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Relationships Across Training Programs, Professional Titles, and Perceptions of Therapy Performance

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RELATIONSHIPS ACROSS TRAINING PROGRAMS, PROFESSIONAL TITLES, AND PERCEPTIONS OF THERAPY PERFORMANCE

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This dissertation submitted by Debra E. Anderson Bach in partial fulfillment of the requirements for the Degree of Doctor of Philosophy from the University of North Dakota has been read by the Faculty Advisory Committee under whom the work has been done, and is hereby approved.

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ABSTRACT

This study was designed to examine the perceptions of students training to be counselors, clinical psychologists, and social workers, regarding the professional titles of counseling psychologist, psychiatrist, clinical psychologists, and social worker. A videotaped counseling session of a therapist and a client, a client description, and a therapist description served as the stimuli. The professional title of the therapist varied in the therapist description and served as the independent variable. One hundred three subjects were grouped according to their training program and then randomly assigned to one of the four treatment groups differentiated by the professionals titles of counseling psychologist, psychiatrist, clinical psychologist, and social worker. The dependent variable consisted of ratings of counseling performance obtained from the Counselor Evaluation Rating Scale (CERS) and the Counselor Rating Form (CRF), which contained three subscales. All subjects completed the dependent measures as well as a personal data form.

Significant main effect analyses indicated that on the CRF total scale and the CRF scale of expertness, clinical

psychology students and social work students rated the therapist higher than did the counseling students. In addition, social work students rated the therapist as being significantly more attractive than did the counseling students. This study did not reveal any significant interactions between the student's training background and the professional title of the therapist. Even though there was no interaction with professional title, the results did indicate significant differences in the perceptions of therapist performance attributed to training background.

CHAPTER 1

INTRODUCTION

Background of the Study

Therapy consists of a relationship between a therapist and a client in which the primary goal is to help the client improve his/her quality of life. While all therapists may agree that their goal is to help clients, not all therapists receive the same training and, therefore, they represent a very diverse group. The many programs that train therapists range from undergraduate programs to post-doctoral programs. For example, social workers are qualified to provide therapy with an undergraduate degree, counselors generally need a master's degree, clinical and counseling psychologists typically have Ph.D's and psychiatrists are presently required to have a medical degree and a three year residency in a psychiatric facility. From these diverse training backgrounds, qualified therapists acquire a variety of professional titles. Despite a common goal, these titles per se may influence how a therapist is perceived. It should be noted that many other factors can influence how

a therapist is perceived, such as the therapist's experience, the therapist's gender, and the therapist's theoretical orienatation. Most research in this area focuses on client perceptions of professional title, but therapists' perceptions of each other also have been of interest. The most conclusive study was done by Granger (1959) who selected 20 job titles within the field of psychology and had an American Psychological Association (APA) sample rank order the titles according to occupational prestige. Subgroups within APA were found to upgrade from one to three ranks the status of titles with which the members were most closely indentified. Of particular importance to this study, counseling psychologists were ranked seventh in status overall, but ranked themselves as fourth. The Ph.D. level clinical psychologist was ranked third overall, following psychology professors and experimental psychologists. Such information is important because it indicates perceptions that occur among professionals. This study examines the perceptions of students training to be therapists. These students represent the following professions frequently associated with providing therapy: Clinical psychology, counseling, and social work. This study specifically examines how these students are influenced by the professional titles of counseling psychology, psychiatry, clinical psychology, and social work.

Literature Review

The review of the literature outlines the historical development of therapy in chronological order and the training requirements for each profession. Factors that have been found to influence the perception of therapeutic process will be discussed and special attention will be given to the effect professional training has on such perceptions.

Historical Review of Psychiatry, Clinical Psychology, Counseling Psychology, and Social Work

The histories of counseling psychology, psychiatry, clinical psychology, and social work have a common basis. Their early history is intermingled and centers around primitive medicine and early philosphy.

In Alexander's (1966) review of the history of psychiatry, he traced the mental health professions to primitive medicine. In the early years B.C., primitive medicine existed in many cultures and consisted of magical procedures performed by medicine men. Medicine men were found in the early civilizations of Babylonians, Egyptians, Hebrews, Persians, and Hindus. Medicine men in these cultures tended to the pain of tribe members regardless of whether this pain was physical or mental. Treatment was generally the same for both physical and mental illness and centered around the mystical powers of the medicine man. The medicine man was often the head priest of a tribe or a man who had survived some unusual incident.

The early Greek philosophers contributed a rational approach to the understanding of nature, man, and society by replacing supernatural traditions with natural phenomena. Rationalism was applied to medicine during the seventh and sixth centuries B.C. During the fourth century Hippocrates applied rationalism to mental diseases. Plato had a significant role by considering psychological phenomena as a total response of the whole organism reflecting the internal state. The contributions of the Greek philosophers disappeared during the Dark Ages but were revived during the Renaissance and are present in modern day psychiatry.

During the first seven centuries, Christian philosophy was dominant and concentrated on the religious and moral aspects of human life. St. Augustine made a significant contribution to psychiatry and psychology when he demonstrated the importance of introspection as a source of genuine psychological knowledge. He was the first person to vividly describe in detail subjective emotional experiences. This principle is considered basic to present day therapy.

During the early Christian era, Arabian physicians were focusing on a more humane orientation to the treatment of mental illness. In particular, Rhazes and Avicenna were famous for attempting to correlate physiological reactions with emotional states. European hospitals were also focusing on a humane orientation, and men such as Cassiodorus and St. Benedict laid the foundation for the

development of an empirical and practical lay medicine. Lay physicians were generally theologians who believed that man was the center of the universe. They felt that if a person were sane it was because heaven had ordained it, and if someone was mad it was because some external force, such as a heavenly body, affected him or her.

By the thirteenth and fourteenth centuries, people with mental illness were labled as witches. During the witch hunt years thousands of mentally ill as well as many others were burned at the stake. The reasoning for this was based on theological rationalizations and magical explanations.

The fifteenth century was a period of transition between medieval times and the modern world. Humanism was beginning to emerge, stressing the idea that man must rely on his own convictions and feelings. Vives from Spain was a humanist who proposed social and educational reforms. He was instrumental in focusing the study of mental illness on the whole man. Superstition was eminent during this renaissance period, but a turning point was reached and there was a reorientation toward reality.

The seventeenth century was a time of great advances in science, including psychiatry in particular (Alexander, 1966). Rene Descartes was one philospher who united philosophy and psychology. During the following two centuries, philosophy was used to analyze issues of psychological relevance. Descartes philosophy of Cartesian dualism became embedded in psychological thought. Descartes' viewed man as composed of a material body and an

independent spiritual soul. This view was altered by Spinoza who contradicted Descartes and established the concept of the holistic organism. Breakthoughs in observation and reason were achieved during the seventeenth century by such men as Bacon and Locke.

Psychiatry

As mentioned above psychiatry had its roots in primitive medicine and early philosophy. By the early eighteenth century, experimentation had replaced deductive abstraction in scientific and medical investigations (Misiak & Sexton, 1966). Physicians were beginning to look for destroyed matter in the brain to explain mental disease and were looking away from superstition. Mental illness was being viewed with more compassion and the problems of mental illness were brought into public focus. Pinel was a French physician who tried to understand and classify mental diseases from a non-philosophical approach. He is known for liberating the insane from their chains and changing the whole regimen of two large asylums in Paris during the late eighteenth century. His method was new and followed a somatic approach of viewing mental illness as the result of either heredity or brain pathology. This view was widely accepted throughout France and was influential in the development of psychiatry in America.

During the last decade of the nineteenth century, care for the mentally ill in America had reached a low level (Bockoven, 1963). Neuropathologists were added to the staffs of mental hospitals signifying the need for research

in psychiatry. Neuropathologists were the physicians most thoroughly trained in the scientific method who dealt with diseases of the nervous system and were consequently the logical choice to direct psychiatric research. Dr. Adolf Meyer was the first neuropathologist to work full-time on research in psychiatry. He used studies, case histories, and mental and physical exams in an attempt to discover the relationship between mental symptoms and pathological changes in body chemistry or brain cells. Meyer unexpectedly found a relationship between patients' habits and their mental illness and concluded that mental illness was a reaction of the total personality to life stresses.

