAS, Cronbach's alpha was employed. This particular test for reliability was chosen chiefly due to its popularity in the literature and for its ease of interpretation.

Helms and Carter (1987), using a sample of 506 university students, determined that the reliabilities ranged from .55 to .77 for the WRIAS full scale. Additionally, in a counselor preference study, Helms and Carter (1987) found reliabilities ranging from .65 to .76.

Helms (1990) asserts that the patterns of correlations for the subscales of the WRIAS demonstrate the construct

validity of the instrument. For example, the Disintegration subscale is correlated the highest with the Reintegration subscale which supports the fact that these two subscales are related to discomfort regarding racial issues. Helms (1990) suggests that the criterion validity of the WRIAS is adequate due to the subscales being correlated with measures of other personality constructs.

Several authors have criticized the psychometric properties of the WRIAS. Behrens (1997) argues that the WRIAS lacks construct validity in that it does not measure Helm's theory of racial identity development, which is the construct that it was designed to measure. Additionally, Behrens asserts that the WRIAS is more parsimonious than the actual theory. In other words, several of the WRIAS's scales correlate too highly with one another which indicates that the scales may actually be measuring the same construct. Furthermore, a factor analysis by Swanson, Tokar, and Davis (1994) of data from 308 college students who completed the WRIAS did not support the psychometric adequacy of the instrument. Lemon and Waehler (1996) examined the test-retest reliability and the construct validity of the WRIAS using data from 100 college students. The authors concluded that the WRIAS should be considered a measure of a state rather than a personality trait given

the relatively low level of test-retest reliability on two of the scales. Additionally, they suggest that more research needs to be undertaken to establish the psychometric properties of the WRIAS.

The Clinical Ratings Questionnaire (CRQ) (Arroyo, 1996) is an adaptation of an original instrument by Lopez (1983). The eight-item measure is used to assess therapeutic bias with Hispanic clients (Appendix IV). Participants rate clients on a seven-point Likert-type scale along dimensions including level of disturbance, need for and likelihood of benefiting from mental health services, prognosis, and willingness to help the client. Responses on the scale range from , "not at all disturbed", "no need for and would not benefit from treatment", "significant deterioration", on the far left to "very seriously disturbed", "most critical need for/would benefit greatly from treatment", and "significant improvement on the far right." Each item on the CRQ served as a dependent variable in subsequent analyses (see "Analyses" section).

I selected the CRQ due to its relevance to this study. No other instrument known to this author measures similar enough dimensions to be utilized in the current study. Additionally, the CRQ has proven to be useful in previous research (Arroyo, 1995; Arroyo, 1996).

The UDS (Miville, Gelso, Pannu, Liu, & Touradji, (1998) is an instrument that measures an individual's universal-diverse orientation (Appendix VI). Miville et al. (1998) define universal-diverse orientation as "an attitude that recognizes and accepts the differences and similarities among people." The UDS contains 45 items that ask the participant to respond on a 6-point Likert-type scale ranging from "Strongly Disagree" to "Strongly Agree." Additionally, the UDS is scored by summing scores across all items, with a higher score indicating higher levels of Universal-Diverse Orientation.

Miville et al. (1995) report both high internal and high test-retest reliabilities for the UDS. Data were gathered in two studies using 93 and 111 college students respectively in introductory psychology courses. The researchers report that the overall reliability alpha coefficient for the UDS ranged was .91 (Miville, et al., 1995). Additionally, the authors demonstrated the validity of the UDS by correlating the UDS with other similar instruments. Miville et al. (1995) report that the UDS was significantly correlated with the Autonomy subscale of the WRIAS (Helms, 1990), the Dogmatism Scale (Troldahl & Powell, 1965; Rodeach, 1960), the Homophobia Scale (Hansen, 1982), and the Perspective-Taking and Empathic Concern

subscales of the Empathy Scale (Davis, 1980).

Videotapes

The videotapes employed in this study are identical to the tapes used by Arroyo (1995). These videotapes are adaptations of the psycholinguistic same-person matched guise technique (Lambert, Hodgson, Gardner, & Fillenbaum, 1960). Arroyo (1995) originally developed four videotapes that are identical to one another except for alterations in skin color and speech accent depending upon the experimental condition. A professional actress played the parts of narrator, therapist, and client. The actress's original light skin was darkened by the use of a tanning salon and makeup for the "dark skin" conditions. The actress uses standard English for the "standard" language conditions and a Hispanic accent for the "non-standard" conditions. In the present study, only two of the original videotapes were used because they represent the two experimental conditions that were utilized. One videotape depicts a White woman [Standard American English (SAE) condition], while the other videotape shows the same woman with a Hispanic accent [Non-standard American English (NSAE) condition].

The videos begin with the narrator introducing the videotape as a reenactment of an intake interview. She

states that the purpose of the video is educational and is to be used as a teaching tool. The client is a woman in her mid thirties whose presenting problem is emotional stress due to family conflict.

Design

The study is a between design that has two experimental conditions. Participants viewed only one experimental condition (SAE or NSAE). When all of the data were gathered, the two groups were compared for differences. It was originally hoped that the two experimental groups would contain 120 participants. Once the data were collected, the total number of participants was 110. The projected number of participants was derived from the use of sample size tables (Cohen, 1977). The criterion used in the selection include an alpha level of .05, a power value of .80, and an F value (standard deviation of standardized means) of .25. Each of these values was selected because they represent conventions. A power value of .80 and an alpha level of .05 guards against Type I errors (false positives) more stringently than Type II errors (false negatives) (Cohen, 1977). Given the assumption that Type I errors are more serious than Type II errors in behavioral research, these criterion appear to be warranted.

In the first experimental condition (SAE), the client in the video was a White woman who speaks SAE. In the second condition the same actor spoke with an Hispanic accent (NSAE). These particular treatment conditions were chosen because of the attention that they have previously received in the literature (Arroyo, 1995; Arroyo, 1996). Standard American English (SAE) can be defined as "the form of the English language used in news programs; it is the language used in the national media; it is the language of legal and governmental functions; and it is the language used in the schools as a vehicle for education" (Akmajian, Demers, Farmer, & Harnish, 1990). For this study, any other dialect was considered Non-standard American English (NSAE).

