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### Consumer preferences for mental health professionals: The effects of being informed

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CONSUMER PREFERENCES FOR MENTAL HEALTH PROFESSIONALS:  
THE EFFECTS OF BEING INFORMED

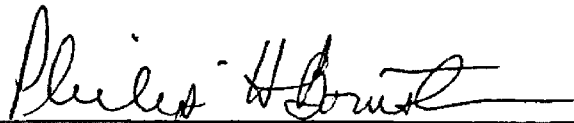
By


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B.A., University of Montana, 1981

Presented in partial fulfillment of the requirements for the degree of  
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1985

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Consumer Preferences for Mental Health Professionals: The Effects of Information (63 pp.)

Co-Director: Philip H. Bornstein, Ph.D. *PHB*  
Co-Director: Christine D. Isaacs, Ph.D. *CDI*

Consumer preferences for particular mental health professionals and the effects of training information were investigated. The subjects included 132 male and 132 female students enrolled in an introductory psychology class. All subjects were randomly assigned to either an information group or a no-information group. Each subject was provided with a series of three case history vignettes and was asked to assign a degree of preference for each of the professionals being used. Psychiatrists, clinical psychologists, and counselors were provided as the choices for each of the case history vignettes.

Results revealed significant differences in preference for professionals for the case history vignettes. Psychiatrists were significantly more preferred than clinical psychologists or counselors in the psychotic depression vignette and the marital disorder vignette. Clinical psychologists were significantly more preferred in the remaining adjustment disorder vignette, than were counselors or psychiatrists. Information about training background amplified the preferences for professionals chosen by the no-information group, to a significant degree.

Further research should include more extensive post-hoc questioning of subjects to obtain a clearer rationale for their preferences. Additionally, in vivo data may be more revealing with regard to actual client preference patterns.

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## Chapter 1

### INTRODUCTION

The number of Americans estimated to be in need of some form of mental health assistance, although a stable ratio since 1954 (Srole & Fischer, 1980), is still quite large. Reiger, Goldberg, and Taube (1978) estimated the proportion of the population to be 15%, or approximately 30 million individuals with serious emotional disorders. This estimate is conservative when compared with the number of people who are experiencing some type of abnormal behavior. Mehr (1984) reported that when only four common types of disorders are considered (i.e., schizophrenia, depression, alcohol and drug abuse, and mental retardation), the number quickly approaches 75 million.

With specific reference to these individuals seeking treatment for mental disorders, the trend of burgeoning referrals is clear. Since 1955 when approximately 23% of clients receiving mental health services (391,000 people) did so on an out-patient basis, the total number has grown to 71% (4,544,000 people) as of 1975 (National Institute of Mental Health [NIMH], 1977b). While this change reflects the movement toward deinstitutionalization and pharmacological treatment, it also indicates an increase in demand for therapist working hours. This growth in demand is evidenced even when the increase in population is considered. Beitman (1983) outlined demographic characteristics and sheer number of hours in psychotherapy by American therapists. His



pilot study revealed that psychiatrists and clinical psychologists engage in 387,000 and 360,000 hours of psychotherapy per week, respectively, on a nationwide basis. Although not exact in nature, these totals suggest a substantial degree of involvement. An estimate of the number of psychotherapy hours for the professional counselor was unavailable although this group appears to be heavily involved in psychotherapeutic work (Coleman, Butcher, & Carson, 1984).

Finally, the magnitude of this demand is further indicated by the amount of money spent on mental health care in the United States. In 1977 approximately \$17 billion were spent for direct care services of individuals with mental illness (NIMH, 1977a). During the same year approximately \$22 billion were expended for indirect costs. Thus the total for 1977 came to approximately \$39 billion. Such an extensive investment of monetary funds from government and private sources would suggest a clear endorsement for the services provided by mental health professionals. Whether or not the consumers of these services are well informed when selecting a professional is an issue warranting further investigation (Bevan, 1982).

In attempting to portray the degree to which consumers understand the vicissitudes inherent in the mental health profession, it is essential to note the lack of consensus in the profession itself. The debatable areas of licensure, competency levels, training backgrounds, accountability, and client-therapist compatibility are all unresolved issues in the professional literature (Greenburg, 1969; King & Seymour, 1982; Koocher, 1979; Manthei, 1983; Margolis, Sorenson, & Galano, 1977). Quite reasonably, consumers may be limited in their

awareness and understanding of differences and similarities in the mental health profession. The extent of that understanding is the focus of this thesis.

The efforts put forth by professional associations such as the American Psychiatric Association, the American Psychological Association, and the American Association for Counseling and Development, perpetuate changeability within the practices of their members. While change often may be equated with progress and other signs of professional growth, it can also create confusion about the organization's identity. The liability of this vagueness of identity has its impact through confused consumers and referral sources alike. Although the respective professional organizations attempt to portray differences that might distinguish them from their mental health "cousins" (e.g., psychiatrists versus psychologists), the users of their services may be uncertain when choosing a professional.

Within the context of change and redefinition, a review of each organizations's efforts toward identity and purpose follows a discussion of the professional literature that has investigated the topic.

### Literature Review

Outlining the extent of the public's assumptions regarding the qualifications of mental health practitioners, Evans and Wante (1975) found a pervasive lack of accurate information and a significant amount of incorrect information being used by their subjects. Addressing 12 different mental health professional titles, these authors examined the students' awareness regarding each title, certification guidelines, and

licensing standards. While this study was conducted in the mid-1970s, using the current standards for the state of Kansas, the findings suggest pertinent results for the balance of the nation.

Evans and Wanty (1979) found that there were erroneous assumptions in each of the categories examined. The majority of participants felt that practitioners across all titles were required to enroll in review courses approximately every 2 to 4 years to maintain therapeutic effectiveness. Moreover, 72-92% of the participants incorrectly assumed that oral, written, and practical exams were required for certification to practice in all professions. Overall, the respondents indicated that more regulation exists, following the attainment of the title, than is actually the case.

Perhaps equally revealing was the background of the subjects used in Evans' and Wanty's (1979) research. Forty females and 38 males enrolled in an undergraduate psychology course in Adjustment completed 12-page questionnaires. The course drew heavily from health related fields such as psychology, social work, and nursing. If these individuals were unable to correctly identify the criteria for professional certification and licensing and were at least moderately acquainted with the title differences, a more accurate discrimination by a member of the general public is improbable.

While the understanding of the public may be regarded as marginal with respect to what mental health professionals do, there are apparently a number of factors contributing to the confusion. Blum and Redlich (1980) examined the changes in the nature of four professional manpower groups over the past 30 years. Their findings

suggest that the roles of psychiatrists, psychologists, social workers, and nurses have evolved from rigid, differentiating tasks toward a more homogeneous state. Although there were apparent differences (salaries, percent of time in private practice), the trend seems to be one of similarity in function. All four groups were actively involved in practicing psychotherapy as a group or individual therapist. This similarity is markedly different than the roles practiced even 15 years ago. Then, the psychiatrist treated the patient, the psychologist tested the patient, the social worker arranged the logistical details following the patient's discharge, and the nurse dispensed medication (Blum & Redlich, 1980).

Interestingly, in spite of the emerging role fusion of mental health professionals evidenced in the research literature (Beitman, 1983; Blum & Redlich, 1980; Fretz, 1982; Holland, 1982), the four manpower groups in the Blum and Redlich study still perceived psychiatrists as being more effective in the role of providing psychotherapy for patients. Further complicating the question surrounding professional roles and responsibilities within the mental health profession are the activities of each group's national organization. Their efforts are directed toward differentiating themselves from one another while continuing to be involved in common professional roles and duties.

#### Psychiatry's Efforts Toward Change

Within the American Psychiatric Association, the response to this ever-increasing shift of psychotherapeutic responsibilities has

been registered. Commentaries and research reports document the most salient concerns of the association members. Beitman's (1983) report on the heterogeneity of psychotherapists' qualifications clearly outlined the ambiguity when attempting to define a competent psychotherapist. Although such a definition is not attempted in a formal sense, Beitman suggested that "psychiatrists may be able to lead psychotherapists toward a clear definition of acceptable, expectable, adequate practice" (p. 45). The notion contained in this article is that the training and experience acquired by the psychiatrist will facilitate the development of effective and competent psychotherapists throughout the mental health profession in general. In providing such direction and focus, Beitman suggested that psychiatry will aid consumers and allied professionals alike with its organized conceptual framework for treatment.

Addressing the dilemmas in psychiatry as a profession, Brodie (1983) enumerated three principal areas of concern in his presidential commentary to the American Psychiatric Association. Brodie envisioned psychiatry in a triangular locus, bordered on three sides by nonmedical mental health disciplines, the biological argument for mental health treatment, and the primary care physician. Each of these fronts exert pressures to alter the existing practice of psychiatry. The first interface, that with nonmedical mental health professionals, is most pertinent to the topic of this thesis.