At the beginning of the twentieth century, psychiatry showed little interest in psychology (Misiak & Sexton, 1966). However, through Meyer's work, American psychiatry began to move from the physical disease theory of mental illness to a psychological understanding of mental illness. During the twentieth century, psychotherapists such as Freud, Jung, Horney, Sullivan, and Fromm have had a significant impact on the field of psychiatry as well as psychology. The use of psychotherapy in conjunction with medical procedures became popular during the 1930's and continues to be the current trend in psychiatry today.

Clinical Psychology

The early roots of clinical psychology are contained within the early historical developments of psychiatry. The historical account of views of mental illness is similar for both professions. Except for the mutual

interest in psychopathology, psychology did not share psychiatry's orientation emphasizing organic reasons for mental illness. In turn, psychiatrists did not see a need for psychology so there was no reason for interaction between the two professions.

In the early 1900's Francois Leuret was a physician who began examining psychological factors in mental illness. He was instrumental in bridging the gap between the two professions. Ideler in Austria and Tuke in Britian were also attributing importance to psychological factors in their treatment of mental illness.

Wilhelm Wundt, who is considered the first experimental psychologist, founded the field of scientific psychology in Germany (Reisman, 1966). He called this new science physiological psychology. Around 1860, Wundt began writing the first textbooks in which he recorded his research findings and his theoretical speculations. Wundt's laboratory in Leipzig was a prominent place for training the early leaders of psychology from several different countries. Students studied under Wundt and then returned to their own countries to establish their own laboratories. Until the turn of the century, Wundt was influential in promoting psychological research, having students conduct reseach in many different areas.

During the late 1800's Americans became interested in psychology and borrowed the idea of experimental psychology from the Germans. American psychology was not as rooted in philosophy as was German psychology, instead claiming

theology, moral philosophy, and mental philosophy as its roots. In the 1880's Americans shifted from a mental philosophy viewpoint of psychology to a scientific viewpoint. The developments in the area of physiological psychology by Germans such as Wundt, Fechner, and Helmholtz were influential. Inspiration also came from the British associationism of James Mill, John Stuart Mill, and Alexander Bain. The evolutionary theory of Charles Darwin had a significant impact on American psychology leading American psychology toward a functional viewpoint that examined mental functions in relation to the entire organism.

William James is considered the founder of American psychology (Misiak & Sexton, 1966). His role in America was similar to Wundt's role in Germany. He studied the active mind and the usefulness of the mind to man. He encouraged American psychologists to view mental process through biology.

G. Stanley Hall was another important person in the history of American psychology. He was a student of William James and also studied under Wundt at Leipzig. Hall was an organizer who established laboratories, founded journals, and organized the American Psychological Association. In 1909 Hall invited Freud, Jung, Jones, and Ferenczi to speak at the twentieth anniversary of Clark University. By doing this he stimulated Americans such as James, Titchener, and Cattell to pursue the study of psychoanalysis. As a result of this meeting, Hall is noted

for bringing psychoanalysis to America.

Many other individuals made significant contributions to American psychology around the turn of the twentieth century. Among those were George Ladd, for stressing the trend toward functionalism, James Cattell, for developing mental tests, James Baldwin, for promoting functional psychology and the psychology of individual differences, and Edward Titchener, for his research on the study of consciousness through introspection.

The branch of psychology which became known as clinical psychology had its earliest roots in America in 1896 when Lightner Witmer opened the first clinic which was service-oriented and focused on diagnosis and classification of individual behavior (Misiak & Sexton, 1966). Witmer's work was mainly with school children, although he stressed that his model could be applied to other populations. His work was not widely accepted and the clinical approach was disregarded until 1909 when William Healy opened a behavior clinic in Chicago which emphasized a therapeutic approach. Healy was influenced by the dynamic approach of Freud and sought to examine the dynamics of delinquent behavior. The Healy clinic became a model for child guidance clinics which were being established around 1920.

During World War I clinical psychology had a predominantly psychometric role. Psychologists were called upon to devise valid, objective military assessments. Psychologists were involved in intelligence testing and personality testing at this time.

Between 1920 and 1940, clinical psychology expanded its services to include clinics, hospitals, courts, and prisons. The duties of the clinical psychologist were primarily in the area of testing with only a limited number involved in therapy (Reisman, 1966). In 1937 the American Association for Applied Psychology was founded and the number of psychological clinics in 1940 was nearly double that of 1930. During World War II clinical psychologists again had a psychometric role, but there was also a high incidence of mental illness and personality disorders among military recruits. Clinical psychologists were now being recognized for their clinical skills, including taking case histories, assisting in the evaluation and diagnosis of patients, designing and participating in research studies, and administering individual and group therapy to several types of patients (Misiak & Sexton, 1966).

After World War II there was an increased demand for clinical psychological services and a greater public and professional acceptance of the field of clinical psychology. The clinical psychologist was now seen as competent in psychological diagnosis, psychotherapy, and research.

Hospitals operated by the Veteran's Administration had become the largest employer of clinical psychologists. In 1946, the Veteran's Administration implemented a four year university training program for clinical psychologists and counseling psychologists which was approved by the American Psychological Assiciation. This helped universities

develop and standardize their own training programs. By 1950, the Veteran's Administration had made the Ph.D. a requirement for employment as a clinical psychologist.

In 1949, the American Psychological Association sponsored a conference, called the Boulder Conference, to discuss training issues for clinical psychology. This conference was essential in bringing together people from various training programs and agencies to develop a solid basis from which training programs should be developed. Since that first meeting, only two other meetings have occurred to discuss training requirements. The most recent, in 1965, was the Chicago Conference on the Professional Preparation of Clinical Psychologists.

During the 1950's, clinical psychology became concerned with protecting its profession and instituted the licensing procedure as well as developed a code of ethics (Korchin, 1976). Because of conflict occurring among psychiatrists, psychologists, and social workers, the American Psychological Association felt it necessary to institute a licensing procedure. This licensing procedure applies to both clinical and counseling psychologists. Licensure has continued to be a symbol of status and protection among clincal and counseling psychologists.

At the present time, clinical psychology is a firmly established practicing profession. Clinical psychologists are frequently involved in providing therapy to clients, as well as providing diagnostic and testing evaluations.

Counseling Psychology

The profession of counseling psychology developed after clinical psychology; however, the two professions share the same early history of psychology. Whitely (1984) reviewed the history of counseling psychology and traced the beginnings to Frank Parson and his associates who began the vocational guidance movement which was of major significance in the development of counseling psychology. Parson and his associates provided vocational assistance to young people and began a counselor training program in Boston during the early twentieth century. In 1909 a national committee concerned with mental health and counseling became involved with this issue. During this period of time the focus was on vocational guidance of young adults in the schools and community agencies.

The mental hygiene movement also influenced the field of counseling. Beers (1909) documented his experiences of being committed to a mental hospital in a book, A Mind That Found Itself, which brought much attention to the conditions of mental hospitals. He was instrumental in the development of the National Committee for Mental Hygiene in 1909.

Alfred Binet's study of individual differences and the psychometric movement also had great influence on the field of counseling. Objective assessment within the area of vocational guidance became possible early in the twentieth century.

World War I had a significant impact on the field of

counseling. Like the clinical psychologists, counselors also became involved in psychometrics. During the depression of the 1930's they again became involved in vocational guidance.

Carl Rogers was influential in bringing therapy into the field of counseling. Psychotherapy was dominated by psychiatry until the 1940's when Carl Rogers expanded counseling's focus to include personal counseling and psychotherapy. Since the 1940's several theories of counseling and psychotherapy have emerged and therapy is now a substantial part of the field of counseling psychology.

Early in the history of counseling there were social and economic forces in society which impacted the profession. The influences of social and political reform, psychometrics, psychotherapy, the psychology of individual differences, and the effects of two world wars, merged to produce a field of applied-scientific psychology. By the end of the Second World War, counseling began focusing on service orientation and research activities in addition to vocational guidance.

In 1946 counseling developed its own division within APA. The first official name was the "Division of Personnel and Guidance Psychologists". In an attempt to distinguish counseling from other helping professions, two activities occurred in 1949. The first was the Ann Arbor Conference which examined training of counselors and established a clearer distinction between counseling and

clinical psychology. APA president John Darley (1949) also described the definition of counseling psychology in terms of its relationship with clinical psychology. He felt that the role of counseling psychologists needed clearer definition as it seemed that clinical psychologists excluded other psychologists from service-related functions.