Analyses

Three multivariate analyses of variance (MANOVA) were employed in this study. The first MANOVA examined group differences between the two experimental conditions (SAE and NSAE) on the clinical ratings as measured by the CRQ and the BPRS. All seven items that comprise the CRQ, along with participants' mean scores on the BPRS, served as dependent variables in the MANOVA.

For the second analysis, the participants were divided into two groups. The first group was comprised of

participants who scored above the mean score for the entire sample on the Contact subscale of the WRIAS. An individual in the Contact stage of racial identity development displays an "obliviousness to racial/cultural issues" (Helms, 1990, p. 68). The second group contained individuals who scored above the mean of the entire sample of scores on the Autonomy subscale. An individual in the Autonomy stage displays a "bicultural or racially transcendent world view" (Helms, 1990, p. 68). These two groups, which represent less sophisticated racial identities (Contact) and more sophisticated racial identities (Autonomy), were compared on the individual items of the CRQ and the mean scores of the BPRS using the MANOVA procedure.

Similarly, a median split was utilized to divide participants' scores on the UDS to represent higher and lower universal-diverse orientations. A third MANOVA procedure was employed to compare these two groups on the mean BPRS scores and on the seven items of the CRQ.

Chapter 4

Results

The data were screened to identify outliers and to check multivariate assumptions. To search for outliers, a boxplot graph was produced for each variable. Any outlier that was identified by the plot was further examined for accurate coding. To check their influence in the analyses of this study, each analysis was performed both with and without the outliers. No statistically significant difference was noted when the outliers were withheld and when they were present in the analyses. Consequently, the outliers were retained in all analyses.

Multivariate assumptions of normality, linearity, and homogeneity of variances were also examined. Modest violations to normality were noted by examining the skewness and kurtosis of the variables in histogram plots. The violations to normality were corrected via square root and logarithmic transformations; however, the transformations did not change the results of the analyses. Consequently, the original values for the variables were retained in the analyses. Similarly, moderate violations of the multivariate assumption of linearity were observed. These violations were corrected with square root transformations; however, no differences were noted in the

analyses with the transformed variables. Subsequently, the original variables were employed.

Analysis I

Three multivariate analyses of variance (MANOVA) were conducted to test the hypotheses in this study. Hypothesis 1 stated that a counselor will rate clients who speak non-standard English as having more severe clinical symptoms, a poorer prognosis, and will perceive less ability to treat the client successfully when compared to their ratings of clients who speak standard American English. A single factor MANOVA was performed on six dependent variables (DVs): how seriously disturbed the client is (DISTURBED), need for mental health treatment(TREATMENT), PROGNOSIS, client's ability to benefit from treatment (BENEFIT), whether the client's problems are internal or external (LOC), and whether the client's problems are due to her cultural background (BACKGROUND). The independent variable (IV), Accent, contained two levels (Standard American English versus Non-standard American English).

The results of the first analysis indicate that the combined DVs were significantly affected by the IV, Accent $F(6, 97) = 3.15$, $p < .01$. To investigate the impact of the main effect on the individual DVs, a stepdown analysis was performed (Table 2). In the stepdown analysis, each DV was

analyzed, in turn, with higher-priority DVs treated as covariates and with the highest-priority DV tested in a univariate ANOVA. The means of the individual DVs are displayed in Table 3; while the pooled within-cell correlations among dependent variables are shown in Table 4.

Table 2

Results of Stepdown Analysis for Analysis I

IV	DV	Univariate *F*	df	Stepdown *F*	df	α
Accent	DISTURBED	1.01946	1/102	1.01946	1/102	.315
	TREATMENT	5.17886	1/102	4.08973	1/101	.046*
	PROGNOSIS	6.90185	1/102	6.30925	1/100	.014*
	BENEFIT	0.06202	1/102	0.62920	1/99	.430
	LOCUS OF CONTROL	0.03178	1/102	0.30217	1/98	.584
	BACKGROUND	7.39620	1/102	5.74423	1/97	.018*

* $p < .05$

Table 3

Means for Dependent Variables in Analysis I

Variable	Standard American English	Non-Standard American English
DISTURBED	4.60	4.34
TREATMENT	5.33	4.78
PROGNOSIS	5.95	6.37
BENEFIT	6.07	6.01
LOCUS OF CONTROL	4.24	4.28
BACKGROUND	3.91	4.71

Table 4

Pooled Within-Cell Correlations Among Dependent Variables

	DISTURBED	TREATMENT	PROGNOSIS	BENEFIT	LOCUS OF CONTROL	BACKGROUND
DISTURBED	1.385*					
TREATMENT	.390	1.353*				
PROGNOSIS	-.058	-.037	.740*			
BENEFIT	-.004	.184	.221	1.122*		
LOC	.002	-.051	.154	-.120	1.341*	
BACKGROUND	.135	-.105	.005	-.007	-.026	1.543*

*Standard Deviations

A unique contribution to predicting differences between those participants receiving the Standard American English condition (SAE) versus the Non-standard American English (NSAE) condition was made by PROGNOSIS, stepdown $F(1, 100) = 6.31$, $p < .05$. Participants who viewed the videotaped vignette of the client with an Hispanic accent rated the client's prognosis, or chances of recovering, significantly better (mean PROGNOSIS = 6.37) than participants who viewed the client who spoke Standard American English (mean PROGNOSIS = 5.95). A difference was also found on whether the client's problems were due to her cultural background, stepdown $F(1, 97) = 5.74$, $p < .05$. The client who spoke with an Hispanic accent was rated as having problems that were due to her cultural background more so than the client who spoke SAE. A significant contribution was also made by TREATMENT (client's need for

mental health treatment), stepdown $F(1, 101) = 4.09$, $p < .05$. The participants rated the client speaking SAE as in more urgent need of mental health treatment than the client who spoke NSAE.