Brodie (1983) pointed out that psychiatrists are competing for patients with psychologists, social workers, and psychiatric nurses whose skills in a given psychotherapy well approximate those of the

psychiatrist. This competition exists only in the out-patient setting, treating patients who are not "suffering from medical illness but rather seeking to improve their own self-awareness--to drive their personal effectiveness to new heights" (p. 966). The response of the American Psychiatric Association to this erosion of optimal expertise was the approval of the Washington Psychiatric Society's position paper endorsing reimbursement for treatment only when medically necessary. In essence, psychiatry is reaffirming its relationship with medicine in an effort to remain distinguishable from the other mental health professions. Perhaps the various dynamics behind psychiatry's mobilization are best described by Brodie:

If psychiatry is to be accorded effective reimbursement in competition with other providers of out-patient psychotherapy, it must educate the public, legislators, and employers to the uniqueness of what psychiatrists do medically. The nation has been blitzed with the psycho-babble of pop psychology: Everyone wants to be a counselor to a client, and there is simply not enough money in the health care system to reimburse every pseudo-therapist offering mental health and happiness. Thus, psychiatry must educate both the public and government leaders through the efforts of the American Psychiatric Association's district branches, staff and officers. Psychiatry must emphasize that its union of medical knowledge with psychotherapeutic skill provides the patient with optimal expertise in the treatment of mental illness. (p. 966)

In their recent review of mental health care providers and costs, Beigle and Sharfstein (1984) assumed a less provocative position regarding a patient's appropriateness for treatment and the therapist's compensation. Instead, they asserted that the ultimate decisions pertinent to these issues must be agreed upon by all the professions involved. Unless some form of recognition is given to the differences between the professions, third-party payers and patients will remain confused in their interactions with the mental health professions.

Moreover, it is their contention that the "major professions are identifiable through their substantial differences in their training. Each is exposed to different clinical experiences during their training. Therefore, a further differentiation within the curricula could create a basis for delineating who ought to be doing what" (p. 670).

In general, psychiatry endorses and encourages efforts of its practitioners in being medically or biologically oriented in the treatment of mental illness. This emphasis clearly delineates those differences between itself and other mental health professions, providing psychiatry with a reserved specialty in the treatment setting.

#### Psychology's Efforts Toward Change

Within the domain of professional psychology, represented by the various divisions of the American Psychological Association, there also are identifiable movements toward self-clarification and identification (Cattell, 1983; Kane, 1982; Levy, 1984; Thyer, 1984). These attempts to reorient the psychologist's role in mental health care delivery create heated deliberations, but serve to benefit the public and professional alike. Endorsing several significant changes, Fox (1982) asserted that psychology now is in the right place at the right time to apply the knowledge held by the profession. His position suggests that the psychologist's exclusive involvement with mentally ill individuals is a role that should be redefined. Instead, practitioners in psychology should broaden their treatment applications to include individuals experiencing difficulties with general health and functioning as well as mental illness. Fox further contended that

this best might be accomplished with the establishment of comprehensive psychological service centers. These centers would target their services for the normal population.

Using rationale very similar to Fox's (1982), Levy (1984) described the efforts toward change as a metamorphosis that occurs as a result of increased specialization within the profession. Psychology, and clinical psychology in particular, has such an absence of a clearly defined role in the treatment setting that some "reconceptualization of the specializations within the profession, if not the profession itself, is called for" (p. 486). Moreover, Levy asserted that the accrediting body of the American Psychological Association finds itself unable to precisely define what a clinical psychologist should know to be considered a clinical psychologist. This situation stems only in part from the evolving nature of psychology. Several areas of study have been developed and expanded, within what once was a circumspect area of clinical work. Distinct areas such as community psychology, rehabilitation psychology, health psychology, and clinical neuropsychology are examples of the growth within the profession (American Psychological Association, 1981).

To compensate for the changes taking place, Levy (1984) suggested that a new label of "human services psychology could be used to describe all professional psychology specialities concerned with the promotion of human well being for the acquisition and application of psychological knowledge concerned with the treatment of psychological and physical disorders" (p. 486). This would essentially encapsulate treatment specialities without necessarily defining clinical psychology's role as



one identified with mental health exclusively. At this point the intent of a human services approach approximates a reorientation that was described by Fox (1982).

While the momentum of change and reconceptualization within psychology includes initiatives such as those described above, it also involves negotiation and communication with other established health service providers. The differences between psychology, psychiatry, and counselors are perhaps most clearly seen in the activities of each profession's representative association. The similarities in function and capabilities within these three professions seem to heighten rather than diminish resistance in cooperative efforts.

In his writing that addresses this issue between psychology and psychiatry, Cattell (1983) pointed out that the amount of information contained in either of the sides (medicine and psychology) challenges the professional to stay current in a very focused area. Specialization within medicine and increasing specialization within psychology has been the result of an enormous amount of information. Cattell posed the question of whether or not it is reasonable to expect a psychiatrist to be an expert in two fields of study when the majority of physicians and psychologists are burdened while attempting to be current in just one. A working relationship is suggested that complements the roles of the psychologist and the physician--one that uses the expertise of the psychologist in psychotherapy and the expertise of the physician in the psychopharmacological treatment applications. Moreover, the training of each professional would include elements of the complementary profession to further increase communicative abilities.

Further inroads into the medical domain by psychologists have occurred in government regulatory agencies such as the Federal Trade Commission (FTC) (Pertschuk & Corriea, 1983; Wiggins, Bennett, Batchelor, & West, 1983). In essence, the FTC prohibited the American Medical Association and its member organizations from interfering in fair competition. In addition to various FTC rulings, the U.S. Supreme Court has determined that professionals do fall under the purview of the FTC and antitrust laws. Such a finding reduces the "one system" approach to mental health treatment.

Within hospitals, psychologists are beginning to be accepted as medical staff and professionals responsible for the care of their patients (Zaro, Ginsberg, Batchelor, & Pallack, 1982). This change in status has not been gained easily or completely, but accrediting bodies such as the Joint Commission on Accreditation of Hospitals are responding to the affirmative actions of psychologists in the rulings of the state and national legislatures.

#### Counseling and Development's Efforts Toward Change

Finally, within the domain of what until recently was referred to as guidance and counseling, there are fundamental changes taking place. Indicative of at least one emphasis is the renaming of the professional organization of counselors. Currently the American Association for Counseling and Development represents the overall membership of professional counselors. Although not immediately apparent, this modification exemplifies a transition toward private practice interests and efforts within the traditional mental health services area (Daniel &

Weikel, 1983). This transition is the result of diminished financial resources in government and private organizations in addition to fundamental changes in the consumer population (Aubrey, 1983). While guidance counseling in the school system is certainly not being abandoned, it apparently does not assume the primary role of emphasis that it once did. The lure of practicing psychotherapy within a wider ranging population of consumers is beginning to have its effect.

To facilitate this gradual change or expansion of professional interests, counselors are beginning to follow the course of other mental health practitioners by lobbying for legislated distinction (Edgar & Davis, 1983). Buttressed by an identified certification of competency, counselors will move confidently into new turf and further challenge the other professions through their eligibility for third-party payment for services (Snow, 1981; Swanson, 1981).

As outlined above, the professions delivering services in mental health treatment are, at best, attempting to meet the therapeutic needs of a very large and varied population of consumers. Given such challenges, each professional group is attempting to respond with a distinctively characteristic approach in relation to the other mental health providers. From a less optimistic perspective, each profession is obscure and undecided with respect to their limitations in treatment. Moreover, the intraprofessional positioning that tends to reduce effective treatment collaboration furthers the confusion at the provider and user levels.

## Experimental Purposes and Hypotheses

The intent of this study was to determine, in part, the degree of influence that being informed of a mental health professional's training background had on that professional's selection as the most appropriate therapist for a given patient problem. In addition to this measure of a lay person's perception of appropriateness, the second measure of the consumer's degree of preference for each professional was examined. While the purpose was not to establish a correct or incorrect consumer choice, the procedures clarified the effect on consumer selection for a particular professional when given information about that person's training background.

It was hypothesized that providing training information will lead to an equalization in the number of preferences for any particular profession. Those individuals not provided with training information were polarized in primary professional selection and their degree of preference. This polarization was strongest for members of the psychiatry profession, supporting their abilities in treatment above those of the counselor and the clinical psychologist.