In 1951 the Northwestern Conference was convened to address the standards of practicum training and training in general of psychologists at the Ph.D. level. It was decided that training should qualify counseling psychologists to work with individuals needing psychological adjustment. This included specific training in research, appraisal of the individual, personality development, knowledge of the social enviroment, professional orientation, and practicum. It was noted that counseling psychologists could function in a variety of settings including hospitals and various community agencies. They recommended that practicum experience should be available in these settings. Psychologists from across the country attended the conference to develop the requirements for a doctoral program in counseling psychology.

During the 1950's research on the counseling process and on the outcome of counseling was beginning to take place. Super was instrumental in stimulating research in the area of vocational development by studying the pattern of careers. Job opportunities for counseling psychologists

increased as the Veterans Administration provided major employment opportunities. The Veterans Administration also implemented a training program for both counseling psychologists and clinical psychologists at this time.

Concern about the status of counseling psychology grew during the 1950's. Division 17 organized a committee to define the speciality of counseling psychology. In 1954 the Journal of Counseling Psychology was developed and in 1955 the American Board of Examiners adopted the title of counseling psychology as a speciality area within psychology. Competition for status was particularly evident between psychiatry, clinical psychology, counseling psychology, and social work. Granger (1959) found that counseling psychology was rated by members of APA as being lowest in status of all specialties in psychology requiring a Ph.D. It was evident that counseling psychology was still lagging behind clinical psychology even though it was growing.

In 1963 Division 17 attempted to organize itself and address the issues of increasing membership, uneven status, and diffuse focus. The Greystone Conference addressed these issues through member participation and discussion. The result was greater clarity about the identity of counseling psychologists. Counseling psychologists were urged to become more psychologically sophisticated and to maintain their uniquiness as vocational counselors. Recommendations were for training to occur in collaboration with clinical psychology with the curriculum to have a

strong psychological foundation. Social influence was recognized as affecting the profession.

Between 1950 and 1967 job opportunities for counseling psychologists in university settings greatly increased. Higher education was enjoying a period of substantial growth and the need for counseling psychologists increased with this growth. Government-funded programs were being developed for work with students whose problems were more immediate than the decision of which college to attend or which career to follow. Emphasis was placed also on cross-cultural counseling and working with minorities. During this period research issues were better understood and higher quality elaborations of theories were occurring. Behavior therapy went through innovations at this time, Carl Rogers expanded his client-centered therapy, Berne (1964) wrote his best-selling book Games People Play, and Roe (1956), Super (1957), and Holland (1966) continued their work with vocational development.

During the 1960's and 1970's the educational/developmental role was given primary status among counseling psychologists. The educational/developmental and preventive roles were seen as being distinct to counseling psychology. The remedial/rehabilitative roles were more clearly those of clinical psychology. Social attitudes were changing during this period of time affecting the field of counseling psychology. The effects of the Vietnam war, Watergate, and an interest in wellness and self-help, all contributed to an increased interest in

counseling. In addition, literature during this time period was becoming more sophisicated and was growing in relevance to the field of counseling psychology. The 1960's and 1970's seemed to be a time when counseling psychology became more solidly founded.

Since the 1970's the profession of counseling psychology and the role of counseling psychologists has become more refined. However, at the present time counseling psychologists and clinical psychologists are very similar. High quality research and theoretical literature have continued to provide support to the profession. The counseling psychologist is now seen as a professional who can handle a wide array of problems ranging from career concerns to more severe psychological disorders.

Social Work

Professional social work had its origin in a voluntary association that undertook to criticize and reform the class of institutions known as "charities and correction" (Trattner, 1974). Around 1880 this group sought to improve the administration of private charities but also became interested in the work of public agencies. During this period social work, which was termed philanthropology, focused on institutions that were supposed to help the "dependent, defective, and delinquent".

The Settlement House Movement at the end of the nineteenth century was considered a major movement. The goal was to bring together the privileged and the under-

privileged to overcome the effects of social disintegration. It was hoped that new Americans could live among well-educated persons in the hopes of making good citizens. The Settlement House movement failed to look at the functioning level of applicants and assumed adequate functioning. When difficulty arose it was viewed as a deficit in society that needed correction. At the same time, the Charity Organization Societies viewed society as well functioning and the families as malfunctioning. They used a system to screen applicants that was very similar to present day casework. While the Settlement House Movement and the Charity Organization Societies differed, both were instrumental in the development of the profession of social work which focused on individual and family needs.

In the early 1900's social reform was occurring in several different areas (Cohen, 1958). Farmers were moving to urban areas and trying to adjust to urban life, women and children were entering the work force, and the economy was unstable. Social workers were needed during this period to encourage and assist with necessary social reform. The Depression was a time in which social workers were needed to aid in family relief because of the unemployment crisis. This began in the voluntary sector but was taken over by government when it was felt that relief recipients needed money, not service. Social workers began to debate the role of relief and relief recipients, as well as public versus private welfare. The enactment of the Social Security Act in 1934 established

the dominance of public welfare.

The charity organizations and settlements were changing and were becoming organized and professional. Paid workers and social workers replaced volunteers. Supervision of employees was occurring and supervisors were accountable for the successful operation of professional employees. By 1930 social work placed less emphasis on social reform and began to focus on family dynamics and individual personality development.

According to Trattner (1974) the concept of individualized casework became popular during the early 1900's. Using this approach it became essential to gather information about clients, their family and associations, as well as information about laws and agencies. Caseworkers were intrigued with Freud's ideas during the 1920's and incorporated the concept of therapy with their clients. During the Depression and the war years, social workers had the opportunity to use their new-found therapeutic skills as well as their casework skills.

In 1934 the National Conference of Social Work was emphasizing the issues of employment, health, and justice. By 1936 the focus was on social work methodology, social agency administration, and social work education. This was viewed as a move toward increased professionalism. In the 1940's and 1950's, social workers became interested in increasing their therapeutic techniques and developing casework skills rather than focusing on the expansion of public services. Because the Social Security Act of 1934

provided citizens with public assistance, social workers were able to focus on individuals needing psychological assistance. Self supporting individuals and families also turned to social workers during the war years and many social workers entered private practice. Because of this, social workers were finding their work more financially rewarding, were enjoying a different type of clientele, and were diverting their attention from social issues (Cohen, 1958; Trattner, 1974).

The movement from social reform did not go without an uneasy feeling from some prominant members of the social work profession. When Benjamin Youngdahl retired as president of the American Association of Social Workers in 1953, he stated that social workers seemed to be limiting their work to the treatment of pathologies rather than addressing prevention. Social workers, as well as Americans in general, seemed to feel that most Americans were prosperous and that poverty was vanishing. It was not until the early 1960's that his view began to change. The civil rights movement made the nation aware of the poor and the changes within society that needed to be made. In 1964 President Johnson declared a war on poverty and established the Office of Economic Opportunity. By the end of the 1960's social work was again beginning to focus on reform. Most social workers at this time viewed themselves primarily as clinicians but acknowledged the importance of social reform.

Schools of social work began recruiting students from

disadvantaged segments of society during the late 1960's. They also began changing curricula to emphasize social policy, public administration, group work, and community organization. The Council on Social Work Education required that curricula be designed to enable graduates to participate in the making of social policy. The importance of an activist role in social change through community organization was recognized during the 1960's (Rothman, 1985).

Professional organizations also placed social problems on the public agenda. The National Association of Social Workers paid a lobbyist to press politial leaders to effectively deal with social problems. Members' responsibility for social action was stressed and research was being conducted and used in the development of social policy.

The history of social work indicates a broadening of public response to social issues (Trattner, 1974). As America grew and social values changed, responsibility for social welfare shifted from local governments to include state governments, and finally, the federal government. While social workers took a break from emphasizing social reform during the 1940's and 1950's, their role as instruments in social change has become increasingly emphasized.

The number of full-time enrollments in master's of social work programs increased every year between 1955 and 1978. In addition, the number of students obtaining

master's degrees has been larger than the number of students obtaining baccalaureate degrees since 1982 (Hidalgo & Spaulding, 1987). Doctoral programs in social work exist but attendance has been consistently low. The standard for social work currently seems to be at the master's level; however, schools of social work are encouraging the doctoral degree for faculty.

Today the roles of the social worker are seen to consist of casework and therapy as well as participation in social programming and change. Psychiatric social work places more emphasis on the therapeutic aspects of this profession.

Training Requirements for Psychiatrists, Clinical Psychologists, Counseling Psychologists, and Social Workers

The professions previously discussed all provide therapy as a speciality area within their respective fields. Although the lines of differentiation are becoming increasingly blurred among these professionals, differences remain in terms of training and specialized skills. An important similarity is supervised practicum experiences that occur with all four of the discussed professions.

