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THE INFLUENCE OF DIAGNOSTIC CLARITY AND
PREJUDICIAL ATTITUDES ON CLINICAL JUDGMENT BIASES

A Thesis in

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by

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ABSTRACT

The author applied the aversive racism theory (Gaertner & Dovidio, 2000) to the area of clinical judgment. The intent was to examine whether counselors are prone to racially biased clinical judgments and, if so, under which clinical conditions. The first hypothesis was that racial bias would be most evident under diagnostic conditions that were ambiguous and when the race of the counselor and the race of the client in a clinical vignette were dissimilar; racial bias was defined as overpathologizing clients through low prognostic functioning ratings and high ratings of the client's severity. It was further hypothesized that underpathologization bias, defined as higher prognostic functioning and lower ratings of the client's severity, would be most likely evidenced by multiculturally sensitive participants rating racially dissimilar clients; in other words, participants would overcompensate so as to avoid the possibility that they would be perceived as racially biased. Towards this end, clinical vignettes were given to a sample of 66 graduate students and professionals within counseling psychology to examine the influences of reported client race, clarity of diagnostic condition, participants' levels of prejudice, and counselor-client racial similarity on participants' clinical judgments. Hierarchical regression analyses were used to test the interactions of participants' levels of prejudice and the racial similarity of diagnostic conditions on prognostic and severity ratings. An analysis of variance was also conducted to evaluate the effects of diagnostic clarity and racial similarity on participants' ratings of the clinical vignette's severity. The results of the study did not support the hypotheses. Regression analyses revealed that there were no significant increases or decreases in ratings of diagnostic severity and

prognosis as a result of racial similarity, diagnostic clarity, and participants' levels of prejudice. Limitations of this study, including the sample's homogeneity and their response homogeneity, as well as suggestions for future research are provided.

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CHAPTER ONE

Introduction

For many years the clinical practice of psychology has made numerous attempts to ensure balance in its treatment of clients from different racial backgrounds. The American Psychological Association's Ethics Code (APA, 1992) and the multicultural counseling competencies (Sue, Arredondo, & McDavis, 1992) have been established towards meeting the goal of providing fair and unbiased treatment to all. For decades, though, inconsistent research findings in the psychotherapy bias literature have failed to definitively answer the question of whether a consistent racial bias exists in clinicians' judgments. A number of early reviews of the literature concluded that while some evidence of social class bias existed, there was little evidence of race or sex bias (Abramowitz & Dokecki; 1977; Smith, 1980; Stricker, 1977). However, based upon the sheer number of studies that have examined racial bias, it seems as though researchers have been doubtful that prejudice and racial bias fail to exist among practitioners, regardless of the numerous studies that have produced a lack of supportive evidence. Instead, it seems that the analysis of this topic has shifted towards examining two main areas: (1) the methodological designs used to examine psychotherapy bias; and (2) the identification of conditions when prejudice and bias will exist in clinical judgment.

The current study adds to the literature through its incorporation of the aversive racism theory (Gaertner & Dovidio, 2000). In contrast to the traditional, dominative form of racism (Kovel, 1970, cited in Gaertner & Dovidio, 2000), the aversive racism theory holds that as overt acts of racism are no longer socially acceptable, nor are racist attitudes, racism becomes manifested through subtle gestures. Demographic variables

were examined to clarify their role as potential contributing factors of judgment biases.

The aim of this study was to better understand whether and under what conditions racial bias exists during clinicians' formation of diagnostic and prognostic judgments.

Psychotherapy Bias Literature

Lopez (1989), in his review of the psychotherapy bias literature, made a number of keen observations that shifted the perceptions about the nature of clinical bias. The term bias implies a prejudgment or prejudice, referring to errors or inaccuracies in clinical judgments towards such groups as women or racial/ethnic minority group members. The conclusion that race or sex bias was insubstantial came under closer examination in the late 1980's as the definition of bias became more inclusive. Bias research tended to equate bias with findings that the clinical populations being studied were perceived to be more disturbed or otherwise required more treatment; this is termed the overpathologizing bias (Lopez, 1983b). However, bias can occur in the opposite direction through the process of minimization, wherein symptoms of actual pathology are minimized. In other words, the pathological symptoms are viewed to be representative of normative behavior; this is classified this as the minimizing bias. Similar errors in classification of diagnostic judgments can also occur with overdiagnosis and underdiagnosis. Overdiagnostic bias refers to clinicians judging one diagnosis as more appropriate than another because of the client's age, race, or sex. In contrast, the underdiagnostic bias happens when a diagnostic category is judged less likely to occur in certain groups.

Studies in the psychotherapy bias literature present a mixed answer to the question of whether psychotherapists demonstrate bias against minority group members,

with results including over-pathologizing African Americans¹ and Whites, under-pathologizing each group, and null findings. There has been little consistency across studies in terms of either results or methodologies. One of the major impediments towards drawing clear conclusions lies within the lack of a coherent operational definition of psychotherapy bias and what components comprise psychotherapy bias. For example, Yamamoto, James, Bloombaum, and Hattem (1967) declared that White therapists demonstrated bias because their White clients were seen for a lengthier course of therapy than the African American clients. Other studies (e.g., Bamgbose, Edwards, and Johnson, 1980; Ridley, 1986; Tomlinson-Clarke & Cheatham, 1993) reviewed in this section have declared the presence or absence of bias based upon such factors as psychotherapy outcome measures, diagnostic and prognostic ratings, and diagnostic accuracy.

Aversive Racism

The aversive racism framework is intended to describe the racial attitudes that characterize many White Americans who hold strong egalitarian values. The aversive racist supports public policies that promote racial equality, identifies with a generally liberal political agenda, regards him or herself as non-prejudiced and nondiscriminatory, but still possesses negative feelings and beliefs about African Americans. The racist beliefs and attitudes are typically excluded from the aversive racist's consciousness because they conflict with the person's self-image; aversive racists consciously endorse egalitarian attitudes and do not discriminate on the basis of race in a situation in which the discrimination would be obvious to themselves and others. Under situations in which the negative portion of their race-related attitudes becomes salient, aversive racists are

motivated to distance themselves from these feelings and try hard to avoid acting in a racist way. However, in situations where race-related attitudes are not salient, aversive racism is most likely to be expressed in subtle, rationalizable ways that limit individuals from recognizing the wrongful nature of their actions.

The Present Study

The purpose of this study is to extend previous psychotherapy bias research that has examined the influence of demographic variables and attitudes towards racial diversity on therapists' diagnostic and prognostic clinical judgments. This study's unique contribution is in utilizing the aversive racism framework to gauge the presence or absence of psychotherapeutic bias against African American clients. Research designs within the psychotherapy bias literature (the analogue designs, in particular) have not been able to consistently present a context in which normative behavior, or arguably even the purpose of the studies, has remained unclear. Consequently, there has been little demonstration of overpathologization bias against African American clients. To the contrary, there appears to have been a consistent minimization of pathology ratings for African Americans. The aim of this study is to test whether psychotherapists' racism, if any should exist, will be demonstrated during ambiguous diagnostic situations in which normative behavior remains uncertain.

Research Questions and Implications

With the aversive framework as a basis for the methodology, clinical vignettes were constructed and questionnaires were administered to clinicians. The following research questions that guided this study were:

1. Does the clarity of the clinical vignettes (clear versus ambiguous) influence the evocation of a biased judgment?
2. Do practitioners demonstrate more bias against clients from a dissimilar race?
3. Are there different levels of bias demonstrated in the clear and ambiguous conditions in terms of the severity ratings of a client's pathology?

The outcome of the proposed study has potential implications for gaining insight into the existence of racial bias within clinical judgment situations. Utilizing the aversive racism framework resulted in the first psychotherapy bias study that attempted to gauge non-conscious racial prejudice. If no significant biases are found, then this study would potentially corroborate the general trend in the literature, suggesting that the existence of racial bias in clinical judgment is without clear empirical support. If biases are observed, particularly the overpathologizing bias towards minority group clients, then the fields of clinical and counseling psychology may need to reexamine the nature of their multicultural competency training methods. In other words, it may not be enough to simply raise consciousness about the need to be multiculturally sensitive if modern-day manifestations of clinical bias occur during ambiguous conditions, which, theoretically, should engage non-conscious decision-making processes. While controversial, perhaps in addition to multicultural competency training, graduate programs may need to be more stringent in their selection criteria of applicants to help screen out those most likely to make racially prejudiced judgments. Chapter two presents an in-depth review of the psychotherapy bias and aversive racism literature bases. Chapter three delineates the methodology to be used in the proposed study, including the study's participants, measures, procedures, and analyses.

Footnote

1. The terms African American and Black will be used interchangeably throughout this manuscript.

CHAPTER TWO

Review of the Literature

The assessment process is critically important to the provision of sound therapeutic services and multiculturally sensitive therapy. Assessment includes all methods by which psychologists gather information about their clients (May & Scott, 1991) and should be viewed as a continuous activity throughout the counseling process (Vacc, 1982). Diagnoses are practitioners' first-line decisions that have the potential power to open doors for some clients and to close them for others. Prognostic decisions also have significant importance to a course of therapy, particularly in terms of the formulation and execution of treatment plans, willingness to treat a client, and self-fulfilling prophecies. Furthermore, prognostic decisions are crucial in arousing the client's expectation of help, a universal characteristic of successful psychotherapies (Frank & Frank, 1991). At this early stage in therapy a practitioner must attempt to make accurate clinical judgment decisions on what is incomplete client information. These clinical judgments become all the more complex as counselors increasingly work with clients who have backgrounds and cultural experiences highly dissimilar to their own (Atkinson, Morten, & Sue, 1993; Sue, Arredondo, & McDavis, 1992). At times a lack of multicultural awareness or sensitivity will lead to biased clinical judgments, resulting in over- and under-pathologization in diagnostic and prognostic decisions.

The aim of this chapter is to examine the relationships among therapists' demographic characteristics, attitudes towards racial diversity, and appreciation for similarities and valuing of differences on therapists' diagnostic and prognostic clinical judgments of racially similar and dissimilar clients. The first section provides an

overview of clinical judgment and factors that contribute to the formation of clinical judgments. The second section reviews empirical studies pertaining to racial bias in clinical judgment. The chapter concludes with the study's proposed hypotheses and research design.

Overview of Clinical Judgment

Clinical judgment, according to the author, can be defined as the process in which a therapist forms impressions of clients based upon a number of sources of information, including verbal and non-verbal communication, the therapist's prejudices and biases, and information culled from the clinical interview or assessment measures. Although no specific time guidelines for the formation of clinical judgments have been offered within the literature, these impressions are oftentimes quickly molded into diagnostic and prognostic decisions due to the nature of cognitive processes as well as pragmatic treatment considerations or demands as required by the agency in which one works or an outside pressure such as managed care. Faced with a vast amount of data that are gathered at both conscious and non-conscious levels, a therapist would quickly be overwhelmed if forced to consider all available information when making decisions. It has been suggested that humans are cognitive misers, and to help compensate for information processing limitations cognitive shortcuts are developed (Fiske & Taylor, 1991). One manifestation of the cognitive miser effect is stereotyping, as people simplify a specific instance to a very general case (Fiske & Taylor, 1984, 1991). For example, a person may imagine that a blonde woman who is very "bubbly" is a hair dresser because of the over-generalization of the attributions placed on that career; a second example would be referring to a forgetful and mindless person as a blonde due to the prevalent

stereotype (Augoustinos & Walker, 1995). These attributions of individuals and groups are made to facilitate an understanding of people's actions, yet, as will be explained in the next section, they are oftentimes inaccurate.

Variables and Processes that Affect the Accuracy of Clinical Judgment

Heuristics. According to Kahneman and Tversky (1973), humans rely on cognitive heuristics, or thinking shortcuts, when making predictions and judgments under uncertainty; when doing so persons do not appear to follow the rules of chance of a statistical theory of prediction. Rather, when paring down large quantities of information into manageable units that are more amenable to quick decision-making inferences, persons rely on a limited number of heuristics. These heuristics, although helpful for managing information and sometimes producing reasonable judgments, at times also lead to severe and systematic errors (Kahneman & Tversky, 1972; Tversky & Kahneman, 1971, 1973). It seems reasonable to anticipate that these errors are likely to happen as practitioners make clinical judgments. Tversky and Kahneman (1974) have identified the following forms of cognitive heuristics: the representativeness, availability, and adjustment and anchoring heuristics.

The representativeness heuristic involves categorization of information or events based on how well they meet the criteria of various groups. What are perceived as the salient features of an object are compared with the characteristics of certain groups to determine if the object fits into that category. This process, insofar as clinical judgments are concerned, holds particular danger for making accurate judgments: namely, when the representativeness heuristic is engaged individuals do not take base rates into account when making diagnostic decisions. The availability heuristic is used when people attempt

to determine how likely it is that a particular event or situation will occur and judgments are based upon information saliency; once again, people ignore base rates. The adjustment and anchoring heuristic occurs when initial beliefs or preconceptions are not revised in light of new, contradictory information. Confirmatory hypothesis testing occurs when a person pursues information in such a manner as to influence the type of information that someone elicits from another party.

Cognitive schemas. Cognitive schemas are a second factor to take into account when considering the nature of human information-processing. A schema is a mental representation of an object or class of objects, including its attributes and the relations among the attributes, that helps persons to limit the information they must access during the recognition process (Fiske & Taylor, 1991). Schemas influence the encoding of new information, memory for old information, and the development of inferences when information is missing. Schemas are heavily influenced by one's organized prior knowledge and are maintained in abstract form. In other words, they are not a collection of all original stimuli, but rather a cognitive structure that represents an amalgam of stimuli. For instance, when thinking of the concept of "automobile," one does not mentally search through a picture of every automobile one has ever seen. Instead, one is apt to employ a schematic representation of a generic object that is comprised of tires, a windshield, and so on. Similarly, there are schemas for racial categorization and mental illnesses, as will be studied during the proposed experiment.