## Chapter 2

### METHODS

#### Design

##### Subjects

Subjects for this investigation were 132 male and 132 female students enrolled in introductory psychology courses at the University of Montana. All participants were given course credit for being in the study. Prospective subjects were told that they would be taking part in a study designed to evaluate therapist suitability for a described mental disorder. Two groups were formed by randomly assigning 64 males and females to each of the conditions of the study. All groups were balanced for gender.

##### Experimental Design

The experiment employed a  $6 \times 3 \times 3 \times 2 \times 2$  factorial design ( $A \times B \times C \times D \times E$ ). The order of the sequence in which the professionals were presented was designated as the A effect, the B effect was the vignette type, the C effect was the particular type of professional, the D effect was the difference in gender between the subjects, and the E effect was the condition of having or not having training background information for each of the represented professions.

## Procedures

All participants were shown a 20-minute videotape presentation depicting clinical interviews with a schizophrenic person, a depressed individual, a manic hospital patient, and an obsessive-compulsive person. The interviews were simulated as a demonstration model for students enrolled in abnormal psychology courses in conjunction with the textbook authored by Davidson and Neale (1982). The purpose of this presentation was to simply orient the participants in the study to the topic of psychotherapy and abnormal behavior. By increasing the level of interest and sensitivity in the subjects toward this topic area, it was expected that a more discriminating measure of their concerns would be obtained. Following the video presentation, subjects were asked to rate their individual levels of interest in the topics covered via a Likert rating scale (copy of document appears in Appendix A).

After completing the self-rating, all subjects were given a packet containing a participant data response sheet (Appendix B) and a sequence of three clinical case histories abstracted from the DSM-III Casebook (Spitzer, Skodol, Gibbon, & Williams, 1981) with a degree of preference scale for each profession on each vignette (Appendix C). All participants also received in the packets, depending upon their experimental condition, training background information (Appendix D) or a series of excerpts from therapy sessions (Appendix E).

### Case History Vignettes

Three different case histories were used to depict a variety of diagnostic categories. The vignettes briefly describe the characteristics of three disorders in accordance with the DSM-III criteria: (a) Adjustment Disorder with Depressed Mood, (b) Major Depression, Recurrent with Psychotic Features, and (c) Marital Problem. While each vignette depicted a situation with clearly maladaptive patient behavior, no indication of the specific diagnosis was given to the subjects. The terms psychiatrist, psychiatric resident, and psychiatric used in the original text were deleted and replaced with therapist or some other neutral term to avoid obvious demand characteristics.

### Professionals as a Consumer Choice

Three distinct professional groups were included in this investigation. Each of these mental health service providers has an identifiable national organization that endorses a variety of acceptable activities and practice applications for its membership. The professional groups--psychiatrists, clinical psychologists, and counselors--all participate in psychotherapeutic activities.

For this study no specific information regarding current psychotherapeutic techniques within any particular profession was discussed. Moreover, the absence of such clarification between professional roles prevented the subjects from using anything other than common knowledge when selecting their preferred therapist. Each of the three professions was considered for assignment as the therapist of choice in a particular vignette.

### Consumer Knowledge

To assess the degree of impact that professional training information would have on a consumer's choice of a therapist, two groups of subjects were formed. Group 1 received specific information regarding each profession's suggested training models. Within the realms of clinical psychology, counseling, and psychiatry, the data were abstracted from the accreditation requirements and training standards of their respective professional associations. Since these guidelines are broad in nature, a random sampling of five programs from each profession was gathered and compared for common courses being offered in each training program. Those courses within the guidelines that occurred most frequently across all five programs were organized to form a composite program in each profession (Appendix D).

Group 2 received no information pertaining to professional training of therapists. Instead, this group was given a series of three written excerpts from different therapy sessions. The excerpts were abstracted from Corsini's (1979) text, Current Psychotherapies. Each passage depicted a different method of psychotherapy in progress, with no mention of professional identification being made. Each passage was essentially equal in length to the others, resulting in a similar amount of reading material for both groups.

### Dependent Measures

A self-report rating scale was used to assess each subject's degree of preference for each of the professionals considered in this study. The scale was divided into 10 portions and was labeled sequentially



from 1-10. The lowest end of the scale (1) represented the least amount of preference for a professional while the highest end (10) represented the most amount of preference. Anchors were used only on the extreme ends of the continuum.

## Chapter 3

### RESULTS

An analysis of variance (ANOVA) was performed on the results of this  $6 \times 3 \times 3 \times 2 \times 2$  experiment. Two main effects and four interactions were found to be significant among the factors. A main effect was found for Type of Professional (counselor = 5.42, psychiatrist = 5.89, clinical psychologist = 5.57),  $F(2,480) = 16.36$ ,  $p < .0001$ . Newman-Keuls analysis indicated that the counselor and clinical psychologist were equally preferred while the psychiatrist was significantly more preferred than the other two professionals. The second main effect was for Vignette Type (Adjustment Disorder = 5.96, Psychotic Depression = 5.24, Marital Discord = 5.67),  $F(2,480) = 19.67$ ,  $p < .0001$ . Although significant, this effect was not central to the purpose of the experiment and no further analyses were deemed necessary.

Interactions were found to be significant at the two-, three-, and four-factor levels. Initially, Informed versus Not Informed  $\times$  Vignette Type,  $F(2,480) = 5.93$ ,  $p < .01$ , and Type of Professional  $\times$  Vignette Type,  $F(2,480) = 181.28$ ,  $p < .0001$ , were interactive. The three-factor interaction included Informed versus Not Informed  $\times$  Type of Professional  $\times$  Vignette Type,  $F(4,960) = 6.53$ ,  $p < .0001$ .

The significant three-factor interaction supported the primary hypothesis of the study to the extent that being informed of training

background does influence the degree of preference for a professional. This interaction's factors are contained in both of the two-way interactions yielding pertinent detailed information with respect to the experimental hypothesis. Figure 1 (Appendix F) depicts the degree of preference on a 10-point Likert scale for the Informed versus Not Informed groups. Clearly indicated is the greater separation between psychiatrist and the other professionals in the Adjustment Disorder and Psychotic Depression vignettes within the Informed group. Subsequent Newman-Keuls analysis revealed several consistencies within the data (see Table 1, Appendix G).

Within the Informed group, under each of the diagnostic vignettes, the following significant comparisons were noted. For the Adjustment Disorder, clinical psychologist was most preferred, with counselor second, followed by psychiatrist. The Psychotic Depression vignette yielded psychiatrist as most preferred, and clinical psychologist and counselor equally preferred. The Marital Discord vignette also resulted in psychiatrist receiving most preferred status while clinical psychologist and counselor again were preferred equally. Newman-Keuls analysis for the Psychotic Depression and Marital Discord vignettes were found to be identical within the Informed and Not Informed groups. Within the Adjustment Disorder vignette (Not Informed group), clinical psychologist and counselor were equally preferred but significantly more so than psychiatrist.

Finally, the only significant four-factor interaction involved Order  $\times$  Gender  $\times$  Type of Professional  $\times$  Vignette Type,  $F(20,960) = 1.87$ ,  $p < .01$ . Further analysis, using Scheffe's pairwise comparison test,

revealed no significant differences between any two means. Depicted in Figure 2 (Appendix F) are the means values for males and females in this interaction. Presentation order for the three different professional groups was a factor in this study, therefore all possible orders were included in the design. Figure 2 contains a representative configuration of the means across all six orders for each of the vignettes.

Additional ANOVA procedures were used to evaluate the Level of Importance and Level of Interest scales. Gender effects were found to be significant for Importance (females = 4.62, males = 3.90),  $F(1,240) = 24.38, p < .0001$ , and Interest (females = 4.90, males = 4.32),  $F(1,240) = 16.03, p < .0001$ .

## Chapter 4

### DISCUSSION

This study investigated the effects that information about professional training would have on consumer selection for a particular professional given a specific referral problem. Following the examination and discussion of the experimental results, a number of implications for the professional groups and consumers are presented. Also, suggestions for future research are offered in an attempt to further refine the nature of the consumer's decision making process when seeking a mental health professional.

Clearly, the results of this study reveal the psychiatrist to be most preferred by mental health consumers. Clinical psychologists and counselors, meanwhile, appear equally preferred to each other but less preferred than psychiatrists; however, results indicate that there are areas in which psychologists and counselors are perceived to be the professionals of choice.

Among the three case history vignettes, Adjustment Disorder elicited the largest degree of preference for all the professionals together. In other words, the subjects within the two groups ranked the professionals very strongly for this case. The Marital Discord vignette was second in strength when eliciting preference points for all the professional groups. Finally, Psychotic Depression resulted in the least amount of preference for the combined professional rankings.