All psychiatrists are physicians who, at a minimum, have an M.D. degree. Most psychiatrists today have also completed a training program in psychiatry. This encompasses a three-year residency at an accredited psychiatric setting. Training focuses on psychiatic nosology, psychopathology, techniques of interviewing,

special diagnostic procedures, medical therapy, and principles of psychotherapy.

The clinical psychologist generally has a Ph.D. in psychology. The degree typically includes four years of graduate education followed by a one year internship. Training includes both didactic instruction and supervised clinical experience. The clinical psychologist is considered to be the most specialized diagnostician of the four professions with competence in selecting, administering, scoring, interpreting, and integrating a variety of diagnostic tests.

The counseling psychologist also has a Ph.D. or Ed.D. in psychology. The degree typically includes four years of graduate education followed by a one year internship in a counseling facility. Training is very similar to the clinical psychologist and includes both didactic instruction and supervised counseling experience. Counseling psychologists receive training in vocational counseling which differentiates that profession from the others.

Practicing social workers may have a bachelor's, master's, or doctoral degree in social work. At the present time more social workers are obtaining master's degrees than bachelor's degrees. Very few social workers pursue a doctoral degree. Undergraduate training focuses on didactic instruction and practicum experiences. Graduate training focuses on didactic instruction and intensive field work experience. Social worker's have

knowledge of city, county, and state welfare agencies as well as their personnel and services offered, which makes them unique from the other professionals discussed.

Factors Influencing the Perception of Therapeutic Process and Outcome

Fee Charged by the Therapist

One factor that has been thought to influence the therapeutic process is the fee charged by the therapist. Trautt and Bloom (1982) examined the effects of fee on credibility and attraction. Using two levels of the fee factor, high fee ($40) and low fee ($15), they found that subjects were significantly more willing to seek assistance when a low fee was charged. Bloom, Schroeder, & Babineau (1981) unexpectedly found that a therapist's high fee seemed to attenuate the subjects' impressions of credibility. The subjects in the high fee condition consistently rated the therapist as having low credibility. Subich and Hardin (1985) asked subjects about their willingness to seek counseling under four different fee conditions: 1) no fee, 2) a $5 fee, 3) a $5 fee for students, $25 fee for nonstudents, and 4) a $25 fee. No differences in willingness to seek counseling with regard to the fee condition were found between any of the groups in this study.

All three of these studies yielded results which are contrary to the commonly held belief that clients are more motivated towards therapy if they make a monetary commitment.

Level of Training

Another factor which has been studied for its effect on the therapeutic process is the level of training of the therapist. Spiegel (1976) found that expert credentials, represented by a high level of training, are an essential component of perceived counselor competence. Dell and Schmidt (1976) found that the level of counselor training/experience did not have any significant effects on ratings of counselor performance. In a related study, Bloom et al. (1981) found that excellent training and credentials were more indicative of a qualified therapist than androgyny, reputation, or fee. Bernstein and Lecomte (1982) compared pre-counseling expectancies of beginning master's students, ending master's students, and practicing professionals. They found that ending student therapists were more optimistic about client outcomes than professional therapists.

Gender of the Therapist

Gender of the therapist is another factor that has been examined in the therapeutic process. Looking at therapists' pre-counseling expectancies along diagnostic, prognostic, and process dimensions, Bernstein and Lecomte (1982) found that therapist gender was more important than client gender. Specifically, the results indicated that male therapists expected to be more directive and anticipated greater client need than did female therapists. Heppner and Pew (1977) conducted a study in which subjects were met by either a male or female counselor and were

presented with identical information. They found that the gender of the counselor did not produce any significant differences in the perceptions of counselor expertise. Simon (1973) examined the factors of age and sex and had subjects rank the following therapists according to which they would most prefer to consult: 1) a 25-year-old female, 2) a 25-year-old male, 3) a 40-year-old male, 4) a 40-year-old female, 5) a 55-year-old male, and 6) a 55-year-old female. It was found that male therapists were generally preferred over female therapists and that 40-year-old therapists were preferred to 25-year-old therapists.

Client-Therapist Similarity

It has frequently been assumed that a client is more likely to view a therapist as helpful when the client and therapist have similar attitudes. Aronson, Turner, & Carlsmith (1963) found that highly credible communicators have greater influence if they are dissimilar to their clientele, whereas communicators with low credibility produced the opposite effect. Butler, Johnson, Neville, Elkin, & Jobe (1975) found results contrary to the Aronson et al. (1963) study. Their results indicated that therapists of low credibility were most likely to give higher improvement ratings to inpatients than high credibility therapists when the initial patient-therapist similarity became greater. They concluded that it is reasonable to assume that similarity and other variables that affect attitude change may affect perceived

credibility and, in turn, affect therapeutic outcome. Spiegal (1976) looked at client-therapist similarity and found similarity to be much less important in a counseling relationship than perceived expertness, which was defined as experience and training.

Therapist Expertness

Expertness is a quality that has frequently been examined for its effect on the therapeutic relationship. Expertness has been defined and measured in many different ways. Heppner and Pew (1977) examined the effects of counselor expertness as determined by degrees and certificates. Counselor credibility was found to be significantly enhanced by the presence of visual evidence of competence, such as diplomas, awards, and certificates. Barak and LaCrosse (1975) presented support for the idea that expertness and trustworthiness are highly related and may belong to the dimension of credibility.

Use of Professional Jargon and Prestigious Introductions

Atkinson and Carskaddon (1975) examined the level of professional jargon used by a counselor and the use of a prestigious introduction on the rating of a counselor's performance. They found that subjects saw the counselor as more credible if he was introduced as a highly prestigious professional who used highly abstract professional jargon rather than laymen's terminology. Strong and Schmidt (1970) found that a prestigious introduction alone did not produce a significant effect on subjects self ratings of achievement motivation. However, when a prestigious

introduction was combined with an expert role portrayed by the therapist, subjects were more likely to have increased achievement motivation.

Effects of Professional Training on the Perception of Therapeutic Process and Outcome

Bernstein and Lecomte (1982) examined counselor's, psycholgist's, and social worker's pre-counseling expectancies regarding either a male or female client description. Professionals in each of the three fields were sent a packet of materials which included a background questionnaire, a male or female client description which contained identical information, and a Therapist Expectancey Inventory (Bernstein, Lecomte, and DesHarnais, 1980). The therapists were asked in the inventory to rate pre-counseling expectancies for the described client in the areas of therapist directiveness, therapist expectancies for client outcomes, and expectancies for client need. The only area in which differences among the professions was apparent was in therapist expectancies for interpretation. The counselors were found to differ most from the social workers by having greater expectancies for offering interpretations. Psychologists rated themselves between counselors and social workers.

While it is interesting to see how the different professions view themselves in regard to pre-counseling expectancies, it is difficult to generalize the results of this study to all counseling situations since the data for

this study were based on only one client description. It would have been interesting to see how the three professions would rate each other.

Simon (1973) asked 169 subjects to assume they had a personal problem and asked them to respond as they would in real life. The subjects, who were all college students, rank ordered six highly recommended therapists on the basis of with whom they would most prefer to consult. The only differences among the therapists that subjects were aware of were their professional titles. The titles that the subjects were asked to rank were: behavioral consultant, emotional counselor, psychiatrist, psychoanalyst, psychologist, and social worker. Psychiatrists and psychologists were ranked the highest and social workers were ranked the lowest. It seems unclear what these results indicate, mainly because the reasoning behind the ranking is not known. No information was provided on the personal problems of the subjects, so it is difficult to determine how this may have influenced the choice of therapist. It also would have been helpful to have subjects rate the therapists on several aspects of performance to more clearly distinguish the differences among the professions. It also seems as though the titles behavioral consultant, emotional counselor, and psychoanalyst are rather vague, especially in regard to the type of degree required and the therapuetic techniques they would employ. Perhaps this is why these three titles were rated very similarly in the overall ranking, ranking in the

middle rather than at either extreme.

Trautt and Bloom (1982) examined the effects of fee and professional title on credibility and attraction. Subjects were presented descriptions that had identical content except for the level of fee, high vs low, and the title of the therapist. The titles used in this study were psychiatrist, clinical psychologist, and counselor. The subjects were told that the descriptions of mental health professionals were being evaluated in order to determine if they portrayed helpful and accurate descriptions to assist clients in selecting a therapist. Subjects then rated the individual in the description using a credibility questionnaire developed by Berlo, Lemert, and Mertz (1970) and the Personal Feelings Scale (Byrne, 1971) which measures attraction. In addition, subjects were asked if they would recommend this therapist to a friend, and to what extent they would be willing to seek therapy from this therapist.

