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I am submitting herewith a dissertation written by John D. Richardson entitled “Preferences among White college students regarding ethnicity of university counseling center therapists.” I have examined the final electronic copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Psychology.

Brent Mallinckrodt, Major Professor

We have read this dissertation
and recommend its acceptance:

Michael Olson

John Lounsbury

Asafa Jalata

Accepted for the Council:

Carolyn R. Hodges
Vice Provost and Dean of the Graduate
School

(Original signatures are on file with official student records.)

**Preferences among White College Students Regarding Ethnicity of University
Counseling Center Therapists**

A Dissertation
Presented for the
Doctor of Philosophy
Degree
The University of Tennessee, Knoxville

John David Richardson
August 2011

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DEDICATION

To my wife and best friend

Destin Stewart-Richardson

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ABSTRACT

This 2-study research project explored whether the ethnicity of university counseling center therapists affects White clients' therapy attendance rates and perception of counselors' trustworthiness and level of expertise. Study 1 examined attendance rate differences of the clients of White therapists versus ethnic minority therapists in a university counseling center to determine if the minority therapists have lower client attendance rates than clients of White counselors. Study 2 examined White undergraduate participants' ratings of profiles of White, African American and non-US Indian counselors portrayed in a mock university counseling center brochure on factors of trustworthiness and expertise. It also examined Big 5 personality traits as covariates to determine if the trait of Openness to Experience positively influences White participants' ratings of ethnic minority therapists. Results for Study 1 showed that practicum-level ethnic minority trainees had significantly lower client attendance rates when compared with practicum level White therapists; no significant differences in client attendance rates were found among intern-level minority and White therapists. Study 2 found that non-US Indian counselors were rated more negatively than White or African American counselors by White participants. However, the trait of Openness did not show a significant interaction with ethnicity of counselor among participants. The article concludes with a discussion of the main findings, future research ideas, and practical implications for university counseling centers regarding assigning clients to ethnically/culturally different counselors.

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CHAPTER I

INTRODUCTION

Premature termination of therapy creates a myriad of problems in mental healthcare settings. For outpatient settings, early termination means that significant time and resources have been wasted in the intake process of a potential client. In an outpatient treatment center such as a university counseling center, a potential client typically attends an initial intake interview lasting roughly 30 minutes and completes paperwork including a psychological assessment, which usually will be entered into a computerized scoring system to generate an interpretive report, often for a fee charged to the outpatient center by the assessment publisher. The intake interviewer must fully document all relevant information after the interview in a case note, which adds another 15 minutes to the intake process for the interviewer. Typically, the potential client will then be assigned a therapist and have a time slot of about an hour reserved for a first session. This process of initial intake, processing of paperwork and assessment results, writing a case note, and assigning the potential client to a therapist means an outpatient facility can easily spend over an hour per potential client. The assigned therapist loses an additional hour of time if the client fails to show up for the scheduled session.

Pekarik (1985) pointed out three main costs of high dropout rates to outpatient treatment facilities: (1) Dropouts may be adversely affected by their premature termination of therapy. (2) Financial resources are wasted as clinical and staff time is spent ineffectively. (3) Therapist and staff morale may diminish, as they may feel

discouraged by low attendance rates; this may contribute to lowered job satisfaction, burnout, and low retention rates among mental health professionals.

The counseling center from which data were collected for Study 1 in the current project reported a client attrition rate of approximately 30% among practicum and intern-level therapists. *Attrition* here is defined as a client who has completed the initial intake, but either fails to attend the first scheduled meeting with the assigned counselor or, after attending this first meeting, fails to show up for a second or subsequent scheduled session with the assigned counselor. An older calculation of the percentages of attrition among adult clients in outpatient settings was reported as falling between 30% and 60% (Baekeland & Lundwall, 1975). Through a meta-analysis examining early terminations across a variety of clinical settings, Wierzbicki and Pekarik (1993) found an average early termination rate of almost 50%. Research on premature termination of therapy specifically in counseling centers has found a similar rate (Hatchet & Park, 2003). The level of pathology of clients being seen in university counseling centers is on the rise (Gallagher, Zhang, & Taylor, 2003), making early termination even more problematic for counseling center clients and for the university environment, given the numbers of students with serious mental illness who remain untreated.

In exploring the variables that relate most significantly to client attendance rates, the tendency has been to focus upon client demographic variables somewhat exclusively to the neglect of considering how therapist variables such as ethnicity relate to the client-therapist dyad (Iwamasa, 1996). Overall, in 1996 15.1% of university counseling center staff members identified themselves as ethnic minority persons (Guinee & Ness, 2000).

The importance of hiring ethnic minority college counseling center staff was emphasized by Stone and Archer (1990), who stressed the need for counseling centers to work effectively with an increasingly diverse student body. As graduate psychology programs and university counseling centers make efforts to diversify their trainees and staff, more research is needed to explore the relationship of minority ethnic status of therapists to client perceptions and behavior in a university environment.

Before describing the hypotheses that will be investigated in this project, a brief review of the literature that has examined premature termination and clients' preferences for counselor ethnicity will be presented. Some researchers have held to the hypothesis that client-therapist ethnic matching facilitates the ease of the establishment of the therapeutic alliance (e.g., Sue, 1988). The available literature indicates that some White clients exhibit strong preferences for White counselors, although others do not share such strong preferences (Proctor & Rosen, 1981). Helms and Carter (1991) point out that the within-group differences of White clients regarding counselor ethnicity preferences may be influenced by within-group individual differences of the clients.

Regarding African American clients' counselor preferences toward race-concordant or race-discordant therapy dyads, there can be within-group differences also. Based on Cross's (1971, 1978, 1991) stages of racial identity development, those ethnic minority clients considered to be in the *preencounter* phase might tend to prefer White therapists, because clients in this stage are thought to have internalized White culture and denigrated or ignored their own.

Past studies of client drop-out rates have focused primarily on age, gender, ethnic status, SES, and education level of clients as correlates of premature termination in various settings (Wierzbicki & Pekarik, 1993). Researchers have also investigated the relation of client demographics to client satisfaction with therapy (Garland, Aarons, Saltzman, & Kruse, 2000) and the correlation of dropout rates with theoretical orientations of therapists (Masi, Miller, & Olson, 2003).

Research within the medical field has demonstrated that patients treated by physicians of their own race report a higher sense of collaboration with the physician than when patients are treated by a physician of a different ethnicity (Cooper-Patrick et al., 1999). In addition, past research in the medical field has demonstrated that physician demographic characteristics affect client satisfaction under certain conditions (Ross, Mirowski, & Duff, 1982). This suggests some interaction between the ethnic status of the healthcare provider and the patient's experience of receiving services in the medical field.

Clearly, ethnic status of service providers in helping professions has some relation to client preferences and utilization of services. A review of articles published in counseling psychology journals (Atkinson, 1983) found a fairly consistent tendency for African American clients to prefer therapists of the same race. Findings varied concerning preferences of White clients. For instance, Pinchot, Riccio and Peters (1975) and Proctor and Rosen (1981) did find that many White clients prefer therapists of their own ethnicity. The latter study found that almost half of the White clients in their sample tended to prefer White therapists. Other studies reviewed reported no such preferences. Atkinson (1983) suggested that individual differences between clients within a particular

ethnicity might account for the variance, such as socio-economic status or attitudinal differences. However, Atkinson found that most studies reviewed did not take within-group differences into account.

Regarding the mixed results of Atkinson's literature review on White client preferences for counselor ethnicity, the review covered research conducted in the 1970's, during which time the vast majority of staff in the helping professions were White (e.g., Thomas & Sillen, 1976) This may have presented difficulties obtaining a large enough sample size of race-discordant therapeutic relationships in which the therapist represented an ethnic minority and the client was White.

A later meta-analysis (Wierzbicki & Pekarik, 1993) of published research examining variables that correlate with dropout rates among outpatient settings found that previous studies varied in defining what exactly constitutes a client's premature termination of therapy. Different studies used different definitions, which presented difficulties in performing the meta-analysis across all studies of dropout. Dropout was defined in these studies as either failure to attend a scheduled session or by therapist judgment of premature termination. When studies used the former definition, dropout rates were typically calculated as lower than when the latter construct was used. Regarding other variables found to contribute to dropout rates in the meta-analysis, minority ethnic status, low education, and low SES were the demographic variables significantly associated with higher dropout rates. The meta-analysis did not include therapist ethnicity as an independent variable because data availability from previous studies on the relation of therapist ethnicity to dropout was too sparse.

A study of male domestic abusers suggested a possible interaction between therapist and client ethnic status regarding dropout rates (Taft, Murphy, Elliot, & Keaser, 2001). This study found that, among male domestic abusers, African American clients were more prone to treatment dropout than White clients in a group treatment facility. The researchers hypothesized that the lower rates of attendance of African Americans may partially be explained by the fact that only 1 of 10 group cotherapists in their sample was an African American; they suggested that a cultural divide may be partially responsible for the low rates and encouraged further research on how racial differences between clients and therapists affect alliance formation.

Nickerson, Helms, and Terrell (1994) found that African American clients who are distrustful of Whites are less likely to seek psychological services from organizations predominated by Caucasian therapists. Among Mexican American adults in outpatient therapy, studies have found that clients with therapists of the same ethnicity tend to exhibit higher retention rates than mismatched clients (Flaskerud, 1986; Sue et al., 1991). Mexican American adolescents and children also exhibit similar trends (McCabe, 2002; Yeh, Eastman, & Cheung, 1994).

A study investigating American Indian and White college student preferences for counselor characteristics (Bennet & BigFoot-Sipes, 1991) found that, in regard to obtaining counseling for personal problems, White students ranked similar attitudes, similar personality, same sex, and similar age as higher priorities than same ethnicity. The American Indian participants placed same ethnicity slightly higher in priority but still prioritized education, same sex, and similar personality as higher preferences than similar

ethnicity. However, it is unclear from the study whether clients associate some of the higher-prioritized characteristics with same ethnicity in actual clinical situations. For instance, if White participants value similar attitudes as the most desirable counselor characteristic, might they also assume that being matched with a counselor of ethnic similarity entails similar attitudes? They may use ethnicity as a basis for judgment about which therapist is most similar in regard to attitudes or personality. The study required participants to prioritize each of the characteristics as separate factors, whereas in clinical settings they might be conflated.

Sue, Fujino, Hu, Takeuchi, and Zane (1991) found that European American, Asian American and Mexican American clients in the Los Angeles County mental health system had significantly lower dropout rates after 1 session when matched to an ethnically similar counselor, although this was not the case for the African American clients. Also, the study found that, for each of the 4 ethnic groups considered, similar ethnic matches were related to a greater number of therapy sessions.