Schemas appear to be double-edged swords. The value of schemas is that through holding expectations, assumptions, and generic prior knowledge (i.e., they hold across many situations) people simplify reality by storing knowledge at a molar, inclusive level,

rather than storing away all experiences one by one (Fiske & Taylor, 1991). Fiske and Taylor asserted that schematic encoding operates from the earliest moments of perception. The quick activation of schemas, in turn, help us function and make meaning in a social world that would otherwise be of overwhelming complexity, allowing for a comforting sense of prediction and control.

Several drawbacks to schemas also exist. One such drawback is that they can blur distinctions between objects and lead to rapid, uncritical judgments. A second limitation to schemas is that they lend themselves easily to an active construction of reality and thereby often lead to confusions of subjectivity and objectivity. The schema concept assumes that perceivers take an active role in constructing reality and attach meaning to processed stimuli. It is the view of the author that because schemas develop from personal experiences, it is possible that they are shaped by specific cultures. To further explain, schemas may be molded in large part from societally-based norms and accepted knowledge. Persons from diverse cultures and even historical eras may have widely disparate schemas for activities (e.g., dating practices, family interactions) as well as well as traits (e.g., intelligence, courage, leadership). These divergences point to the notion that reality is socially constructed through the interplay between participants involved in interpersonal interaction (Jussim, 1991). Social constructivist theory assumes that social perception creates reality as much or more than it reflects social reality and social constructivism also emphasizes the inaccuracy of social beliefs (e.g., Fiske & Taylor, 1991). A third limitation is that people tend to selectively attend to information and traits that confirm their perceptions and to take longer to encode and assimilate schema-inconsistent information, particularly when schemas are well-developed (e.g., Bargh &

Thein, 1985; Belmore & Hubbard, 1987, as cited in Fiske & Taylor, 1991). Memory is therefore biased in coding information to fit expectations and may lead directly to stereotyping, based on original expectations in memory (Leyens, Yzerbyt, & Schadron, 1994).

Four types of social schemas have been identified by Fiske and Taylor (1991): role, self, event, and person schemas. A role schema is the cognitive structure that organizes one's knowledge about a set of behaviors that is expected of a person in a particular social position; these are achieved roles that one acquires by effort and intent, such as through a job, team membership, or training. There are also ascribed roles that one acquires at birth or automatically such as age, race, and sex. Each of these characteristics carries certain role-based expectations for behavior and is a plausible contributor to account for stereotyping.

Self-schemas, the second type, are trait dimensions along which individuals have clear self-conceptions, i.e., individuals are self-schematic, whereas dimensions which individuals are less clear about are those on which they are aschematic. In effect, individuals manage information about themselves in some ways that are similar to how they manage information about other people. The idea of a self-schema suggests that encoding, memory, and inferences about information pertinent to individuals will be influenced by their generic self-knowledge.

A third form of schemas is event schemas, which describe appropriate sequences of events in well-known situations. These schemas explain such activities as complex sequences of behavior, typical procedures for getting things done, and so on. Regardless of the particular script, they are used to organize people's expectations regarding a likely

sequence of events.

Fourth are person schemas, which contain people's understanding of the psychology of particular individuals, focusing on their traits and goals. These schemas about people and people-in-situations aid in encoding, memory, and inference processes. For example, a schema for the trait “intelligence” might include examples of intelligent people, what they might do, and subcategories of intelligent persons (e.g., book smart, naturally gifted, hard-working, lazy).

Bias in Clinical Judgment

Race bias, social class bias (e.g., Bamgbose, Edwards, & Johnson, 1980; Lorion, 1973; Leupnitz, Randolph, & Gutsch, 1982; Vail, 1970), and sex bias (e.g., Broverman, Broverman, Clarkson, Rosenkrantz, & Vogel, 1970; Jones & Zoppel, 1982; Lopez, Smith, Wolkenstein, & Charlin, 1993; McCranie, Horowitz, & Martin, 1978) have been well-studied topics within the clinical judgment literature. Taken collectively this type of research has been referred to as the psychotherapy bias literature (Lopez, 1989).

According to Lopez, the term bias implies a prejudgment or prejudice, referring to errors or inaccuracies in clinical judgments towards such groups as women or racial/ethnic minority group members, for example. A number of early reviews of the literature concluded that while some evidence of social class bias existed, there was little evidence of race or sex bias (Abramowitz & Dokecki; 1977; Smith, 1980; Stricker, 1977).

The conclusion that race or sex bias was insubstantial came under closer examination in the 1980's when bias was redefined in a more inclusive manner. Lopez (1989) noted that bias research tended to equate bias with findings that the clinical populations being studied were perceived to be more disturbed or otherwise required

more treatment and termed this the overpathologizing bias (Lopez, 1983b). However, Lopez stated that researchers erred in classifying a uni-directional mode of bias towards the perception of greater disturbance. Lopez illustrated that bias can occur in the opposite direction through the process of minimization, wherein symptoms of actual pathology are minimized. In other words, the pathological symptoms are viewed to be representative of normative behavior; Lopez (1983b) classified this as the minimizing bias. For example, Luepnitz, Randolph, and Gutsch (1982), in a study of bias and social class, found that low socioeconomic status (SES) African Americans were diagnosed correctly as alcoholics 90 percent of the time, high SES Whites were diagnosed correctly as alcoholics only 20 percent of the time, and high SES African Americans were diagnosed correctly as alcoholics only 30 percent of the time. In effect, higher social class led to a minimization bias in which the actual pathological symptoms were overlooked as much as 80 percent of the time.

Similar errors in classification of diagnostic judgments can occur with overdiagnosis and underdiagnosis (Lopez, 1989). Overdiagnostic bias refers to clinicians judging one diagnosis as more appropriate than another because of the client's age, race, or sex. In contrast, the underdiagnostic bias happens when a diagnostic category is judged less likely to occur in certain groups. For example, as indicators of overdiagnosis and underdiagnosis Lopez pointed to Blake's (1973) oft-cited study that a case summary identified as an African American patient was more often ascribed a schizophrenia type of diagnosis than an identical summary of a White patient and Tractman's (1971) finding that lower social class clients are less likely to be judged as neurotic than a middle-class client, respectively. In Blake's study 17 White psychiatric residents (16 men,

predominantly Jewish and ranging in age between mid-twenties and early thirties) were presented with one of two forms of a case analogue that differed only in the identified race of the client. Respondents were asked to diagnose the client as having either one of three forms of schizophrenia (latent type, schizo-affective type, or pseudo-neurotic type), borderline personality, obsessive compulsive personality, character disorder, or other (obsessive compulsive neurosis, obsessive compulsive personality with chronic underlying depression, or personality disorder of undetermined type). Fifty-five percent of the Black client analogues were assigned a schizophrenic diagnosis whereas not a single White identified client was diagnosed in the schizophrenic range (50% were assigned an obsessive compulsive personality diagnosis).

In a meta-analysis, Lopez (1989) considered 60 clinical judgment bias studies in which he analyzed the percentage of bias based upon the old and new definitions of bias for severity judgments and for diagnostic judgments. For severity judgments the old definition referred only to the overpathologizing bias, whereas the new definition of bias referred to the overpathologizing and the minimizing biases. When applying the old definition of bias, .24 of the severity-related cases and .22 of the diagnostic cases showed evidence of bias. When applying the more inclusive definition of bias, .44 of the severity-related cases and .60 of the diagnostic cases demonstrated evidence of judgment biases, nearly twice as much as had been discovered using the old definition of bias.

This study was guided by two leading schools of thought as applied solely to the study of racial bias. One school promotes that bias is a result of information-processing errors rather than prejudice (Lopez, 1989) and the other school is the aversive racism framework (Dovidio & Gaertner, 1981), which suggests that racism is no longer typically

overt and dominative but subtle and aversive. The information-processing perspective suggests that a great deal of past research was conducted on the assumption that bias should be elicited by the patient's sex or another salient characteristic, regardless of other patient attributes. In turn, the biased clinician was characterized as a prejudiced individual who made judgments based primarily on a single characteristic. Lopez claimed that it is unlikely that many current therapists fit this extreme model of bias and, therefore, there isn't much available research evidence to support this view of the biased mental health practitioner. Instead, the biased clinician is like any other information processor who has to synthesize a considerable amount of complex information to make decisions regarding diagnosis and treatment; when doing so, clinicians use shortcuts. In this regard the information-processing perspective seems to align itself with the general principles of schematic processing.

There are two sources of evidence to support the information-processing model of the biased clinician. In his review of one group of studies, Lopez (1989) found that bias was frequently identified as problem specific, or that errors in clinical judgment were more likely to occur for particular symptoms, problems, or disorders. Such findings are contrary to the prejudiced-therapist notion because prejudiced therapists should demonstrate negative attitudes across most presenting problems. A second group of studies was conducted in which clinicians made systematic errors in clinical judgments of men, Whites, and middle social class members as well as of women, African Americans, and lower social class members. Therapists' errors in their judgments of patients from groups that are not traditionally discriminated against further supports the notion that clinical judgment errors are the result of selective information processing rather than

prejudice. To help shed further light on this idea, the following section reviews the relevant psychotherapy bias literature.

Psychotherapy Bias Literature

Lopez and Hernandez (1986) studied whether distinct cultural norms were used, properly applied, and positively or negatively affected the quality of patient care in the clinical judgment process. Their study had two major purposes: (a) to identify at which point in the evaluation process culture is considered, and (b) to measure therapists' attitudes toward the role of culture in the evaluation of culturally diverse patients. A mail survey was randomly distributed to 100 professionals in each of three major professions: psychiatry, psychology, and social work. Of the 300 surveyed, 118 clinicians responded (49 masters level social workers, 43 doctoral level psychologists, 3 masters level psychologists, and 23 psychiatrists), a 40.8 percent response rate. The sample was comprised of 73 men and 45 women; 84 identified as Anglos, nine as Jewish, three as African American, one as Asian, one as Chicano, and nine as "other."

Respondents completed a Likert-based questionnaire that assessed three components: (a) clinicians' attitudes towards culture; (b) the way clinicians report taking culture into account when making diagnoses, and (c) clinicians' personal and professional background. An example item was, "Do culturally diverse groups differ in their expression of mental health disorders?" There was an additional section of two open-ended questions that instructed respondents to describe a time when they took culture into account while evaluating and/or diagnosing a culturally diverse client and whether their evaluation or diagnosis would have been different had they not considered culture.

Results indicated that 39 percent of the sample rated culture to be extremely important in their evaluations, and 68.4 percent of the sample indicated that they believed that symptom expression differs for some disorders across culturally diverse groups. Overall, 83 percent of the sampled therapists reported taking culture into account for most or all of their culturally different patients. Through a qualitative analysis of 96 brief case reports (22 respondents did not provide a case report and were excluded from the analyses), representing a range of racial/ethnic groups provided by the sample, participants described a case that had cultural differences. Using descriptive statistics, Lopez and Hernandez (1986) determined that 13.5 percent of the clinicians noted culture in the initial evaluative process in order to more fully understand the patient's problem. Culture was also considered by 21.8 percent of the clinicians during the clinical judgment process as they were forming their non-diagnostic impressions of the presenting problems. During diagnostic formulation, 15.6 percent of the clinicians altered their diagnoses of the patient when considering culture. Of the 96 cases reviewed, 35 therapists referred to any change in the perception of the disorders as a result of cultural considerations. Thirty-two out of the 35 therapists subsequently reported judging the problem to be less severe or pathological after having taken culture into their ratings of client severity and diagnosis. Of the 96 cases examined, 10 therapists reported seeking some type of consultation in the assessment of the cultural factors relevant to the case; none of the remaining 86 therapists reported how they knew some symptom or behavior was culturally based.

Overall, this study appears to indicate that clinicians attested to the value of culture but there is less certainty that they in fact appropriately considered culture in their

decisions. The following two sections of this paper further examine clinicians' judgments based upon cultural factors. The first section contains a review of survey, field, and archival studies that utilized genuine case histories and/or admission patterns at clinics and hospitals, and the second provides a review of analogue empirical studies.

Survey, Field, and Archival Studies

Yamamoto, James, Bloombaum, and Hattem (1967) examined the effects of 15 Caucasian (no other demographic information was available) psychotherapists' ethnocentricity, as measured by the Bogardus Social Distance Scale (SDS; Bogardus, 1959), on treatment differences between 594 consecutive new admissions of Caucasian, African American, and Mexican American patients at a hospital outpatient clinic. Willingness to see patients was dichotomized between those who saw patients for six or more sessions and those who saw patients for less than six sessions. Therapists were also split into dichotomous groups of low ethnocentricity and high ethnocentricity based on their SDS scores. There were not enough Mexican American patients to yield statistically significant findings. Scores on therapists' SDS were correlated with greater willingness to see African American patients for six or more interviews. Low ethnocentricity psychotherapists ($n = 6$) saw Caucasian and African American patients for six or greater sessions at a roughly equivalent rate (28% vs. 27%, respectively). However, chi-square tests revealed statistically significant differences within those psychotherapists in the high ethnocentricity group, as they saw Caucasian patients at a rate four times higher than African American patients (31 percent vs. 8 percent, respectively, $p < .01$).

In another study of patient admissions, Baskin, Bluestone, and Nelson (1981) questioned whether psychiatric diagnostic differences existed between low

socioeconomic status African American, White, and Hispanic American patients seen in a community mental health center. Participants were 27 male and 29 female therapists of mixed ethnicity (11 African American, 26 White, 10 Hispanic American, 8 Asian, and 1 unknown), and discipline (20 psychiatrists, 7 psychologists, 16 social workers, 6 nurses and recreation therapists, 7 'other' professionals). The total sample included 1,968 patients admitted to the outpatient department of a New York City mental health center, including 1,119 males, 833 females, and 16 unknown sex cases. The ethnic composition included 578 African American, 569 Hispanic-American, 120 White, 1 Asian, and 700 unknown ethnic status patients. Using chi-square analyses, no significant differences were found for White therapists' diagnoses of African American and White patients in terms of the relative percentage of diagnostic judgments of alcoholism, schizophrenia, and non-psychotic disorders. In contrast, African American therapists diagnosed African American patients as far more likely than White patients to be alcoholic (73% and 46%, respectively); however, African American therapists saw just 28 White patients, making this finding difficult to draw conclusions from.