The results indicated that overall, the psychiatrist was rated significantly higher than the clinical psychologist on all the dependent measures. The counselor was rated between the psychiatrist and the clinical psychologist, but was not significantly different from either profession.

It seems difficult to draw conclusions from this study for several reasons. First, professional title was not examined as an isolated variable, but rather was looked at within a fee group. Because level of fee was also being

manipulated in the descriptions, its effects on professional title are unknown, and cannot be ignored.

Another reason for the difficultly in making assumptions is that the term doctor was used in each description. Subjects frequently reported that the therapist must be highly qualified because he was a doctor. This may have elevated responses and narrowed the differences between professions. This study also used introductory psychology students for subjects making it difficult to generalize the results to another population.

Gelso and Karl (1974) compared college students' perceptions of three conseling titles (high school counselor, college counselor, and counseling psychologist) with each other and with the titles advisor, psychiatrist, and clinical psychologist. Students completed a questionnaire by Strong, Hendel, and Bratton (1971) that contained 100 adjectives describing personal characteristics and nine problem topics. Each student completed a questionnaire for only one of the six titles. The students rated how well each of the 100 adjectives described the "role person" on a 5-point scale ranging from 1) not at all descriptive, to 5) very descriptive. They also rated how likely they would be to discuss each of nine problems with the "role person". This ranged from 1) very unlikely, to 5) very probably.

The results indicated that more differences were apparent among the three counseling specialties than between counseling psychologists and either clinical

psychologists or psychiatrists. Counseling psychologists differed from psychiatrists on the adjective list only as being more casual. Counseling psychologists were seen as more knowledgeable, inquistive, and analytic than high school and college counselors. Since college counselors frequently are counseling psychologists, the authors concluded that it may be more desirable for them to use the label counseling psychologist.

The questionnaires in this study were given to introductory psychology students during their first class of the semester. While it seems useful to use relatively unsophisticated subjects, it is also possible that these subjects had unequal knowledge about the various professions. Since the subjects were not presented with any background information or a particular stimulus, they rated the professions solely on the basis of pre-set attitudes or perceptions they had. The results seemed to indicate that the subjects did, in fact, have unequal knowledge about the various professions and perhaps this could have been controlled. For instance, the subjects were significantly more likely to discuss personal concerns with psychiatrists than college counselors, advisors, and high school counselors, indicating that they were probably quite knowledgeable about the role of a psychiatrist. However, the counseling professions were not rated as being more helpful in dealing with occupational choice and academic difficulty. Since vocational guidance is considered a speciality area within the counseling field it

seems reasonable to expect subjects to rate the counseling professions higher in these areas. Because this did not occur, the subjects' level of knowledge about each of the various professions and, therefore, the results of this study, seem difficult to generalize.

Granger (1959) selected 20 job titles as representative of the field of psychology and asked an APA sample to rank order the 20 titles according to occupational prestige. The results indicated that each subgroup within APA tended to upgrade from one to three ranks the status of the titles with which the groups' members were most closely identified. The clinical and counseling diplomates, the social associates, and the school psychologists had a tendency to upgrade the status of service-oriented titles. It was also found that the titles academic-scientific and research-oriented were upgraded most by the experimental psychologists. The ranking of counseling psychologists was especially interesting. The counseling diplomates ranked this title fourth; however, overall it was seventh. Granger (1959) concluded that there are different prestige levels within the field of psychology and that there is a high degree of agreement among these discriminations.

The results of this study did indicate some very clear discriminations, however, including discriminations based on education level. Education requirements were listed with each job title and these requirements clearly affected the rankings. The first nine positions required Ph.D.'s, the next eight required M.A.'s, and the last three required

B.A.'s. The effects of these educational requirements should not be overlooked.

While this study looked at pre-set perceptions, it did not include any stimulus which the subjects could evaluate. This would have been difficult to incorporate with such diverse speciality areas, but it would have placed all the various titles in equal standing before being evaluated.

This study is almost 30 years old and it is unknown whether a similar study has since been conducted. It seems reasonable to believe that perceptions have changed since this study was done.

Summary

A review of the literature indicates that much research has been conducted to examine factors which influence client perceptions of therapists. While several factors have been investigated, only a few studies have looked at the factor of professional title. Only one study was found that solely examined professional title (Simon, 1973) and this study lacked descriptive data. However, the research that has been conducted indicates that clients may have different therapeutic perceptions based on the professional title of their therapist.

No studies were found that examined the perceptions of various mental health professionals about each other. Granger (1959) examined the perceptions of psychologists regarding the speciality areas within psychology. He found distinct discriminations and a tendency for each area to

upgrade their own ranking. It seems essential to know not only how therapists are perceived by clients but, also, how they are perceived by other therapists with different professional backgrounds. The present study examined this issue by comparing the perceptions of students in counseling, clinical psychology, and social work regarding the performances of counseling psychologists, psychiatrists, clinical psychologists, and social workers.

CHAPTER II

METHODOLOGY

Statement of the Problem

At the present time there is little research that examines the effects of professional title in a therapeutic relationship. In particular, there is a lack of research on how therapists with different professional titles perceive themselves and each other. This study used students training to be counselors, clinical psychologists, and social workers, and compared their ratings of one therapist whom they believed to be either of their own profession or of a related mental health profession. The study was designed to reveal selective perceptions of students in counseling, clinical psychology, and social work towards counseling psychologists, psychiatrists, clinical psychologists, and social workers.

Hypotheses

The following hypotheses were tested:

1. There are no significant differences in perceptions of therapeutic performance provided by subjects from the three different training backgrounds.

2. There are no significant differences in perceptions of therapeutic performance across the four professional titles by subjects from the three different training backgrounds.backgrounds.

Subjects

The research population included students from counseling, clinical psychology, and social work classes at the University of North Dakota in Grand Forks, North Dakota. Three nonrandom samples were comprised from the students in the programs of counseling, clinical psychology, and social work.

Students for the counseling sample were obtained from a practicum class and a counseling methods course. The counseling sample was composed of two seniors and 36 first and second year graduate students. Thirty-four of these students were pursuing a master's degree in counseling. Four of these students were either school or medical personnel who were enrolled in the counseling methods course because of their interest in counseling. Twenty-seven of the counseling subjects were women and 11 were men.

Students for the clinical psychology sample were obtained by placing sign-up sheets in the psychology graduate lounge and by personally inviting students to participate in the study. Students in this sample were pursuing either a master's degree or a Ph.D. in clinical psychology. Nine of the students were first year

students, nine were second year students, four were third year students, six were fourth year students, and three were beyond fourth year students. Twenty-two of the clinical psychology students were women and nine were men.

Students for the social work sample were obtained by using a sign-up sheet that was distributed by faculty in the social work department. The faculty encouraged students who had practicum experience to sign-up for the study. The social work sample was composed of one sophmore, 20 juniors, and 13 seniors. Twenty-eight of the social work students were women and six were men.

TABLE 1

SUBJECT'S YEAR IN SCHOOL

Year in School	Frequency	Percent
Sophmore	1	1.0
Junior	20	19.4
Senior	15	14.6
First year graduate student	28	27.2
Second year graduate student	26	25.2
Third year graduate student	4	3.9
Fourth year graduate student	6	5.8
Beyond fourth year student	3	2.9
Total	103	100.0

As listed in Table 1, a total of 103 students were used in the study: Thirty-eight from counseling, 31 from clinical psychology, and 34 from social work. Twenty six students were men and 77 were women. The subjects ranged in age from 20 to 53 with a mean age of 29.

Forty percent of the subjects reported that they had received therapy. Some of the subjects received more than one form of therapy and several subjects noted that they had both satisfactory and unsatisfactory therapy experiences. Table 2 shows a breakdown of previous therapy experience by subjects' training background.