Although many studies were conducted on ethnic matching related to client retention and outcome in the 1990's, most researchers who examine counselor characteristics related to retention now focus on other factors they consider more determinative of positive outcome than ethnic matching (e.g., Rogler, Malgady, & Rodriguez, 1989; Sue, 1998; Zane, Hatanaka, Park, & Akutsu, 1994). Several meta-analyses have supported the current trend away from considering ethnic match as related to client retention. A meta-analysis (Maramba & Hall, 2002) including 7 studies of client-therapist ethnic matching found contrasting results from Sue et al.'s (1991) findings;

regardless of ethnic group, ethnically similar client-therapist dyads were not significantly related to client retention after the first session or the total number of sessions. A meta-analysis of ethnic matching for White and African American clients (Shin et al., 2005), which included 10 studies, concluded that no significant differences between ethnically similar versus ethnically different client-clinician dyads with respect to clients' level of functioning, retention, and total number of session. This meta-analysis differed from Maranda and Hall (2002) in that dissertation data was included in the analysis and ethnicity of clients was limited to the consideration of White and African American clients in order to rule out possible language effects; the researchers were concerned that language differences rather than ethnicity per se may be a confounding variable when considering whether ethnic mismatch is related to lower client retention.

However, results of individual studies continue to be mixed regarding ethnic matching, suggesting that perhaps results vary depending on factors associated with the client populations of particular studies. Recent research on an adolescent sample of substance abusers utilizing treatment centers in Pennsylvania (Wintersteen, Mensinger, & Diamond, 2005) reported that when clients were racially mismatched with therapists, retention rates were negatively affected. Ethnically matched pairs averaged 79% and 76% retention rates for White-White and minority-minority pairs, respectively. For ethnically mismatched pairs, the retention rates dropped to 66% for minority therapists with White clients and 48% for White therapists with minority clients. Further, client-therapist language differences that concerned Shin, et al. (2005) were unlikely to play a factor in this research, since most of the ethnic minority therapists were African American.

Another study investigating ethnic matching and treatment outcomes with Hispanic and White clients among teen substance abusers in family therapy (Flicker, Waldron, Turner, Brody, & Hops, 2008) found that only among Hispanic clients did ethnically similar therapy dyads improve outcome. Outcome was measured by posttreatment reduction in substance use rather than client retention or number of sessions. The Hispanics' primary language was English, and thus language differences did not account for the better outcome of Hispanic clients matched with Hispanic therapists.

Little research has investigated the experience of non-US ethnic minority mental health professionals' clinical experiences in the US. We found no empirical investigations of international trainees' experiences working with White clients. However, research on the overall increased suspiciousness toward international peoples after 9/11 suggests that being an international counselor may bring with it certain difficulties in working with US clients. This applies to those of Arab descent or those perceived to be as such, but also to international peoples in general – and these negative attitudes manifest in many forms. In addition to an increase in prejudice against Arabs (e.g., Perry, 2003; Bhatia & Ram, 2009; Bushman & Bonacci, 2003), the US has demonstrated increased hypervigilance more generally. One example of this is the US's thickening of borders between itself and its two North American neighbors. One commentator wrote, “The events of 9/11 changed, dramatically and seemingly forever, the notion that there was a North American community waiting to happen” (Drache, Valdes-Ugalde, & Van Schoik, 2008, p. 1). Romero (2008) commented on the anti-

immigrant backlash after 9/11, stating, “Exclusion, detention, and surveillance of non-citizens all became the concern of counterterrorism legislation, which included the *Patriot Act*, the *Homeland Security Act*, and the *Enhanced Border Security and Visa Entry Reform Act*” (p. 45). She argued that conflating immigration control with criminal law enforcement under the Department of Homeland Security has obscured the differences between an immigrant and a potential terrorist.

A mixed method study of international mental health trainees’ views of their multicultural training while being trained in the US (Smith & Ng, 2009) revealed that international trainees rated the helpfulness of their acquired multicultural knowledge and awareness of self and others as helpful; however, they tended to rate their multicultural skill training as less helpful. Apparently, this sample of international trainees felt that their multicultural training was somewhat ineffective in applying the acquired knowledge to their clinical practice while training in the US. In fact, a survey of multicultural course syllabi (Priester et al., 2008) revealed that 48% of syllabi examined had a low level of emphasis upon acquisition of multicultural skills and another 28% had no mention of skill development as a course objective.

Added difficulties for international trainees from non-English speaking countries consist of language differences with US White clients (Killian, 2001; Mittal & Weiling, 2006; Ng 2006). In addition to difficulties with the English language for international trainees from non-English speaking countries, international students also may have differences in accent, regardless of language proficiency. Fuertes, Potere, & Ramirez (2002) conducted a literature review from the fields of psycholinguistics,

communications, and social psychology regarding the effects of variations in speech accents in same-language use; they then discussed implications of the findings for international counselors. Two studies cited in the review (Fuertes, 1999; Fuertes & Gelso, 2000) examined the effects of speech accents on the initial impressions formed by White participants toward Hispanic counseling psychologists. These studies found that White participants were more willing to attend long-term therapy with a Hispanic psychologist if the psychologist had a standard US accent versus a Spanish accent. Further, they found that individual differences determined whether the perceived Spanish accent was viewed positively or negatively; participants high in *universal-diverse orientation* (Fuertes, Miville, Mohr, Sedlacek, & Gretchen, 1999; Miville et al., 1999), which refers to multicultural awareness and the valuing of differences and similarities between self and others, rated the Hispanic psychologist with the Spanish accent more positively. Those low in universal-diverse orientation viewed this psychologist with the Spanish accent more negatively. Fuertes, Potere, & Ramirez (2002) conclude their review by discussing difficulties faced by international trainees whose accent reflects different cultural background; clients may react to the accent negatively by assuming that the counselor is less competent, trustworthy or attractive than US English speaking counselors.

Regarding the mixed results among White clients in ethnic matching studies, individual differences may influence how clients respond to the ethnicity of a therapist. Ekehammar and Akrami (2003) observe that there have been two general theoretical explanations for why some people are more prejudiced than others; personality psychologists believe that personality differences account for the variance, whereas social

psychologists attribute the variance to differences in group membership, the latter theoretical perspective holding more sway in the past several decades. However, in recent years, research has tended to support the idea that individual personality differences relate to constructs associated with prejudice. Peterson, Smirles, and Wentworth (1997) examined the Big Five personality factors and found that authoritarianism, a construct that tends to correlate with prejudice, showed a negative correlation with the personality factor of Openness to Experience; none of the other Big Five factors correlated significantly with authoritarianism.

Ekehammar and Akrami (2003) found a significant negative relationship ($p < .001$) between generalized prejudice and two of the Big Five factors: Openness to Experience and Agreeableness. Ekehammar, Akrami, Gylje and Zakrisson (2004) also found the same significantly negative relationship between generalized prejudice and the two personality factors but reported that the magnitude of the correlation was weaker than previously found. However, they also reported that a shorter 44-item measure of the Big Five factors was employed in the second study, which likely did not have the same level of reliability and construct validity as Costa & McCrae's significantly longer NEO-PI-R (1992).

The current research arose from conversations with ethnic minority therapists in a university counseling center at a large southeastern university of a predominantly White student body. The anecdotal impression of many of these student colleagues of color was that their clients were more likely to not attend a first session, or not return for a second session than the clients of their White student colleagues. The purpose of Study 1 in this

project was to examine the archival evidence to determine with precision the extent of this problem. The thrust of this research was the potential identification of a problem rather than discovering a suitable solution. Study 2 in this project was an experiment that presented simulated counselor “profiles” to randomly assigned groups of undergraduates. The profiles were equivalent except for two factors: (a) counselor ethnicity (White vs. African American, vs. International Indian), and professional training level. The project will examine the following four hypotheses:

Hypothesis 1 (Study 1): Ethnic minority and international counselors providing individual therapy will have a significantly higher client dropout rate than their White colleagues at the same level of experience. *Dropout* is defined as either (a) discontinuation of services after the first individual therapy session, or “no-show” (non-attendance of first session with assigned therapist).

Hypothesis 2 (Study 2): There will be a general tendency among participants to rank and rate the White therapist profiles more highly than their rankings and ratings of African American or Indian international therapists.

Hypothesis 3 (Study 2): Participants who are high in the personality trait of Openness to Experience will not exhibit a preference for the White Counselor profiles (identified in Hypothesis 2).

Hypothesis 4 (Study 2): International counselors will be less preferred by White participants than the African American counselors.

CHAPTER II

METHODS

Study 1

The aim of Study 1 was to examine whether ethnic minority and international therapists and White therapists differ regarding the proportion of premature termination of therapy by the predominantly White clients in a university counseling center. No-show rates for a sample of interns and practicum-level counselors representing both ethnic groups within the past several years were compared. We hypothesized that White counselors will have higher client attendance rates than ethnic minority therapists.

Method

The attendance records of clients of twelve university counseling center counselors who served as trainees from 2005-2008 were recorded. Over 3 years, these counselors were assigned to see a total of 474 clients in individual therapy. Although ethnic demographic data were unavailable for all clients seen at this center, approximately 80-85% of the clientele of this counseling center indicate an ethnic/racial identification of "White." Of the twelve counselors, six were practicum-level trainees and six were intern-level trainees. Of the six in each training level group, three were ethnic minority trainees and three were White. All three of the practicum-level counselors were international students of three different nationalities, whereas only one of the intern trainees was international. All therapists in the study were female. The case files of all ethnic minority trainees who served at the Counseling Center during the three-year data collection period were examined. Each was paired with a randomly selected White

counselor trainee of the same sex and training level for comparison. Upon IRB approval, client data was only examined if the client had previously agreed to his or her records being used in psychological research. The Director of the UT Counseling Center granted permission to use the Center's archival data for this study. Thus, the basic design research design of Study 1 involved a two-level independent variable, counselor ethnicity (White vs. ethnic minority/international); and a three-level dependent variable, attendance (attended the first two sessions vs. attended the first session but no-showed for the second vs. no-showed for the very first session). No-shows were differentiated into two types because a client who no-showed for the first session would be doing so without ever having a chance to meet her/his therapist, whereas "second session no-shows" would have much more information about their counselor based on the first meeting.

Study 2

In this study, our aim was threefold: To examine whether there are significant differences in a sample of university students concerning their perceptions and preferences for the ethnicity of therapists when given a choice of White, African American, and International Indian counselors – all matched to the subject's sex. Second, these conditions were crossed with two levels of counselor training (represented as Masters level and Ph.D. level counselors) to examine the possibility of significant interactions between training level and counselor ethnicity. Third, the Big-5 personality factors were examined as possible covariates that might influence the character of this interaction. For example, Openness to Experience might be associated with more favorable perceptions of ethnically diverse counselors.

Method

Participants and Design

Undergraduate students ($N = 234$) from the university psychology department's undergraduate pool were recruited to participate in the project. Students over the age of 18 were invited to participate regardless of ethnicity. Participants responded to demographic items asking about their age, sex, and ethnic/racial identification. Although data were collected from all participants regardless of self-described ethnic/racial identification, only data from White participants were analyzed in this study. Of the 234 participants 187 (79.9%) identified themselves as White. A repeated measures multiple analysis of covariance (MANCOVA) was used to analyze the data. The within-subjects independent variables were level of counselor training (medium vs. high) and counselor ethnicity (White vs. African American vs. International Indian). The between-subjects independent factor was sex of participant. Thus the design was 2 (within) X 3 (within) X 2 (between) mixed model. The covariates were positive impression management and the Big Five personality traits. The two dependent variables were the participants' ratings of counselor expertise and trustworthiness. The within-subject independent variables were manipulated by means of mock counselor profiles described next.