Jones (1982) studied 164 African American and White outpatients at several psychology clinics and psychiatric agencies in the San Francisco Bay Area (M age 28.3 years; 58.6% female; 35.4% of African American clients were males and 47.6% of White clients were males; all clients were between 18 and 45 years of age); they were divided equally by race and seen in individual therapy by 136 psychotherapists for a mean of 31.2 hours. Psychotherapists were comprised of 67 percent psychologists, 17 percent social workers, and 17 percent psychiatrists. Therapists' experience ranged from 1 to 25 years with a mean of 4.4 years. Treatment was dynamic, insight-oriented therapy ranging from

eight to more than 100 sessions, with a sample mean of 31.2 hours. The patient sample was evenly distributed into four categories: African American clients seen by African American therapists, African American clients seen by White therapists, White clients seen by White therapists, and White clients seen by African American therapists ($n = 41$ per group); groups were balanced in terms of sex, range of educational level, and socioeconomic status, and the number of therapy sessions were roughly equivalent.

After client terminations had been completed, the professionals assessed their clients on measures of psychotherapy outcome and behavioral descriptions. Rating scales were analyzed by means of a three-way ($2 \times 2 \times 2$) analysis of variance in which therapist race and patient race were the fixed effects and “before” and “after” ratings served as repeated measures. Results indicated racial differences in assessments by African American and White therapists regardless of the patients’ race. African American therapists reported that their clients displayed more improvements and rated their clients as significantly less impaired both pre- and post-therapy. White therapists rated their African American clients as significantly more impaired than their White clients. Behavioral descriptions (the 12 most frequently chosen adjectives were anxious, dissatisfied, nervous, confused, dependent, intelligent, sensitive, moody, defensive, emotional, friendly, and self-punishing), as measured by Gough’s Adjective Checklist (Gough & Heilbrun, 1965), indicated little differences between the African American and White patients. In an apparent contrast to the findings of White therapists’ views that African American clients were significantly more impaired than White clients, race-crossed effects demonstrated that White therapists reported a more positive picture of African American clients than their White clients. African American therapists,

meanwhile, reported a more positive description of White clients. Statistics for these ratings were not provided by Jones (1982) and it is uncertain whether these differences reached statistical significance.

Data from Mukherjee, Shukla, Woodle, Rosen, & Olarte (1983) indicated that African Americans and Puerto Rican Hispanics with bipolar affective disorder were more likely than Whites with bipolar affective disorder to have been misdiagnosed as having schizophrenia. All patients with a diagnosis of bipolar disorder at the outpatient department of an inner-city hospital were registered with the hospital's psychopharmacology program and 77 consecutive admissions to the program were included in the study. None of the patients had a history of non-affective psychotic episodes. The sample consisted of 37 Whites, 21 African Americans, and 18 Hispanics (one Asian Indian was excluded from the analyses) with a mean age of 41.03 years and mean number of hospitalizations of 7.4. Using a 2 x 2 contingency table (comparisons between ethnic groups of schizophrenic diagnoses and symptoms in 76 bipolar patients) and chi-square tests, no significant differences in mean age, sex, marital status, or income level existed among the ethnic groups. Only final diagnoses at the time of discharge were considered for inclusion in the study.

Of the 76 patients, 68 percent had a previous misdiagnosis of schizophrenia (51% of Whites, 86% of African Americans, and 83% of Hispanics) rather than a correct diagnosis of bipolar illness. For the patients who had had persecutory delusions, 39 percent of Whites, 40 percent of Hispanics, and 100 percent of African Americans were misdiagnosed as having paranoid schizophrenia, making African American patients significantly more likely than the other ethnic groups to be misdiagnosed. Eight of the 18

improperly diagnosed African American patients had at some point been treated by African American psychiatrists, which had not led to a change of diagnosis in a single case. The authors failed to note how misdiagnoses were discovered or what the criteria were for making such a classification. Casting further ambiguity on the study's findings is the lack of discussion regarding all demographic information concerning who or whomever was making the diagnoses and what their credentials were.

In one of the few studies to include counselor ethnicity as an independent variable, Tomlinson-Clarke and Cheatham (1993) studied archival data to determine whether counselors' intake judgments differed as a function of counselor and client ethnicity. Case records were controlled for demographic and pretreatment moderator variables (i.e., client's perception of the reason for seeking service, client's estimated severity of problem). Clients were 41 African American and 41 White female clients at a predominantly White university counseling service. African American clients ranged in age from 17 to 38 years with a mean age of 19.7 years, while White clients ranged in age from 18 to 38 years with a mean age of 20.6 years. There were no significant differences in the mean ages of the two client groups. All clients self-reported personal-emotional issues as their reason for seeking counseling and, as a result of the study's matching process, client perceptions of the main reason for seeking services were identical for both client groups. Clients were seen by one of 13 female counselors, nine of whom were White and four were African American. Five (2 African American and 3 White) counselors were advanced doctoral students and the remainder were senior staff members with an average of five years of experience. Clients were randomly assigned to counselors through a daily rotating intake system. Counselor judgments included clinical

disposition, severity of diagnostic rating, need for psychological treatment, and predicted number of sessions per client. Chi-square analysis revealed no significant differences on any counselor judgments for African American and White female clients. This study is limited by its relatively small sample size and a lack of data regarding potential bias in within-counselor differences.

In a similar archival study at a predominantly White university's counseling center, Tomlinson-Clarke and Camilli (1995) examined the influence of counselors' ethnicity and sex upon clinical judgments. Counselors were 31 women and 14 men. Sixteen (8 White women, 2 African American women, and 6 White men) were professional staff with an average of 10 years postdoctoral experience. Eleven (8 White women and 3 White men) were pre-doctoral interns with an average of four years of supervised experience. Eighteen counselors (11 White women, 2 African American women, and 5 White men) were advanced graduate assistants with at least two years of supervised graduate training. Three hundred and forty-four students' case records were reviewed; 245 were White (85 men and 160 women) and 99 were African American (24 men and 75 women). Clients ranged in age from 17 to 39 years ($M = 21.1$, $SD = 3.67$). Counselor judgments included severity of condition and severity of diagnostic rating, each made on a 3-point Likert scale ranging from (1) *mild* to (3) *severe*. Multiple regression analyses indicated that counselor sex was significantly associated with ratings of severity (accounting for 19% of the variance) and condition as female counselors made consistently higher ratings (i.e., more severe) for all clients; no effects for ethnicity were found. This study is limited by the small number of African American therapists ($n = 4$), making analysis of counselors' race and its effects on treatment ratings indeterminate.

Chung, Mahler, and Kakuma (1995) examined whether differences existed between treatment of African American and White patients in an inpatient psychiatric treatment facility. Archival data were collected on 76 African American (M = 31.9 years) and 88 White (M = 35.3 years) patients between the age of 18 and 65 with principal Axis I discharge diagnoses of major mood or psychotic disorders. All treating staff were White with the exception of one African American staff nurse and two Asian-American resident psychiatrists. Eight attending psychiatrists and 12 psychiatric residents were responsible for the care of the inpatients involved in this study (no further demographic information about treatment staff was provided). Analyses of variance indicated no differences between the patient ethnicities existed for number of previous hospitalizations or Global Assessment of Function scores upon admission. Whites were more likely than African Americans to receive a diagnosis of psychotic disorder upon discharge (72 percent compared with 59 percent, respectively), but this difference failed to reach statistical significance. There was a statistically significant difference in length of stay, however, with Whites staying an average of six days longer than African Americans even when controlling for socioeconomic status. Among patients with positive results on urine drug screens, African American patients were 17.5 times more likely than Whites to receive a comorbid diagnosis of a drug or alcohol use disorder at discharge, yet this conclusion was based on just 15 such patients, making interpretation difficult. Although there was no difference in the average length of stay for patients with a psychotic disorder, African Americans with non-psychotic disorders stayed an average of 16 days whereas Whites stayed 28 days. African Americans with non-psychotic disorder were also 6.1 times more likely than Whites to receive a comorbid diagnosis of a drug or alcohol disorder, and

Whites were 3.8 times more likely to receive a comorbid diagnosis of an Axis II personality disorder. Chung et al. hypothesized that the earlier discharge rates for African American patients may have been reflective of the lesser severity and more rapid improvement implied by non-psychotic patients with psychoactive substance-induced mental disorders. It remains possible, as well, that Whites were underdiagnosed for substance abuse disorders.

Summary and Critique

Survey, field, and archival studies in the psychotherapy bias literature present a mixed answer to the question of whether psychotherapists demonstrate bias against minority group members. The results from these studies have included over-pathologizing both African Americans and Whites, under-pathologizing each group, and null findings. There has been little consistency across studies in terms of either results or methodologies. One of the major impediments towards drawing clear conclusions lies within the lack of a coherent operational definition of psychotherapy bias and what components comprise psychotherapy bias. For example, Yamamoto, James, Bloombaum, and Hattem (1967) declared that White therapists demonstrated bias because their White clients were seen for a lengthier course of therapy than the African American clients. Other studies reviewed in this section have declared the presence or absence of bias based upon such factors as psychotherapy outcome measures, diagnostic and prognostic ratings, and diagnostic accuracy.

In addition to inconsistent operational definitions, studies have utilized a range of temporal foci in their investigations. In other words, some studies have examined psychotherapy bias during the intake process while others have examined psychotherapy

bias after therapy has been completed. These methodological concerns are minor, however, in comparison to the common difficulties within this literature based in terms of the participant samples under study. In several cases (e.g., Yamamoto, James, Bloombaum, & Hattem, 1967; Tomlinson-Clarke & Cheatham, 1993; and Tomlinson-Clarke & Camilli, 1995), the sample sizes were too small to draw meaningful and confident conclusions. Similarly damaging the credibility of the findings is that in a number of cases the participant samples have been so vaguely described that a meaningful interpretation of the results becomes difficult to determine; many important demographic variables, such as age and years of clinical experience, have not been reported. In addition, in all but one study there has been a near absence of ethnic minority counselors, clouding the picture as to whether biases demonstrated against minority clients are a function of the therapists' race or, more simply, occupation. As Tomlinson-Clarke and Cheatham (1993) have pointed out, few studies have attempted to control for potential counselor-client variables, such as race/ethnicity, gender, age, and severity of presenting concern that may influence counselor judgments during the intake interview. In the absence of such control, it is nearly impossible to determine whether counselors have been influenced by racial bias when other sociopsychological variables may have influenced counselor judgments.

In addition, the instruments that are generally utilized within this literature are typically absent of psychometric support. Virtually no study has used a psychometrically valid test of psychotherapy bias and instead has tended to rely on Likert scale measures that have been constructed for each individual experiment.

Analogue Studies

Fischer and Miller (1973) used 2 x 2 x 2 factorial design wherein two distinct clinical vignettes (mild and severe pathology), each with two social class (lower and upper) and two race (White and Black) versions, were randomly administered via mailed questionnaires to a sample of 360 professional social workers (43% male, of whom 76% were married, and 57% female with 46% married; 32.5% were between the ages of 20-29; 25.4% between the ages of 30-39; 23.6% between the ages of 40-49; and 18.5% were 50 years and older; 39 of the participants, or 10.8% were nonwhites, including 26 Black, nine Asian, and four “other”). No mention was made of the selection criteria or what the response rate was. Furthermore, it is unknown whether the vignettes were tested before administration. A 24-item, six-point Likert style Treatment Decision Inventory (TDI) was created by the authors to collect clinical judgments typically made in clinical practice; the items were intended to capture diagnostic (e.g., “overall degree of disturbance of client”), treatment (e.g., “would you tend to deal mainly with intrapsychic or interpersonal behavior with this client?”) and attitudinal judgments (e.g., “how would you characterize your personal reaction to this client?”). A factor analysis of the TDI items identified five factors: (1) a global “Assessment” factor, e.g., degree of client disturbance; (2) “Suitability for Treatment,” e.g., client’s prognosis in treatment; (3) Social Emphasis in Treatment,” e.g., would the caseworker mainly deal with intrapsychic or interpersonal material; (4) “Tenor of Relationship,” e.g., would the caseworker tend to be directive or nondirective; and (5) an “attitude” factor, e.g., how enthusiastic would the worker be to have this person as a client.

An analysis of variance on the Assessment factor revealed statistically significant

effects for race, although, contrary to expectations, Black clients were seen as significantly less pathological than White clients ($p < .05$). Furthermore, an interaction between race and social class ($p < .05$) indicated that when the social class of the client was low and the client was White, clients were seen as more pathological than in any other condition. Consistent with other research findings (e.g., Luepnitz, Randolph, & Gutsch, 1982), lower client social class was negatively correlated with judgments of pathology and suitability for treatment.

Schwartz and Abramowitz (1975) studied psychiatrists' clinical inferences in relation to one of four versions of a clinical vignette about a hypothetical patient. Characteristics of the patient were manipulated by race (African American or White) and sex. Twenty-one percent ($N = 102$) of 491 prospective participants replied to a randomly selected survey administration; participants' race, sex, and other demographic variables were not reported. Participants rated the desirability of four treatment alternatives (hospitalization, electroconvulsive therapy, pharmacotherapy, and insight-oriented therapy) and also judged the severity of patient maladjustment and prognosis. An interaction for race and sex was found as there were more recommendations of insight-oriented therapy for White men than African American men, although no effect was found among women. In addition, Whites were seen as more suitable for inpatient hospitalization treatment than African Americans. In terms of prognostic impressions, African American-designated patients' chances of recovery were viewed more optimistically than those of the White-designated patients. In addition, as in Fischer and Miller's (1973) study, African American patients were rated as more attractive than White patients. All results were statistically significant at $p < .05$.