TABLE 2

PREVIOUS THERAPY/COUNSELING EXPERIENCE
BY SUBJECTS' TRAINING BACKGROUND

Training Program	Total	Type of Therapy/ Counseling				Satisfied?		
		P	C	M	F	Yes	No	Both
Counseling	16	14	4	4	1	11	2	3
Clinical Psychology	8	6	1	0	1	6	1	1
Social Work	15	13	1	2	0	10	4	1
Total	39	33	6	6	2	27	7	5

P=Personal, C=Career, M=Marital, F=Family

Design of the Study

This study used a 3 x 4 factorial design. Subjects were grouped according to their academic majors and then randomly assigned to one of the four treatment groups. The treatment groups were differentiated by four written therapist descriptions (See Appendices A, B, C, and D) in which the only difference was the professional title of the therapist. The four professional titles were: 1) counseling psychologist, 2) psychiatrist, 3) clinical psychologist, and 4) social worker. The descriptions were arranged so that the four different versions were given randomly to the subjects and subjects were under the assumption that they were all receiving the same material. All subjects viewed a 20 minute videotape of a therapy session. The dependent variable was the rating of therapy performance on two rating instruments.

Stimulus Materials

All subjects viewed the same 20 minute videotape of a therapy session. The male therapist and the female client were unknown to the subjects. The client presented the problem of depression.

Before viewing the videotape, the subjects read one of the four written therapist descriptions. The description was identical for all subjects with the exception of the professional title of the therapist. The subjects also read a written description of the client that described her background leading to the videotaped session (See Appendix E).

Instruments

Two measures of therapist performance were used in this study. After watching the videotaped therapy session, the subjects completed the two rating forms. The two measures used were the Counselor Evaluation Rating Scale (CERS) and the Counselor Rating Form (CRF).

The CERS was developed by Myrick and Kelly (1971) as an instrument for assessing trainees' performance in counseling and supervision. Only the items pertaining to counseling performance were used for this study (See Appendix F). This revised instrument contains thirteen items scored on a six point scale ranging from strongly agree to strongly disagree. Newman (1985) reported a split-half reliability coefficient of .95 and a test-retest reliability over a four week period of .94 on these thirteen items.

The CRF, developed by Barak and LaCrosse (1976), is used to assess counselor expertness, counselor attractiveness, and counselor trustworthiness (See Appendix G). The total scale consists of 36 pairs of bipolar adjectives which are rated along a 7-point scale. Each subscale consists of 12 pairs of adjectives which are rated along a 7-point scale. Split-half reliability for the three scales were reported as follows: counselor expertness, .85; counselor attractiveness, .87; and, counselor trust-worthiness, .91 (LaCrosse & Barak, 1976). According to Ponterotto and Furlong (1985), the CRF is considered reliable and has some validity evidence within

framework of the social influence model.

Both the CERS and the CRF contain the word "counselor" which could have caused biases or misperceptions among the subjects. Therefore, the word "counselor" was changed to "therapist" on the rating forms.

Experimental Procedures

The materials were presented to groups of subjects with a supervisor present to provide standardized instructions, obtain informed consent (See Appendix H), and answer any questions. Each subject received a written therapist description, a written client dsciption, a demographic sheet (See Appendix I), and the two rating instruments. The therapist descriptions were randomly arranged. After reading the therapist and client desciptions, subjects viewed the videotape and then completed a demographic sheet and the two rating instruments.

Demographic data consisted of age, sex, year in school, and whether or not the subject had been in therapy. Previous therapy experience was categorized as personal, career, or family. Subjects were also asked to indicate whether they were satisfied or dissatisfied with the therapy they received. After all forms were completed, the supervisor collected them and dismissed the subjects.

Statistical analysis consisted of analysis of variance on a 3 x 4 design. The Student-Newman-Keuls range test was used to analyze significant main effects.

CHAPTER III

RESULTS

This study examined the perceptions of students training to be counselors, clinical psychologists, and social workers regarding the professional titles of counseling psychologist, psychiatrist, clinical psychologist, and social worker.

The following hypotheses were tested:

1. There are no significant differences in perceptions of therapeutic performance provided by subjects from the three different training backgrounds.
2. There are no significant differences in perceptions of therapeutic performance across the four professional titles by subjects from the three different training backgrounds.
3. There are no significant interactions between the professional titles of therapists and subjects from the three different training backgrounds.

A 3 x 4 analysis of variance was performed on the dependent measures. The results of this analysis are presented for each dependent measure in Tables 3 through 7.

TABLE 3

ANALYSIS OF VARIANCE FOR COUNSELOR EVALUATION RATING SCALE

Source of Variance	Sum of Squares	DF	Mean Square	F Ratio	Significance of F-Ratio
Training Program	2.06	2	1.03	1.73	0.18
Professional Title	2.44	3	0.81	1.37	0.26
Training Program x Professional Title	3.77	6	0.63	1.06	0.04

The CERS did not yield any significant results regarding training program, professional title, or the interaction of training program and professional title.

TABLE 4

ANALYSIS OF VARIANCE FOR COUNSELOR RATING FORM - TOTAL

Source of Variance	Sum of Squares	DF	Mean Square	F Ratio	Significance of F-Ratio
Training Program	6.56	2	3.28	3.72	0.03
Professional Title	1.32	3	0.44	0.50	0.68
Training Program x Professional Title	2.93	6	0.49	0.54	0.77

The CRF total scale yielded a significant main effect with regard to training program. No significant results were found with regard to professional title or the interaction of training program and professional title.

TABLE 5

ANALYSIS OF VARIANCE FOR RATING FORM - EXPERTNESS

Source of Variance	Sum of Squares	DF	Mean Square	F Ratio	Significance of F-Ratio
Training Program	7.68	2	3.84	3.88	0.02
Professional Title	1.07	3	0.36	0.36	0.78
Training Program x Professional Title	5.52	6	0.92	0.93	0.48

The CRF scale of expertness yielded a significant main effect with regard to training program. No significant results were found regarding professional title or the interaction of training program and professional title.

TABLE 6

ANALYSIS OF VARIANCE FOR COUNSELOR RATING FORM-ATTRACTIVENESS

Source of Variance	Sum of Squares	DF	Mean Square	F Ratio	Significance of F-Ratio
Training Program	9.43	2	4.72	3.95	0.02
Professional Title	2.01	3	0.67	0.36	0.64
Training Program x Professional Title	3.10	6	0.52	0.43	0.86

The CRF scale of attractiveness yielded a significant main effect with regard to training program. No significant results were found regarding professional title or the interaction of training program and professional title.

TABLE 7

ANALYSIS OF VARIANCE FOR COUNSELOR RATING FORM-TRUSTWORTHINESS

Source of Variance	Sum of Squares	DF	Mean Square	F Ratio	Significance of F-Ratio
Training Program	4.44	2	2.22	2.43	0.09
Professional Title	1.79	3	0.60	0.66	0.58
Training Program x Professional Title	3.65	6	0.61	0.67	0.67

The CRF scale of trustworthiness did not yield any significant results with regard to training program, professional title, or the interaction of training program and professional title.

The CRF total scale, CRF scale of expertness, and the CRF scale of attractiveness yielded a significant main effect at the .05 level with regard to training program, leading to the rejection of hypothesis one. The Student-Newman-Keuls range test was used to analyze these main effects shown in Table 8.

TABLE 8

STUDENT-NEWMAN-KEULS RANGE TEST FOR MAIN EFFECTS

Measure of Performance	Training Program	Mean	SD	Difference at .05 level
CRF - Total				
	Counseling (C)	4.36	.95	
	Clinical Psych(CP)	4.84	.73	C/CP
	Social Work (SW)	4.92	1.03	C/SW
CFR - Expertness				
	Counseling	4.80	.93	
	Social Work	5.28	1.14	C/SW
	Clinical Psych	5.43	.85	C/CP
CFR - Attractiveness				
	Counseling	3.60	1.15	
	Clinical Psych	4.09	.92	
	Social Work	4.30	1.09	C/SW

As indicated in Table 8, on the CRF total scale and the CRF scale of expertness, clinical psychology students and social work students rated the therapist significantly higher than did the counseling students. In addition, social work students rated the therapist as being significantly more attractive than did the counseling students.

Hypothesis two looked at the perception of therapeutic performance across the four professional titles. The main effect for professional titles was not significant at the .05 level, failing to reject hypothesis two.

The analysis of variance did not yield any significant interactions between the professional titles of therapists

and subjects from the three taining backgrounds. These results failed to reject hypothesis three.

An inspection of the raw data indicated that clinical psychology students tended to rate the profession of clinical psychology higher than the other professions on each scale. However, as noted, mean differences were not significant.

Overall, the results indicated that subjects perceptions about the various professional titles were not related to their rating of the therapist's performance. Even though there was no interaction with professional title, the results did indicate significant differences in the perceptions of therapist performance attributed to training background.