Analysis II

Hypothesis two stated that counselors whose own racial identity is less sophisticated will rate clients who speak non-standard English as having more severe clinical symptoms, a poorer prognosis, and will perceive less ability to treat the client successfully when compared to counselors whose racial identities are more sophisticated. It should be noted that only Caucasian participants were included in this particular analysis. People of color were excluded because the WRIAS was developed to measure the construct of White Racial Identity. Using the WRIAS with other race or ethnic groups would limit the validity of the instrument. A single-factor MANOVA was employed using four DVs: how seriously disturbed the client is (DISTURBED), need for mental health treatment(TREATMENT), PROGNOSIS, and the client's ability to benefit from treatment (BENEFIT). The IV, Level of Development, contained two levels (more sophisticated racial identities and less sophisticated racial identities).

The designation of a participant to a particular level

of the IV was accomplished by the following procedure. The participants were divided into two groups. The first group was comprised of participants who score above the mean score for the entire sample on the Contact subscale of the WRIAS. The second group contained individuals who scored above the mean of the entire sample of scores on the Autonomy subscale of the WRIAS. An unforeseen problem arose with this splitting procedure. Approximately 25 percent of the sample scored high on both the Contact and Autonomy subscales. Since their high scores on both scales would have made any interpretation of the results ambiguous, these participants were excluded from the analysis. The resulting analysis contained 67 participants. In the analysis, the DV was not significantly affected by the IVs $F(8, 58) = .615$, $p > .05$. These results suggest that, for this sample, there is no difference between Caucasian counselors with different levels of racial identity development on the clinical dimensions measured. The results of analysis II are displayed in Table 5.

Table 5

Multivariate Tests of Significance for Analysis II

Test Name	Value	Exact *F*	Hypoth. DF	Error DF	Significance of *F*
Pillais	.09801	.78777	8.00	58.00	.615
Hotellings		.78777	8.00	58.00	.615

Wilks	.78777	8.00	58.00	.615

Analysis III

Hypothesis III stated that counselors who display a weaker universality-diversity orientation will rate clients who speak non-standard English as having more severe clinical symptoms, a poorer prognosis, and will perceive less ability to treat the client successfully than counselors who display stronger universality-diversity orientations. A single-factor MANOVA was employed using six DVs: how seriously disturbed the client is (DISTURBED), need for mental health treatment (TREATMENT), PROGNOSIS, client's ability to benefit from treatment (BENEFIT), whether the client's problems are internal or external (LOC), and whether the client's problems are due to her cultural background (BACKGROUND). The two-level IV, UDSLevel, is composed of participants whose mean score on the UDS was above the median (Group 1) and participants whose mean score on the UDS fell below the median (Group 2). A median split was chosen over a mean split in this analysis in order to ensure approximately equal groups of participants at each level of the IV.

One hundred and four participants were retained in the analysis, while six participants were rejected due to

missing data. The results indicate that the DV was not significantly affected by the IVs $\underline{F}(6, 97) = 1.39$, $\underline{p} > .05$. Participants in this particular sample who were identified as having stronger universality-diversity orientations displayed no significant difference in their clinical ratings than their counterparts who scored below the median on the UDS. The results of Analysis III are summarized in Table 6.

Table 6

Multivariate Tests of Significance for Analysis III

Test Name	Value	Exact *F*	Hypoth. DF	Error DF	Significance of *F*
Pillais	.07931	1.39	6.00	97.0	.225
Hotellings	.08614	1.39	6.00	97.0	.225
Wilks		1.39	6.00	97.0	.225

Several post-hoc analyses were performed in order to gain a better understanding of the results of this study. A series of MANOVAS were ran splitting the data by gender and race. The MANOVAS that were performed in Analyses I, II, and III were completed again using males or females only, and then using either Caucasian participants or participants who identified themselves as belonging to a race other than Caucasian. One interesting result deserves comment. When participants who identified themselves as a minority were excluded from Analysis I, the main effect

achieved a higher level of significance. Likewise, when the analysis included only minorities, the main effect was not significant. In other words, the minority participants tended to perceive no difference between the client who spoke SAE and the client who spoke NSAE on the clinical ratings.

In addition to the above analyses, three reliability analyses were performed on the BPRS, WRIAS, and the UDS. The reliabilities of these instruments were all similar to those reliabilities reported in other studies (Overall and Gorham, 1962; Helms and Carter, 1987; Miville et al., 1995). Table 7 gives a visual illustration of the reliabilities of these three instruments.

Table 7

Reliability Coefficients for the BPRS, WRIAS, and UDS

Instrument	Alpha
BPRS	.80
WRIAS	.47
UDS	.85

Chapter 5

Discussion

This chapter will summarize the results of this study, discuss the strengths and limitations of the current research, examine the implications of the results, and provide guidance for further research in this area.

The current research examined three main areas: 1) counselors' perceptions of a client who does not speak English as a native language; 2) counselors' perceptions of a client who speaks non-standard American English and how that is related to their own racial identity development; and 3) counselors' reactions to a client who speaks non-standard American English and how it is related to counselors' universal-diverse orientation.

Three hypotheses were tested as well. The hypothesis that a counselor will rate clients who speak non-standard English as having more severe clinical symptoms, a poorer prognosis, and will perceive less ability to treat the client successfully was not supported. In fact, the opposite was found. Participants rated the client who spoke Non-standard American English (NSAE) as having a significantly better prognosis than the participant who spoke Standard American English (SAE). Likewise, the

client who spoke SAE was seen to be in more urgent need of mental health treatment than the client who spoke NSAE. This reverse-bias has been noted in the literature previously. Merluzzi and Merluzzi (1978) found that counselors assessed African-American clients more favorably than the White clients. Additionally, Umbenhauser & Dewitte (1978) found that participants rated African-American clients as significantly more motivated for change than their White counterparts. These studies concluded that the results likely represent an attempt by the raters to appear socially desirable. Furthermore, social desirability has been significantly correlated with self reports of high levels of multicultural competence (Constantine & Ladany, 2000).