In one of the very few studies that had African American practitioners for the sample, Benefee, Abramowitz, Weitz, and Armstrong (1976) had practitioners (55 professionals in mental health and related fields attending a convention of African American Psychologists; over 90% had attained a post-baccalaureate degree and about one-third had a doctorate; mean age of 31 years, with an average experience of 4.9 years) rate a clinical vignette that was manipulated by race of the client as either African American or White. Practitioners were separated into a traditional or untraditional category based upon their score on a version of the traditional social beliefs scale (Jessor & Jessor, 1974). Using a 2 (traditional beliefs vs. untraditional beliefs) x 2 (White vs. Black) x 2 (higher vs. lower clinical experience) analyses of variance design, chi-square tests demonstrated statistically significant differences in prognostic and diagnostic patterns for untraditional and traditional practitioners. The untraditional practitioners exhibited a pro-African American attitude whereas the traditional practitioners demonstrated a pro-White attitude on such dimensions as prospects for gain maintenance, emotional maturity, and social maturity. The authors accounted for these findings by suggesting that liberal African American therapists may overreact against racial stereotypes of African Americans and view them in an overly favorable light while African American therapists with conservative attitudes may internalize the stereotypes and unfairly view African American clients negatively.

Bloch, Weitz, and Abramowitz (1980) extended Benefee et al.'s (1976) study by sampling only White professionals selected to closely parallel the Benefee et al. sample (34 mental health professionals and 15 professionals-in-training with an average of 6.9 years of experience; no other demographic information was available). Comparisons of

mean scores between Benefee et al.'s African American practitioner sample and Bloch et al.'s White practitioner sample revealed uniformly more positive ratings by the White practitioners on such pre-therapy and post-therapy dimensions as prognosis and success of therapy, but only success of therapy reached statistical significance ($p < .05$). The authors proposed two explanations for these findings. First, the White participants were likely sensitized to the analogue's hidden racial bias agenda. Second, the African American participants may have been aware of a perception that African American professionals underassess levels of pathology in African American clients and attempted to counteract this.

Merluzzi and Merluzzi (1978) studied 86 White male and female (no other demographic information is available) counseling graduate students' assessments of intake case summaries. Participants received one of three sets of intake summaries: African American, White, or no race-labeled clients. Case summaries were then rated on 11 items scored on a 7-point Likert scale, ranging from a positive (1) to a negative view (7) of counselors' assessment of the personal characteristics of the client, the client's orientation toward counseling and counseling readiness, the effects of the environment on the client, and the predicted outcome. Using a one-way analysis of variance on the total scale score for the race-labeled groups and then a stepwise multiple regression analysis (the independent variables were Black, White, counselor experience, minority contact, and Social Distance) results indicated that Black-labeled cases were rated significantly more positively than White and no-label cases, suggesting possible overcompensation for professional bias against minority clients.

Bamgbose, Edwards, and Johnson (1980) sampled 61 male clinical psychologists

(21 African Americans and 40 Whites; no other demographic information available) to compare their diagnoses and severity ratings on ten validated case histories of African American and White clients, each with four variations based upon race and social status. Case validation was achieved through three consensual reviews and a four year follow-up of the men described in each case, with each case having been determined as having a positive or negative outcome (a positive outcome meant that the patient completed the treatment program, returned to his occupational position, didn't have another psychiatric hospitalization or consultation, and had no involvement with law enforcement institutions; negative outcomes including failing to meet any of the previously listed criteria). Therapists were assigned one case each and asked to assign a diagnosis and to rate the severity of psychopathology on a seven-point Likert scale. Correlational analyses revealed that diagnoses were in fact accurately related to the case history outcomes. No effects for race or social class were found on psychologists' diagnoses of clients' severity ratings.

Ridley (1986) studied the effects of client race, client use of self-disclosure, and observer race on observers' ratings of clients in a videotape therapy analogue experiment. The participant sample was composed of 20 African American and 20 White graduate student volunteers in APA-approved clinical and counseling psychology programs and ranged in age from 23 to 42. White participants had a mean age of 28.2 and a mean counseling experience of 3.6 years; African American participants had a mean age of 30.8 and a mean counseling experience of 6.1 years. Participants were randomly assigned to one of four experimental conditions defined by crossing two levels of participants' race (Black and White) with two levels of client self-disclosure (high and low). A

modification of the Counselor Questionnaire (Libby, 1970) measured participants' descriptive and attitudinal ratings of clients. The instrument contains three sections: a Likert-type symptom rating scale, an assessment scale to measure global psychological functioning (e.g., problem severity, motivation for counseling, prognosis), and an attitude scale, which measured therapists' personal reactions to the client (e.g., interest in the client's problems). A three-way analysis of variance was used to test for the effects of client and participant race and client disclosure. Attitudinal ratings and assessment of the client were measured. Racial effects for the observers indicated that White participants rated the African American clients as depressed significantly more often than the African American participants did. African American observers, conversely, rated White clients as more depressed than the African American clients. Overall findings for the observers' attitudes demonstrated that, contrary to expectations, African American clients were perceived as significantly more friendly than White clients and observers held more favorable attitudes toward the African American clients.

Strickland, Jenkins, Myers, and Adams (1988) studied the effects of client and therapist race on judgments of client psychopathology, appropriateness for therapy, verbal facility, and likelihood of treatment success using standardized videotaped depictions of clients; scripts were verbatim to ensure equivalency of psychopathology across African American and White vignettes. Six stimulus conditions were employed, and actors portrayed African American and White clients as normal, neurotic, or psychotic. Clinicians were 10 African American and 10 White students from a behaviorally oriented APA-approved doctoral program (six males, 14 females, ranging in age from 22 to 33 years). After viewing one of the conditions participants rated five

measures on a seven-point Likert scale: (a) degree of client psychopathology; (b) verbal skills of the client; (c) appropriateness for therapy; (d) likelihood of successful therapy; and (e) socioeconomic status of the client. A sixth measure, the type of psychopathology of the client, was rated normal, neurotic, or psychotic. Analyses of variance tests yielded no significant differences for main effects of race of therapist, race of client, or diagnosis for ratings of the severity or degree of psychopathology, but a significant interaction between diagnosis and race of client was obtained as White neurotics and psychotics were given higher ratings of severity than African American neurotics and psychotics. In concordance with lower ratings of mental disturbance for African American clients, they were also ascribed higher ratings of the likelihood of successful therapy than were White clients.

Using a random sample of psychiatrists (290 replied to a questionnaire, a 59.4% response rate; no additional demographic information was offered) chosen from membership lists of the American Psychiatric Association, Loring and Powell (1988) studied the influence of sex and race on diagnostic assessments. Respondents rated two case studies and then chose a diagnosis from a list of options provided by the experimenters including undifferentiated schizophrenic disorder, paranoid schizophrenic disorder, brief reactive psychosis, recurrent depressive disorder, or other. The African American male client was diagnosed 47% of the time by White male psychiatrists, 27% of the time by male African American psychiatrists, 53% of the time by White female psychiatrists, and 42% of the time by female African American psychiatrists as having paranoid schizophrenic disorder. In contrast, not one psychiatrist diagnosed the White male client as having paranoid schizophrenic disorder, the most severe diagnosis of the

choices.

In contrast to Loring and Powell's (1988) findings, Lewis, Croft-Jeffreys, and David (1990) studied 139 psychiatrists' (118 men, 21 women, mean age 49 years, mean years of experience 21 years) responses to a case vignette of a psychotic illness in a White or African American client. In this experiment African American client vignettes were less likely to be diagnosed as schizophrenic than the White client vignettes (38.5% vs. 49.2%, respectively).

Finally, Jenkins-Hall and Sacco (1991) examined White therapists' evaluations of videotaped vignettes of African American and White female depressed and non-depressed clients. Participants were 23 White male and 39 White female therapists with at least Master's level training and/or at least three years of experience in individual psychotherapy and had a mean age of 36 years old. The experimenters created two measures for the study: (a) an adjective checklist consisting of 17 general bipolar adjectives rated on a six-point scale (coefficient alpha of .82); and (b) an interpersonal rating scale of 23 socially competent behaviors (coefficient alpha of .93), which was scored on a seven-point scale from *not at all characteristic* to *extremely characteristic* of the client. Two (race) X 2 (disorder) X 2 (sex of participant) analyses of variance on the adjective checklist and the interpersonal rating scales indicated that although no differences in mean therapists' ratings were found for non-depressed clients, African American depressed clients were rated significantly more negatively than White depressed clients on both scales. Jenkins-Hall and Sacco reported that the client's disorder may have given "justifiable" reason for rating the African American client more negatively than the White client, but in the absence of such a disorder the White

therapists may have been hesitant to demonstrate negative attitudes towards African American clients for fear of appearing racially biased to self and others.

Summary and Critique

The analogue studies, much like the survey, field, and archival studies, do not allow for clear conclusions to be drawn. However, taken on the whole, this literature appears to indicate that Black clients were rated more positively and diagnosed with less pathological severity than were White clients. While this runs contrary to the notion of the biased practitioner, alternative explanations exist. One such explanation is the appearance of a “halo effect” (Abramowitz & Murray, 1983, as cited in Strickland, Jenkins, Meyers, & Adams, 1988), in which clinicians may have become more conscious of avoiding pathologizing and stereotyping Black clients and made compensatory efforts to avoid doing so. The analogue nature of the research designs, too, may have been too transparent to allow for uncensored ratings of pathology. As demonstrated by the number of psychotherapy bias studies that have been performed, the notion that psychotherapists, particularly those who are White, act without bias towards Black clients continues to be met with skepticism in an age filled with acts of overt and subtle racism. Psychotherapy bias may indeed exist, but is unlikely to be discovered with such artificial and transparent research designs that tap into psychotherapists’ conscious decision-making processes. Consequently, this review will now turn its attention towards the aversive racism construct to shed additional light on the nature of bias and prejudice and its non-conscious manifestations.

Aversive Racism

Gaertner and Dovidio (2000) proposed an alternative theoretical perspective to

explain the nature of racism. Noting that overt acts of racism or racist attitudes are no longer socially acceptable, nor are racist attitudes, they posited that racism is expressed through subtle gestures. This model is in contrast to the traditional, dominative form of racism (Kovel, 1970, in Gaertner & Dovidio, 2000), in which racism is openly expressed. The aversive racism framework is intended to describe the racial attitudes that characterize many White Americans who hold strong egalitarian values. According to the authors, aversive racists support public policies that promote racial equality, identify with a generally liberal political agenda, regard themselves as non-prejudiced and nondiscriminatory, but still possess negative feelings and beliefs about African Americans. The racist beliefs and attitudes are typically excluded from the aversive racist's consciousness because they conflict with the person's self-image; aversive racists consciously endorse egalitarian attitudes and do not discriminate on the basis of race in a situation in which the discrimination would be obvious to themselves and others. Under situations in which the negative portion of their race-related attitudes become salient, aversive racists are motivated to distance themselves from these feelings and try hard to avoid acting in a racist way. However, in situations where race-related attitudes are not salient, aversive racism is most likely to be expressed in subtle, rationalizable ways that limit individuals from recognizing the wrongful nature of their actions.

The aversive racism theory has been the subject of considerable empirical study. In a seminal study that helped to set the stage for the later development of the aversive racism framework, Gaertner (1973) conducted two field studies examining the helping behavior and racial discrimination among 230 New York City Liberals and Conservative Party members. As participants were not informed that they were engaging in an

experiment (this study was conducted by making supposedly wrong number phone calls to various persons), no specific demographic information about the participants was available other than their political affiliation, although participants were judged by experimenters as White on the basis of name, area of residence, and voice characteristics. Confederates, who were identifiable as either White or African American by their speech dialects, called the participants and pretended to accidentally dial participants' telephone numbers rather than an auto garage to seek help for their broken down vehicle. Help was defined in this case as calling a fictional auto garage. Through chi-square analyses of refusals to help, discrimination against African American callers was found to be 15 percent greater among Conservatives than Liberals. What was surprising, however, was the difference in the number of premature hang-ups, as defined by terminating the telephone call before the caller could ask for help. Chi-square analyses revealed that Liberals prematurely hung up twice as often on African American callers than White callers (16.7% and 8.3%, respectively). Gaertner offered that the claim that Liberals hold less anti-African American sentiment than Conservatives do is not entirely supported and that the level of anti-African American sentiment may be consistent, but more likely to be expressed under certain conditions. Specifically, in the absence of normative structure, i.e., when the Liberals were not directly asked for help and forced to act upon their egalitarian principles, Liberals were able to rationalize their lack of helping to African Americans through premature hang-ups.

Gaertner (1975), in another study concerning racial attitudes and helping behaviors, utilized an experimental design influenced by Darley and Latané's (1968) research, which demonstrated that when a bystander is the only witness to an emergency

the normatively appropriate behavior, helping, is clearly defined. However, when other bystanders are believed to be present, the normative response is less clear, and bystanders tend to diffuse responsibility to help and conclude that someone else will act. Participants (40 White females enrolled in Introductory Psychology at an Eastern public university; no other participant information was offered) were randomly assigned to one of four experimental conditions: one Alone condition (one other person present) and three Together conditions (from two to four other people present). All of the confederates were female. Participants were led to believe that another individual, an African American or White female victim in a separate room down the corridor, was injured and in an emergency situation. A helping response was scored if the participant left her room within a three-minute period of time to help the victim. An analysis of variance on the raw latency measure, or the amount of time elapsed before a participant would offer help to a victim, revealed that participants in the Alone condition helped African American and White victims equally, although the latency for intervention was twice as long for the African American victim ($M = 16.4$ seconds) than for the White victim ($M = 7.8$ seconds). In the Together condition differences emerged as White victims were helped three times more often than African American victims (90% vs. 30%).