CHAPTER IV

DISCUSSION

Summary of Results

This study was designed to examine the influence of professional titles on perceptions of therapist performance by students training to be counselors, clinical psychologists, and social workers. Subjects were grouped according to their training program and then randomly assigned to one of four treatment groups which were differentiated by the professional titles of counseling psychologist, psychiatrist, clinical psychologist, and social worker. Subjects viewed a videotaped therapy session and then rated the therapist's performance using two instruments: the Counselor Evaluation Rating Scale (CERS) and the Counselor Rating Form (CRF), from which a total score and three subscales were used. Analysis of variance was conducted on a 3 x 4 design. Significant main effect analyses indicated that on the CRF total scale and CRF scale of expertness, clinical psychology students and social work students rated the therapist higher than did the counseling students. In addition, social work students rated the therapist as being significantly more attractive than did the counseling students. The above significant

results were from the CRF; no significant results were found using the CERS.

Discussion

Differences in the perception of therapeutic performance were found among the three training backgrounds. Insofar as clinical psychology and social work students rated the therapist significantly higher on the CRF total scale and scale of expertness, it is likely that different professions view the therapy process differently or that different training programs focus on different skills. Social work students tended to rate performance higher than the counseling and clinical psychology students. Because of their lack of therapeutic experience they may have been less likely to recognize therapeutic skills, and therefore, attended to the videotape in a less critical manner. Students generally become more critical evaluators with experience and this seems to be reflected in these results. The counseling students were the most critical evaluators and this may be attributed to the courses they were taking while participating in this study. The counseling subjects were taking either Counseling Methods or Counseling Practicum at the time of their participation. Both these courses place emphasis on counseling skills and, therefore, these subjects may have been more familiar with specific therapeutic skills than were the clinical psychology or social work subjects. While the clinical psychology

students in this study have the highest range of education, the majority were in their first two years of study and did not receive methods and practicum experiences similar to that of the counseling students. In terms of experience in recognizing therapeutic skills, the counseling students had the most exposure and the social work students had the least exposure. This may explain why the counseling students were the most critical and the social work students were the least critical.

In addition, the counseling students may have been more sensitive to the use of these counseling instruments. While the word "counseling" was not used on the rating instruments, terms were used that may have been more indicative of the counseling profession. This may have caused the counseling students to be more sensitive and, therefore, more critical.

The CERS did not yield any significant results. The reasons for this are unclear, but it is possible that the items were viewed as more complex as compared to the CRF items and that the subjects answered in a more vague sense. The subjects were required to read a sentence and rate it with regard to the therapist on the CERS. On the CRF subjects read two adjectives on a continuum and rated the therapist according to where they believed he ranked on the continuum. The CRF also contained a 7-point continuum while the CERS contained a 6-point rating system. These differences between the two instruments may have

contributed to the CRF yielding signficant results while no significance was found using the CERS.

In a related study Bernstein and Lecomte (1982) found that in regard to pre-counseling expectancies, counselors differed most from social workers by having greater expectancies for offering interpretations. Psychologists ranked between social workers and counselors. Since a skill such as interpretation is considered a more advanced skill, this supports the idea that training programs may focus on different skills and that therapeutic experience affects the ability to critically evaluate another therapist's performance.

While no significant interactions were found, clinical psychology students consistently rated the profession of clinical psychology higher than the other professions on each scale. Perhaps with different conditions, such as a larger sample or a sample consisting of professionals rather than students, the results would reflect significant differences. Granger (1959) found distinct discriminations among psychologists regarding the speciality areas within psychology. Specifically, he found a tendency for each area to upgrade their own ranking. The results of this study suggest the possibility of this occurrence.

In general, the results of this study are encouraging. The results indicate that students in counseling, clinical psychology, and social work are able to rate therapeutic performance quite objectively, not being influenced by the professional titles of counseling, psychiatry, clinical

psychology, and social work. Since mental health professionals frequently work together and often convey their attitudes to clients, it is encouraging to see acceptance of related professionals.

A main limitation of this study is that the subjects were not professionals working in their respective fields. The three training groups used for this study are rather isolated from each other and have little oportunity to interact. In the mental health profession, there are frequently exchanges between various professionals and a greater familiarity with other related professions. The subjects used in this study may not have had enough experience to make assumptions about different professions. While it is interesting to see the perceptions of students in training, their perceptions are probably not as formulated as professionals in the field. There is merit in studying the perceptions of professionals who have completed their programs and are practicing in their chosen professions.

Another limitation is the varying level of training among the subjects. The social work students were all undergraduates, the counseling students were mainly first or second year graduate students, and the clinical psychology students ranged from first year graduate students to beyond their fourth year. Ideally, it would be advantageous to have subjects with relatively equivalant levels of training. As previously mentioned, this difference seemed to influence the manner in which the

subjects evaluated the therapist's performance.

This study was also limited by the fact that only students from one institution were used. It is possible that perceptions differ with geographical location and incorporating this factor into the study would greatly enhance the results.

It also would have been interesting to have the subjects measure the credibility of the therapist. While some of the questions addressed this issue, this study did not have a specific subscale that measured credibility. Credibility seems to be an important qualification for a therapist and it would be helpful to determine if there are any perceptions affecting it.

Generalizing the results of this study beyond University of North Dakota students in counseling, clinical psychology, and social work is difficult. If this study were replicated, it is recommended that the sample include a large group of mental health professionals from diverse geographical locations. This would seem to more accurately address the original issue which precipitated this study.

Conclusion

Therapists are a diverse group, coming from several different training programs. Despite a common goal to help clients, professional titles differ, along with training, and this may influence how a therapist is perceived. This study examined whether perceptions regarding professional title influenced ratings of therapist performance in

students training to be therapists. The results of this study indicate that rating of therapy performance is not influenced by professional title. Differences in the perceptions of therapist performance were found to be attributed to subjects' training background. Furthur research in this area is strongly recommended.

APPENDICES

APPENDIX A

DESCRIPTION OF COUNSELING PSYCHOLOGIST

THERAPIST DESCRIPTION

The therapist in the videotape is Dr. Robert Garber. Dr. Garber is a counseling psychologist who obtained his degree from the University of Connecticut in 1978. In May of 1978 Dr. Garber began working with mentally ill adults and children at Augusta Mental Health Institute in Augusta, Maine. At Augusta he worked primarily with inpatients, but also saw outpatients and did community outreach work. Dr. Garber's experience during this time included; individual therapy, family therapy, group therapy, testing, and diagnosis. In September of 1981 Dr. Garber moved to Bangor, Maine to begin a position as a couples and family therapist with a community mental health center. At this time Dr. Garber also began his own private practice focusing on individual therapy. By October of 1983, Dr. Garber's practice had grown substantially and he decided to leave his position at the mental health center to pursue his private practice full time. Dr. Garber has continued to work as an independent practitioner and currently specializes in individual therapy, but also does groups, couples therapy, and family therapy.

APPENDIX B

DESCRIPTION OF PSYCHIATRIST

THERAPIST DESCRIPTION

The therapist in the videotape is Dr. Robert Garber. Dr. Garber is a psychiatrist who obtained his degree from the University of Connecticut in 1978. In May of 1978 Dr. Garber began working with mentally ill adults and children at Augusta Mental Health Institute in Augusta, Maine. At Augusta he worked primarily with inpatients, but also saw outpatients and did community outreach work. Dr. Garber's experience during this time included; individual therapy, family therapy, group therapy, testing, and diagnosis. In September of 1981 Dr. Garber moved to Bangor, Maine to begin a position as a couples and family therapist with a community mental health center. At this time Dr. Garber also began his own private practice focusing on individual therapy. By October of 1983, Dr. Garber's practice had grown substantially and he decided to leave his position at the mental health center to pursue his private practice full time. Dr. Garber has continued to work as an independent practitioner and currently specializes in individual therapy, but also does groups, couples therapy, and family therapy.

APPENDIX C

DESCRIPTION OF CLINICAL PSYCHOLOGIST

THERAPIST DESCRIPTION

The therapist in the videotape is Dr. Robert Garber. Dr. Garber is a clinical psychologist who obtained his degree from the University of Connecticut in 1978. In May of 1978 Dr. Garber began working with mentally ill adults and children at Augusta Mental Health Institute in Augusta, Maine. At Augusta he worked primarily with inpatients, but also saw outpatients and did community outreach work. Dr. Garber's experience during this time included; individual therapy, family therapy, group therapy, testing, and diagnosis. In September of 1981 Dr. Garber moved to Bangor, Maine to begin a position as a couples and family therapist with a community mental health center. At this time Dr. Garber also began his own private practice focusing on individual therapy. By October of 1983, Dr. Garber's practice had grown substantially and he decided to leave his position at the mental health center to pursue his private practice full time. Dr. Garber has continued to work as an independent practitioner and currently specializes in individual therapy, but also does groups, couples therapy, and family therapy.