Counselor Profiles

A mock university counseling center brochure was created containing eight different counselor profiles; six of these profiles were matched to the gender of the participant and depicted counselors of various experience levels and ethnicities (two White counselors, two African American counselors, and two Indian international

counselors; each pair contained one high-experience and one low-experience counselor). To add realism, and in an attempt to mask the true purpose of the study, two additional White counselor profiles were included of counselors of the opposite sex to the other six (that is, also the sex opposite of the participant).

In the brochure for men, ethnicity and experience varied in this order: the opposite-sex distracter profile of high training level; African American low training; African American high training; distracter low training; White high training; Indian high training; White low training; Indian low training. For the women, ethnicity and experience varied in the following order: the opposite-sex distracter profile of high training level; African American low training; Indian high training; distracter low training; White high training; African American high training; White low training; Indian low training. Photos were selected by requesting permission to use them from either university counseling center staff, faculty or other volunteers. Some were already posted online on staff or faculty websites, and we took some of the pictures when needed to complete all the profiles. We attempted to depict the counselors as having similar expressions, using a similar camera angle.

Measures

Impression management. Participants completed the Impression Management subscale (IM: 20 items) of the Balanced Inventory of Desirable Responding (BIDR; Paulhus, 1984, 1988) in order to assess the degree to which participants' ratings and of mock therapist profiles might be influenced by socially desirable responding. Sample items include "I always obey laws, even if I'm unlikely to get caught" and "I never cover

up my mistakes.” Participants rate items on a 7-point scale ranging from 1 (not true) to 7 (very true). Paulhus (1991) recommended that one point be assigned to responses of 6 or 7, after reverse-scoring negative items. Paulhus (1991) reported internal consistency reliability of the subscale as having a coefficient alpha range falling between .75 and .86. Test-retest reliability was found to be .65 over a five-week period among undergraduate college students. Regarding convergent validity, Paulhus (1991) reported that the IM scale correlates highly with lie scales such as the MMPI Lie scale and Eysenck’s lie scale. It also correlates with the Marlow-Crowne Social Desirability Scale. Cronbach’s alpha for the 20-item Impression Management subscale in the current study was .76.

Personality traits. *Personality.* The 48-item personality measure used in this study was the Resource Associates Adolescent Personal Style Inventory (APSI) for College Students. The APSI is a normal personality inventory contextualized for adolescents and has been used for early, middle, and late adolescents (Jaffe, 1998) from middle school through high school and college. Scale development, norming, reliability, criterion-related validity, and construct validity information for the APSI can be found in Lounsbury, Gibson, and Hamrick (2004); Lounsbury, Gibson, Sundstrom, Wilburn, and Loveland; (2003); Lounsbury, Hutchens, & Loveland (in press); Lounsbury, Loveland, and Gibson, (2003); Lounsbury, Steel, Loveland, and Gibson (2004); Lounsbury, Sundstrom, Loveland, and Gibson, 2003; and Lounsbury, Tatum, Gibson, Park, Sundstrom, Hamrick, and Wilburn (2003). When considered collectively, the research reported in the preceding works shows that the APSI constructs are internally consistent; where appropriate, they display generally high convergence with common traits on other

widely used personality inventories, including the 16 PF, NEO-PI-R, Myers-Briggs Temperament Inventory; and they significantly predict academic performance (reflected by course grades and cumulative GPA) in all grades from middle school through high school and all class levels in college, teacher ratings of behavior, school absenteeism, adjustment, at-risk behavior, sense of community, leadership, satisfaction in variety of areas, vocational interests, career decidedness, and wide variety of logically related (to specific APSI traits) psychological constructs, such as rule-adherence, vigilance, self-esteem, sensation-seeking, self-actualization, empathy, etc. Moreover, an adult version of the APSI has been found to be related to job performance, job satisfaction, and career satisfaction in a wide variety of occupations in many different business and industry settings. Regarding criterion-related validity, the measure has been shown to have significant correlations ($p < .05$ for Openness, $p < .01$ for all others) with a measure of Overall Life Satisfaction (Lounsbury & Gibson, 2004) for all 5 personality traits among samples of college students. In the current study, Coefficient alphas for each of the Big Five subscales were as follows: Extraversion, $\alpha = .86$; Openness, $\alpha = .77$; Agreeableness, $\alpha = .80$; Conscientiousness, $\alpha = .79$; Emotional Stability, $\alpha = .88$.

Therapist rating. Participants completed the Trustworthiness and Expertise subscales of the Counselor Rating Form – Short version (CRF-S) (Corrigan & Schmidt, 1983) for each of the eight mock profiles. The two subscales contain four questions asking the participant to rate the therapist on a 7-point scale for each item, ranging from “not very” to “very.” Regarding the development of the Short version of the CRF, the four items comprising each subscale were chosen from among the 5-6 item subscales of

the full-length CRF. The selection process was made based upon two criterion: those items that had consistently shown high loadings on the respective dimensions in previous factor analyses and items containing language requiring no higher than an 8th grade reading level for comprehension (Corrigan & Schmidt, 1983). All items chosen were among the top five loadings in at least 50% of six factor analyses previously completed on the original CRF. Inter-item reliability for the subscales of Attractiveness, Expertness, and Trustworthiness was .86, .87, and .76, respectively, when administered to a sample of 155 outpatient clients in two community health centers in a Midwestern urban area (Corrigan & Schmidt, 1983). Given the high intercorrelation of the subscales (Tracey, Glidden, & Kokotovic, 1988), researchers often consider the total score as a valid measure of client perception of therapists (e.g., Hanson & Claiborn, 2006). Regarding validity, data from various studies have reported that the total score of the CRF-S is a valid measure of client/participant perceptions of the therapist and that interpretation of scores should consider the three specific factors as well as the overall score (Heppner & Claiborn, 1989). We chose to use only the Expertise and Trustworthiness subscales because prior research demonstrated that these factors rather than Attractiveness predicted client retention in a university counseling center; when clients perceived the therapist to be highly trustworthy and competent, they were more likely to return (Kokotovic & Tracey, 1987).

Therapist ranking. Participants were also asked to rank-order all eight profiles in the mock brochure according to their preferences. They were asked, “If you were to seek counseling, which of the therapists would you most prefer to see?” Participants rank-

ordered the profiles from 1-8, 1 indicating the profile depicting the counselor that the client would be most likely to choose and 8 indicating the counselor the participant would be least likely to choose.

Procedure

Student participants were recruited from the course “Psychology 110: Introduction to Psychology.” These students signed up to participate through the psychology department’s “Human Participation in Research” (HPR) website that describes various research projects students can participate in to earn points toward their grades in Psychology 110. On the website, our project was entitled, “Student ratings of university counseling center brochure.” Participants were informed on the site that they will be asked to complete several surveys that measure personal characteristics and then will be asked to rate and give feedback about the design and content of a university counseling center brochure.

Students were required to participate in the study in person, in order to ensure that all participants complete the survey under equal conditions that facilitated attentiveness in completing the study requirements. They received course credit equivalent to one hour of participation by completing the participation requirements.

Groups ranging from approximately 10-50 students at a time completed the project procedures. Each of these meetings was supervised by the primary researcher and a trained research assistant. The assistant was given specific instructions on how to administer the materials to the participants, in order to ensure uniformity of conditions. Participants were instructed to remove only the white forms from their envelopes (rather

than the tan forms, which were the mock brochures). The consent forms were distributed before the packets, and students were asked to read and sign the form. They were each provided with an additional copy for their own records.

After participants read and signed the informed consent forms, the packet materials were distributed, including the scales and the mock brochure. The packets were in manila envelopes and varied slightly in size and color according to gender, which indicated to the research assistant whether the packet was to be distributed to a male or female participant. This procedure was intended to mask the fact that male and female participants were receiving different mock brochures according to their gender. Participants were asked to record demographic data, limited to sex, age and ethnic identification. Names or other identifying information were not collected so that anonymity could be assured. After recording demographic information, participants were instructed to complete items 1-71 and then to put pencils down and wait for further instructions.

After everyone indicated they had finished items 1-71 by putting pencils down, students were instructed to remove the tan packet from the manila envelope. Then, the principle researcher stated, "We are designing a university counseling center brochure and would like your feedback on the design and content. Please take a few minutes to look over the brochure and then complete the remaining items in the white packet pertaining to the brochure. Once you are done, please keep your consent forms separate and insert the other materials back into your manila envelope. Then, please remain seated and wait for further instructions." After everyone completed the remaining items, consent

forms and research materials were collected separately. Then, participants were debriefed about the true purpose of the study and afterwards were dismissed as a group.

CHAPTER III

RESULTS

Study 1

To examine differences in attendance patterns a 2 X 3 (counselor by attendance pattern) chi-square was conducted separately for archival data from practicum students and from interns. Results shown in Table 1 reveal a statistically significant difference in patterns of attendance rates of White practicum counselors versus ethnic minority counselors $\chi^2(2, N = 145) = 14.96, p < .001$. Examination of adjusted standardized residuals (ASR) indicated that there was a significant difference in the rates of no-shows after the first session (ASR = 3.6, $p < .01$) between the clients of White practicum counselors (5.7%) and international counselors (28%). Table 1 also shows that there was a significant difference in the rates of complete attendance (ASR = 3.7, $p < .01$) between the clients of White practicum counselors (87%) and international counselors (60%). Figure 1 shows the pattern of the interaction for practicum-level therapists. The rates of no-show BEFORE the first session were not significantly different. Table 2 shows that for interns there were no significant differences between any of the three rates of attendance. $\chi^2(2, N = 328) = 1.92, p = .383$. Figure 2 shows the pattern of the interaction for intern-level therapists.

We also examined individual attendance rates of the minority practicum-level counselors to rule out whether one particular counselor had a particularly low client attendance rate, thus affecting the total score. However, we did not find a statistically

significant difference between the attendance rates of the clients of individual minority practicum students. $\chi^2(4, N = 75) = 7.36, p = .118$.

Study 2

As a preliminary analysis, a 3-way (2 X 3 X 2) MANCOVA was conducted. The between-subjects factor was participants' sex. The two within-subjects factors were counselor ethnicity (White, Africa-American, International) and counselor training level (low vs. high). Social desirability (BIDR scores) served as the covariate. With regard to statistical assumptions for MANCOVA, Box's test for equality of covariance matrices was significant, $p < .001$, indicating that covariance of dependent variables are not equivalent across groups. Mauchly's test for sphericity was also significant for both dependent variables. Therefore, tests of significance for within subjects effects reported below are corrected using the Greenhouse-Geisser adjustment to degrees of freedom.