Gaertner and Dovidio (1977) studied whether high and low prejudice-scoring White students would help African American or White victims in emergency situations. The clarity of norms regarding intervention were varied, as 75 White female participants enrolled in an Introductory Psychology course (no further demographic information was provided) were led to believe that they were the only bystanders or were among three witnesses (all White) to an emergency involving an African American or White victim.

Using chi-square analysis, the findings were that when White bystanders believed they were the only witnesses to the emergency they were more likely to help an African American than a White victim (94% vs. 81%). However, they were only half as likely to help African Americans, as compared to White victims (38% vs. 75%) when other bystanders were present. According to the authors, when witnesses could rationalize nonintervention, White bystanders discriminated against African American victims. Levels of self-reported prejudice did not correlate with responses to the African American victim in either bystander condition. One additional note of interest in this study was the monitoring of participants' heart rates before and immediately following the emergency. Similar to the helping behavior, participants who believed that they were the only witness showed slightly more heart rate elevation when the accident occurred to an African American victim than a White victim (Means = +14.52 vs. +11.39 beats per minute, respectively). However, when participants thought that other bystanders were capable of helping they showed lower levels of arousal with African American than with White victims (Means = +2.40 vs. +10.84 beats per minute, respectively), demonstrating less evidence of personal concern in both physiological response and helping behaviors for victims than for White victims.

Dovidio and Gaertner (1981) studied the effects of status and ability on prosocial behavior. Participants were 96 White males in Introductory Psychology classes (no other demographic information was offered). Participants were told that they would be working with a supervisor or subordinate, who were experimental confederates, on a group task; race of the confederates was manipulated between African American and White. After completing an analogy test, participants were told that their supervisors or subordinates

were higher or lower than themselves in cognitive ability. To assess for the effects related to the participants' prejudice score on helping behavior, the authors used multiple regression analysis, treating the prejudice score as a continuous variable and race, role, and ability as dichotomous independent variables. Results indicated that participants differentially offered help to White and African American confederates according to the confederates' status and ability. With respect to status, a Race x Role interaction indicated that African American supervisors were helped less than African American subordinates (58.3% vs. 83.3%). White supervisors were helped slightly more often than White subordinates (54.2% vs. 41.7%); African American supervisors were not helped significantly less frequently, overall, than White supervisors. In regards to ability, a Race x Ability interaction revealed that participants helped high and low ability partners equally (70.8% each) but helped high ability Whites more frequently than low ability Whites (66.7% vs. 29.2%).

These results indicate that status influenced prosocial behavior toward African American partners whereas ability affected prosocial behavior toward White partners. Dovidio and Gaertner (1981) believed that these findings shed light on the complexities of aversive racism, in that the more positive reaction to subordinates than to supervisors reinforces and perpetuates the dependency and subordination of African Americans. An additional finding of interest was that participants accepted high cognitive ability White partners as being somewhat more intelligent than themselves but high ability African American partners were rated as significantly less intelligent than themselves. Whites were apparently unwilling to accept that an African American person may possess higher intelligence and greater competence than themselves.

In another study on helping behaviors, Frey and Gaertner (1986) examined helping behaviors within a sample of 130 randomly selected White female undergraduates enrolled in an Introductory Psychology class (no other demographic information was offered). A 2 x 2 x 2 factorial experimental design was used; the three manipulated factors were the race of the potential recipient of help, the perceived causal locus of dependency, and the source of the request for help. MANOVAs revealed that that under conditions in which the appropriateness for helping behavior was ambiguous, participants discriminated against African American recipients of help, offering less than half of the amount of help afforded to White recipients (33.3% vs. 73.3%, respectively). Under conditions in which helping was normatively clear and expected, no bias was demonstrated towards recipients.

Dovidio and Gaertner (2000) explored both the overt expression of racial attitudes and discrimination in simulated employment decisions for two samples across a 10-year period, from 1988-1989 to 1998-1999. On the basis of previous work showing that racial stereotypes are most influential in ambiguous situations (Fiske, 1998), Dovidio and Gaertner predicted that discrimination against African American applicants would occur when the match between the candidate's qualifications in the position criteria was unclear, i.e., in the ambiguous qualifications condition, but not when candidates were clearly well qualified or unqualified for the position, as in the clear condition. Participants were 194 undergraduate Introductory Psychology students at a northeastern liberal arts college during the 1988-1989 academic year ($n = 112$; 48 White male and 64 White female undergraduates) or the 1998-1999 academic year ($n = 82$; 34 White male and 48 White female undergraduates); student populations were scholastically and

demographically comparable across the time periods. The mean age of the participants or other demographic information was not provided. Using an analogue design participants rated the strength of candidates' job qualifications based upon interview excerpts that were systematically varied among three conditions (clearly strong, ambiguous, clearly weak) to manipulate the candidates' qualifications; the race of the candidates (White or African American) was balanced across conditions. Preliminary analyses demonstrated no systematic effects for the sex of the participant, so this factor was excluded from subsequent analyses. A 3(qualifications) x 2 (race of candidate) x 2 (time: 1988-1989, 1998-1999) analysis of variance was conducted and an expected main effect was significant for manipulated qualifications on perceived qualifications ($p < .001$). There was no main effect for the candidate's race. When an African American candidate's credentials were clearly sufficient or insufficient for the position, no discrimination was evidenced. However, as hypothesized, results demonstrated that bias against the African American candidates became evident primarily when the candidate's qualifications were ambiguous, as they were recommended significantly less strongly than were comparable White candidates ($M = 4.82$ vs. 5.91), $t(64) = 2.79$, $p < .001$).

In the aversive racism studies, various forms of bias were universally demonstrated by White participants towards African Americans in the absence of normative guidelines for social behavior. When the norms for prosocial behavior and employment situations were clear no discrimination was demonstrated. Still, this apparent bias against African Americans may not be a function of racism but instead a function of group behavior. In Dovidio and Gaertner's (2000) review, they noted that the biases found within the results could be indicative of in-group favoritism and out-group

derogation and pointed to Hewstone (1990), who found that an out-group member's behavior, when potentially negative, is judged as more negative and intentional and is more likely to be attributed to the person's personality than when it is performed by an in-group member. Therefore, when given room for interpretation in the ambiguous conditions, Whites may have given other White persons the "benefit of the doubt," but did not offer the same benefit to African Americans, or out-group members.

The aversive racism framework has made a significant contribution to psychology's understanding of racism. Using a creative methodology that has attempted to go beyond conscious processing, the sum of Dovidio and Gaertner's experiments offer reasons to suspect that while racism towards African American may be nearing extinction during conscious acts, a person's unconscious behaviors may reveal a different image and manifestation of racism.

The Present Study

The current study is an extension of previous clinical bias research that has examined the direct and indirect influence among demographic variables and attitudes towards racial diversity on therapists' diagnostic and prognostic clinical judgments. This study's unique contribution is in regard to utilizing the aversive racism framework to gauge the presence or absence of psychotherapeutic bias against African American clients. Research designs within the psychotherapy bias literature base (the analogue designs, in particular) have not been able to consistently present a context in which normative behavior, or arguably even the purpose of the studies, has remained unclear. Consequently, there has been little demonstration of overpathologization bias against African American clients. To the contrary, there appears to have been a consistent

minimization of pathology ratings for African Americans. In any event, no evidence appears to suggest that psychotherapists are unbiased, fair processors of information, i.e., whether minimizing or pathologizing clients' problems, differences between ratings and judgments for Black and White clients have consistently been demonstrated. It is the aim of this study to test whether psychotherapists' racism, if any should exist, will be demonstrated during ambiguous diagnostic situations.

Hypothesis 1

Overpathologization bias of the racially dissimilar clinical vignette, regardless of the clarity of diagnostic information presented, will be highest by those therapists with low Quick Discrimination Index (QDI; Ponterotto, Burkard, Rieger, & Grieger, 1995) scores. The overpathologization bias will be based on the following: (a) a less optimistic prognosis of functioning the vignette client is judged capable of achieving after completing therapy; (b) a higher rating of the overall degree of the client's disturbance; (c) a lower score on a global assessment of functioning rating; and (d) a more pathological diagnosis of the clinical vignette, which will be defined as the assignment of a personality disorder diagnosis (Axis II) in the absence of supporting DSM-IV (APA, 1994) criteria.

Hypothesis 2

Underpathologization bias will be greatest by those with high scores on the QDI when the clinical vignettes are racially dissimilar and the diagnostic status is clear. Thus, a Caucasian therapist who is high in multicultural sensitivity will underpathologize the African American client in the clear condition. The underpathologization bias will be based on the following: (a) a better prognosis of functioning the vignette client is judged

capable of achieving after completing therapy; (b) a lower rating of the overall degree of the client's disturbance; (c) a higher score on the global assessment of functioning; and (d) a less pathological diagnosis of the clinical vignette on Axis I. Regarding diagnosis, underpathologization will be indicated when participants assign a V-code diagnosis when an Axis I diagnosis is warranted from the diagnostic evidence provided in the clinical vignette.

Hypothesis 3

Overpathologization bias will most clearly be evident during prognostic and diagnostic judgments of racially dissimilar vignettes under the ambiguous diagnostic condition (e.g., when a Caucasian therapist judges the African American client in the ambiguous condition). Overpathologization bias will be indicated by higher ratings of diagnostic severity and lower prognostic ratings.

CHAPTER THREE

Method

Participants

Eighty-six graduate students and counseling professionals from various social service professions were sampled from across the United States. Due to problems in participants' self-reports, it could not be determined which percentage of participants were graduate students or professionals. The initial sample included 68 White, seven Black, three Asian, two Latino, five multiracial, and one unidentified race participants. The low number of non-White participants was insufficient for reliable data analysis and they were deleted from the final participant sample (two of the White participants were also deleted due to missing data). The final sample of 66 participants was comprised of 19 males and 47 females, whose ages ranged from 23 to 66 years old ($M = 36.62$; $SD = 10.87$). Participants were predominantly heterosexual (87.9%), and described their family of origin's economic status, as well as their own current status, as working/middle class (89%), and characterized the community they grew up in as suburban (54.5%). Certain demographic information, such as highest degree achieved, theoretical orientation, and years of clinical experience were unable to be reliably analyzed due to participants' apparent confusion regarding these queries and inapplicable responses, which will be explained in greater detail in the discussion.

Research Design

An informal pilot study was conducted in which 15 counseling psychologists were given one of two clinical vignettes that varied in terms of the diagnostic information that was provided to participants; the race of the identified patient in the vignette was not

included. One condition contained clear diagnostic information, in which it was expected that a diagnosis of Panic Disorder Without Agoraphobia would be readily identified. The clinical vignette includes the following criteria: recurrent, unexpected panic attacks; absence of agoraphobia; the panic attacks are not due to the direct physiological effects of a substance; and the panic attacks are not better accounted for by another mental disorder, such as social or specific phobia. The vignette did not clearly indicate that at least one of the attacks has been followed by one month (or more) of one (or more) of the following: (a) persistent concern about having additional attacks; (b) worry about the implications of the attack or its consequences (e.g., losing control, having a heart attack, "going crazy"); and (c) a significant change in behavior related to the attacks. The ambiguous condition contained a mixed symptom picture that fit no DSM-IV (APA, 1994) diagnosis. A priori conditions were met to assess for content validity, as there was greater than 85% rater agreement for the clear condition and less than 50% agreement for the ambiguous condition.

An experimental design was utilized in which four clinical vignettes (see Appendix A) were used as the stimuli for the current study. They contain identical information except for two main manipulations of the independent variables, clarity of diagnostic information and client race. The presenting problem was structured to be either clear or ambiguous, leading to a straightforward or uncertain diagnosis of the presented client, respectively. The clear condition was composed of DSM-IV (APA, 1994) diagnostic criteria for Panic Disorder Without Agoraphobia. The ambiguous condition contained both depressive, anxious, and generalized anxiety symptoms that do not meet the minimum criteria for any particular diagnosis. The race of the client was

manipulated so that clients were presented as either White or African American. The vignettes reflect the major sections of a common college counseling center intake report (presenting problem, social support, academic performance, drug and alcohol usage, and family history).

The independent variables were race of participant, clarity of condition, race of the client (i.e., racially dissimilar or racially similar to the participant's race) in the clinical vignettes, and scores on a racial attitude measure. The dependent variables were prognostic and diagnostic ratings.

Instruments

Three measures were used in this study: a demographic sheet, assessment and treatment planning questions which have been created specifically for the current study, and the Quick Discrimination Index (QDI; Ponterotto, Burkard, Rieger, & Grieger, 1995).

Demographic sheet. The participants completed a demographic survey (Appendix B) that was used to collect the following information: age, race, sex, sexual orientation, years of graduate education, major field of practice, marital status, years of clinical experience, theoretical orientation, and socioeconomic status.

Assessment and treatment planning questions. To measure prognostic and diagnostic judgments, a series of open-ended and Likert-scale questions (Appendix C) were developed for this study by the author. Adapted from Franklin (1985), the Likert scales assess participants' ratings of client pathology, insight, and maturity, attitudes towards working with the client, prognostic outlook, and recommendations for care (e.g., urgency of care and length of treatment). Open-ended questions recorded participants'

diagnosis of the clinical vignette on Axis I and/or Axis II DSM-IV criteria and a global assessment of functioning (GAF) score. Question number three and question number five assessed for participants' ratings the vignette client's severity and prognostic outlook, respectively. All other items were included for post hoc analyses.

Quick Discrimination Index (QDI)). The QDI (Ponterotto, Burkard, Rieger, & Grieger, 1995; Appendix D) was used in this study to examine whether a relationship exists between participants' racial attitudes and their diagnostic and prognostic ratings of same and other-race paired clients. The current study limited its focus to the QDI's total score; high scores reflect non-racist and non-sexist attitudes. The QDI was developed to assess attitudes towards racial equality and women's equity issues. It is composed of 30 items, of which 23 measure three factors: Factor I is cognitive racial attitudes toward racial diversity (9 items); Factor II is comprised of specific attitudes regarding contact and personal comfort with racial diversity (7 items); and Factor III assesses general attitudes regarding women's equality (7 items). The remaining seven items do not fall on any factor but are retained for increasing the robustness of the overall score (Ponterotto, et al., 1995). The items and the factors that they contribute to are listed in Appendix D.