APPENDIX D

DESCRIPTION OF SOCIAL WORKER

THERAPIST DESCRIPTION

The therapist in the videotape is Dr. Robert Garber. Dr. Garber is a social worker who obtained his degree from the University of Connecticut in 1978. In May of 1978 Dr. Garber began working with mentally ill adults and children at Augusta Mental Health Institute in Augusta, Maine. At Augusta he worked primarily with inpatients, but also saw outpatients and did community outreach work. Dr. Garber's experience during this time included; individual therapy, family therapy, group therapy, testing, and diagnosis. In September of 1981 Dr. Garber moved to Bangor, Maine to begin a position as a couples and family therapist with a community mental health center. At this time Dr. Garber also began his own private practice focusing on individual therapy. By October of 1983, Dr. Garber's practice had grown substantially and he decided to leave his position at the mental health center to pursue his private practice full time. Dr. Garber has continued to work as an independent practitioner and currently specializes in individual therapy, but also does groups, couples therapy, and family therapy.

APPENDIX E

CLIENT DESCRIPTION

CLIENT DESCRIPTION

The client in the videotape is a 22 year old graduate student majoring in biology. Sally recently moved to Maine to begin her graduate program. Her presenting problem was that she missed her boyfriend who she had been living with for two years. They separated because she came to graduate school in Maine and he returned to Boston to finish his undergraduate degree. Since school began four weeks ago, Sally has received very little communication from her boyfriend. She is concerned that he may be seeing somebody else or that he may be considering breaking up the relationship. Sally says that she is very dependent on him and does not want the relationship to end. Sally went to Boston to visit her boyfriend last weekend and she said that it did not go very well. She was looking for reassurance that their relationship was okay, but her boyfriend said he would like to have a little distance. Sally is very upset about this and is having a difficult time making it through the day without crying and becoming emotionally upset. Sally feels that she is so enmeshed in this relationship that she cannot see herself as a separate individual. She feels that she has a very poor self-image and she would like to work on gaining self-respect.

Sally describes her family as undependable and says that she is not very close to them. Sally describes her father as physically and verbally abusive, and her mother

as emotionally neglectful. Sally seems to realize that her emotional development has been stifled as a result of this. Sally has not allowed herself to feel the rejection by her father, even though she continues to carry this with her. It seems very likely that Sally is experiencing a fear of rejection from her boyfriend which is similar to the rejection she received from her father.

This is Sally's fourth session with Dr. Garber. Sally continues to be afraid that her boyfriend is rejecting her. She is having a difficult time completing her studies and she feels that she is not being accepted by the faculty in the biology department. Sally cries alot during the day and she now is thinking about quiting school in Maine and trying to get into a program in Boston so she can be closer to her boyfriend.

APPENDIX F

COUNSELOR EVALUATION RATING SCALE

COUNSELOR EVALUATION RATING SCALE

Below are listed some statements related to evaluating counseling performance. Please consider each statement with reference to your observations of the counselor. Mark each statement according to how strongly you agree or disagree.

	Strongly Agree	Agree	Slightly Agree	Slightly Disagree	Disagree	Strongly Disagree
1. Demonstrates an interest in client's problem.	1	2	3	4	5	6
2. Tends to approach client in a mechanical manner.	1	2	3	4	5	6
3. Tends to talk more than client during counseling.	1	2	3	4	5	6
4. Is sensitive to dynamics of self in counseling relationship.	1	2	3	4	5	6
5. Is genuinely relaxed and comfortable in the counseling relationship.	1	2	3	4	5	6
6. Is aware of both content and feeling in counseling session.	1	2	3	4	5	6
7. Tends to be rigid in counselor behavior.	1	2	3	4	5	6
8. Lectures and moralizes in counseling.	1	2	3	4	5	6
9. Can be spontaneous in counseling, yet behavior is relevant.	1	2	3	4	5	6

COUNSELOR EVALUATION RATING SCALE--(Continued)

	Strongly Agree	Agree	Slightly Agree	Slightly Disagree	Disagree	Strongly Disagree
10. Lacks self-confidence in establishing counseling relationship.	1	2	3	4	5	6
11. Can express thoughts and feelings clearly in counseling.	1	2	3	4	5	6
12. Verbal behavior in counseling is appropriately flexible and varied, according to the situation.	1	2	3	4	5	6
13. Applies a consistent rationale of human behavior to counseling.	1	2	3	4	5	6

APPENDIX G

COUNSELOR RATING FORM

COUNSELOR RATING FORM

Please circle the response which most accurately reflects your perceptions of the therapist's performance.

1.	Alert	7	6	5	4	3	2	1	Unalert
2.	Agreeable	7	6	5	4	3	2	1	Disagreeable
3.	Confidential	7	6	5	4	3	2	1	Revealing
4.	Analytic	7	6	5	4	3	2	1	Difuse
5.	Appreciative	7	6	5	4	3	2	1	Unappreciative
6.	Dependable	7	6	5	4	3	2	1	Undependable
7.	Clear	7	6	5	4	3	2	1	Vague
8.	Attractive	7	6	5	4	3	2	1	Unattractive
9.	Honest	7	6	5	4	3	2	1	Dishonest
10.	Confident	7	6	5	4	3	2	1	Unsure
11.	Casual	7	6	5	4	3	2	1	Formal
12.	Open	7	6	5	4	3	2	1	Closed
13.	Experienced	7	6	5	4	3	2	1	Inexperienced
14.	Cheerful	7	6	5	4	3	2	1	Depressed
15.	Reliable	7	6	5	4	3	2	1	Unreliable
16.	Expert	7	6	5	4	3	2	1	Inexpert
17.	Close	7	6	5	4	3	2	1	Distant
18.	Respectful	7	6	5	4	3	2	1	Disrespectful
19.	Informed	7	6	5	4	3	2	1	Ignorant
20.	Compatible	7	6	5	4	3	2	1	Incompatible
21.	Responsible	7	6	5	4	3	2	1	Irresponsible

22.	Insightful	7	6	5	4	3	2	1	Insightless
23.	Enthusiastic	7	6	5	4	3	2	1	Indifferent
24.	Selfless	7	6	5	4	3	2	1	Selfish
25.	Intelligent	7	6	5	4	3	2	1	Stupid
26.	Friendly	7	6	5	4	3	2	1	Unfriendly
27.	Sincere	7	6	5	4	3	2	1	Insincere
28.	Logical	7	6	5	4	3	2	1	Illlogical
29.	Likeable	7	6	5	4	3	2	1	Unlikeable
30.	Straightforward	7	6	5	4	3	2	1	Deceitful
31.	Prepared	7	6	5	4	3	2	1	Unprepared
32.	Sociable	7	6	5	4	3	2	1	Unsociable
33.	Trustworthy	7	6	5	4	3	2	1	Untrustworthy
34.	Skillful	7	6	5	4	3	2	1	Unskillful
35.	Warm	7	6	5	4	3	2	1	Cold
36.	Unbiased	7	6	5	4	3	2	1	Biased

APPENDIX H

CONSENT FORM

CONSENT FORM

You are invited to participate in a study designed to examine the therapeutic relationship as perceived by students training to be mental health professionals. Participation in this study involves a one hour session which includes reading a client and therapist description, watching a videotape of a therapy session, and completing two therapist rating forms and a personal data form. All information obtained in this study will remain confidential. Results of this study will be made available to subjects upon request. Please feel free to ask any questions you may have before the study begins.

I have read the above statement and willingly agree to participate in this study.

_____

Subjects Signature Date

_____

Witness Date

If you have any questions regarding this study, please contact Debra Anderson Bach at 207-866-7520.

APPENDIX I

PERSONAL DATA FORM

PERSONAL DATA FORM

1. Age: _____

2. Sex: Male Female (Circle one)

3. Year in school: _____Freshman
_____Sophmore
_____Junior
_____Senior
_____First year graduate student
_____Second year graduate student
_____Third year graduate student
_____Fourth year graduate student
_____Beyond fourth year graduate student

4. Have you ever been in therapy? _____Yes _____No

5. If yes, was it _____personal _____career _____marital

6. If yes, were you satisfied with the therapy you received? _____Yes _____No

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