Results suggested that there was a significant between subjects main effect for social desirability, Wilkes Lambda = 0.960, $F(2,183) = 3.83, p = .02$, eta squared = .04; but not for sex, Wilkes Lambda = 0.987, $F(2,183) = 1.17, p = 0.31$, eta squared = .013. For the within subjects factors, significant main effects were found for counselor ethnicity, Wilkes Lambda = 0.972, $F(4,734) = 2.62, p = .03$, eta squared = .014; and counselor training level, Wilkes Lambda = 0.483, $F(2,183) = 98.11, p < .000$, eta squared = .517. The counselor ethnicity X training level interaction was significant, Wilkes Lambda = 0.917, $F(4,734) = 8.11, p < .000$, eta squared = .042. None of the interactions involving sex differences were significant, but the counselor ethnicity X sex interaction should be noted, Wilkes Lambda = 0.984, $F(4,734) = 1.46, p = .212$, eta squared = .008.

Because of the size of this effect (although it was not significant), the different numbers of male and female subjects which led to different cell sizes, and the complexity of interpreting three-way interactions, separate analyses were conducted for the 85 men and 102 women. No other two-way interactions were significant.

Therefore, for male subjects only, a 2-way (counselor ethnicity X training level) MANCOVA was conducted. In addition to the two within-subjects factors, social desirability (BIDR scores) served as the covariate. With regard to statistical assumptions for MANCOVA, Mauchly's test for sphericity was also significant for trustworthiness. Therefore, tests of significance reported below are corrected using the Greenhouse-Geisser adjustment to degrees of freedom. There was a significant main effect for the social desirability as a covariate, Wilkes Lambda = 0.894, $F(2,82) = 4.851$, $p = .01$, eta squared = .106. The main effect for ethnicity was not significant, Wilkes Lambda = 0.970, $F(4,330) = 1.25$, $p = .291$, eta squared = .015; but the main effect of training level was significant, Wilkes Lambda = 0.453, $F(2,82) = 49.60$, $p < .000$, eta squared = .547. Perhaps most important, the counselor ethnicity X training level was significant, Wilkes Lambda = 0.905, $F(4,330) = 4.24$, $p = .002$, eta squared = .049. Figure 1 shows the nature of this interaction. Apparently men did not distinguish the level of expertise for the three counselors portrayed as having a low level of training. However, for the three high training level counselors, ethnicity did make a difference in ratings of expertise. The White counselor was rated as most expert, followed by the African American counselor, followed by the international counselor. Table 6 shows results of univariate tests for

differences in ratings of Expertise and Trustworthiness for men. Figures 3 and 4 show the nature of this interaction.

Next, only for female subjects, a 2-way (counselor ethnicity X training level) MANCOVA was conducted. In addition to the two within-subjects factors, social desirability (BIDR scores) served as the covariate. With regard to statistical assumptions for MANCOVA, Mauchly's test for sphericity was also significant for trustworthiness. Therefore, tests of significance reported below are corrected using the Greenhouse-Geisser adjustment to degrees of freedom.

The main effect for the social desirability as a covariate was not significant, Wilkes Lambda = (.985), $F(2,99) = .771$, $p = .465$, eta squared = .015.

The main effect for ethnicity was significant, Wilkes Lambda = (.936), $F(4,398) = 3.32$, $p = .011$, eta squared = .032; and the main effect of training level was significant, Wilkes Lambda = (.502), $F(2,99) = 49.18$, $p < .001$, eta squared = .498.

Perhaps most important, and similar to men, the counselor ethnicity X training level was significant, Wilkes Lambda = (.918), $F(4,398) = 4.33$, $p = .002$, eta squared = .042. Table 7 shows results of univariate tests for differences in ratings of Expertise and Trustworthiness for women. Figures 5 and 6 show the nature of this interaction.

We then ran separate MANCOVA analyses for each gender and for each of the 5 personality factors, to determine if these covariates significantly influenced the dependent variables. For women, Conscientiousness and Extraversion demonstrated significant interactions with ethnicity of counselor ($p = .048$, $\eta^2 = .024$; $p = .003$, $\eta^2 = .039$, respectively). No other traits demonstrated a significant interaction in the analysis for

men or women. In the univariate analysis of Extraversion for women, ethnicity * Extraversion showed a significant interaction with Expertise ratings of the counselors in particular ($p = .004$, $\eta^2 = .055$). Results are displayed in Table 8.

CHAPTER IV

DISCUSSION

For Study 1, we hypothesized that ethnic minority and international counselors providing individual therapy will have a significantly higher client dropout rate than their White colleagues at the same level of experience.. This hypothesis was supported in analyses of clients assigned to practicum-level counselors but not clients of intern-level counselors. Thus, our results for the practicum counselors corresponded to prior research on race-concordant versus discordant therapeutic dyads (Wintersteen, Mensinger, & Diamond, 2005), which found a significant discrepancy between race-discordant matches of White clients with ethnic minority therapists ($p < .05$); that study found a 34% dropout rate among White clients matched to ethnic minority therapists versus a 21% dropout rate among White clients matched to White therapists among adolescents in outpatient substance abuse treatment. However, Wintersteen et al. did not consider experience levels of counselors as an independent variable, although the study reported a wide array of experience levels among the therapists examined. In our Study 1, it is unclear whether the disparity in client attendance rates between practicum-level and intern-level ethnic minority trainees results from differing training levels or international status, since the practicum-level non-White counselors were exclusively international trainees, whereas the three intern-level trainees included a mixture of international and U.S. ethnic minority counselors.

Regarding the disparity between the client dropout rates of practicum-level versus intern-level counselors, there are several plausible explanations. First, the practicum-level

ethnic minority trainees were all international students, whereas only 1 of the 3 intern-level ethnic minority therapists was of international status. Perhaps clients were most reactive to the international status of the ethnic minority trainees over and above mere race/ethnicity. If the client perceived the counselor to have a non-US cultural heritage, as suggested by such factors as the therapist's accent, perhaps the White, US-born clients assumed that the counselor may be unable to understand and properly address the client's presenting issues, or there was some feeling of discomfort toward the international therapist. This would help explain why clients were willing to attend an initial therapy session with an ethnic minority therapist; even if the counselor's name denoted ethnic minority status, it is impossible to tell from this whether the therapist has a different nationality. During the initial session the client notices the international status of the counselor; this may have the most influence regarding discontinuance. Study 2 was designed to distinguish between White undergraduates' reaction to mere racial status versus international/non-US cultural status of counselors.

Yet another explanation for the difference in client attendance rates by experience level of trainees may be due to more skilled cultural broaching (Day-Vines, et al., 2007) by the intern-level therapists in comparison with the less experienced trainees, regarding the therapists' own ethnic differences from the clients. The term "cultural broaching" refers to "the counselor's ability to consider how sociopolitical factors such as race influence the client's counseling concerns" (p. 401). The intern-level counselors who were culturally or ethnically different from the majority of their clients may have been more skilled at rapport-building and perhaps used some form of cultural broaching to

discuss the counselor's own ethnic differences with the client, which in turn increased client retention.

The purpose of Study 2 was to examine differences in perception by White college students of counselors who vary in training level and ethnicity. Due to difficulties analyzing rank ordered data with parametric statistics, we decided to use only the CRF-S domains of expertise and trustworthiness as the only dependent variables in multivariate analyses. Ranked data can not be included in MANOVA or MANCOVA. The first hypothesis in Study 2, that there will be a general tendency among participants to rank and rate the White therapist profiles more highly than their rankings and ratings of African American or Indian international therapists, was supported. A significant interaction occurred between perceived training level of the counselor and ethnicity of counselor. Among the mock counselor profiles, ratings of the counselors with higher training level were differentiated, whereas all three counselors were rated very similarly in the low training level condition. At the higher training levels, the White counselor received the highest expertise ratings, followed by the African American counselor, followed by the non-US international counselor. Although the interaction of ethnicity * trustworthiness was not found to be significant, a noteworthy pattern can be seen in Figure 2. The White therapist received the highest Trustworthiness ratings, followed by the African American counselor, followed by the international counselor. At the lower levels of training, the African American was rated higher in trustworthiness; this may be due to the fact that this counselor was portrayed as having attended graduate school at a geographically proximal institution to that of the participants, whereas the White low-

training counselor was depicted as attending a relatively unfamiliar and geographically distal institution.

Considering the results of Study 2 for women, again there was a significant interaction between counselor ethnicity and training level in multivariate analyses, although neither of the subscales of the CRF-S showed a significant interaction at the univariate level. Figures 3 and 4 depict the pattern of this interaction with expertise and trustworthiness, respectively. Different from men, the women seemed to rate the African American counselor of high training more equally with the White high training counselor in regard to expertise and trustworthiness.

Our third hypothesis, that participants who are high in the personality trait of Openness to Experience will not exhibit a preference for the White Counselor profiles, was not supported. None of the Big Five factors showed significant associations with the dependent variables for men. Only for women did we find a significant interaction for two factors (Conscientiousness and Extraversion) with the dependent variables. Openness to Experience showed no significant interaction for men or women. Thus, we found no support for the hypothesized relationships of Openness to Experience with ratings of non-White counselors in the study.

The fourth hypothesis stated that international counselors will be less preferred by White participants than U.S. ethnic minority therapists. This hypothesis received strong support. At both low and high levels of counselor training, the non-US Indian counselors were rated lowest on trustworthiness by male participants, and at the high training level the Indian counselors were rated lowest on expertise. For women, ratings were similar

between African American and White counselors of high training levels. The high training non-US Indian counselors were rated lower in expertise than the White and African American counselors of the same training level. Also, the low and high training Indian counselors were rated lower in trustworthiness than the low and high training White and African American counselors, following the same pattern evidenced among male participants. Also similar to males, the women rated the low training African American counselors as more trustworthy than the White or Indian counselors of equal experience. This again may reflect the influence of familiarity with the geographically proximal training institution depicted in the African American counselor's profile compared to the less familiar schools of the low training-level White and Indian counselors.

From these findings we conclude that men tend to view both African American and Indian/international counselors as less expert and less trustworthy than White counselors. White female participants viewed White and African American counselors as similar in regard to expertise and trustworthiness. Also, both men and women reported the much more negative perceptions of the Indian counselors than the African American counselors in general. However, this may be due to the fact that prejudice against ethnic minority groups such as African Americans is currently less socially acceptable among US Whites than prejudice against Indians or Arabs. Thus, although we attempted to control for social desirability, participants may have been able to mask or moderate their prejudice against African Americans more successfully in the study than prejudice against the Indian therapists.

As Mittal and Wieling (2006) point out in their qualitative study, research that focuses on issues related to international students in mental health is quite sparse. Mittal, an international Indian faculty member, points out the “subtle racist attitudes” she has experienced from some clients in the course of her training (Mittal & Wieling, 2006, p. 370). Mittal and Wieling’s study, which was based upon thematic material drawn from interviews of 13 international doctoral-level students or graduates in marriage and family therapy, reported that 7 of the 13 professionals recalled experiences of subtle or overt ethnic prejudice while working with clients. One of the participants reported an incident in which the client, upon learning the international status of the therapist, called back and requested an “American” therapist. Several other participants recounted similar incidences. An autobiographical account of an international Indian clinical psychologist (Rastogi & Woolford-Hunt, 2005) described her experiences in academia post-9/11; she recounts the increased suspicion she perceived among White students toward immigrants.