The client who spoke with an Hispanic accent was rated as having problems that were due to her cultural background more so than the client who spoke SAE. Within the scope of this study, it is impossible to ascertain the explicit meaning behind the participants' responses; however, a possible explanation will be offered. Being counselors-in-training, these participants may be more multiculturally sensitive than most people. This fact might have led the participants to be more aware of what role the client's cultural background is playing in her current difficulties.

For example, the participants may have wondered if the traditional Hispanic roles of dominant male and submissive female may have been in conflict with the client's wishes for she and her husband to share in child-rearing and other domestic affairs. This conflict may, in turn, contribute to the client's presenting symptoms. Conversely, the participants may have processed the client's behavior using schemata that they developed during their multicultural training. They may have learned about the common roles of males and females in Hispanic cultures and applied these generalities to the individual they saw in the vignette. This cognitive processing error also represents a type of bias or faulty schemata. In other words, the client's problems may have had nothing to do with culture. The participants were looking so intensely through their multicultural "lenses" that they saw nothing but cultural explanations for behavior.

Strengths and Limitations

The design of the present study makes improvements in both internal and external validities over previous methodologies. The adequate sampling size used in this study gives the methodological design sufficient power. Additionally, the use of counselors-in-training in this study is adequately generalizable to mental health

professionals providing services; although, using post graduates would increase the external validity even further. Using this population is desirable over the use of undergraduate students or others from the general population.

Another strength of the present research was the use of videotaped vignettes. This method is favored over other forms of analog procedures such as transcripts or audiotaped vignettes that are more removed from "real world" conditions. Obviously, the use of experimental conditions that are "live" is the most preferrable.

The present research represents, to this author's knowledge, the first attempt to measure the effects of racial identity and universality-diversity on therapist bias. The exploratory nature of this study can be perceived as a strength because it attempts to link these two constructs with bias in psychotherapy.

The use in this study of an adapted form of the White Racial Identity Attitude Scale (WRIAS) is a limitation of the present research. The WRIAS was originally developed to measure Caucasian racial identity development as it relates to perceptions of African-Americans. The racial identity development of people of color is conceptualized as a different construct and is thus measured by different

means. Consequently, using even a modified version of the WRIAS with the people of color who participated in this study is not methodologically sound. Any interpretations of the data that include the participants of color should be made with caution.

Another methodological limitation of this study is the indistinct manner with which participants were classified in Analyses I and II. More clearly defined categories to describe individuals who have more or less sophisticated racial identities and universal-diverse orientations would likely have been useful in this research. For example, a number of participants scored high on both the Contact and Autonomy subscales of the WRIAS. A score such as this leads to the paradoxical interpretation that the participant has concurrently an unsophisticated and sophisticated racial identity. This ambiguity is likely an artifact of either the relatively imprecise construct of racial identity, or a flawed research design. Hopefully, this study will serve as impetus for development of more elegant research designs in this area.

The major problem with analog studies may have surfaced in this research. It is possible that the design used was simply not deceitful enough. In other words, the participant were not "fooled" into believing that their

general "social attitudes" were being measured. Instead, being counselors-in-training, the participants may have been hypersensitive to ethnic and racial issues and made deliberate, overcompensating attempts to appear nonbiased. Perhaps introducing the study as more of a "clinical" exercise would have elicited the participants "unconscious" racial attitudes if the focus of the study was on assessment, diagnosis, intervention, rather than on social attitudes.

Finally, there were no demograhic data gathered on whether the participants had taken a course on multicultural issues in counseling. Using this data as a covariate could have proven interesting and is suggested to be included in further research on this topic.

Implications

An optimistic interpretation of the results of this study could be that the current generation of counselors is so well trained in multicultural issues that bias in psychotherapy has been eliminated, or at least consciousness is being raised. The counseling profession may indeed be reaping the benefits of sweeping curriculum changes that includes a multicultural component that affects nearly every graduate of accredited training programs in the counseling field. It is likely that

counselors trained today are more sophisticated in multicultural issues than those trained 20 years ago.

Conversely, the counseling profession likely self-selects students who tend to have values that are consistent with the values of the counseling field in general. These values may include characteristics such as sensitivity, appreciation of diversity, openness, being non-judgemental, among others. It may not be surprising that these particular participants displayed a reverse bias.

As mentioned previously, social cognition theorists such as Lopez and Hamilton have identified key information processing errors such as the fundamental attribution error, faulty schemata, base rates, and confirmatory biases. Aside from the previous discussion regarding faulty schemata, it appears that the participants in this study are generally free from these errors that are central to social cognition theory. This statement is supported by a qualitative review of the participants' written comments. In general it appeared that the participants remarked more about environmental factors such as marital problems or misbehavior by the client's children than about personality factors such as dependency needs that contribute to the client's difficulties. It should be noted that a thorough,

systematic qualitative analysis was not performed. Instead, the qualitative data was examined and trends were noticed in the remarks of the participants.

A commonality in each of these cognitive errors mentioned above is a disregard of information in the participant's stimulus field. This lack of processing errors is illuminated by the fact that in the face of information that could be perceived as cultural stereotypes, the participants may have looked for alternative explanations to account for the behavior such as low self-esteem and marital conflict. What may be especially positive for this group of participants is their apparent lack of bias that leads to making the fundamental attribution error. As described previously, this error is made when personality characteristics are overestimated and environmental factors are underestimated in explaining someone's behavior.

Additionally, counselors-in-training tend to appreciate the similarities and differences between people. In other words, they typically have stronger universal-diverse orientations. There is a strong cognitive component to universality and diversity in that complex cognitive processes are taking place. One needs to perceive and process information and make comparisons based

on schemas, base rates, etc. One might argue that people who have strong universal-diverse orientations are free from the informations processing errors described above because they value differences instead of making false assumptions based on these differences.

It is the hope of this author that the present study will help generate more interest in the area of multicultural research and, more specifically, in the areas of racial identity and universality-diversity and how these concepts are related to bias in therapy. Future research on this topic should continue to focus on therapist characteristics as well as client variables to continue to develop a comprehensive model of bias in psychotherapy.