Differences resulting from gender were noted in the initial scales inquiring about Importance and Interest levels in the topic of mental health. Women assigned significantly higher levels of importance and interest to the topic than men did. Although this finding has many corollaries in the demographic studies of mental health service users, it was not consistently borne out in the remaining data. Men and women responded similarly to the dependent measures throughout the study. Only in the four-way interaction was gender a significant factor. The large number of factors involved with gender prevented further discrimination of its effect.

Like the other significant interactions, the type of vignette or case history contributed to the significance, as did the ratings of the particular professionals. Unlike the remaining interactions, however, this four-factor relationship also involved the order in which the professionals were presented. This particular interaction, in addition to being unwieldy in interpretation, offered nothing in more detailed analysis. The net result of such an interaction is that order of professionals being considered apparently interacts with the consumer's gender and referral issues, thereby culminating in a particular choice of professional.

The central interaction for this study was the significant relationship between being informed or not, professional title, and type of case. College students responded in a manner that suggests they categorized professionals according to the type of case being presented. Being informed of training background apparently only accentuated the direction of the initial preferences. That is,

uninformed subjects made the same selection for preferences as informed subjects in each of the case history vignettes. The only difference was degree of preference.

This consistency across groups suggests that information regarding training of a respective professional does not change one's mind about the professional of choice. There were only two exceptions where information actually reduced the preference for a professional. For the medicated psychotic, clinical psychologist and counselor received decreased levels of preference when subjects were informed of their training. In a like fashion, psychiatrist also decreased in preference with the adjustment disordered client when informed of training experience.

In general the psychiatrist was significantly more preferred than the clinical psychologist or the counselor for two of the three vignettes. While the preference for a psychiatrist given a medicated psychotic client may not be surprising, it does highlight the level of general knowledge held by the Not Informed group. This result may suggest a somewhat better informed group of people than were Evans' and Wanty's (1979). The findings for the Marital Discord vignette were also somewhat unexpected given the popular usage of terms such as marriage counselor when referring to a mental health professional in a marital therapy setting. In spite of this minor amount of loading for the counseling profession in the marital therapy vignette, the psychiatrist still remained most preferred across both groups.

The Adjustment Disorder vignette actually resulted in a refinement for preferences when the subjects were provided with training information.

Those subjects who were not given training information chose clinical psychologist and counselor as essentially equivalent preferences over psychiatrist. Given information about training, however, the clinical psychologist was then seen by the subjects as significantly more preferred than the counselor, and both were more preferred than the psychiatrist. This vignette was the only case history that resulted in a clarification of this sort.

Interpretation of this study's findings suggest that psychiatrist was seen as being more preferred for the psychotic depression and marital case. Information about background increases that perception of preference. A potential alternative explanation for these results could be the subjects' preconceived notions of an ultimate expert. If that were the case, the most qualified professional should treat the most disturbed patient. In a traditional sense the psychiatrist is seen as being the doctor (Blum & Redlich, 1980). These subjects could be using the traditional perceptions of the psychiatrist as being the ultimate expert in matters of serious mental disorder. As a result they prefer the psychiatrist in the more serious situations, and the clinical psychologist-counselor preference is reserved for less critical situations. While such an alternative explanation is plainly speculative in nature, the findings of studies such as Blum's and Redlich's, sampling the perceptions of fellow mental health professionals, essentially confirmed this perception. Could the reasoning of college students be of a similar vein? There is no evidence for it in this study's results because measures addressing the rationale for preferences were not included in the design.



## Implications

While the results of this study could be regarded as a sophisticated popularity contest, with each profession seeking the endorsement of the public, a more measured purpose is intended here. These findings have quite significant messages to convey to all of the professions involved.

Perhaps the most salient implication for the professions is the potential consumer's tendency to see a particular therapist as suitable and most preferred for a particular referral problem. Current literature suggests that the field of mental health and therapy are awash with therapists from every background, doing everything and sometimes being perceived by the consumer as all alike (Beigle & Sharfstein, 1984; Bevan, 1982; Brodie, 1983; Koocher, 1979). Apparently the subjects in this study perceive distinctions between the professions. These uninformed distinctions are also amplified when the subjects are given specific training information.

Although psychiatry dominated the preference scales, the endorsement of the counseling profession proved even more enlightening. When given information about counseling training programs, the subjects consistently equated the counselor with clinical psychologist. This finding seems to parallel the counseling profession's own efforts toward self-validation. A specific case in point is the licensure movement within the counseling field. If these results are even moderately generalizable to the public, in particular various state legislatures, the counseling profession may be well poised for its licensure arguments. In spite of the basic differences between

counseling and clinical psychology training programs, the counselor fares well in the comparison.

If the above observations are accurate, what are the implications for clinical psychologists when competing for clients with counselors? Initial speculations suggest that the road ahead will be vitally important with regard to psychology's emphasis in direction. Serious considerations dealing with training emphasis, master's level licensure, specialization, and third-party compensation loom ever larger as issues requiring attention. Without a doubt psychology, and clinical psychology in particular, has these issues to solve if it is to remain viable as a distinctive, service-providing profession.

Psychiatry apparently is perceived in a fashion that is enviable from the perspective of the other two professions. The focus of the psychiatric profession as described by Brodie (1983) is to maintain this position through the emphasis on its medical approach. Apparently this emphasis, in addition to some measure of traditional expectations, is continuing the public's preference for the MD degree.

#### Future Research

Further investigation of this research area might be more revealing if the responses of the subjects were in vivo, i.e., the decisions of an actual client might be different from an introductory psychology student. In addition, more extensive inquiry procedures addressing the reasoning of the subject would greatly enhance the understanding of each subject's choices. The limitations of this study in that

regard prevented an in-depth portrayal of the actual process involved in the selection of professionals.

If the professional labels of each therapist were removed and a more detailed description of each profession's background were given, the results would reflect the preference based solely on background. Such a study, however, begins to leave the probability generalization even further behind because most people do not choose a therapist in this manner.

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**A P P E N D I X   A**  
**Interest Rating Sheet**

Now that you have watched the video presentation and have heard what this study is going to be about, please rate the topics listed below. Simply put an X on the scale where you feel it's most appropriate.

Thank you.

Your level of interest:

<u>                  </u> : not at all interested	<u>                  </u> : almost no interest	<u>                  </u> : little interest	<u>                  </u> : some interest	<u>                  </u> : moderate interest	<u>                  </u> : very interested	<u>                  </u> : extremely interested
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How important is this topic to you?

<u>                  </u> : not at all important	<u>                  </u> : almost no importance	<u>                  </u> : little importance	<u>                  </u> : some importance	<u>                  </u> : moderate importance	<u>                  </u> : very important	<u>                  </u> : extremely important
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**A P P E N D I X   B**  
**Participant Data Sheet**

## PARTICIPANT DATA SHEET

1. What is your age? \_\_\_\_\_
2. Your sex?        FEMALE        MALE        (circle one)
3. What is your major field of study at the university?
  - \_\_\_\_\_ A.) General Studies
  - \_\_\_\_\_ B.) Social Sciences
  - \_\_\_\_\_ C.) Undeclared area
  - \_\_\_\_\_ D.) Don't know yet
4. Have you ever been a consumer of mental health services?
  - YES        NO        (circle one)
5. Have any of your relatives obtained help from a mental health professional?
  - YES        NO        (circle one)
6. If you answered YES to question 4, which group of professionals did your therapist or mental health services provider belong in?
  - \_\_\_\_\_ A.) PSYCHOLOGISTS
  - \_\_\_\_\_ B.) PSYCHIATRISTS
  - \_\_\_\_\_ C.) SOCIAL WORKERS
  - \_\_\_\_\_ D.) COUNSELORS
  - \_\_\_\_\_ E.) NURSES
  - \_\_\_\_\_ F.) OTHERS \_\_\_\_\_ (please specify)
7. If you answered YES to question 5, which group of professionals did your relative seek assistance from?
  - \_\_\_\_\_ Indicate the correct category by using the capital letters from the list in question 6.
  - If OTHER, please specify: \_\_\_\_\_

A P P E N D I X C

Vignettes

While reading the case histories below, imagine that the principal character is a friend of yours. Being concerned about your friend's good health, you need to consider the degree of preference you would have for each of the male mental health professionals listed. Included are counselors, clinical psychologists and psychiatrists. All of the professionals have obtained a degree status that makes them eligible for licensure within their profession. Please rate your preference for all three professionals.

**CASE #1**

A 24-year old, single, female nursery school teacher terminated brief therapy after ten sessions. She had entered treatment two weeks after she discovered that the man she had been involved with for four months was married and wanted to stop seeing her. She reacted with bouts of sadness and crying, felt she was falling apart, took a week's leave from her job, and had vague thoughts that the future was so bleak that life might not be worth the effort. She felt that she must be in some essential way "flawed"; otherwise she would not have gotten so involved with someone who had no intentions of maintaining a long-term relationship. She felt that others "would have seen it", that only she was "so stupid" as to have been deceived. There were no other signs of a depressive syndrome, such as loss of interest or appetite or trouble concentrating. She responded to mixed supportive-insight therapy and toward the end of treatment began dating a law student whom she met at a local cafe.