Although prior research has shown a connection between White clients’ negative perceptions of international trainees from non-English speaking countries (Killian, 2001; Mittal & Weiling, 2006; Ng 2006), our research suggests that there are factors in addition to language differences that account for White clients’ negative perceptions of international counselors; first, in Study 1 the practicum-level international trainees had varying levels of mastery of the English language, with at least one of high proficiency. If language issues were a primary factor regarding client attendance, we would have expected to see variance within this group of trainees regarding attendance rates, but no significant differences were found.

Regardless of English proficiency, prior research has shown that non-US accents can negatively influence White client perceptions of psychologists (Fuertes, 1999; Fuertes & Gelso, 2000). However, results of Study 2 may suggest that White clients judge international counselors negatively on other factors in addition to perceived language or accent differences, since we did not use spoken language as a stimulus (although it is possible that participants assumed language differences after perceiving the international status of counselors in the mock brochure).

It is possible that participants in our study reacted particularly negatively to the international counselors depicted by the mock brochure based upon other factors such as assumptions about cultural differences or because of the post-9/11 increased suspiciousness toward internationals. The international counselors in the brochure were of Indian ethnicity; undergraduates' suspicion of Arab Muslims due to ongoing US conflicts in the Middle East may have been generalized to the counselors of Asian Indian descent, since there are some similar physical features such as skin tone between these different ethnicities. There are multiple accounts of US anger toward Arab Muslims being directed toward other nationalities. For instance, Perry (2003) recounted several incidences of overt racism in which Indian Americans were the victims of hate crimes in the weeks following 9/11, giving evidence that American hostility toward Arab Muslims may be generalized to include Indians. One of the perpetrators allegedly reported to police that he or she had wanted to "get back at the Arabs for what they did in New York" (p. 184). There are many other accounts of cases in which prejudice against Arab

Muslims has been directed toward Indians; Bhatia and Ram (2009) reported many incidences of Sikh Indians being the target of prejudice aimed at Arabs.

Subtle prejudice against Arabs has also been measured by Bushman and Bonacci (2003), who found that White participants who scored high on an Arab-American prejudice scale and who were later “accidentally” sent a misaddressed email informing a student of a scholarship award were less likely to forward the email to the designated recipient if the email was addressed to someone with an Arab name. Also, this study found that, based upon prejudice scores, White participants had a stronger dislike of Arabs than their dislike of African Americans or Hispanics. Likely, both subtle and overt racism directed at Arabs by Whites would also be directed at Indians if White Americans easily confuse their ethnicities. Our finding that the Indian counselors were least favored in comparison with the White and African American counselors seems to fit the pattern found in prior research on prejudice against Arabs.

Our review of the literature could locate no quantitative, empirical research on experiences with clients reported by international students training in any of the mental health professions. Thus, our study highlights some of the discouraging difficulties some international mental health trainees in the U.S. may face during their clinical training that has until now been explored merely anecdotally.

Limitations

There were several limitations of Study 1. First, the practicum-level ethnic minority trainees were all international students, whereas among the intern-level group of minority trainees only one was a international student. This confound made it difficult to

interpret the meaning of the differences in attendance rates for non-White counselors at these two different training levels. Also, the two minority groups were ethnically different both within and between groups, which made it impossible to examine prejudice against specific ethnic minority groups. Another limitation of Study 1 is that we did not have demographic information from the clients regarding their ethnicity. Thus, we must only suppose that the clients of the twelve therapists were predominantly White, based upon the overall demographics of the counseling center clients. Last, there were a limited number of ethnic minority counselors in the study; thus, generalizations based upon the Study 1 results must be made with great caution.

With regard to the limitations in Study 2, the mock brochure was intended to portray six counselors who varied in ethnicity and experience levels. Three counselors of different ethnicities were considered “high” experience and three were considered “low” experience. It was challenging to produce distinct profiles depicting three counselors of different ethnicities having an equal level of training while also portraying uniqueness among the counselors. For example, in the case of the low experience level African American counselor, this counselor’s training institution may have been more familiar to participants due to factors such as geographical proximity and sports notoriety, which may have elevated the participants’ views of the counselor’s trustworthiness and expertise over the other counselors who were intended to be portrayed at the same level of training. We also varied clinical interest areas of each counselor. Although we tried to make these differences as benign as possible, this also may have influenced participants in unknown ways.

We did not vary the order in which the profiles were presented in the brochure; thus, participant ratings may have been influenced by the order in which counselors were presented. Also, we did not alternate pictures between the high and low experience-level counselors from each ethnicity. Distributing mock brochures that alternated the pictures of the pairs of counselors equally among participants would have helped ensure that participants' responses were not influenced by a particular counselor's picture.

Also, although we did observe lower ratings of African American counselors compared to White counselors among the male participants, our measures may not have been sensitive enough to detect the more subtle or "aversive" forms of racism (Dovidio & Gaertner, 2004) toward African Americans, thus appearing that participants were "less prejudiced" against these counselors versus the Indian counselors. It may be that social desirability elevated the ratings of the African American counselors more than would be the case with more implicit measures of racism (Fazio & Olson, 2003) even though we attempted to control for social desirability. Indians may have been rated lowest because of a more socially acceptable form of racism due to fears of terrorism.

Implications

Research. Future research on counseling center client retention could investigate the effects of counselors' cultural broaching on client retention. For clients assigned to ethnic minority therapists, they could be randomly divided into two groups: one in which the ethnic minority counselor uses a cultural broaching statement to discuss the ethnic and cultural differences between the counselor and client in the first session and one group that does not receive the broaching statement. Client retention could then be

tracked to determine if the group who received the cultural broaching statement has a higher retention rate than the other group.

Building on the research idea developed from the implications of our Study 1 regarding the use of cultural broaching, if we found that cultural broaching increases attendance of White clients, we could also measure the level of prejudice of White clients before and after working with an international or ethnic minority counselor. Some measure of the level of prejudice could be completed by the client during intake; we could then use a cultural broaching statement in the initial session with this client, measure levels of prejudice upon termination and compare with the pre-therapy levels of prejudice. It would be interesting to ascertain possible changes that initially prejudiced White clients experience after building a successful alliance with an ethnically/culturally different counselor; hopefully, they would evidence lower levels of prejudice upon completion of therapy.

Olson and Fazio (2006) found that research participants would demonstrate lower levels of prejudice on implicit measures after a conditioning process that replaces prejudiced, stereotypic associations with alternate, more positive associations. We could explore if a real-world therapeutic relationship between White clients and minority counselors could serve as a successful conditioning process by using implicit measures of racism before and after completion of therapy.

Another possible research trajectory is to examine the five-factor personality profiles of participants who showed significant prejudice in our sample of Study 2 participants to explore whether there is a personality “profile” that tends to correspond

with high levels of prejudice. However, we are encouraged to see that we found sparse evidence for a strong influence of personality factors on ethnic prejudice, since personality is a relatively fixed style of relating to the world. Perhaps our findings evidence that prejudice is more transient than personality and thus still susceptible to intervention and change.

Finally, we could replicate our study but use only international therapists of various nationalities to determine whether the prejudice we found against Indian therapists is similar to prejudice against other non-US nationalities. We suspect that the prejudice toward Indians among White participants relates to negative feelings about Arab Muslims, but the international counselors in our brochure were all Indian. Thus, in subsequent research we could examine whether White participants differentiate between different non-US nationalities or whether they generalize prejudice to all non-US nationalities. Further, we could include both Indian and Arab counselors to test our suspicion that prejudice against Arab Muslims by US Whites is generalized toward Indians.

Theory. Although prejudice against ethnic minority groups has become less socially acceptable in recent decades and “dominative” forms of racism (Kovel, 1970) are on the decline, current research on racial prejudice evidences that it still influences dominant group perceptions of and attitudes toward ethnic minority groups. “Aversive racism” (Kovel, 1970) refers to this more subtle form of prejudice by people who generally identify with egalitarian values concerning ethnic minorities but who unconsciously harbor negative or ambivalent feelings and attitudes toward minorities. We

suggest that this type of racism may impact the therapeutic relationship between white clients and ethnic minority counselors, which may help explain the lower attendance rates among clients of the ethnic minority counselors in Study 1.

Likely, the majority of clients did not have overtly prejudiced reactions toward the minority counselors but may have instead felt a diffuse discomfort during the initial session. Instead of, “I don’t like that counselor because she is Black,” clients may have had thoughts such as, “I don’t feel that the therapist really understood my problems,” or even, “I’m really too busy right now to be going to therapy.” Client attendance is particularly susceptible to the influences of aversive racism, because it is easy to rationalize why one might want to discontinue therapy without having to acknowledge negative feelings directly related to the ethnic status of the counselor.

Terror Management Theory (TMT; Greenberg, Pyszczynski & Solomon, 1986) may help account for the consistently lower ratings given to Indian international counselors on expertise and trustworthiness when compared to the ratings of both the White and African American counselors. TMT bases its premises on evolutionary psychology regarding humans; we are biologically conditioned toward ensuring our own survival. When the possibility of death occurs to us, humans react by increasing their commitment to their own cultural beliefs, institutions and symbols that promise to ensure existential continuance. Research on TMT related to terrorism portrayed in the media (Das, Bushman, Bezemer, Kerkhof, & Vermeulen, 2009) has demonstrated that when White participants are exposed to news media depicting terrorist activity against Whites

by Arab Muslim extremists, participants become more prejudiced against out-groups in comparison with participants not exposed to the same news media.

We suggest that because US Whites are continually exposed to terrorist threats reported by the country's media, this increases mortality salience among the population. Thus, we surmise that the Indian counselors depicted in the mock-brochure represented threats to the White participants, resulting in the lower ratings. Individuals look for safety and trustworthiness in potential therapists. Because media exposure to threats of terrorism increases fears and suspicions toward Indians (by way of increasing suspicion toward Arab Muslims), this may have influenced participants to rate the Indian counselors lowest on expertise and trustworthiness.

Practice. Counseling center directors might consider providing new clients with literature at the intake session that discusses and extols the value of the ethnic diversity of the counseling center staff, and they might encourage staff to briefly conduct a pre-therapy induction during which the counselor discusses the diversity of staff members in a positive manner during intake meetings. This may help prime a more positive attitude toward diverse counselors when the client is matched with an ethnically different counselor. In addition, cultural broaching by the assigned therapist during the first session regarding the ethnic difference between the client and counselor may also help to buffer the effects of client ethnic prejudice.