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Appendix I

Demographic Sheet

Directions: Please answer each question by filling in the blank or circling the letter that best describes you.

1) Age ____
2) Gender: Female ____ Male ____

3) Racial Identity (circle all that apply)

a) African-American/Black
b) American Indian/Native American
c) Asian/Asian American
d) Caucasian
e) Hispanic/Latino(a)
Other (please explain): _____

4) Academic Program (circle one):

a) Counseling Psychology
b) Clinical Psychology
c) Community Counseling
d) Counseling and Development
e) General Psychology
f) Social Work
Other (please explain): _____

5) Degree that you are currently working towards (circle one):

a) Doctorate degree b) Masters degree

6) Socioeconomic status (circle one):

a) Low
b) Low-Middle
c) Middle
d) High-Middle
e) High

7) Percentage of people in your last school or work environment who were of your ethnicity (0%-100%):_____

Appendix II

BRIEF PSYCHIATRIC RATING SCALE

OVERALL AND GORHAM

DIRECTIONS: DRAW A CIRCLE AROUND THE TERM UNDER EACH SYMPTOM WHICH BEST DESCRIBES THE PATIENT'S PRESENT CONDITION.

1. SOMATIC CONCERN - DEGREE OF CONCERN OVER PRESENT BODILY HEALTH. RATE THE DEGREE TO WHICH PHYSICAL HEALTH IS PERCEIVED AS A PROBLEM BY THE PATIENT, WHETHER COMPLAINTS HAVE REALISTIC BASIS OR NOT.

NOT PRESENT VERY MILD MILD MODERATE MOD. SEVERE SEVERE EXTREMELY SEVERE

2. ANXIETY - WORRY, FEAR, OR OVER-CONCERN FOR PRESENT OR FUTURE. RATE SOLELY ON THE BASIS OF VERBAL REPORT OF PATIENT'S OWN SUBJECTIVE EXPERIENCES. DO NOT INFER ANXIETY FROM PHYSICAL SIGNS OR FROM NEUROTIC DEFENSE MECHANISMS.

NOT PRESENT VERY MILD MILD MODERATE MOD. SEVERE SEVERE EXTREMELY SEVERE

3. EMOTIONAL WITHDRAWAL - DEFICIENCY IN RELATING TO THE INTERVIEWER AND THE INTERVIEW SITUATION. RATE ONLY DEGREE TO WHICH THE PATIENT GIVES THE IMPRESSION OF FAILING TO BE IN EMOTIONAL CONTACT WITH OTHER PEOPLE IN THE INTERVIEW SITUATION.

NOT PRESENT VERY MILD MILD MODERATE MOD. SEVERE SEVERE EXTREMELY SEVERE

4. CONCEPTUAL DISORGANIZATION - DEGREE TO WHICH THE THOUGHT PROCESSES ARE CONFUSED, DISCONNECTED OR DISORGANIZED. RATE ON THE BASIS OF INTEGRATION OF THE VERBAL PRODUCTS OF THE PATIENT; DO NOT RATE ON THE BASIS OF THE PATIENT'S SUBJECTIVE IMPRESSION OF HIS OWN LEVEL OF FUNCTIONING.

NOT PRESENT VERY MILD MILD MODERATE MOD. SEVERE SEVERE EXTREMELY SEVERE

5. GUILT FEELINGS - OVER-CONCERN OR REMORSE FOR PAST BEHAVIOR. RATE ON THE BASIS OF THE PATIENT'S SUBJECTIVE EXPERIENCES OF GUILT AS EVIDENCED BY VERBAL REPORT WITH APPROPRIATE AFFECT; DO NOT INFER GUILT FEELINGS FROM DEPRESSION, ANXIETY, OR NEUROTIC DEFENSES.

NOT PRESENT VERY MILD MILD MODERATE MOD. SEVERE SEVERE EXTREMELY SEVERE

6. TENSION - PHYSICAL AND MOTOR MANIFESTATIONS OF TENSION, "NERVOUSNESS", AND HEIGHTENED ACTIVATION LEVEL. TENSION SHOULD BE RATED SOLELY ON THE BASIS OF PHYSICAL SIGNS AND MOTOR BEHAVIOR AND NOT ON THE BASIS OF SUBJECTIVE EXPERIENCES OF TENSION REPORTED BY THE PATIENT.

NOT PRESENT VERY MILD MILD MODERATE MOD. SEVERE SEVERE EXTREMELY SEVERE

7. MANNERISMS AND POSTURING - UNUSUAL AND UNNATURAL MOTOR BEHAVIOR, THE TYPE OF MOTOR BEHAVIOR WHICH CAUSES CERTAIN MENTAL PATIENTS TO STAND OUT IN A CROWD OF NORMAL PEOPLE. RATE ONLY ABNORMALITY OF MOVEMENTS; DO NOT RATE SIMPLE HEIGHTENED MOTOR ACTIVITY HERE.

NOT PRESENT VERY MILD MILD MODERATE MOD. SEVERE SEVERE EXTREMELY SEVERE

8. GRANDIOSITY - EXAGGERATED SELF-OPINION, CONVICTION OF UNUSUAL ABILITY OR POWERS. RATE ONLY ON THE BASIS OF PATIENTS STATEMENTS ABOUT HIMSELF OR SELF-IN-RELATION-TO-OTHERS, NOT ON THE BASIS OF HIS DEMEANOR IN THE INTERVIEW SITUATION.

NOT PRESENT VERY MILD MILD MODERATE MOD. SEVERE SEVERE EXTREMELY SEVERE

9. DEPRESSIVE MOOD - DESPONDENCY IN MOOD, SADNESS. RATE ONLY DEGREE OF DESPONDENCY; DO NOT RATE ON THE BASIS OF INFERENCES CONCERNING DEPRESSION BASED UPON GENERAL RETARDATION AND SOMATIC COMPLAINTS.