<b>Counselor</b>										
1	2	3	4	5	6	7	8	9	10	
Very Low									Very High	
<b>Psychiatrist</b>										
1	2	3	4	5	6	7	8	9	10	
Very Low									Very High	
<b>Clinical Psychologist</b>										
1	2	3	4	5	6	7	8	9	10	
Very Low									Very High	

**CASE #2**

A 50-year old widow was transferred to a therapy center from her community mental health center, to which she had been admitted three weeks previously with severe agitation, pacing, and hand-wringing, depressed mood accompanied by severe self reproach, insomnia, and a 6-8 kg (15 pound) weight loss. She believed that her neighbors were against her, had poisoned her coffee, and had bewitched her to punish her because of her wickedness. Seven years previously, after the death of her husband, she had required hospitalization for a similar depression, with extreme guilt, agitation, insomnia, accusatory hallucinations of voices calling her a worthless person and preoccupation with thoughts of suicide. Before being transferred, she had been treated with Doxepin HCL, 200 mg, with only modest effect on the depression and no effect on the delusions.

<b>Counselor</b>										
1	2	3	4	5	6	7	8	9	10	
Very Low									Very High	
<b>Psychiatrist</b>										
1	2	3	4	5	6	7	8	9	10	
Very Low									Very High	
<b>Clinical Psychologist</b>										
1	2	3	4	5	6	7	8	9	10	
Very Low									Very High	

**CASE #3**

A 30-year old, female chemist was referred by her internist because she wanted to talk to someone about her shaky marriage. During five years of courtship and two years of marriage, there have been numerous separations, usually precipitated by her dissatisfaction. Although she and her husband share many interests and until recently have had a satisfactory sexual relationship, she thinks that her husband is basically a cold and self centered person who has no real concern about her career or feelings. Her dissatisfaction periodically builds up to a point that leads to fights, which often result in temporary separations. She then feels lonely and comes "crawling back" to him.

<b>Counselor</b>										
1	2	3	4	5	6	7	8	9	10	
Very Low									Very High	
<b>Psychiatrist</b>										
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Very Low									Very High	
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Very Low									Very High	

**CASE #3**

A 30-year old, female chemist was referred by her internist because she wanted to talk to someone about her shaky marriage. During five years of courtship and two years of marriage, there have been numerous separations, usually precipitated by her dissatisfaction. Although she and her husband share many interests and until recently have had a satisfactory sexual relationship, she thinks that her husband is basically a cold and self centered person who has no real concern about her career or feelings. Her dissatisfaction periodically builds up to a point that leads to fights, which often result in temporary separations. She then feels lonely and comes "crawling back" to him.

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Psychiatrist										
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Very									Very	
Low									High	
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Very									Very	
Low									High	
<b>Counselor</b>										
1	2	3	4	5	6	7	8	9	10	
Very									Very	
Low									High	

**CASE #3**

A 30-year old, female chemist was referred by her internist because she wanted to talk to someone about her shaky marriage. During five years of courtship and two years of marriage, there have been numerous separations, usually precipitated by her dissatisfaction. Although she and her husband share many interests and until recently have had a satisfactory sexual relationship, she thinks that her husband is basically a cold and self centered person who has no real concern about her career or feelings. Her dissatisfaction periodically builds up to a point that leads to fights, which often result in temporary separations. She then feels lonely and comes "crawling back" to him.

<b>Psychiatrist</b>										
1	2	3	4	5	6	7	8	9	10	
Very									Very	
Low									High	
<b>Clinical Psychologist</b>										
1	2	3	4	5	6	7	8	9	10	
Very									Very	
Low									High	
<b>Counselor</b>										
1	2	3	4	5	6	7	8	9	10	
Very									Very	
Low									High	



While reading the case histories below, imagine that the principal character is a friend of yours. Being concerned about your friend's good health, you need to consider the degree of preference you would have for each of the male mental health professionals listed. Included are counselors, clinical psychologists and psychiatrists. All of the professionals have obtained a degree status that makes them eligible for licensure within their profession. Please rate your preference for all three professionals.

### CASE #1

A 24-year old, single, female nursery school teacher terminated brief therapy after ten sessions. She had entered treatment two weeks after she discovered that the man she had been involved with for four months was married and wanted to stop seeing her. She reacted with bouts of sadness and crying, felt she was falling apart, took a week's leave from her job, and had vague thoughts that the future was so bleak that life might not be worth the effort. She felt that she must be in some essential way "flawed"; otherwise she would not have gotten so involved with someone who had no intentions of maintaining a long-term relationship. She felt that others "would have seen it", that only she was "so stupid" as to have been deceived. There were no other signs of a depressive syndrome, such as loss of interest or appetite or trouble concentrating. She responded to mixed supportive-insight therapy and toward the end of treatment began dating a law student whom she met at a local cafe.

Psychiatrist										
1	2	3	4	5	6	7	8	9	10	
Very Low									Very High	

---

Counselor										
1	2	3	4	5	6	7	8	9	10	
Very Low									Very High	

---

Clinical Psychologist										
1	2	3	4	5	6	7	8	9	10	
Very Low									Very High	

### CASE #2

A 50-year old widow was transferred to a therapy center from her community mental health center, to which she had been admitted three weeks previously with severe agitation, pacing, and hand-wringing, depressed mood accompanied by severe self reproach, insomnia, and a 6-8 kg (15 pound) weight loss. She believed that her neighbors were against her, had poisoned her coffee, and had bewitched her to punish her because of her wickedness. Seven years previously, after the death of her husband, she had required hospitalization for a similar depression, with extreme guilt, agitation, insomnia, accusatory hallucinations of voices calling her a worthless person and preoccupation with thoughts of suicide. Before being transferred, she had been treated with Doxepin HCL, 200 mg, with only modest effect on the depression and no effect on the delusions.

Psychiatrist										
1	2	3	4	5	6	7	8	9	10	
Very Low									Very High	

---

Counselor										
1	2	3	4	5	6	7	8	9	10	
Very Low									Very High	

---

Clinical Psychologist										
1	2	3	4	5	6	7	8	9	10	
Very Low									Very High	

### CASE #3

A 30-year old, female chemist was referred by her internist because she wanted to talk to someone about her shaky marriage. During five years of courtship and two years of marriage, there have been numerous separations, usually precipitated by her dissatisfaction. Although she and her husband share many interests and until recently have had a satisfactory sexual relationship, she thinks that her husband is basically a cold and self centered person who has no real concern about her career or feelings. Her dissatisfaction periodically builds up to a point that leads to fights, which often result in temporary separations. She then feels lonely and comes "crawling back" to him.

Psychiatrist										
1	2	3	4	5	6	7	8	9	10	
Very Low									Very High	

---

Counselor										
1	2	3	4	5	6	7	8	9	10	
Very Low									Very High	

---

Clinical Psychologist										
1	2	3	4	5	6	7	8	9	10	
Very Low									Very High	

A P P E N D I X D  
Training Background Information

## ESSENTIAL TRAINING BACKGROUND FOR PSYCHIATRISTS

### Undergraduate training to bachelor's degree:

- A. May be from any undergraduate degree area (e.g., chemistry, microbiology, psychology, etc.).
- B. Usually takes a strong biological and chemical course load that culminates in a premedicine degree.

### Graduate training (medical school)

- A. Typically, each medical student is required to take two years worth of course work in a formal classroom setting. These are initially such courses as physiology, chemistry, astronomy, and biology. During the second year of course work the student is exposed to more advanced topics such as clinical medicine. Upon completion of the first two years of course work, a comprehensive examination is taken. Successfully completing this exam permits the student to progress to the second phase of the medical training.
- B. The ensuing two years of training are considered practical learning experiences. Typically, the student rotates through several different "clerkships" that provide exposure to all of the major specialties of medicine (e.g., family practice, surgery, general medicine, psychiatry, etc.). These clerkships range from 2-13 weeks in duration, depending upon the specialty. Psychiatry clerkships are usually 5-7 weeks.
- C. Successful completion of A and B results in the student's obtaining a degree of Medical Doctor (M.D.). No emphasis has been declared.

### Residency training--PSYCHIATRY

- A. A minimum of two years in a general psychiatric residency is required by the American Psychiatric Association. This experience includes rotations through in-patient services, emergency room, walk-in services, and crisis intervention. The resident, although an M.D. is supervised during the residency program by psychiatrists and more senior residents. Emphasis during residency is very heavy with respect to experience. Theoretical training is somewhat narrow.
- B. One year for electives in psychiatry is offered in areas such as gerontology, forensic (legal), rural, research, community, or hospital psychiatry.