Our findings may be discouraging for ethnic minority therapists and, in particular, for international mental health counselors and trainees. However, the identification of a problem is the first step toward finding solutions. We believe that

international trainees working with White college students may benefit from knowing in advance that they may experience lower client attendance rates than their White fellow trainees; this knowledge could help the international trainee avoid self-blame when noticing lower attendance rates, which can be particularly discouraging for new trainees. Since we found that White clients demonstrated prejudice against the non-US counselors to a more noticeable degree than against African American counselors, it would behoove university counseling centers to offer support to international trainees in particular as they work with US White populations. Supervisors of international trainees who are made aware of our findings could help normalize the experience for these trainees and work with the non-US counselor to develop effective ways of using cultural broaching that addresses not only ethnic/racial differences but also nationality differences. This also may help diminish the effects of prejudice among White clients as they experience a therapeutic alliance with a therapist who is culturally and ethnically different, which will hopefully transfer to the clients' other encounters with diversity outside of the therapy room.

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APPENDIX

Table 1

Proportion of client no-show rates by ethnicity of practicum counselor

Ethnicity of Counselor	Attendance			Row total
	Attendance complete <i>n</i> %	No-show before first session <i>n</i> %	No-show after first session <i>n</i> %	
White	61 (87%) ^a	5 (7.1%)	4 (5.7%) ^b	70
Ethnic minority	45 (60%) ^a	9 (12%)	21 (28%) ^b	75
Column total	106	14	25	

Note. $\chi^2(2, N = 145) = 14.96, p = .001$. The ethnic minority counselors in this analysis were three international students. Superscripts indicate pairs of cells that are significantly different.

Table 2

Proportion of client no-show rates by ethnicity of intern counselor

Ethnicity of Counselor	Attendance			Row total
	Attendance Complete <i>n</i> %	No-show before first session <i>n</i> %	No-show after first <i>n</i> %	
White	107 (74%)	21 (14.5 %)	17 (12%)	145
Ethnic minority	123 (67%)	9 (16.4%)	30 (16.4%)	162
Column total	230	30	47	

Note. $\chi^2(2, N = 328) = 1.92, p = .383$. The ethnic minority counselors in this analysis were one international student, one U.S. African-American, and one U.S. Asian-American intern. No pair of cells was significantly different.

Table 3
Correlational matrix for men

	Social Desirability	White low training: Exp.	White low training: Trust.	White high training: Exp.	White high training: Trust.	African Am. low training: Exp.	African Am. low training: Trust.	African Am.high training: Exp.	African Am.high training: Trust.	Indian low training: Exp.	Indian low training: Trust.	Indian high training: Exp.	Indian high training: Trust.
Agreeableness	.43**	.34**	.14	.13	.14	.20	.19	.14	.24*	.28**	.26*	.273	.219
Conscientiousness	.40**	.02	.13	.05	.13	-.10	.05	-.09	.06	-.17	.11	-.111	-.057
Emotional Stability	.24*	.28**	.13	.16	.10	.18	.05	.00	.07	.09	.13	.043	.089
Extraversion	-.04	.15	.04	.02	-.01	.02	-.18	-.09	-.10	-.02	-.09	-.028	-.130
Openness	.13	-.00	-.10	.03	-.13	.09	-.10	-.05	-.03	-.06	-.04	.030	-.050
Social Desirability	--	.24*	.36**	.19	.24*	.12	.30**	.07	.31**	.16	.26*	.159	.204

Note. N=87. Social Desirability = Impression Management subscale of the Balanced Inventory of Desirable Responding, Exp = Counselor Rating Form (Short) Expertise, Trust. = Counselor Rating Form (Short) Trustworthiness.

** = $p < .01$.

* = $p < .05$.

Table 4
Correlational matrix for women

	Social Desirability	White low training: Exp.	White low training: Trust.	White high training: Exp.	White high training: Trust.	African Am. low training: Exp.	African Am. low training: Trust.	African Am.high training: Exp.	African Am.high training: Trust.	Indian low training: Exp.	Indian low training: Trust.	Indian high training: Exp.	Indian high training: Trust.
Agreeableness	.50**	-.09	-.08	-.15	-.10	-.13	-.16	-.10	-.07	-.15	-.10	-.02	-.11
Conscientiousness	.24*	-.04	-.08	-.02	-.01	-.22*	-.14	-.03	-.03	-.03	-.12	.03	-.09
Emotional Stability	.30**	.04	.03	-.01	.12	-.03	-.00	.01	.09	.04	.03	.04	.05
Extraversion	-.00	-.11	-.02	-.01	.11	-.17	-.04	-.14	.04	.04	-.04	.05	.06
Openness	.03	-.08	.07	.09	.08	.04	.16	.07	.05	.04	.04	.14	.10
bidr.2	--	.17	.17	-.14	.02	.00	.02	-.03	.11	.06	.14	-.11	.08

Note. N=102. Social Desirability = Impression Management subscale of the Balanced Inventory of Desirable Responding, Exp = Counselor Rating Form (Short) Expertise, Trust. = Counselor Rating Form (Short) Trustworthiness.

** = $p < .01$.

* = $p < .05$.

Table 5
Means and Standard Deviation by Sex, for Counselor Ethnicity and Experience

Ethnicity		White				African American				Indian			
Training Level		Low		High		Low		High		Low		High	
Measure		<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
CRF-S Expertise	Men	4.50	.98	6.48	.58	4.56	1.02	6.24	.86	4.56	1.07	5.95	1.07
	Women	4.81	.97	6.41	.76	4.98	.92	6.42	.65	4.84	1.04	6.11	.72
CRF-S Trust- worthy	Men	5.16	1.13	5.77	1.14	5.34	1.14	5.65	1.20	5.03	1.22	5.52	1.35
	Women	5.56	1.15	5.93	1.07	5.72	1.14	5.95	1.06	5.34	1.20	5.74	1.08
^a Counselor rank	Men	6.16	1.50	2.12	1.53	5.62	1.40	2.39	1.26	6.93	1.44	4.33	1.43
	Women	5.25	1.92	2.12	1.80	4.65	1.88	2.85	1.49	6.82	1.45	4.65	1.74

Note. N = 187 (85 men, 102 women)

^aLower ranks indicate a higher preference.

Results of MANOVA,

Direct effects of Sex: $F(2,183) = 1.87, p = .313, \eta^2 = .013$.

Direct effects of Counselor Ethnicity: $F(4,734) = 2.62, p = .034, \eta^2 = .014$.

Direct effects of Counselor Training Level: $F(2,183) = 98.11, p < .001, \eta^2 = .517$.

Sex * Counselor Ethnicity: $F(4,734) = 1.46, p = .212, \eta^2 = .008$.

Sex * Counselor Training Level: $F(3,183) = 1.50, p = .45, \eta^2 = .009$.

Ethnicity * Training Level: $F(4,734) = 8.11, p < .001, \eta^2 = .042$

Sex * Counselor Ethnicity * Counselor Training Level: $F(4,734) = 2.48, p = .043, \eta^2 = .013$.

Table 6

Adjusted Means and Standard Deviation for Men, Counselor Ethnicity and Experience, Controlling for Social Desirability

-----Factor-----				
Ethnicity	Training level	Dependent variable	M	Standard Error
White	Low	expertise	4.58	.11
White	Low	trust.	5.28	.13
White	High	expertise	6.47	.08
White	High	trust.	5.83	.12
Af. Am.	Low	expertise	4.60	.11
Af. Am.	Low	trust.	5.41	.13
Af. Am.	High	expertise	6.24	.09
Af. Am.	High	trust.	5.73	.13
Indian	Low	expertise	4.61	.12
Indian	Low	trust.	5.12	.13
Indian	High	expertise	5.97	.10
Indian	High	trust.	5.60	.13

Note. Means adjusted for social desirability (BIDR scores).

Results of MANCOVA for men

Direct effects of Counselor Ethnicity: $F(4,330) = 1.25$, $p = .291$, $\eta^2 = .015$

Direct effects of Counselor Training Level: $F(2,82) = 49.61$, $p < .001$, $\eta^2 = .547$

Direct effects of Social Desirability: $F(2,82) = 4.85$, $p = .010$, $\eta^2 = .106$

Ethnicity * Training Level: $F(4,330) = 4.25$, $p = .002$, $\eta^2 = .049$

Ethnicity * Social Desirability: $F(4,330) = 0.69$, $p = .600$, $\eta^2 = .008$

Training * Social Desirability: $F(2,82) = 0.18$, $p = .556$, $\eta^2 = .004$

Ethnic * Training * Social Desirability: $F(4,330) = 0.39$, $p = .816$, $\eta^2 = .005$

Table 7

Adjusted Means and Standard Deviation for Women, Counselor Ethnicity and Experience, Controlling for Social Desirability

-----Factor-----				
Ethnicity	Training level	Dependent variable	M	Standard Error
White	Low	expertise	4.74	.10
White	Low	trust.	5.47	.13
White	High	expertise	6.41	.07
White	High	trust.	5.86	.12
Af. Am.	Low	expertise	4.96	.10
Af. Am.	Low	trust.	5.67	.12
Af. Am.	High	expertise	6.12	.08
Af. Am.	High	trust.	5.67	.11
Indian	Low	expertise	4.80	.11
Indian	Low	trust.	5.26	.12
Indian	High	expertise	6.39	.09
Indian	High	trust.	5.88	.12

Note. Means adjusted for social desirability (BIDR scores).

Results of MANCOVA for women

Direct effects of Counselor Ethnicity: $F(4,398) = 3.32$, $p = .011$, $\eta^2 = .032$

Direct effects of Counselor Training Level: $F(2,99) = 49.18$, $p < .001$, $\eta^2 = .498$

Direct effects of Social Desirability: $F(2,99) = 0.77$, $p = .465$, $\eta^2 = .015$

Ethnicity * Training Level: $F(4,398) = 4.33$, $p = .002$, $\eta^2 = .042$

Ethnicity * Social Desirability: $F(4,398) = 0.76$, $p = .554$, $\eta^2 = .008$

Training * Social Desirability: $F(2,99) = 1.71$, $p = .187$, $\eta^2 = .033$

Ethnic * Training * Social Desirability: $F(4,398) = 2.40$, $p = .050$, $\eta^2 = .024$

Table 8
Multivariate (MANCOVA) Analysis of Big-5 Personality Factors as Covariates

Big-5 Personality Factor	Gender	Wilkes Lambda	<i>F</i>	<i>df</i>	<i>p</i>	Eta ²
Openness	Men	0.987	.55	(4,330)	.702	.007
	Women	.978	1.116	(4,398)	.348	.011
Conscientiousness	Men	.036	1.54	(4,330)	.191	.018
	Women	.953	2.42	(4,398)	.048	.024
Extraversion	Men	.962	1.64	(4,330)	.165	.019
	Women	.923	4.06	(4,398)	.003	.039
Agreeableness	Men	.960	1.69	(4,330)	.151	.020
	Women	.994	.310	(4,398)	.871	.003
Emotional Stability	Men	.978	.908	(4,330)	.459	.011
	Women	.990	.512	(4,398)	.727	.005

Note. Big-5 Personality Factor used as covariate interacting with counselor ethnicity.