NOT PRESENT VERY MILD MILD MODERATE MOD. SEVERE SEVERE EXTREMELY SEVERE

10. HOSTILITY - ANIMOSITY, CONTEMPT, BELLIGERENCE, DISDAIN FOR OTHER PEOPLE OUTSIDE THE INTERVIEW SITUATION. RATE SOLELY ON THE BASIS OF THE VERBAL REPORT OF FEELINGS AND ACTIONS OF THE PATIENT TOWARD OTHERS; DO NOT INFER HOSTILITY FROM NEUROTIC DEFENSES, ANXIETY NOR SOMATIC COMPLAINTS. (RATE ATTITUDE TOWARD INTERVIEWER UNDER "UNCOOPERATIVENESS".)

NOT PRESENT VERY MILD MILD MODERATE MOD. SEVERE SEVERE EXTREMELY SEVERE

11. SUSPICIOUSNESS - BELIEF (DELUSIONAL OR OTHERWISE) THAT OTHERS HAVE NOW, OR HAVE HAD IN THE PAST, MALICIOUS OR DISCRIMINATORY INTENT TOWARD THE PATIENT. ON THE BASIS OF VERBAL REPORT, RATE ONLY THOSE SUSPICIONS WHICH ARE CURRENTLY HELD WHETHER THEY CONCERN PAST OR PRESENT CIRCUMSTANCES.

NOT PRESENT VERY MILD MILD MODERATE MOD. SEVERE SEVERE EXTREMELY SEVERE

12. HALLUCINATORY BEHAVIOR - PERCEPTIONS WITHOUT NORMAL EXTERNAL STIMULUS CORRESPONDENCE. RATE ONLY THOSE EXPERIENCES WHICH ARE REPORTED TO HAVE OCCURRED WITHIN THE LAST WEEK AND WHICH ARE DESCRIBED AS DISTINCTLY DIFFERENT FROM THE THOUGHT AND IMAGERY PROCESSES OF NORMAL PEOPLE.

NOT PRESENT VERY MILD MILD MODERATE MOD. SEVERE SEVERE EXTREMELY SEVERE

13. MOTOR RETARDATION - REDUCTION IN ENERGY LEVEL EVIDENCED IN SLOWED MOVEMENTS AND SPEECH, REDUCED BODY TONE, DECREASED NUMBER OF MOVEMENTS. RATE ON THE BASIS OF OBSERVED BEHAVIOR OF THE PATIENT ONLY; DO NOT RATE ON BASIS OF PATIENT'S SUBJECTIVE IMPRESSION OF OWN ENERGY LEVEL.

NOT PRESENT VERY MILD MILD MODERATE MOD. SEVERE SEVERE EXTREMELY SEVERE

14. UNCOOPERATIVENESS - EVIDENCES OF RESISTANCE, UNFRIENDLINESS, RESENTMENT, AND LACK OF READINESS TO COOPERATE WITH THE INTERVIEWER. RATE ONLY ON THE BASIS OF THE PATIENT'S ATTITUDE AND RESPONSES TO THE INTERVIEWER AND THE INTERVIEW SITUATION; DO NOT RATE ON BASIS OF REPORTED RESENTMENT OR UNCOOPERATIVENESS OUTSIDE THE INTERVIEW SITUATION.

NOT PRESENT VERY MILD MILD MODERATE MOD. SEVERE SEVERE EXTREMELY SEVERE

15. UNUSUAL THOUGHT CONTENT - UNUSUAL, ODD, STRANGE, OR BIZARRE THOUGHT CONTENT. RATE HERE THE DEGREE OF UNUSUALNESS, NOT THE DEGREE OF DISORGANIZATION OF THOUGHT PROCESSES.

NOT PRESENT VERY MILD MILD MODERATE MOD. SEVERE SEVERE EXTREMELY SEVERE

16. BLUNTED AFFECT - REDUCED EMOTIONAL TONE, APPARENT LACK OF NORMAL FEELING OR INVOLVEMENT.

NOT PRESENT VERY MILD MILD MODERATE MOD. SEVERE SEVERE EXTREMELY SEVERE

Appendix III

White Racial Identity Attitude Scale (WRIAS)
Adapted Version ("Hispanic" has
been substituted for "Black")

This questionnaire is designed to measure people's social and political attitudes. There are no right or wrong answers. Use the scale below to respond to each statement. On your answer sheet beside each item number, write the number that best describes how you feel.

1	2	3	4	5
Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree

---

1. I hardly think about what race I am.

2. I do not understand what Hispanics want from my race.

3. I get angry when I think about how my race has been treated by Hispanics.

4. I feel as comfortable around Hispanics as I do around members of my own race.

5. I involve myself in causes regardless of the race of the people involved in them.

6. I find myself watching Hispanic people to see what they are like.

7. I feel depressed after I have been around Hispanic people.

8. There is nothing that I want to learn from Hispanics.

9. I seek out new experiences even if I know a large number of Hispanics will be involved in them.

10. I enjoy watching the different ways that Hispanics and members of my own race approach life.

11. I wish I had an Hispanic friend

12. I do not feel that I have the social skills to interact with Hispanic people effectively.

13. An Hispanic person who tries to get close to you is usually after something.

14. When an Hispanic person holds an opinion with which I disagree, I am not afraid to express my viewpoint.

15. Sometimes jokes based on Hispanic people's experiences are funny.

16. I think it is exciting to discover the little ways in which Hispanic people and people of my race are different.

17. I used to believe in racial integration, but now I have my doubts.

18. I'd rather socialize with members of my race only.

19. In many ways, Hispanics and my race are similar, but they are also different in some important ways.

20. Hispanics and my race have much to learn from each other.

21. For most of my life, I did not think about racial issues.

22. I have come to believe that Hispanic people and members of my race are very different.

23. People from my race have bent over backwards trying to make up for their ancestors' mistreatment of Hispanics, now it is time to stop.

24. It is possible for Hispanics and my race to have meaningful social relationships with each other.

25. There are some valuable things that my race can learn from Hispanics that they can't learn from other members of my race.