Respondents are asked to report the degree to which they agree or disagree with statements, using a Likert-type scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). Each participant receives a score for each subscale by summing the item scores from each subscale. Higher scores indicate more awareness, sensitivity, and receptivity to racial diversity and gender equality. The following are examples of items from each subscale: "I really think affirmative action programs on college campuses constitute reverse discrimination (Factor I, cognitive)," "I feel that I could develop an intimate

relationship with someone from a different race (Factor II, affective),” and “It upsets (or angers) me that a woman has never been President of the United States (Factor III, attitudes regarding women’s equity).”

Across three studies the average coefficient alphas for the scores on the QDI subscales are .85 for Factor I (cognitive); .76 for Factor II (affective); and .72 for Factor III (women’s equity). The full scale Cronbach’s alpha for the overall QDI scores was .88 (Ponterotto, Burkard, Rieger, & Grieger, 1995). A three-factor oblique extraction, which accounted for 41% of the total scale variance, emerged as the clearest and most interpretable solution from exploratory factor analysis. Using a .40 factor coefficient cutoff criterion, 23 of the 30 items had unique coefficients on one of the three factors. As noted earlier, seven items (numbers 2, 5, 10, 12, 21, 25, and 28) did not reach the criterion and are not calculated as part of the subscale scores, but remain as contributing items due to their contributions to the internal consistency and content validity of the total score (Ponterotto, et al., 1995). Cronbach’s alphas for the scores on Factors 1, 2, and 3 were .80, .83, and .76, respectively. A confirmatory factor analysis compared the three-factor oblique model with the null model and two theoretically competing models: a global factor of discrimination and the three-factor orthogonal extraction. The goodness of fit index increased progressively from the null model to the three-factor oblique model, indicating the greatest degree of fit for this extraction. Using rho parameter (Bentler & Bonett, 1980), Ponterotto et al. (1995) identified the three-factor oblique model as the best-fit model.

Ponterotto et al. (1995) tested the QDI for convergent and discriminant validity against three measures: (1) the New Racism Scale (NRS; Jacobson, 1985), an instrument

designed to measure White people's racism toward Blacks; (2) the Multicultural Counseling Awareness scale (MCAS; Ponterotto et al., 1993); (3) and the Social Desirability Scale (SDS; Crowne & Marlowe, 1960), which measures the participant's need to seek approval in a culturally acceptable manner. The NRS was significantly correlated with all three QDI factors. The QDI factors and MCAS factors ranged from .21 to .51, with four of six comparisons reaching statistical significance. According to the authors, these correlations demonstrate moderate relationships between multicultural counseling knowledge/skills/awareness and racism/sexism. The QDI subscale correlations (-.16, -.04, and -.19 on the three factors) with the SDS indicated that social desirability contamination is not a concern; in addition, the title of the QDI is listed as the Social Attitude Survey to help reduce participant expectancy bias (Ponterotto et al., 1995).

Procedure

Data were collected from practicing therapists through an Internet-based administration, face to face requests, email invitations distributed via academic personnel, and mailed surveys. The author also recruited participants through an e-mail solicitation sent to listservs of major professional organizations within psychology (i.e., Division 17, Ethic and Racial Diversity; Division 45, Society for the Psychological Study of Ethnic Minority Issues; Division 17 Student Affiliate Group). Participants were told that this was a study investigating clinical judgments. Therapists who volunteered completed a web site survey that was made available by the researcher to consenting participants. The web site and paper version of the survey contained an informed consent form, an explanation of the study and directions, a demographic sheet, and the

instruments of the study. No data were collected that could be used to identify the participants. All participants were randomly assigned to one of four experimental conditions; during the online administration a computer algorithm randomly assigned respondents to receive one of the four vignettes; for the paper and pencil administration respondents were handed or mailed copies of the protocol in a double-blind format. In both the online and paper administrations, participants were presented with materials in the following order: (1) informed consent; (2) demographic information sheet; (3) a randomly assigned clinical vignette; (4) assessment and treatment planning scale; and (5) the Quick Discrimination Index.

CHAPTER FOUR

Results

To determine the effects of racial similarity and diagnostic clarity on clinical judgments, a 2 x 2 experimental design was used in which participants were randomly assigned to one of four groups, based on the conditions of race and diagnosis. When participants' and the vignette client's race was the same, the condition was labeled as racial similarity; when participants were racially different from the vignette, then the condition was labeled racial dissimilarity. When clear diagnostic information was presented, the condition was coded as the clear diagnostic group. The resultant groups were labeled in the following manner: (a) ambiguous diagnosis – same race (AMBIG-SAME); (b) ambiguous diagnosis – dissimilar race (AMBIG-DIFF); (c) clear diagnosis – same race (CLEAR-SAME); and (d) clear diagnosis – dissimilar race (CLEAR-DIFF). Preliminary analyses are presented first, followed by descriptive statistics and the findings associated to the study's three hypotheses.

Preliminary Analyses

A series of analyses were conducted to examine whether characteristics of the participants influenced their judgments of the clinical vignettes. A 2 x 4 cross-tabulation analysis was conducted to determine whether an equivalent or proportional number of males and females were present in the four group conditions and was found not to be statistically significant, Cramer's Phi (1, $N = 65$) = .226, $p = .348$. There was roughly a two to one ratio of females to males distributed across all groups. Participants' confidence using the DSM-IV was 3.05 (with 1 being "very confident" and 7 being "not at all confident" and a one-way ANOVA was analyzed to determine whether participants

in the four groups differed on mean DSM-IV confidence. No statistical significance was found, $F(3, 62) = .869, p = .462$. Finally, a one-way ANOVA was conducted to test whether the participants in the four groups differed on mean age. Again, no statistical significance was found, $F(3, 62) = 1.93, p = .13$, as the group mean age ranged from 33 to 38 years of age ($SD = 8.69$ to 12.63 years).

Descriptive Statistics

Means and standard deviations for all group conditions are presented in Table 1 for measures of severity, prognosis, and prejudice. Severity ratings ranged from 2 to 6, with mean scores for the four groups found between 4.18 and 4.47. Prognostic ratings ranged from 2 to 7, with group mean prognostic ratings at the higher end (5.62 to 6.44). A standard deviation of 1.40 for the prognostic measure under the similar-ambiguous condition, in contrast to standard deviations of the other conditions, could be indicative of possible systematic differences in the variance between the conditions. However, F tests indicated that there were no statistically significant differences from the standard deviations of the other three conditions. The overall mean for participants' levels of prejudice (as measured by the Quick Discrimination Index) was 118.77 with a standard deviation of 14.12; scores ranged from 85 to 150. Mean scores across the four groups ranged from 116 to 119.

Descriptive statistics, including means, standard deviations and correlations for the same measures were collapsed across all conditions and are presented in Table 2. All correlations between severity, prognosis, or levels of prejudice were not statistically significant ($p > .05$), save for one correlation: racial similarity and prognosis. This

correlation indicated that White participants rated Black identified vignettes with higher prognoses than the White identified vignettes, but the effect size was small (.5%).

Table 1

Means and Standard Deviations for Experimental Conditions on Measures of Prognosis, Severity, and Prejudice (N = 66)

Prognosis

Racial Similarity	Ambiguous Condition			Clear Condition		
	<i>M</i>	<i>SD</i>	<i>n</i>	<i>M</i>	<i>SD</i>	<i>n</i>
Similar	5.62	1.40	16	6.06	.66	17
Dissimilar	6.13	.91	15	6.44	.78	18

Severity

Racial Similarity	Ambiguous Condition			Clear Condition		
	<i>M</i>	<i>SD</i>	<i>n</i>	<i>M</i>	<i>SD</i>	<i>n</i>
Similar	4.18	1.17	16	4.47	1.12	17
Dissimilar	4.26	.88	15	4.33	1.08	18

Prejudice

Racial Similarity	Ambiguous Condition			Clear Condition		
	<i>M</i>	<i>SD</i>	<i>n</i>	<i>M</i>	<i>SD</i>	<i>n</i>
Similar	116.50	14.74	16	119.82	12.34	17
Dissimilar	119.73	18.42	15	119.00	11.90	18

Table 2

Descriptive Statistics and Correlations Between Experimental Conditions and Outcomes

Variable	<i>M</i>	<i>SD</i>	1	2	3	4	5
1. Prognosis	6.08	.99	---				
2. Severity	4.32	1.05	-.16	---			
3. Prejudice	118.77	14.12	.13	.08	---		
4. Racial Similarity			-.23	.01	-.04	---	
5. Clarity of diagnostic condition			.20	.08	.05	-.03	---

Note. $N = 66$. Cronbach alpha for QDI (Prejudice) scores $\alpha = .89$; Possible score range: Prognosis = 1 to 7; Severity = 1 to 7; Prejudice = 30 to 150, with high scores indicating more awareness, sensitivity, and receptivity to racial diversity and gender equality.

Hypothesis Testing for Racial Similarity and Level of Prejudice Effects (Hypotheses 1 and 2)

As hypotheses 1 and 2 were tested at the same time, analyses of both are addressed here. Hypothesis 1 predicted that overpathologization bias of the racially dissimilar clinical vignette, regardless of the clarity of diagnostic information presented, would be rated highest by those therapists who reported low levels of multicultural sensitivity, as demonstrated by a less optimistic prognosis of functioning (Hypothesis 1a) and a higher rating of the overall degree of the client's disturbance (Hypothesis 1b). Hypothesis 2 predicted that underpathologization bias would be greatest by multiculturally sensitive therapists when the clinical vignettes were racially dissimilar and the diagnostic information was clear; underpathologization would be evidenced by more optimistic prognoses of functioning and lower ratings of the overall degree of the client's disturbance.

Hierarchical regression analyses for Hypotheses 1 and 2 were utilized with prognostic and severity ratings, respectively, as the dependent variables and participants' levels of prejudice, racial similarity of diagnostic condition, and the interaction of these as independent variables. Effect coding was used for the categorical predictors and the products were standardized to address multicollinearity of the predictors used twice in the analysis—once as a main effect and part of an interaction effect (Frazier, Tix, & Barron, 2004). Participants' levels of prejudice, using the Quick Discrimination Index, were standardized. The group of dissimilar race participants who received the clear diagnostic vignette condition were utilized as the reference group. The multivariate assumptions of normality, linearity, and homoscedasticity, based on a plot of standardized predicted

scores and residual scores and the normal probability plot of residuals, were met. The Tolerance and VIF values were within expected ranges for low collinearity (Tabachnik & Fidell, 1996).

For Hypothesis 1a the first model, level of participants' prejudice, similarity of racial pairing (coding), and clarity of diagnostic condition were entered simultaneously into the analysis and were not statistically significant in predicting prognostic ratings, Adjusted $R^2 = .10$, $F(3,62) = 2.28$, $p = .09$. In the second model, the four interaction terms (racial similarity x diagnostic clarity; diagnostic clarity x level of participants' prejudice; racial similarity x level of participants' prejudice; racial similarity x diagnostic clarity x level of participants' prejudice) were also found not to be statistically significant in predicting prognosis of the vignettes, Change in $R^2 = .11$, $F(7,58) = 1.01$, $p = .43$. See Table 3 for the regression of prognosis on prejudice, racial level, and diagnostic status.

For Hypothesis 1b similar steps were used in the moderator regression. In the first model of the analysis, level of participants' prejudice, similarity of racial pairing, and clarity of diagnostic condition were not statistically significant in predicting severity ratings, Adjusted $R^2 = .013$, $F(3,62) = .262$, $p = .85$. In the second model, the four interaction terms were added to the first model to determine whether clarity of diagnostic condition or racial similarity moderated the relationship between levels of prejudice and their effects on clinicians' judgments of the vignette client's prognosis. The interaction terms were not statistically significant in predicting prognosis of the vignettes, Change in $R^2 = .011$, $F(7,58) = .196$, $p = .98$. The regression summary of these findings for Hypothesis 1b is also contained in Table 3.

Table 3

Hypotheses 1 and 2: Summary of Moderator Regression Analysis Using Dissimilarity, Clarity, and Prejudice to Predict Severity and Prognosis Ratings (N = 66)

Predictors	B	Std. Error	Beta	t	p
<i>Severity</i>					
Model 1					
Racial similarity	.02	.13	.02	.16	.88
Clarity of diagnostic condition	.08	.13	.08	.63	.53
Prejudice	.08	.13	.07	.58	.56

Model 2					
Racial similarity	.02	.13	.01	.11	.92
Diagnostic clarity	.09	.14	.08	.63	.53
Prejudice	.09	.14	.09	.66	.51
Racial similarity x Diagnostic clarity	.05	.14	.05	.36	.72
Diagnostic clarity x Prejudice	.07	.14	.07	.50	.62
Racial similarity x Prejudice	-.04	.14	-.04	-.29	.78
Racial similarity x Diagnostic clarity X Prejudice	-.06	.14	-.06	-.45	.66

<i>Prognosis</i>					
Model 1					
Racial similarity	-.22	.12	-.22	-1.82	.07
Diagnostic clarity	.18	.12	.18	1.51	.14
Prejudice	.10	.12	.11	.89	.38

<i>(table continues)</i>					

Predictors	B	Std. Error	Beta	t	p
Model 2					
Racial similarity	-.21	.12	-.22	-1.72	.09
Diagnostic clarity	.17	.12	.18	1.40	.17
Prejudice	.11	.13	.11	.89	.38
Racial similarity x Clarity	.02	.12	.02	.14	.89
Diagnostic clarity x Prejudice	-.01	.13	-.02	-.12	.91
Racial similarity x Prejudice	.09	.13	.09	.69	.49
Racial similarity x Diagnostic clarity x Prejudice	-.02	.13	-.02	-.15	.88

For Hypothesis 2, underpathologization was conceptualized as containing four subcomponents: (a) a more optimistic prognosis of functioning the vignette client would be deemed capable of achieving after completing therapy; (b) a lower rating of the overall degree of the client's severity of disturbance; (c) a higher score on the global assessment of functioning (GAF); and (d) a less pathological diagnosis of the clinical vignette on Axis I. Parts (c) and (d) were not analyzed due to the unreliability of the participants' responses. Specifically, it was uncertain whether participants used a DSM-IV when assigning GAF scores or were skilled with the coding metrics, as the responses indicated that the participants were uncertain of their choices or simply unfamiliar with the scale. Similarly, numerous participants' diagnoses contained unusual and vague responses that made for unwieldy analysis (e.g., "comorbidity," "Axis I," and "Diagnosis Deferred").