- C. Following the successful completion of the resident program, the resident now is eligible to apply for licensure. An examination is given and if it is passed the resident becomes a psychiatrist licensed to practice.

## ESSENTIAL TRAINING BACKGROUND FOR CLINICAL PSYCHOLOGISTS

### Undergraduate training to bachelor's degree:

- A. May be from any undergraduate degree area (e.g., chemistry, psychology, social work, philosophy, etc.).
- B. Usually takes a strong course load in behavior sciences (e.g., psychology or other related liberal arts field).

### Graduate training: doctoral level

- A. Typically, each student is required to take batteries of course work that usually take 3 to 4 years to complete. This advanced course work is in areas such as cognitive bases of behavior, psychopathology, biological bases of behavior, personality theory, social bases of behavior, and research methods.
- B. Concurrently, the doctoral student is also required to participate in supervised clinical practicum experience. This is usually for a 3- to 4-year period also.
- C. Doctoral students are also expected to generate a major independent research project to be analyzed for their dissertation requirement.
- D. During the final year of training, comprehensive exams are administered to the student. Successful completion of these exams allows the student to apply for internship training and doctoral candidacy.

### Internship--CLINICAL PSYCHOLOGY

- A. A minimum of one year experience in an applied psychotherapy setting. This experience generally includes rotations through in-patient services and out-patient services. Within each area specialties such as family interventions, pediatric or child therapy, neuropsychology and neuropsychological assessment, and geriatric intervention are experienced.
- B. Successful completion of the internship typically indicates that the intern (doctoral candidate) has completed the required measures and is granted the Ph.D.

### Licensure--CLINICAL PSYCHOLOGY

- A. Following successful completion of the Ph.D, a minimum of 1,500 hours of supervised therapy is required before a

clinical psychologist may apply to take the licensure examination. This exam typically consists of an oral portion and a written portion. Both portions of the exam must be successfully completed before a license is given. Once obtained, the clinical psychologist may practice independently as a licensed psychologist.

## ESSENTIAL TRAINING BACKGROUND FOR COUNSELORS

### Undergraduate training to bachelor's degree:

- A. May be from any undergraduate degree area (e.g., social work, psychology, education, chemistry, etc.).
- B. Usually takes a strong course load from behavioral sciences (e.g., psychology, education, or other related fields).

### Graduate training: master's level

- A. Typically, each student is required to take two years of course work that focuses on various issues in the counseling practice. These include courses in family counseling, group counseling, individual counseling, and marital counseling.
- B. A minimum of 120 hours of supervised practicum (actual counseling) is requested for the two-year period. This may be obtained by the student's participation in actual agencies within the community or by assignment from an academic supervisor.
- C. Internship experiences are recommended for counseling students. This experience should not be less than 300 hours in duration. While serving as an intern, the student is expected to perform all the duties that a regular staff member of the agency would perform.
- D. Successful completion of the course work and practicum experiences entitles the student to the master's degree and eligibility for further work toward licensure readiness. At this point licensure for counselors is not required in the majority of the states. In, however, those states that do require a license, the number of required therapy experience hours is considerably higher. This figure varies between states but is usually around 1,000 to 2,000 hours of supervised experience.

**A P P E N D I X   E**  
**Excerpts from Therapy Sessions**



EXCERPT 1

T-1: [reading from the biographical information form that the clients at the Institute for Rational-Emotive Therapy in New York City fill out before their first session]: Inability to control emotions; tremendous feelings of guilt, unworthiness, insecurity; constant depression; conflict between inner and outer self; overeating; drinking; diet pills.

T-1: All right, what would you want to start on first?

C-1: I don't know. I'm petrified at the moment!

T-2: You're petrified--of what?

C-2: Of you!

T-3: No, surely not of me--perhaps of yourself!

C-3: [laughs nervously]

T-4: Because of what am I going to do to you?

C-4: Right! You are threatening me, I guess.

T-5: But how? What am I doing? Obviously, I'm not going to take a knife and stab you. Now, in what way am I threatening you?

C-5: I guess I'm afraid, perhaps, of what I'm going to find out--about me.

T-6: Well, so let's suppose you find out something dreadful about you--that you're thinking foolishly, or something. Now why would that be awful?

C-6: Because I, I guess I'm the most important thing to me at the moment.

T-7: No, I don't think that's the answer. It's, I believe, the opposite.' You're really the least important thing to you. You are prepared to beat yourself over the head if I tell you that you're acting foolishly. If you were not a self-blamer, then you wouldn't care what I said. It would be important to you--but you'd just go around correcting it. But if I tell you something really negative about you, you're going to beat yourself mercilessly. Aren't you?

C-7: Yes, I generally do.

T-8: All right. So perhaps that's what you're really afraid of. You're not afraid of me. You're afraid of your own self-criticism.

C-8: [sighs] All right.

T-9: So why do you have to criticize yourself? Suppose I find you're the worst person I ever met? Let's just suppose that. All right, now why would you have to criticize yourself.?

C-9: [pause] I'd have to. I don't know any other behavior pattern, I guess, in this point of time. I always do. I guess I think I'm just a shit.

T-10: Yeah, But that, that isn't so. If you don't know how to ski or swim, you could learn. You can also learn not to condemn yourself, no matter what you do.

C-10: I don't know.

T-11: Well, the answer is: you don't know how.

C-11: Perhaps.

T-12: I get the impression you're saying, "I have to berate myself if I do something wrong." Because isn't that where your depression comes from?

C-12: Yes, I guess so. [Silence for a while]

T-13: Now, what are you mainly putting yourself down for right now?

C-13: I don't seem quite able, in this point of time, to break it down very neatly. The form gave me a great deal of trouble. Because my tendency is to say everything. I want to change everything; I'm depressed about everything; et cetera.

T-14: Give me a couple of things, for example.

C-14: What I'm depressed about? I, uh, don't know that I have any purpose in life. I don't know in what direction I'm going.

T-15: Yeah. But that's--so you're saying, "I'm ignorant!" [Client nods] Well, what's so awful about being ignorant? It's too bad you're ignorant. It would be nicer if you weren't--if you had a purpose and knew where you were going. But just let's suppose the worst: for the rest of your life you didn't have a purpose, and you stayed this way. Let's suppose that. Now, why would you be so bad?

C-15: Because everyone should have a purpose!

T-16: Where did you get the should?

C-16: 'Cause it's what I believe in. [Silence for a while]

T-17: I know. But think about it for a minute. You're obviously a bright woman; now, where did that should come from?

C-17: I, I don't know! I'm not thinking clearly at the moment. I'm too nervous! I'm sorry.

T-18: Well, but you can think clearly. Are you now saying, "Oh, it's hopeless! I can't think clearly. What a shit I am for not thinking clearly!" You see: you're blaming yourself for that.

(From C-18 to C-26 client upsets herself about not reacting well to the session, but the therapist shows her this is not overly important and calms her down.)

EXCERPT 2

- T: I see there are some cigarettes here in the drawer. Hm? Yeah, it is hot out.  
[Silence of 25 seconds]
- T: Do you look kind of angry this morning, or is that my imagination?  
[Client shakes his head slightly.] Not angry, huh?  
[Silence of 1 minute, 26 seconds]
- T: Feel like letting me in on whatever is going on?  
[Silence of 12 minutes, 52 seconds]
- T: [softly] I kind of feel like saying that "If it would be of any help at all I'd like to come in." On the other hand if it's something you'd rather--if you just feel more like being within yourself, feeling whatever you're feeling within yourself, why that's OK too--I guess another thing I'm saying, really, in saying that is, "I do care. I'm not just sitting here like a stick."  
[Silence of 1 minute, 11 seconds]
- T: And I guess your silence is saying to me that either you don't want to or can't come out right now and that's OK. So I won't pester you but I just want you to know, I'm here.  
[Silence of 17 minutes, 41 seconds]
- T: I see I'm going to have to stop in a few minutes.  
[Silence of 20 seconds]
- T: It's hard for me to know how you've been feeling, but it looks as though part of the time maybe you'd rather I didn't know how you were feeling. Anyway it looks as though part of the time it just feels very good to let down and--relax the tension. But as I say I don't really know--how you feel. It's just the way it looks to me. Have things been pretty bad lately?  
[Silence of 45 seconds]
- T: Maybe this morning you just wish I'd shut up--and maybe I should, but I just keep feeling I'd like to--I don't know, be in touch with you in some way.  
[Silence of 2 minutes, 21 seconds]  
[Client yawns.]
- T: Sounds discouraged or tired.  
[Silence of 41 seconds]
- C: No, just lousy.
- T: Everything's lousy, huh? You feel lousy?  
[Silence of 39 seconds]
- T: Want to come in Friday at 12 at the usual time?
- C: [Yawns and mutters something unintelligible.]  
[Silence of 48 seconds]
- T: Just kind of feel sunk way down deep in these lousy, lousy feelings, hm?--Is that something like it?
- C: No.
- T: No?  
[Silence of 20 seconds]