26. I am curious to learn in what ways Hispanic people and members from my race differ from each other.

27. I limit myself to activities involving only people from my race.

28. Society may have been unjust to Hispanics, but it has also been unjust to my race.

29. I am knowledgeable about which values Hispanics and my race share.

30. I am comfortable wherever I am.

31. In my family, we never talked about racial issue.

32. When I must interact with an Hispanic person, I usually let him or her make the first move.

33. I feel hostile when I am around Hispanics.

34. I think I understand Hispanic people's values.

35. Hispanics and members of my race can have successful intimate relationships.

36. I was raised to believe that people are people regardless of their race.

37. Nowadays, I go out of my way to avoid associating with Hispanics.

38. I believe that Hispanics are inferior to my race.

39. I believe I know a lot about Hispanic people's customs.

40. There are some valuable things that my race can learn from Hispanics that they can't learn from other members of my race.

41. I think that it's okay for Hispanic people and my race to date each other as long as they don't marry each other.

42. Sometimes I'm not sure what I think or feel about Hispanic people.

43. When I am the only member of my race in a group of Hispanics, I feel anxious.

44. Hispanics and my race differ from each other in some ways, but neither race is superior.

45. I am not embarrassed to admit that I am a member of my race.

46. I think my race should become more involve in socializing with Hispanics.

47. I don't understand why Hispanic people blame my race for their social misfortunes.

48. I believe that my race look and express themselves better than Hispanics.

49. I feel comfortable talking to Hispanics.

50. I value the relationship that I have with my Hispanic friends.

Appendix IV

Clinical Ratings

1. How seriously disturbed is this client?

not at all disturbed 1 2 3 4 5 6 7 very seriously disturbed

1a. What factors contribute to your answer for this item?

2. To what extent is this client in need of mental health treatment?

no need at all 1 2 3 4 5 6 7 most urgent need

2a. What factors contribute to your answer for this item?

3. Given adequate mental health treatment, what would be this client's prognosis, or chances of recovering?

significant deterioration 1 2 3 4 5 6 7 significant improvement

3a. What factors contribute to your answer for this item?

4. To what extent would this client be able from mental health treatment?

would not benefit 1 2 3 4 5 6 7 would benefit greatly

4a. What factor(s) contribute to your answer for this item?

5. What do you think is(are) the major cause(s) of this client's problems?

6. To what extent is(are) the cause(s) of the client's problems internal, or within the person? For example, an internal cause of irritability could be a personality style or trait.

totally internal 1 2 3 4 5 6 7 not all internal

6a. What factor(s) contribute to your answer for this item?

7. In your opinion, what is the cultural background of the client? Culture refers to the values, beliefs and norms within a group. Anglo American in this context applies to majority of mainstream, Anglo American cultural values as opposed to nonAnglo American which applies to ethnic or racial minorities with more diverse cultural values.

nonAnglo American 1 2 3 4 5 6 7 Anglo American

7a. What factor(s) contribute to your answer for this item?

8. To what extent is the client's problem due to her cultural background? Culture refers to the values, beliefs, and norms within a group that may contribute to the way in which distress is expressed or to the development of a particular problem.

not due to culture 1 2 3 4 5 6 7 definitely due to culture

8a. What factor(s) contribute to you answer for this item?

8b. To what cultural or ethnic group do you think this client might belong?

Appendix V

Informed Consent Form

You are invited to participate in a study exploring social attitudes. First, the researcher will briefly describe the experiment to you. Next, in this classroom, you will be asked to watch a videotape of a counseling intake session. Finally, you will be asked to complete four questionnaires in the order that they are presented in the packet that will be given to you. The researcher will then gather the packets with the completed questionnaires in them. Your participation should take no longer than 30 minutes.

Possible benefits of participating in this study include an increased understanding of counseling intake procedures and increased knowledge of client placement after the intake. No foreseeable risks exist for participating in this study; however, some items on the questionnaires are of a personal nature and might be viewed as sensitive questions.

Participation in this study is completely voluntary. If you choose to participate, please complete the four questionnaires and place them inside the envelope which has been provided for you. There is no penalty for not participating and you have the right to withdraw your consent and participation in this study at any time without penalty by contacting the person administering the questionnaires. Additionally, you may omit any question that you deem to be too sensitive.

All information collected for this study is strictly confidential. No individuals will be identified. Surveys will be tracked by numbers only and no identifying information will be collected. The informed consent form will be separated from the completed questionnaires to ensure your identity remains confidential and cannot be traced.

Your participation in this study is greatly appreciated. If you have any questions concerning this study, please feel free to contact Brian Snider at (405) 292-7435. You may also contact Gay Clarkson, IRB Executive Secretary, University Research Services, 203 Whitehurst Hall, Oklahoma State University, Stillwater, OK 74078, (405) 744-5700.

If you are interested in obtaining the results of this study, please complete the "Results Request Form" included in your packet and return it to the researcher when you have finished.

"I have read and fully understand the consent form and a copy has been provided for me. I sign it freely and voluntarily."

_____
Date

_____
Signature of Participant

Appendix VI

Social Attitude Scale (Form U)

The following items are made up of statements using several terms which are defined below for you. Please refer to them throughout the rest of the questionnaire.

Culture refers to the beliefs, values, traditions, ways of behaving, language of any social group. A social group may be racial, ethnic, religious, etc.

Race or racial background refers to a sub-group of people possessing common physical or genetic characteristics. Examples include White, Black, American Indian.

Ethnicity or ethnic group refers to specific social group sharing a unique cultural heritage (i.e., customs, beliefs, language, etc.). Two people can be of the same race (e.g., White), but be from different ethnic groups (e.g., Irish-American, Italian American).

Country refers to groups that have been politically defined; people from these groups belong to the same government (e.g., France, Ethiopia, United States). People of different races (White, Black, Asian) or ethnicities (Italian, Japanese) can be from the same country (United States).

Instructions: Please indicate how descriptive each statement is of you by filling in the number corresponding to your response. This is not a test, so there are no right or wrong, good or bad answers. All responses are anonymous and confidential.