Overpathologization Bias (Hypothesis 3)

For Hypothesis 3, I tested whether overpathologization bias would be evident during prognostic and diagnostic judgments of racially dissimilar vignettes under the ambiguous diagnostic condition. Overpathologization bias would be indicated by higher ratings of diagnostic severity and lower prognostic ratings.

A 2 (diagnostic clarity: unambiguous vs. ambiguous) x 2 (racial pairings: similar vs. dissimilar) ANOVA was conducted to evaluate the effects of diagnostic clarity and racial pairings on severity. As displayed in Table 4, none of the findings were statistically significant: diagnostic clarity, $F(1, 62) = .44, p = .51$, racial pairing $F(1, 62) = .01, p = .91$, and diagnostic clarity x racial pairing $F(1, 62) = .17, p = .69$. Another 2 (diagnostic clarity) x 2 (racial pairings: similar vs. dissimilar) ANOVA was conducted to evaluate the effects of diagnostic clarity and racial pairings on prognostic ratings. Again, no

statistically significant effects were found: diagnostic clarity, $F(1, 62) = 2.4, p = .13$, racial pairings, $F(1, 62) = 3.46, p = .07$, and diagnostic clarity x racial pairing $F(1, 62) = .07, p = .80$.

Table 4

Hypothesis 3: Analysis of Variance Summary Table of Similarity and Clarity Conditions for Severity and Prognosis Ratings (N = 66)

Source	SS	df	MS	F	p
<u>Criterion: Severity Ratings</u>					
Racial similarity	1.39	1	1.39	.01	.91
Diagnostic clarity	.50	1	.50	.44	.51
Racial similarity x Diagnostic clarity	.19	1	.19	.17	.69
Residual	71.60				
<u>Criterion: Prognosis Ratings</u>					
Racial similarity	3.28	1	3.28	3.46	.07
Diagnostic clarity	2.28	1	2.28	2.40	.13
Racial similarity x Diagnostic clarity	6.18	1	6.18	0.07	.80
Residual	57.16				

CHAPTER FIVE

Discussion

The purpose of this study was to examine the possible presence of psychotherapeutic bias against Black clients. Since previous research designs that were constructed to uncover bias towards minority members may have been flawed in their transparency (Garb, 1997), the current study was designed to determine whether psychotherapeutic bias could be illuminated by using ambiguous diagnostic situations in which the ground rules for normative behavior were uncertain. In essence, the design was setup in an effort to bypass conscious processing and socially desirable responding by tapping into non-conscious racial prejudices via presentations of case vignettes of varying clarity and diagnostic severity (Dovidio & Gaertner, 2000; Greenwald, McGhee, & Schwarz, 1998).

For the first hypothesis it was expected that under ambiguous diagnostic conditions in which the proper diagnosis was uncertain due to a client's unclear presenting problems, racially dissimilar participants (i.e., those participants whose race was different than the race of the client in the clinical vignette) would be more likely to assess the racially dissimilar client as having significantly higher pathology and significantly lower prognostic ratings than a same-race client with the same presenting symptom picture. When diagnostic clarity was clear and a proper diagnosis was clearly identifiable it was expected that no differences would emerge on diagnostic or prognostic ratings for either same- or dissimilar race clinical vignettes. In addition, an overpathologization bias towards the Black race identified vignettes was expected to be most markedly displayed by White psychotherapists with higher levels of prejudice as

measured by their scores on the Quick Discrimination Index (Ponterotto, et al., 1995).

In contrast, the author predicted in the second hypothesis that underpathologization bias would be greatest by those White psychotherapists with low levels of prejudice when presented with clinical vignettes that were diagnostically clear and racially dissimilar. In other words, overcompensation against the possibility of appearing prejudiced would occur under these conditions and, thus, a Caucasian therapist who would be low in prejudice (high in multicultural sensitivity) was expected to underpathologize the racially dissimilar, or African American client, when diagnostic information was clear.

Lastly, the third hypothesis was that regardless of therapists' levels of prejudice, overpathologization was expected to be most clearly evident during prognostic and diagnostic judgments of racially dissimilar vignettes under the ambiguous diagnostic condition. Specifically, the overpathologization bias was expected to be found and indicated by higher ratings of diagnostic severity and lower prognostic ratings.

The results of the study did not support the hypotheses. Regression analyses revealed that there were no significant increases or decreases in ratings of diagnostic severity and prognosis as a result of racial similarity, diagnostic clarity, and participants' levels of prejudice. For the second and third hypotheses, it appears that levels of prejudice did not meaningfully contribute to counselors' evaluations of clients. Generalizability of this finding seems implausible in real world clinical situations. Prejudice can be a nonconscious process (Gaertner & Dovidio, 2000) and may affect counselors' evaluations of clients but perhaps in more subtle ways, though, than in terms of prognosis and diagnosis. While speculative at this point, prejudice might display itself

through a variety of therapeutic interactions such as levels of intimacy, numbers of supportive comments, frequency of empathy responses, number of verbalizations, time limits in session, and other factors that were not studied in this experiment (Lopez, 1989).

An alternative conception to the effects of prejudice can be found in Abreu's (1999) research concerning racial stereotypes. Abreu found that participants who were unconsciously primed with Black stereotypes responded to stimuli in ways that were consistent with negative racial stereotypes. Nonetheless, when those same participants were directly asked about their overall impressions of a Black target they responded with significantly more favorable ratings. Abreu concluded that participants' desire to respond in socially acceptable ways may have led them to overcompensate for potential racial bias by responding with favorable ratings. It is plausible to extend Abreu's findings to the current study, i.e., when the participants had to offer their clinical judgments their thought processes shifted towards conscious processing and regulatory judgments were enacted that minimized the appearance of bias. Participants' benign rating of vignette clients may be suggestive of possible overcompensation.

Limitations of the Current Study

The current study had a number of limitations. Three problems existed within the participant sample. First, the participant sample was homogenous, as the few non-Caucasian participants' data were removed from the analyses due to insufficient numbers for proper analysis; additionally, participants were recruited through email invitations distributed through academic personnel, via self-selection online, or through face to face requests. Consequently, the sampling procedures did not produce a representative sample for the study of racial prejudice.

A second problem with the sample existed in terms of response homogeneity. Specifically, the response spread among participants was small – not a single participant scored as “highly prejudiced / low multicultural sensitivity.” Are counselors, as a general statement truly not racially prejudiced? While it is difficult to say with certainty, it seems unlikely (Bamgbose, Edwards, & Johnson, 1980; Ridley, 1986; Tomlinson-Clarke & Cheatham, 1993). A probable contributor to the sample’s responses may be found in the instrument that was utilized to assess levels of prejudice, the Quick Discrimination Index. This measure may have been more transparent than intended; a participant sample comprised of psychology-trained students and professionals may have been able to divine the purpose of the test and alter their responses in socially desirable ways (Abreu, 1999; Crowne & Marlowe, 1960). This appears likely given the unusually low levels of prejudice that were detected within this study’s sample, as is depicted in Table 1. Ponterotto, Potere, and Johansen (2002) summarized normative data for scores on the QDI and, in a review of the total QDI scores in five studies found mean scores ranging from 84.67 to 88.93, considerably lower than the mean scores in the current study that ranged from 116 to 119.

A third problem was that participants did not seem to be familiar with the DSM-IV (APA, 1994) and seemed to lack confidence in using the manual. Some participants offered Diagnostic and Statistical Manual numeric codes, others provided the nomenclature only, and others still offered vague responses such as “Anxiety,” “Axis I,” or “Comorbidity.” Others chose not to respond at all or wrote in “Not enough information.” Similarly, global assessment of functioning (GAF) scores were of questionable validity. Some participants, rather than offering a score, would write in “not

familiar with this scale” or explain that they had forgotten how to use it. Consequently, participants’ diagnostic responses were unable to be reliably determined and analyzed.

There were a number of methodological problems in terms of the data collection. Participants appeared to evidence confusion regarding the demographic information sheet’s experience-related questions. That is, a query for “Highest Degree Achieved” was meant to assess which degree a participant possessed, not which degree was in progress. A considerable percentage of the sample were beginning graduate students but few participants indicated that their highest degree was “Bachelor’s.” As a result, respondents’ responses to this item were largely inaccurate and could not be utilized in the analyses. Similarly, a query probing for “Number of Years of Clinical Experience” was not qualified by the nature of those clinical experiences or whether those experiences were post-baccalaureate or post-graduate. Again, the data were unreliable.

Controls for the participants’ numbers of years of training, exposure to multicultural coursework, and familiarity with diagnostic procedures are suggested. This study was completed by a majority of amateur therapists, thus limiting generalization of the results to a more seasoned, professional sample. While speculative, it may be possible that amateurs who have a limited sense of diagnostic competence were more cautious in their clinical judgments, which may explain the homogeneity of neutral responses for diagnostic and prognostic judgments across the four vignette conditions. Furthermore, manipulation checks for participants’ certainty about each of their severity and prognostic ratings would be indicated (the current study assessed for an overall measure of confidence, and results indicated that the sample’s responses indicated a neutral level of confidence in their judgments as a whole, but not specifically for each criterion).

In future studies, it is recommended that participation only occur when participants have access to a Diagnostic and Statistical Manual and feel confident in their mastery of diagnostic principles (user confidence scores were moderate, averaging 3.08 on a seven point Likert scale ranging from 1 indicating *very confident* to 7 indicating *not at all confident*, with 20 percent of the sample scoring a five or higher on this scale. Furthermore, participants should be instructed to include numeric codes for their diagnostic judgments rather than writing in a response, which will allow for a more specific codification system.

The analogue nature of the experimental design raises cautionary flags, as well, for the reliability of these findings. Attempting to assess prejudicial beliefs and discriminatory behaviors via a paper and pencil measure may have alerted participants to the nature of the study and, consequently, may have led to socially desirable responses that limited the appearance of racism. Participants were notified of the vignette client's racial characteristic and this may have been an overt cue leading participants to guess the nature of the study included examination of race-related variables.

Future Proposed Research

Several avenues for future research are possible. This study needs to be replicated with a sample of seasoned professional clinicians (i.e., one with at least a master's degree and five years of clinical practice), which would help to address the question about the possibility that the current findings were due to the experience level of the counselors. While the author was unable to find experimental literature to support this speculation, it is possible that inexperienced counselors may make more cautious judgments than experienced counselors. Furthermore, access to a Diagnostic and Statistical Manual

would be required to ensure that participants have access to the same diagnostic information they would have in their practices.

Potential limitations lie in the clinical vignettes that were utilized in this study. It is possible that the clear diagnostic information was not, in fact, as clear as the author had expected it to be. The clear vignettes did not report that at least one of the panic attacks had been followed by one month (or more) of one (or more) of the following: (a) persistent concern about having additional attacks; (b) worry about the implications of the attack or its consequences (e.g., losing control, having a heart attack, "going crazy"); and (c) a significant change in behavior related to the attacks (DSM-IV, 2000). In short, the difference between the clear and the ambiguous conditions may not have been great enough to be sensitive to ratings differences and both conditions may have been perceived as similarly ambiguous.

An additional limitation is that clinical bias is likely too complex to adequately identify through single item ratings of prognosis and diagnostic severity. It is the author's opinion that bias can be shown in ways that may be too subtle to identify through Likert scale ratings. For instance, counselors may show bias through nonverbal behaviors, their interpersonal warmth, number of times they interrupt a client, and so on, all of which are exceedingly challenging to measure.

Future research in this area may require the use of more implicit measures of prejudice, rather than the potentially transparent Quick Discrimination Index, to assess for participants' levels of prejudice that could not be circumvented by socially desirable response patterns. One such measure is the Implicit Associations Test (Greenwald, 1998), which attempts to measure implicit attitudes by measuring their underlying automatic

evaluations; in effect, these evaluations cannot be consciously manipulated and could be a truer measurement of prejudicial and racist attitudes. On a broader scale, the usage of analogue research designs to study measures of racial attitudes and prejudice may be too transparent in this age of heightened political correctness and sensitivity to judgment. The simple inclusion of a racial designation of White or Black in a clinical vignette may raise participants' awareness of race to such an extent that they will become more likely to respond in socially desirable ways even when unaware of an experiment's purpose.

To increase generalizability of the findings, it would also be well to replicate the current study among a variety of racial groups to test whether differential judgments are made by non-White clinicians towards similar and dissimilar race vignettes. The current study was only able to analyze the results of White clinicians and leaves a gap in the literature that previous research similarly failed to address. It is uncertain at this point whether there is similarity in the judgment strategies and outcomes of clinicians from various racial groups.