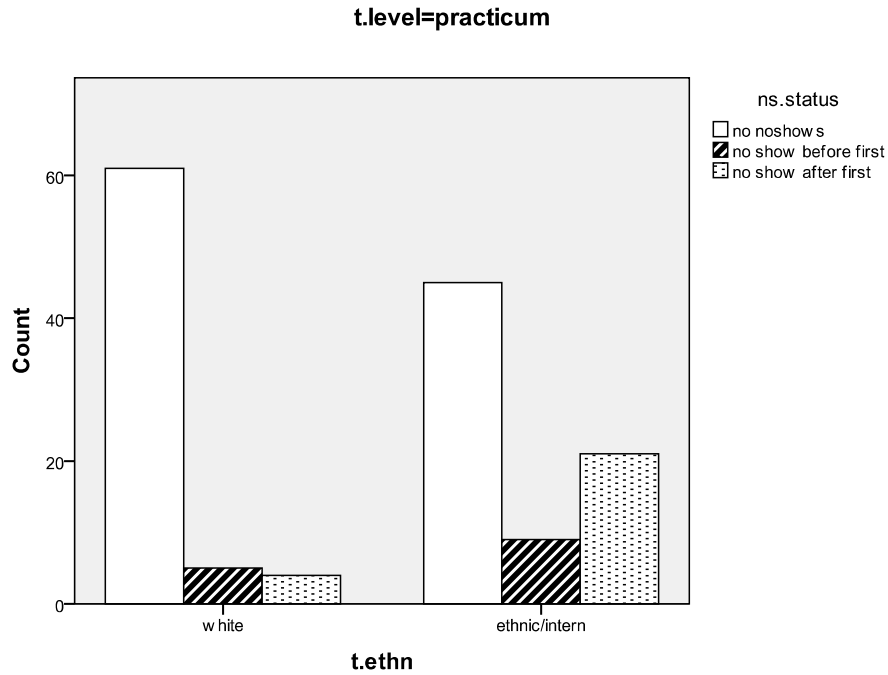


Figure 1. Attendance of clients of practicum-level counselors by ethnicity.

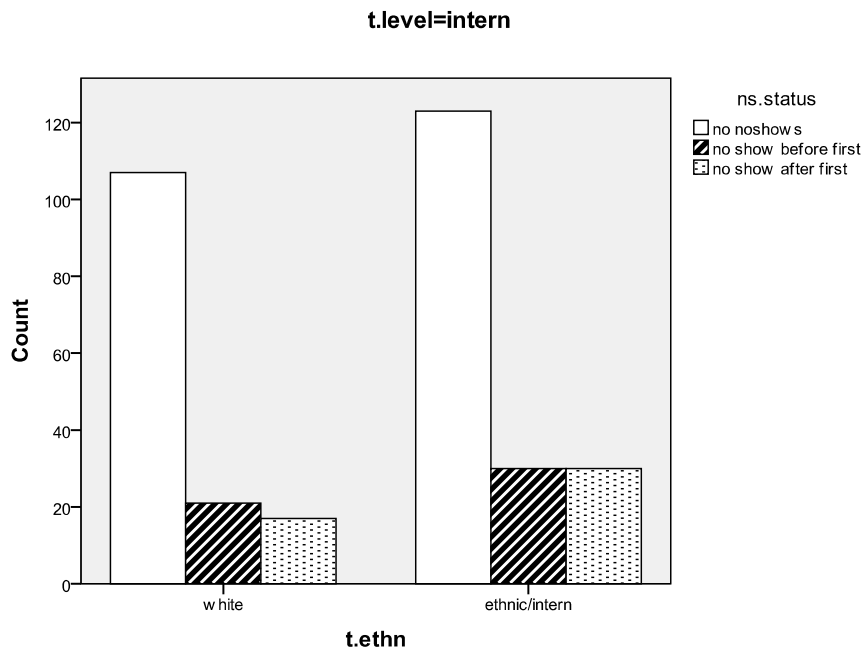
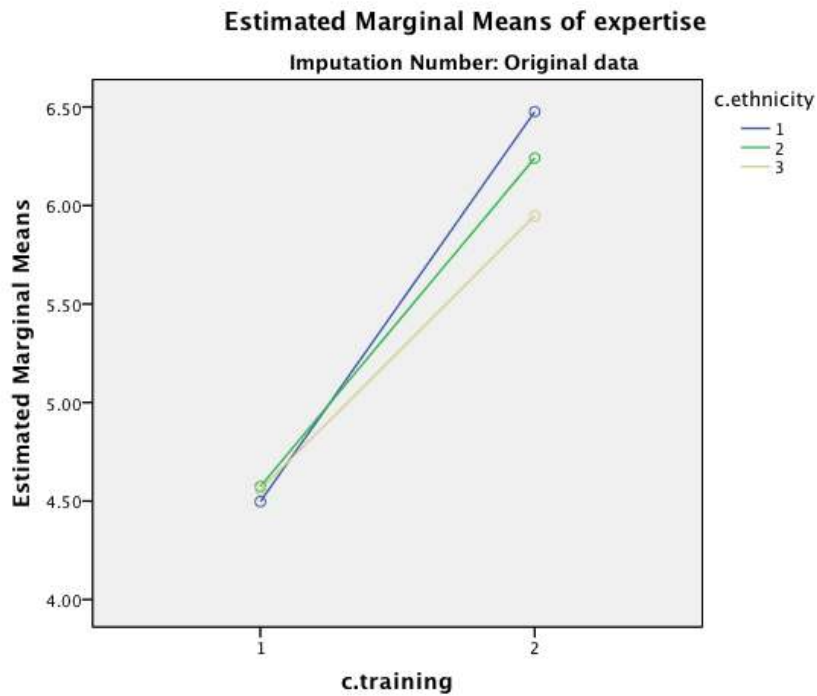
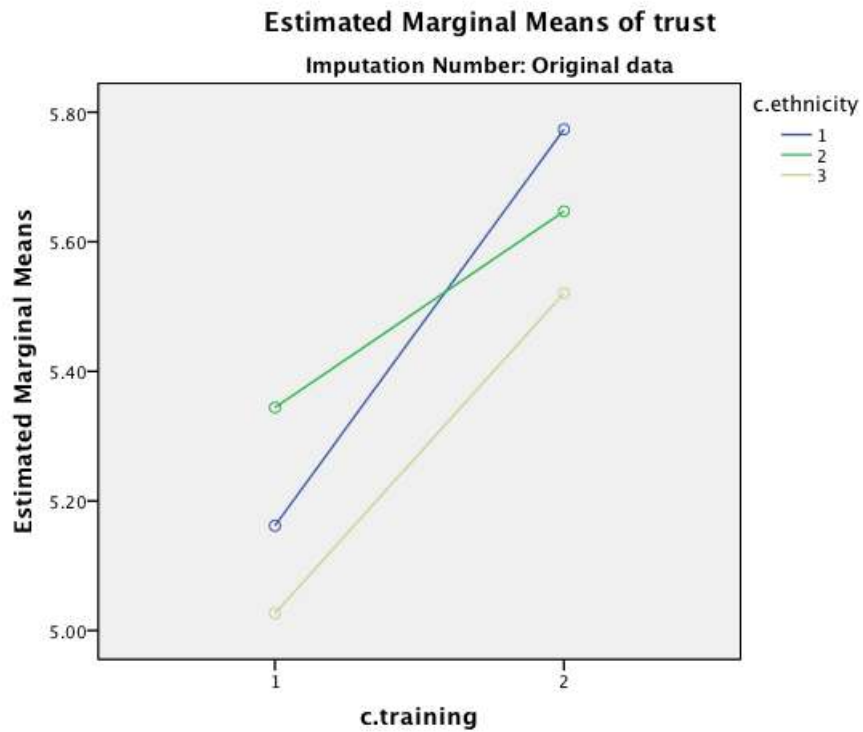


Figure 2. Attendance of clients of intern-level counselors by ethnicity.



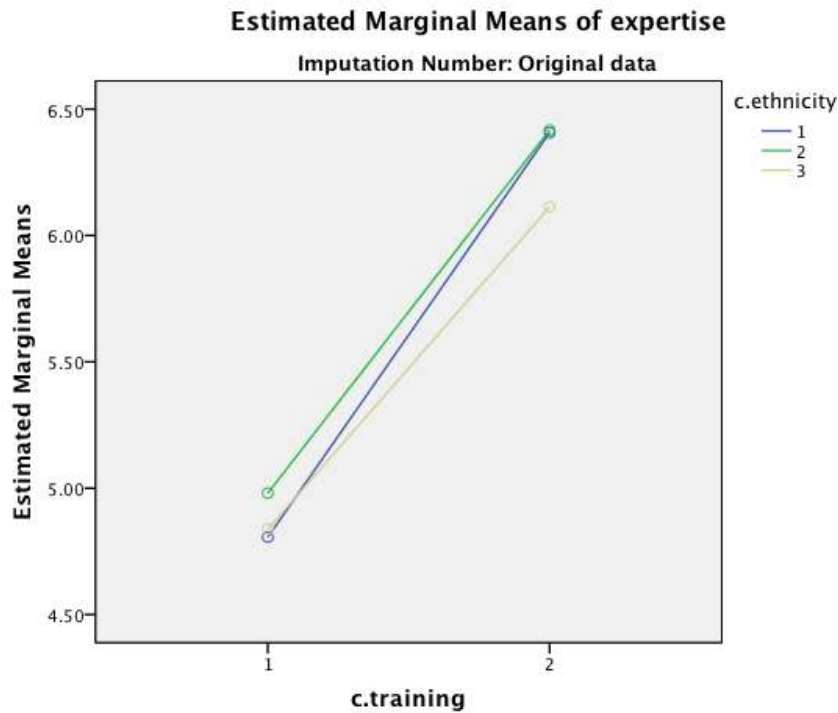
Covariates appearing in the model are evaluated at the following values: $\text{bidr.2} = 4.1529$

Figure 3. Estimated marginal means of expertise ratings by level of training among men, controlling for social desirability. For counselor ethnicity, 1 = White; 2 = African American; 3 = Indian/International. For level of training, 1 = low; 2 = high.