1	2	3	4	5	6
Strongly Disagree	Disagree	Disagree a little bit	Agree a little bit	Agree	Strongly Agree

1._____ I am interested in knowing people who speak more than one language.

2._____ It deeply affects me to hear persons from other countries describe their struggles of adapting to living here.

3._____ I attend events where I might get to know people from different racial backgrounds.

4._____ I feel a sense of connection with people from different countries.

5._____ I am not very interested in reading books translated from another language.

6._____ Knowing about the experiences of people of different races increases my self understanding.

1	2	3	4	5	6
Strongly Disagree	Disagree	Disagree a little bit	Agree a little bit	Agree	Strongly Agree

7._____ I sometimes am annoyed at people who call attention to racism in this country.

8._____ Knowing someone from a different ethnic group broadens my understanding of myself.

9._____ Knowing how a person differs from me greatly enhances our friendship.

10.____ I don't know too many people from other countries.

11.____ I place a high value on being deeply tolerant of others' viewpoints.

12.____ It's really hard for me to feel close to a person from another race.

13.____ It grieves me to know that many people in the Third World are not able to live as they would choose.

14.____ I would like to join an organization that emphasizes getting to know people from different countries

15.____ In getting to know someone, I try to find out how I am like that person as much as how that person is like me.

16.____ When I hear about an important event (e.g., tragedy) that occurs in another country, I often feel as strongly about it as if it had occurred here.

17.____ It's hard to understand the problems that people face in other countries.

18.____ I can best understand someone after I get to know how he/she is both similar and different from me.

19.____ I often feel irritated by persons of a different race.

20.____ It does not upset me if someone is unlike myself.

21.____ I would like to know more about the beliefs and customs of ethnic groups who live in this country.

22.____ It's often hard to find things in common with people from another generation.

1	2	3	4	5	6
Strongly Disagree	Disagree	Disagree a little bit	Agree a little bit	Agree	Strongly Agree

23.____ When I listen to people of a different race describe their experiences in this country, I am moved.

24.____ I often feel a sense of kinship with persons from different ethnic groups.

25.____ I would be interested in participating in activities involving people with disabilities.

26.____ Knowing abut the different experiences of other people helps me understand my own problems better.

27.____ Persons with disabilities can teach me things I could not learn elsewhere.

28.____ I am often embarrassed when I see a person with disabilities.

29.____ I am only at ease with people of my race.

30.____ I would like to go to dances that feature music from other countries.

31.____ For the most part, events around the world do not affect me emotionally.

32.____ Placing myself in the shoes of a person from another race is usually too tough to do.

33.____ I often listen to the music of other cultures.

34.____ If given another chance, I would travel to different countries to study what other cultures are like.

35.____ I have friends of differing ethnic origins.

36.____ Knowing how a person is similar to me is the most important part of being good friends.

37.____ It is important that a friend agrees with me on most issues.

38.____ In getting to know someone, I like knowing both how he/she differs from me and is similar to me.

1	2	3	4	5	6
Strongly Disagree	Disagree	Disagree a little bit	Agree a little bit	Agree	Strongly Agree

39.____ Getting to know someone of another race is generally an uncomfortable experience for me.

40.____ I would be interested in taking a course dealing with race relations in the United States.

41.____ Becoming aware of experiences of people from different ethnic groups is very important to me.

42.____ I am interested in learning about the many cultures that have existed in this world.

43.____ I am interested in going to exhibits featuring the work of artists from different minority groups.

44.____ I feel comfortable getting to know people from different countries.

45.____ I have not seen many foreign films.

Appendix VII

Script of Oral Solicitation of Participants

I would like to invite you to participate in a study investigating social attitudes. Participation in this study will take approximately 30 minutes of your time. Your involvement is completely voluntary. By participating in this experiment, you are helping to increase knowledge regarding the relationship between the counseling profession and social attitudes. Your time is greatly appreciated if you choose to participate.

Appendix VIII

OKLAHOMA STATE UNIVERSITY
INSTITUTIONAL REVIEW BOARD

DATE: 10-28-98 **IRB #: ED-99-041**

Proposal Title: COUNSELOR BIAS AS IT RELATES TO THE CLIENT'S ACCENT AND THE THERAPIST'S RACIAL IDENTITY DEVELOPMENT

Principal Investigator(s): John S.C. Romans, Brian R. Snider

Reviewed and Processed as: Expedited

Approval Status Recommended by Reviewer(s): Approved

Signature:  Date: November 6, 1998

Carol Olson, Director of University Research Compliance
cc: Brian R. Snider

Approvals are valid for one calendar year, after which time a request for continuation must be submitted. Any modification to the research project approved by the IRB must be submitted for approval. Approved projects are subject to monitoring by the IRB. Expedited and exempt projects may be reviewed by the full Institutional Review Board.

Vita

Brian Snider

Candidate for the Degree of

Doctor of Philosophy

Thesis: BIAS IN PSYCHOTHERAPY AS IT RELATES TO THE CLIENT'S ACCENT AND COUNSELORS' RACIAL IDENTITY DEVELOPMENT AND UNIVERSALITY-DIVERSITY ORIENTATION

Major Field: Applied Behavioral Studies

Biographical:

Education: Graduated from Union High School, Tulsa, Oklahoma in May 1988; received Bachelor of Science Degree in Psychology from Oklahoma State University, Stillwater, Oklahoma in May 1993; received Master of Arts in Psychology from University of Central Oklahoma, Edmond, Oklahoma in July, 1995. Completed the requirements for Doctoral Degree in Applied Behavioral Studies at Oklahoma State University in July, 2000.

Experience: Employed as a graduate teaching and research assistant by the University of Central Oklahoma, Edmond, Oklahoma, 1993-1995; employed as a graduate teaching and research assistant by Oklahoma State University, Stillwater, Oklahoma, 1995-1998; Predoctoral intern, Oklahoma Health Consortium, Oklahoma City, Oklahoma, 1998-1999; Employed as an outpatient therapist, Associated Centers for Therapy, Tulsa, Oklahoma, 1999-Present.

Professional Memberships: American Psychological Association