- C: No, I just ain't no good to nobody, never was, and never will be.
- T: Feeling that now, hm? That you're just no good to yourself, no good to anybody. Never will be any good to anybody. Just that you're completely worthless, huh?--Those really are lousy feelings. Just feel that you're no good at all, hm?
- C: Yeah. [Muttering in low, discouraged voice] That's what this guy I went to town with just the other day told me.
- T: This guy that you went to town with really told you that you were no good? Is that what you're saying? Did I get that right?
- C: M-hm.
- T: I guess the meaning of that if I get it right is that here's somebody that--meant something to you and what does he think of you? Why, he's told you that he thinks you're no good at all. And that just really knocks the props out from under you. [Client weeps quietly.] It just brings the tears.  
[Silence of 20 seconds]
- C: [Rather defiantly] I don't care though.
- T: You tell yourself you don't care at all, but somehow I guess some part of you cares because some part of you weeps over it.  
[Silence of 19 seconds]
- T: I guess some part of you just feels, "Here I am hit with another blow, as if I hadn't had enough blows like this during my life when I feel that people don't like me. Here's someone I've begun to feel attached to and now he doesn't like me. And I'll say I don't care. I won't let it make any difference to me--But just the same the tears run down my cheeks."
- C: [Muttering] I guess I always knew it.
- T: Hm?
- C: I guess I always knew it.
- T: If I'm getting that right, it is that what makes it hurt worst of all is that when he tells you you're no good, well shucks, that's what you've always felt about yourself. Is that--the meaning of what you're saying? [Client nods slightly, indicating agreement.] --M-hm. So you feel as though he's just confirming what--you've already known. He's confirming what you've already felt in some way.  
[Silence of 23 seconds]
- T: So that between his saying so and your perhaps feeling it underneath, you just feel about as no good as anybody could feel.  
[Silence of 2 minutes, 1 second]
- T: [Thoughtfully] As I sort of let it soak in and try to feel what you must be feeling--It comes up sorta this way in me and I don't know--but as though here was someone you'd made a contact with, someone you'd really done things for and done things with. Somebody that had some meaning to you. Now, wow! He slaps you in the face by telling you you're just no good. And this really cuts so deep, you can hardly stand it.  
[Silence of 30 seconds]
- T: I've got to call it quits for today, Jim.  
[Silence of 1 minute, 18 seconds]
- T: It really hurts, doesn't it? [This is in response to client's quiet tears.]

- [Silence of 26 seconds]
- T: I guess if the feelings came out you'd just weep and weep and weep.  
[Silence of 1 minute, 3 seconds]
- T: Help yourself to some Kleenex if you'd like--Can you go now?  
[Silence of 23 seconds]
- T: I guess you really hate to, but I've got to see somebody else.  
[Silence of 20 seconds]
- T: It's really bad, isn't it?  
[Silence of 22 seconds]
- T: Let me ask you one question and say one thing. Do you still have that piece of paper with my phone number on it and instructions, and so on? [Client nods.] OK. And if things get bad, so that you feel real down, you have them call me. 'Cause that's what I'm here for, to try to be of some help when you need it. If you need it, you have them call me.

### EXCERPT 3

Jim S: I'd like to start with saying where I am and what I'm experiencing at this moment. This seems very artificial to me, all of these lights and the cameras and the people around. I feel breathless and burdened by the technical material, the equipment, etc., and I'm much more interested in getting away from the lights and the cameras and getting more in touch with you. [Inquires as to the names of participants of the group and introduces himself.]

I am assuming that all of you were in the audience this morning, that you saw the film and the demonstration; and my preference would be to work with you as you feel ready to work. I'll reiterate our contract, or agreement. In Gestalt therapy the essence of the contract is to say where you are, what you are experiencing at any given moment; and, if you can, to stay in the continuum of awareness, to report where you are focusing, what you are aware of.

We have a couple of empty chairs and sometimes if it becomes appropriate for you to work with a part of yourself, or another person, I'll ask you to imagine that that part of you or the other person is in the empty chair and to work "as if." I'm willing to work with you on anything--a dream, an interpersonal problem, an intrapsychic conflict, whatever.

I'd like to start first with having you say who you are and if you have any programs or expectations.

Jim 2: Right now I'm a little tense, not particularly because of the technical equipment because I'm kind of used to that. I kind of feel a little strange about being in a situation with you. This morning I was pretty upset because I didn't agree with a lot of the things you were talking about, and I felt pretty hostile to you. Now I more or less accept you as another person.

Jim S: I'm paying attention to your foot now. I'm wondering if you could give your foot a voice.

Jim 2: My foot a voice? You mean how is my foot feeling? What's it going to say?

Jim S: Just keep doing that, and see if you have something to say, as your foot.

Jim 2: I don't understand.

Jim S: As you were telling me about feeling hostile this morning, you began to kick and I'm imagining that you still have some kick coming.

Jim 2: Uh, yeah. I guess maybe I do have some kick left, but I really don't get the feeling that that's appropriate.

Mary: My heart was really racing. It still is. I feel very hot . . . no life . . . hot, sweating off anxiety. I found you this morning surprisingly kind and gentle, much more so than I had experienced you in the films that I'd seen. I felt that I could have been either one of those other two women you spoke of.

Jim S: Would you be willing to say what you are experiencing at this moment?

Mary: Well, my whole body is throbbing. I feel my whole . . . well, it's just pulsing. I'm just pulsing.

Jim S: That excites me. I like your pulsing.

Mary: That pleases me.

Jim S: I hope this is in color. You look very colorful now.

Mary: I feel colorful. I feel alive. I felt alive this morning.

Lavonne: Right now I'm feeling very tense.

Jim S: Who are you talking to, Lavonne?

Lavonne: I was just thinking about this morning. I was feeling very hostile. I still think I am somewhat hostile.

Jim S: I am aware that you are avoiding looking at me.

Lavonne: Yes, because I feel that you are very arrogant.

Jim S: That's true.

Lavonne: And as if I might get into a struggle with you.

Jim S: You might.

Lavonne: So the avoidance of eye contact is sort of a putoff of the struggle. I have some things that I'd like to work on. I don't know whether they can be resolved.

Jim S: Would you be willing to tell me what your objections are to my arrogance?

Lavonne: Well, it's not very comforting. If I have a problem and I talk to you about it and you're arrogant, then that only makes me arrogant.

Jim S: You respond in kind is what you are saying. Your experience is you respond that way.

Lavonne: Yes. Right on. Then at this university I feel that I must be arrogant and I must be defensive at all times. Because I'm black, people react to me in different ways . . . different people . . . and I feel that I have to be on my toes most of the time.

Jim S: [looks at her toes]: I was checking.

Lavonne: Well, I am on my toes now.

Mary: I want to work on my feelings for my older son and the struggle that I have with him--only, I suspect it is really a struggle I'm having with myself.

Jim S: Can you say this to him? Give him a name and say this to him.

Mary: All right. His name is Paul.

Jim S: Put Paul here [empty chair] and say this to Paul.

Mary: Paul, we have a lot of friction. Everytime you go out of the drive on your own, independent, I hate you for it. But . . .

Jim S: Just a moment. Say the same sentence to Mary. Mary, each time you go out the drive, independent, I hate you for it.

Mary: That fits. Mary, each time you go out the drive, independent, I hate you for it, because you are not being a good mother.

Jim S: I don't know about your because.

Mary: No. That's my rationale. That's the same I do to myself doing yoga.

Jim S: You sound identified with Paul.

Mary: I am. I know this. I envy his freedom, even from the time he was a little kid and went to the woods. I envied his ability to go to the woods.