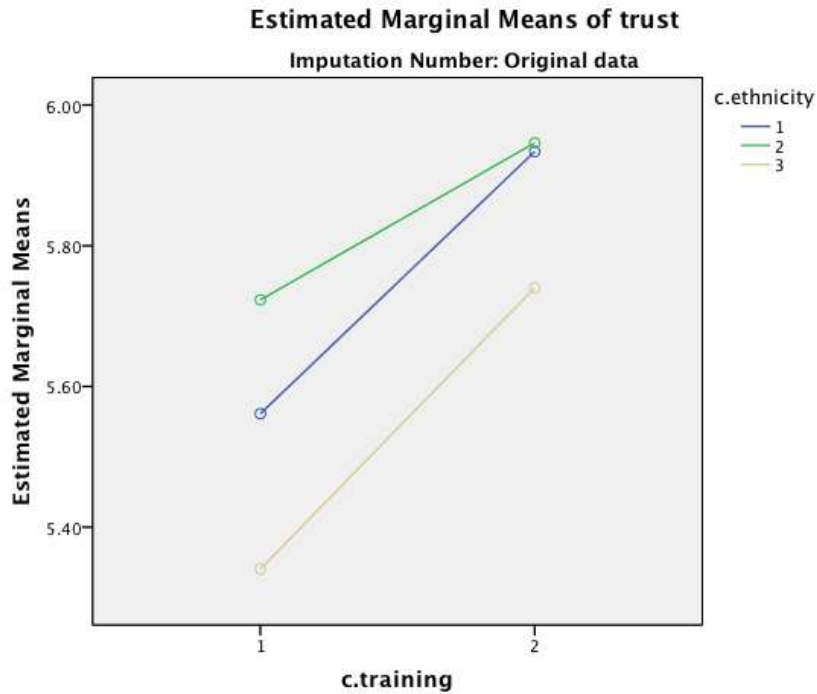
Covariates appearing in the model are evaluated at the following values: $\text{bidr.2} = 4.1529$

Figure 4. Estimated marginal means of trustworthiness ratings by level of training among men, controlling for social desirability. For counselor ethnicity, 1 = White; 2 = African American; 3 = Indian/International. For level of training, 1 = low; 2 = high.



Covariates appearing in the model are evaluated at the following values: bdr.2 = 6.2647

Figure 5. Estimated marginal means of expertise ratings by level of training among women, controlling for social desirability. For counselor ethnicity, 1 = White; 2 = African American; 3 = Indian/International. For level of training, 1 = low; 2 = high.



Covariates appearing in the model are evaluated at the following values: $\text{bidr.2} = 6.2647$

Figure 6. Estimated marginal means of trustworthiness ratings by level of training among women, controlling for social desirability. For counselor ethnicity, 1 = White; 2 = African American; 3 = Indian/International. For level of training, 1 = low; 2 = high.

BIDR Version 6 – IM subscale

Using the scale below as a guide, write a number beside each statement to indicate how much you agree with it.

1-----2-----3-----4-----5-----6-----7
Not true Somewhat Very True
True

- ☐ 1. I sometimes tell lies if I have to.
- ☐ 2. I never cover up my mistakes.
- ☐ 3. There have been occasions when I have taken advantage of someone.
- ☐ 4. I never swear.
- ☐ 5. I sometimes try to get even rather than forgive and forget.
- ☐ 6. I always obey laws, even if I'm unlikely to get caught.
- ☐ 7. I have said something bad about a friend behind his or her back.
- ☐ 8. When I hear people talking privately, I avoid listening.
- ☐ 9. I have received too much change from a salesperson without telling him or her.
- ☐ 10. I always declare everything at customs.
- ☐ 11. When I was young I sometimes stole things.
- ☐ 12. I have never dropped litter on the street.
- ☐ 13. I sometimes drive faster than the speed limit.
- ☐ 14. I never read sexy books or magazines.
- ☐ 15. I have done things that I don't tell other people about.
- ☐ 16. I never take things that don't belong to me.
- ☐ 17. I have taken sick-leave from work or school even though I wasn't really sick.
- ☐ 18. I have never damaged a library book or store merchandise without reporting it.
- ☐ 19. I have some pretty awful habits.
- ☐ 20. I don't gossip about other people's business.

Counselor Rating Form – Short version

INSTRUCTIONS: Each of the following characteristics is followed by a seven-point scale that ranges from “not very” to “very”. Please mark an “X” at the point on the scale that best represents how you viewed the therapist. For example:

FUNNY

Not Very X | | | | | | | Very

WELL DRESSED

Not Very | | | | | X | | Very

These ratings might show that the counselor did not joke around much, but was dressed well.

Though all of the following characteristics we ask you to rate are desirable, counselors may differ in their strengths. We are interested in knowing how you view these differences.

FRIENDLY

Not Very | | | | | | | Very

LIKEABLE

Not Very | | | | | | | Very

SOCIAL

Not Very | | | | | | | Very

WARM

Not Very | | | | | | | Very

EXPERIENCED

Not Very | | | | | | | Very

EXPERT

Not Very | | | | | | | Very

PREPARED

Not Very | | | | | | | Very

SKILLFUL

Not Very | | | | | | | Very

HONEST

Not Very | | | | | | | Very

RELIABLE

Not Very | | | | | | | Very

SINCERE

Not Very | | | | | | | Very

TRUSTWORTHY

Not Very | | | | | | | Very



PERSONAL STYLE INVENTORY FOR ADOLESCENTS

(Version 2006)

INSTRUCTIONS:

First, print your name here: _____

As you read each of the following sentences, think about how you act or feel most of the time. Think about whether you agree or disagree with each sentence. Beside each sentence, there are five numbers that measure how much you agree with the sentence. For each sentence, decide which of the 5 numbers best describes how much you agree with the sentence. Circle that number.

For example, if you agree with the sentence, you might want to circle the number 4 or 5, depending on whether you agree or strongly agree with the sentence. If you disagree with the sentence, you might want to circle the number 1 or 2, depending on whether you strongly disagree or disagree with the sentence. If you are unsure about whether you agree or disagree, or if you feel in-between about the sentence, you might want to circle the number 3. You can use a pencil or pen to mark your answers. If you change your mind about an answer, make sure you erase your old answer completely. Then mark your new answer clearly.

Here are three examples:

EXAMPLE 1:

I will do anything I can to make sure a school project gets done on time. 1 2 3 4 ⑤

In this example, the person circled number 5. This means that the person strongly agrees with the sentence. The person thinks it is important to turn in work on time.

EXAMPLE 2:

When I am working on a problem, I hate it when a person tries to talk to me. 1 ② 3 4 5

In this example, the person circled number 2. This means that the person disagrees with the sentence. The person does not mind when someone talks to him or her while he or she is working on a problem.

EXAMPLE 3:

For me to feel good about myself, it is important that I get good grades. 1 2 ③ 4 5

In this example, the person circled number 3. This means that the person is in-between or that they cannot decide on whether it is important to get good grades to feel good about himself or herself.

There are no right or wrong answers to the questions. Please answer each of the questions from your point of view. Do not answer the questions like you think your parents or your teacher would expect you to answer. BE HONEST in how you answer the questions. If you do not understand these instructions, ask the person who gave you this form to explain what you don't understand.

Directions: Read each sentence. **Circle** the answer that describes you the best. Use the following scale to help you answer each statement:

1 = **Strongly Disagree** – you strongly disagree with the sentence; it really does not describe you at all.

2 = **Disagree** – you disagree with the sentence; it does not describe you.

3 = **In-between** – you are not sure whether you agree or disagree with this sentence; you are undecided.

4 = **Agree** – you agree with this sentence; it describes you.

5 = **Strongly Agree** - you strongly agree with the sentence; it really describes you.

Remember, answer all of the questions honestly. **All of your answers will be kept confidential.**

	Strongly Disagree	Disagree	In-Between	Agree	Strongly Agree
1. I try to get along with other people, even if I don't agree with them.	1	2	3	4	5
2. I am always very careful when I am doing school work.	1	2	3	4	5
3. My mood goes up and down more than most people.	1	2	3	4	5
4. I like meeting new people.	1	2	3	4	5
5. I like to learn about new ways of doing things.	1	2	3	4	5
6. I sometimes make fun of other kids in school.	1	2	3	4	5
7. I always finish everything I start.	1	2	3	4	5
8. Sometimes I don't feel like I'm worth much.	1	2	3	4	5
9. It is hard for me to make new friends.	1	2	3	4	5

10. I would like to keep going to school for many years just to learn new things.	1	2	3	4	5
11. People who know me well think I am a very nice, kind person.	1	2	3	4	5
12. I like to plan things before I do them.	1	2	3	4	5
13. I often feel tense or stressed out.	1	2	3	4	5
14. I am very outgoing and talkative.	1	2	3	4	5
15. I like to read books on different subjects.	1	2	3	4	5
16. If anybody says something mean to me, I say something mean right back to them.	1	2	3	4	5
17. I am always on time for meetings with other people.	1	2	3	4	5
18. I sometimes feel like everything I do is wrong or turns out bad	1	2	3	4	5
19. I smile a lot when I am around other people.	1	2	3	4	5
20. I like to try new things.	1	2	3	4	5
21. I am very easy to get along with.	1	2	3	4	5
22. I try to be very neat and organized in my homework and class assignments.	1	2	3	4	5
23. I feel like I can't handle everything that is going on in my life.	1	2	3	4	5
24. I like to go to big parties where there are a lot of people.	1	2	3	4	5
25. I like to take classes where I learn something I never knew before.	1	2	3	4	5
26. I sometimes trick other people into doing what I want them to do.	1	2	3	4	5
27. My teachers can always count on me to do what they ask me to do in class.	1	2	3	4	5
28. I sometimes feel like I'm going crazy.	1	2	3	4	5
29. It is fun for me to talk to people I have just met.	1	2	3	4	5
30. I like to work on problems and puzzles.	1	2	3	4	5
31. I am always polite to other people.	1	2	3	4	5
32. I like to keep everything I own in its proper place.	1	2	3	4	5
33. I get mad easily.	1	2	3	4	5
34. I am a fairly quiet person in most group settings.	1	2	3	4	5
35. I like to visit new places.	1	2	3	4	5
36. I sometimes like to argue with other people just for fun.	1	2	3	4	5
37. I put away all of my things when I am done with them.	1	2	3	4	5
38. I sometimes feel sad or blue.	1	2	3	4	5
39. If I am in a group and no one says anything, I will say something first.	1	2	3	4	5
40. I like to find out how people live in other places in the world.	1	2	3	4	5
41. I like to help other people whenever they need it.	1	2	3	4	5

42. I always clean up after I have made a mess.	1	2	3	4	5
43. I feel good about myself most of the time.	1	2	3	4	5
44. I am usually a cheerful person.	1	2	3	4	5
45. I would like to learn how to read and speak a foreign language.	1	2	3	4	5
46. I like to learn new games and hobbies.	1	2	3	4	5
47. Sometimes I say things on purpose to hurt other people's feelings.	1	2	3	4	5
48. I enjoy coming up with new solutions for everyday problems.	1	2	3	4	5

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VITA

John David Richardson was born in the suburbs of Richmond, VA and spent the first 18 years of his life there. After graduating from Belmead High School in Powhatan, VA in 1994, he eventually moved to Dallas, TX and attended Criswell College as a counseling major. Upon graduation in 2000 he continued his education at Wheaton College in IL, where he completed an MA in theology. He then completed another master's degree in humanities at University of Dallas in 2006, where he pursued studies in philosophy, cultural studies and psychology. In the fall of 2006 he entered the University of Tennessee Counseling Psychology PhD program. Currently he has completed all coursework and research requirements for his doctoral degree and has obtained admission to the predoctoral internship program at Southern Illinois University Counseling Center from August 2010-July 2011.