As no clear conclusions can be drawn from the current research due to its limitations, are the null findings suggestive that White clinicians tend to be free of psychotherapeutic bias against Black clients? This premise seems unlikely given prior research (Bamgbose, Edwards, & Johnson, 1980; Pope-Davis & Coleman, 1987) and the unceasing calls for enhanced multicultural competence among clinicians (Arredondo, et al., 1996; Pope-Davis & Dings, 1994; Sue, Arredondo, & McDavis, 1992). However, the lack of significance does reinforce the need to consider the null hypotheses—namely the effectiveness of a low-bias counselor. Thus, it may be beneficial for the focus of future research to be on identifying necessary and possibly sufficient qualities of culturally

sensitive and effective White counselors. This type of study may require the use of qualitative research designs where clients and counselors from diverse backgrounds are queried periodically between sessions about the effectiveness of counseling and a varied number of counselor qualities are measured. This topic has been broached by Pope-Davis et al. (2002), who assessed 10 counseling clients' perceptions of their multicultural counseling experiences. As one might imagine, the results of their study were complex and inconclusive. In essence, clients who defined their presenting problem as culturally constructed seemed to prefer racially or gender-similar counselors; clients who placed less emphasis on culture also placed less weight on the importance of their counselor's cultural competence. The limitations of the study were, in part, due to the lack of quantitative assessment methods for assessing cultural competence and bias. In future research it would be noteworthy to apply measures such as Ponterotto's Quick Discrimination Index and Greenwald's Implicit Associations Test to determine the concurrence between the qualitative perceptions of client's attributions and the numbers driven data of bias that quantitative assessments can provide.

Conclusions

In sum, this study leaves many unanswered questions. Are counselors racially biased and to what extent? Under what conditions is racial bias most likely to be demonstrated? Does the aversive racism tenet that states ambiguity leads to greater bias apply to genuine counseling scenarios, which might be argued to be inherently ambiguous? Do counselors overpathologize same-race clients and underpathologize different-race clients in an attempt to appear non-biased? Which type of research design is most appropriate and sensitive to measuring clinical bias? While there are no clear

answers to these questions at this time, it is clear that the call for continued study into dimensions of clinical judgment biases and multicultural counseling remains as strong as ever.

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APPENDIX A

Clinical Vignettes

Ambiguous condition - Caucasian

Presenting problem: Joe is a Caucasian 19 year-old Sophomore with an undeclared major. Joe's presenting problem description was extremely vague. Joe reported feeling on edge and irritable. He goes into "funks" that last for several hours at a time. He has been having difficulty concentrating and meeting the demands of his schoolwork. He stated that he "gets off on the wrong track" and cannot focus his thoughts. He noted that sometimes he feels nauseous and has repetitive thoughts that vary in content, never focusing on any particular thought. He's been worrying about a number of life areas including school and work. His difficulties are heightened at night, when he feels most lonely. Joe also struggles with falling asleep; on average it takes him between 60 and 90 minutes but can last as long as several hours. A doctor at the health center prescribed him melatonin pills for his sleep onset problems but Joe has found this unhelpful.

He has entertained the possibility of having various mental illnesses. He jokingly wondered if he has Tourette's Syndrome because he has unusual impulses at times, such as to pluck a piece of someone's hair; he can resist these impulses. He has also wondered if he has a form of Attention Deficit Disorder, noting that he is a "space cadet."

Social support: Joe has a few casual friends with whom he can socialize but does not feel close to them. He is pessimistic about developing closer friendships because he perceives them to be immature people. Joe hesitates to share personal material with others and fears that he is imposing on them and making them feel uncomfortable; consequently, he has nobody to share his deeper feelings with.

Academics: Joe reported satisfaction with his academics, although stated that it's been more difficult lately for him to maintain his concentration while studying.

Drugs and alcohol: Joe reports drinking an average of one night per week. Over four or five hours he consumes roughly ten beers. He stated that he uses marijuana a few times per year.

Family history: There is some family history of depression; mother has been treated for clinical depression for the past six years. His father, Frank, is reportedly an alcoholic. Joe stated that he has never been emotionally or physically abusive. He said that his father is supportive of Joe and his two younger sisters, but "before 5 p.m.," indicating his drinking pattern. Joe feels that he has a good relationship with father but that it would be much better if he didn't drink alcohol. He raised his concern with him only once, when he was drunk, and he reacted angrily.

Ambiguous condition – African American

Presenting problem: Joe is an African American 19 year-old Sophomore with an undeclared major. Joe's presenting problem description was extremely vague. Joe reported feeling on edge and irritable. He goes into "funks" that last for several hours at a time. He has been having difficulty concentrating and meeting the demands of his schoolwork. He stated that he "gets off on the wrong track" and cannot focus his thoughts. He noted that sometimes he feels nauseous and has repetitive thoughts that vary in content, never focusing on any particular thought. He's been worrying about a number of life areas including school and work. His difficulties are heightened at night, when he feels most lonely. Joe also struggles with falling asleep; on average it takes him between 60 and 90 minutes but can last as long as several hours. A doctor at the health center prescribed him melatonin pills for his sleep onset problems but Joe has found this unhelpful.

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Social support: Joe has a few casual friends with whom he can socialize but does not feel close to them. He is pessimistic about developing closer friendships because he perceives them to be immature people. Joe hesitates to share personal material with others and fears that he is imposing on them and making them feel uncomfortable; consequently, he has nobody to share his deeper feelings with.

Academics: Joe reported satisfaction with his academics, although stated that it's been more difficult lately for him to maintain his concentration while studying.

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Family history: There is some family history of depression; mother has been treated for clinical depression for the past six years. His father, Frank, is reportedly an alcoholic. Joe stated that he has never been emotionally or physically abusive. He said that his father is supportive of Joe and his two younger sisters, but "before 5 p.m.," indicating his drinking pattern. Joe feels that he has a good relationship with father but that it would be much better if he didn't drink alcohol. He raised his concern with him only once, when he was drunk, and he reacted angrily.

Clear condition - Caucasian

Presenting problem: Joe is a Caucasian 19 year-old Sophomore with an undeclared major. Joe referred himself to the counseling center. He reported experiencing panic attacks. In fact, he indicated that he experienced one shortly before the onset of school and thought that the attack was connected to the stress of leaving home. He did not have another panic attack until three weeks ago; since then he has had one or two per day, typically lasting between 2-to 30 minutes in length; most are under 10 minutes' duration. Joe has experienced sweating, hot flushes, shortness of breath, accelerated heart rate, tightness in his chest, hyperventilation, and fears of dying during these panic attacks. He explained that they have happened in numerous contexts without any identifiable antecedents that he is aware of.

Social support: Joe has a few casual friends with whom he can socialize but does not feel close to them. He is pessimistic about developing closer friendships because he perceives them to be immature people. Joe hesitates to share personal material with others and fears that he is imposing on them and making them feel uncomfortable; consequently, he has nobody to share his deeper feelings with.

Academics: Joe reported satisfaction with his academics, although stated that it's been more difficult lately for him to maintain his concentration while studying.

Drugs and alcohol: Joe reports drinking an average of one night per week. Over four or five hours he consumes roughly ten beers. He stated that he uses marijuana a few times per year.

Family history: There is some family history of depression; mother has been treated for clinical depression for the past six years. His father, Frank, is reportedly an alcoholic. Joe stated that he has never been emotionally or physically abusive. He said that his father is supportive of Joe and his two younger sisters, but "before 5 p.m.," indicating his drinking pattern. Joe feels that he has a good relationship with father but that it would be much better if he didn't drink alcohol. He raised his concern with him only once, when he was drunk, and he reacted angrily.

Clear condition – African American

Presenting problem: Joe is an African American 19 year-old Sophomore with an undeclared major. Joe referred himself to the counseling center. He reported experiencing panic attacks. In fact, he indicated that he experienced one shortly before the onset of school and thought that the attack was connected to the stress of leaving home. He did not have another panic attack until three weeks ago; since then he has had one or two per day, typically lasting between 2-to 30 minutes in length; most are under 10 minutes' duration. Joe has experienced sweating, hot flushes, shortness of breath, accelerated heart rate, tightness in his chest, hyperventilation, and fears of dying during these panic attacks. He explained that they have happened in numerous contexts without any identifiable antecedents that he is aware of.

Social support: Joe has a few casual friends with whom he can socialize but does not feel close to them. He is pessimistic about developing closer friendships because he perceives them to be immature people. Joe hesitates to share personal material with others and fears that he is imposing on them and making them feel uncomfortable; consequently, he has nobody to share his deeper feelings with.

Academics: Joe reported satisfaction with his academics, although stated that it's been more difficult lately for him to maintain his concentration while studying.

Drugs and alcohol: Joe reports drinking an average of one night per week. Over four or five hours he consumes roughly ten beers. He stated that he uses marijuana a few times per year.

Family history: There is some family history of depression; mother has been treated for clinical depression for the past six years. His father, Frank, is reportedly an alcoholic. Joe stated that he has never been emotionally or physically abusive. He said that his father is supportive of Joe and his two younger sisters, but "before 5 p.m.," indicating his drinking pattern. Joe feels that he has a good relationship with father but that it would be much better if he didn't drink alcohol. He raised his concern with him only once, when he was drunk, and he reacted angrily.

APPENDIX C

Assessment and Treatment Planning

1. Using your knowledge of DSM-IV diagnostic categories, please enter what you consider to be the most appropriate diagnosis for this client on Axis I and/or Axis II:

2. Please enter a Global Assessment of Functioning (GAF) rating for this client: _____

Using the scales below, please rate the client on the following dimensions:

3. Level of Disturbance

Please rate the client's overall degree of disturbance from (1) not at all disturbed to (7) highly disturbed:

Not at all disturbed					Highly disturbed	
1	2	3	4	5	6	7

4. Urgency of Care

Please rate the urgency of care needed for this client on the following scale ranging from not at all urgent (1) extremely urgent (7):

Not at all Urgent					Extremely Urgent	
1	2	3	4	5	6	7

5. Prognostic Scale

Please rate the highest level of adaptive functioning (i.e., prognosis after completing therapy) which could be expected for this client on the following scale ranging from Grossly Impaired (1) to Superior (7):

Grossly Impaired					Superior	
1	2	3	4	5	6	7

APPENDIX D

Social Attitude Survey

Please respond to all items in the survey. Remember there are no right or wrong answers. The survey is completely anonymous, do not put your name on the survey. Please circle the appropriate number to the right.

Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
1	2	3	4	5

1. I do think it is more appropriate for the mother of a newborn baby, rather than the father, to stay home with the baby during the first year.

1	2	3	4	5
---	---	---	---	---

2. It is as easy for women to succeed in business as it is for men.

1	2	3	4	5
---	---	---	---	---

3. I really think affirmative action programs on college campuses constitute reverse discrimination.

1	2	3	4	5
---	---	---	---	---

4. I feel I could develop an intimate relationship with someone from a different race.

1	2	3	4	5
---	---	---	---	---

5. All Americans should learn to speak two languages.

1	2	3	4	5
---	---	---	---	---

6. I look forward to the day when a woman is President of the United States.

1	2	3	4	5
---	---	---	---	---

7. Generally speaking, men work harder than women.

1	2	3	4	5
---	---	---	---	---

8. My friendship network is very racially mixed.

1	2	3	4	5
---	---	---	---	---

9. I am against affirmative action programs in business.

1 2 3 4 5

10. Generally, men seem less concerned with building relationships than do women.

1 2 3 4 5

11. I would feel O.K. about my son or daughter dating someone from a different race.

1 2 3 4 5

12. I look forward to the day when a racial minority person is President of the United States.

1 2 3 4 5

13. In the past few years there has been too much attention directed toward multicultural issues in education.

1 2 3 4 5

14. I think feminist perspectives should be an integral part of the higher education curriculum.

1 2 3 4 5

15. Most of my close friends are from my own racial group.

1 2 3 4 5

16. I feel somewhat more secure that a man, rather than a woman, is currently President of the United States.

1 2 3 4 5

17. I think that it is (or would be) important for my children to attend schools that are racially mixed.

1 2 3 4 5

18. In the past few years there has been too much attention directed towards multicultural issues in business.

1 2 3 4 5

28. I would enjoy living in a neighborhood consisting of a racially diverse population (e.g., Asians, Blacks, Hispanics, Whites).

1 2 3 4 5

29. I think it is better if people marry within their own race.

1 2 3 4 5

30. Women make too big of a deal out of sexual harassment issues in the workplace.

1 2 3 4 5

Factor I: 3, 9, 13, 18, 19, 22, 23, 26, 27

Factor II: 4, 8, 11, 15, 17, 24, 29

Factor III: 1, 6, 7, 14, 16, 20, 30

Additional items: 2, 5, 10, 12, 21, 25, 28

VITA
Brad Hieger
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Education

05/07 Ph.D., Counseling Psychology, The Pennsylvania State University
05/97 M.A., Counseling Psychology and Social Psychology, Ball State University
05/95 B.A., Psychology, Magna Cum Laude, Adelphi University

Clinical Experiences

09/06 – present Clinician, GRN Community Service Board, Norcross, GA
Provide counseling and triage to children, adolescents, and adults.

10/05 – present Counselor / Psychometrist, Atlanta Area Psychological Associates,
Marietta, GA
Provide counseling and psychological assessments.

05/04 – 07/06 Counselor, Accord Psychological Associates, Marietta, GA
Offered individual therapy and administered psychological assessments.

08/01 – 05/02 Staff Counselor, Student Counseling Services, Illinois State University
Provided brief therapy, and initial assessment and triage.

08/00 – 08/01 Pre-doctoral Intern, Student Counseling Services, Illinois State
University
Offered individual, group, crisis, and career counseling in a brief therapy
format. Supervised a master's practicum student. Engaged in
organizational consultation, initial assessment and triage, testing and
assessment, liaison work for residence hall, campus outreach,
developmental programming, and undergraduate course instruction.

08/99 – 05/00 Counselor, Lawrence T. Clayton and Counseling Associates, Inc.
Conducted intake evaluations and individual, family, and intensive out-
patient substance abuse counseling.

Teaching Experiences

Courses taught:

- Abnormal Psychology
- Career Counseling
- Counseling Theory
- Cultural Awareness and Interracial Understanding
- Developmental Psychology: Adolescence
- Foundations of Chemical Dependency Counseling
- Group Procedures in Guidance and Counseling
- Human Development and Learning
- Individual Counseling Procedures
- Introduction to Sociology
- Senior Seminar in Psychology
- Social and Cultural Foundations
- Social Psychology