Jim S: Tell Paul

**A P P E N D I X F**

**Figures**



Appendix F

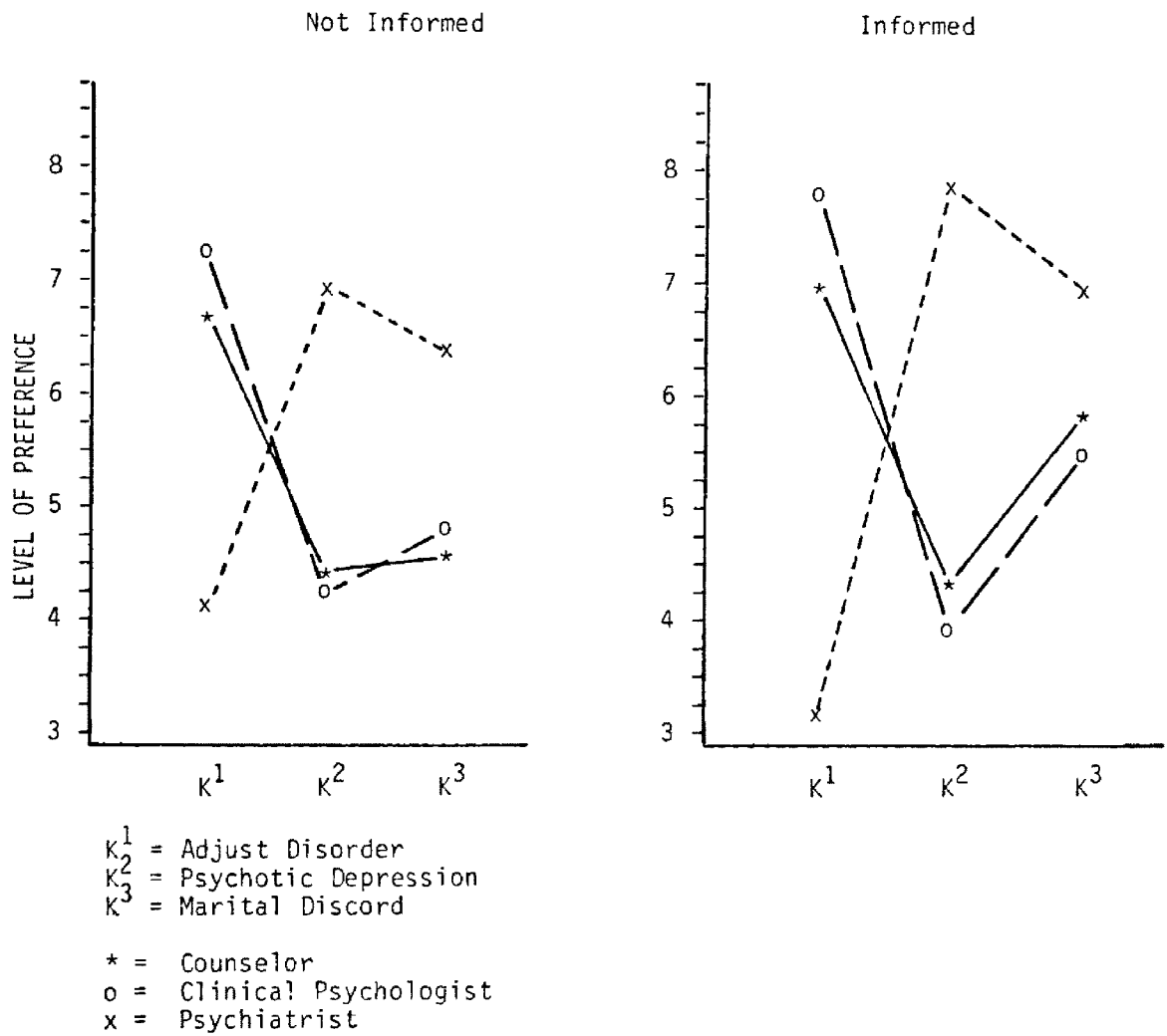


Figure 1

Graphical representation of the three factor interaction; Informed versus Not Informed X Type of Professional X Vignette Type

Appendix F

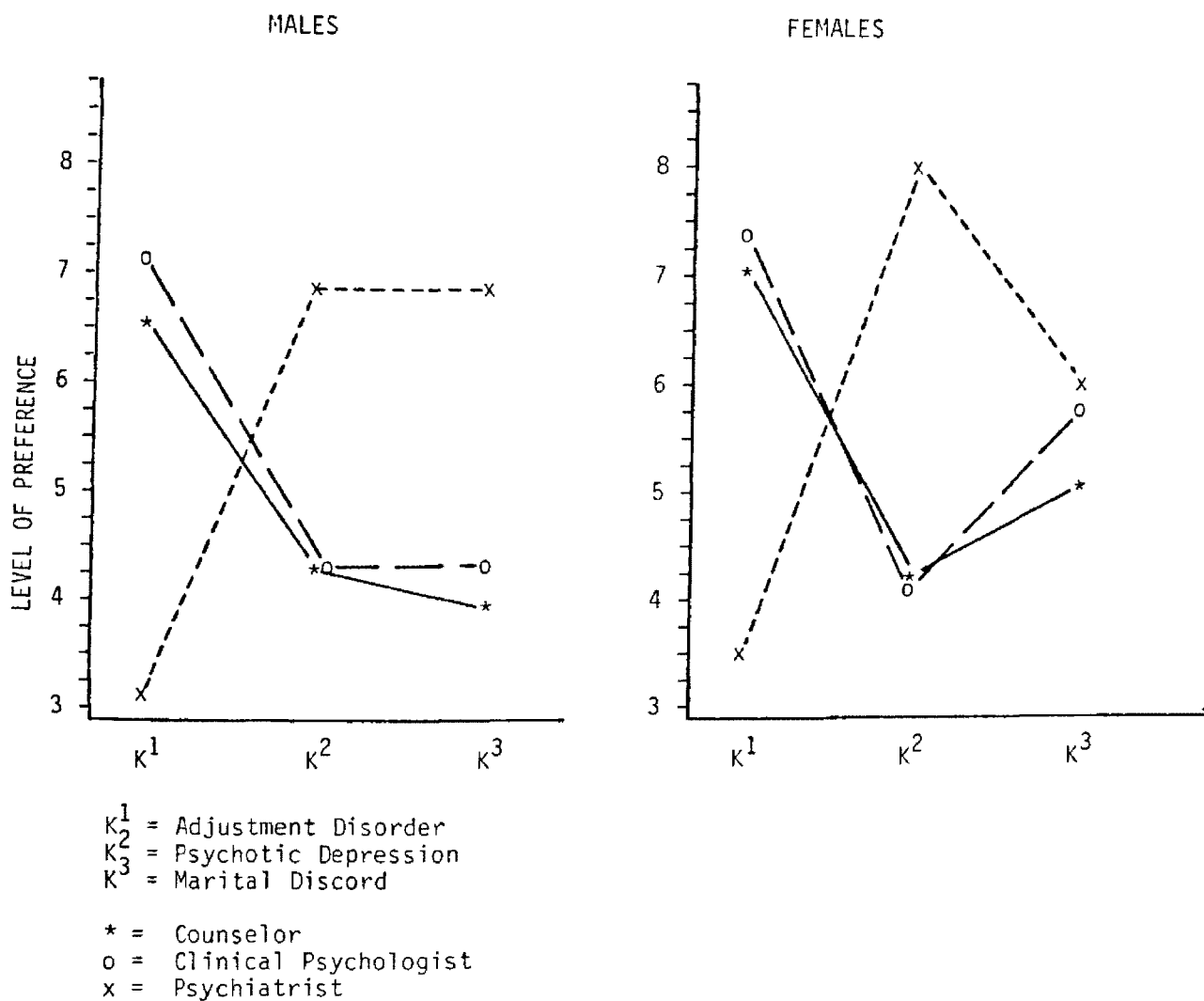


Figure 2

Graphical representation of the four factor interaction; Order X Gender X Type of Professional X Vignette Type

**A P P E N D I X G**

**Table**

Table 1  
Newman-Keuls Summation\*

Vignette type	Informed group	$\bar{X}$	Not informed group	$\bar{X}$
Adjustment Reaction	Clinical Psychologist	7.71 <sup>A</sup>	Clinical Psychologist	7.26 <sup>A</sup>
	Counselor	6.86 <sup>B</sup>	Counselor	6.61 <sup>A</sup>
	Psychiatrist	3.21 <sup>C</sup>	Psychiatrist	4.13 <sup>B</sup>
Psychotic Depression	Psychiatrist	7.86 <sup>A</sup>	Psychiatrist	6.84 <sup>A</sup>
	Counselor	4.31 <sup>B</sup>	Counselor	4.37 <sup>B</sup>
	Clinical Psychologist	3.83 <sup>B</sup>	Clinical Psychologist	4.25 <sup>B</sup>
Marital Disorder	Psychiatrist	6.90 <sup>A</sup>	Psychiatrist	6.42 <sup>A</sup>
	Counselor	5.71 <sup>B</sup>	Clinical Psychologist	4.88 <sup>B</sup>
	Clinical Psychologist	5.48 <sup>B</sup>	Counselor	4.65 <sup>B</sup>

\* Means with dissimilar letters following them indicate significant differences.