The Influence of Psychological Assessment Language On Counselor Trainees' Evaluations of Client Characteristics

by

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ABSTRACT

Psychological assessments contain important diagnostic information and are central to therapeutic service delivery. Therapists' personal biases, invalid cognitive schemas, and emotional reactions can be expressed in the language of the assessments they compose, causing clients to be cast in an unfavorable light. Logically, the opinions of subsequent therapists may then be influenced by reading these assessments, resulting in negative attitudes toward clients, inaccurate diagnoses, adverse experiences for clients, and poor therapeutic outcomes. However, little current research exists that addresses this issue. This study analyzed the degree to which strength-based, deficit-based, and neutral language used in psychological assessments influenced the opinions of counselor trainees (N= 116). It was hypothesized that participants assigned to each type of assessment would describe the client using adjectives that closely conformed to the language used in the assessment they received. The hypothesis was confirmed (p = .000), indicating significant mean differences between all three groups. Limitations and implications of the study were identified and suggestions for further research were discussed.

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TABLE OF CONTENTS

Page

Page

LIST OF TABLES

Table Page

LIST OF FIGURES

Figure Page

CHAPTER 1

INTRODUCTION

> We need to maintain a constant awareness of the impact of the words we choose to describe the behavior, attitudes, skills, limitations, emotions, and so on of …patients, family members, friends, and other staff members. Labels—diagnostic or descriptive, clinical or colloquial, benign or disparaging—have a tendency to stick, to spread… to resist modification, even in the face of contradictory evidence, [and] to trim or inflate our observations to conform to an established diagnosis. (Caplan, 1995, p. 234)

The practice of professional therapy has long been informed by the study of therapist-client communication dynamics[1]. Much research has examined the nuances of therapist-client communication, including analyses of language used (Small & Manthei, 1986); effective communication techniques (Sache, 1993); progress elicitation (Strong & Turner, 2008); and beyond. However, little research exists regarding communication dynamics between therapists, and even less regarding therapists' influences on each other's opinions about clients. This paucity is counterintuitive since modern therapy frequently requires client information to be shared between therapists, and since the information shared can affect diagnostic and treatment decisions.

Therapists commonly compose an important document, the psychological assessment, to communicate information about clients. This document synthesizes

[1] In the academic literature, the words "therapist" and "counselor" are used interchangeably to describe practitioners with at least master's-level training in mental health counseling or a closely related discipline. In this literature review, "therapist" will be used when referencing the academic literature and "counselor" or "counselor trainee" will be used when referencing the participants of this study.

information about a client from various sources including client self-report, medical records, interview of significant people in the client's life, results of psychological tests, and records from prior therapists (Groth-Marnat, 2009). The information is transcribed into a structured description of the client and interpreted in the assessing therapist's own words from his or her own perspective. Decisions about the client's diagnosis and treatment are based upon this document. However, two problems arise from this process: first, the biased opinions of therapists may be reflected in the language they use in their assessments; and second, this language may influence subsequent readers' opinions about clients. The current study addresses the second problem. In the following review, therapists' biases toward specific populations of clients, the effect of bias on assessment, and the influence of biased assessment on subsequent therapists are discussed.

Core Condition Compromised?

In his seminal 1957 article, "The Necessary and Sufficient Conditions of Personality Change," Carl Rogers introduced his model for what was to later become the foundation of person-centered therapy. Most notable in his model was the core condition that "the therapist experiences unconditional positive regard for the client" (p. 96). Rogers defined unconditional positive regard as a respectful, "warm acceptance" of the client's personhood and avoidance of imposing any "conditions of acceptance" or "selective evaluating attitude" (p. 98). He posited that the therapist's expression of these qualities encouraged self-disclosure and engendered the therapeutic process.

However, Rogers (1957) conceded that subjective factors within the therapist may prevent him or her from experiencing unconditional positive regard at all times:

> …the effective therapist experiences unconditional positive regard for the client during many moments of his [*sic*] contact with him [*sic*], yet from time to time he [*sic*] experiences only a conditional positive regard — and perhaps at times a negative regard, though this is not likely in effective therapy. (p. 98)

The following literature review will discuss several reasons why therapists may experience conditionally positive or negative regard for their clients. First, they can subscribe to biases and stereotypes against clients. Second, they can apply inaccurate cognitive schemas when assessing clients. Third, they can experience negative emotions toward clients, thereby compromising their clinical judgment. These biases, stereotypes, cognitive errors, and emotions may then be expressed in the language that therapists use in their assessments.

Therapists' Biases and Stereotypes Applied Toward Specific Populations

Racial and cultural bias. Among the most studied of therapist biases are racial and cultural biases. Recent data collected by the U.S. Department of Health and Human Services (2013, p. 9) indicated that approximately one third of clients receiving mental health counseling identified as racial minorities, whereas only 10% of therapists did. This dominant representation of Caucasian therapists can result in a presumption of Caucasian cultural values and definitions during the assessment process. For example, clients experiencing symptoms consistent with ataque de nervios or other forms of demonstrative stress response that are common in Latino cultures may be characterized as "hysterical," (Guarnaccia, Canino, Rubio-Stipec, & Bravo, 1993, p. 160) or "acting out" (Oquendo, 1994, p. 61) by therapists who subscribe to Caucasian definitions of stress response. Research indicates that therapists may also pathologize African American

clients. Specifically, African Americans are more likely to receive psychiatric diagnoses than any other racial group and are more likely to be diagnosed with schizophrenia (Whaley, 1997). African American clients are also likely to be described as "paranoid" (Whaley, 1997, p. 2), "angry" (Brown, 1990, p. 14), and "dangerous, criminal, or deviant" (Sue et al., 2007, p. 276).

Culture-related communication issues between therapist and client may also lead to biased assessment. Language barriers and the absence of an equivalent translation for symptoms may hinder clients from describing their symptoms in ways that are mutually understood, causing therapists to form their own interpretations. Additionally, clients of both Asian and Latino cultures may be hesitant to discuss the severity of their symptoms, may minimize or underreport symptoms, and are unlikely to challenge diagnoses due to cultural norms that emphasize agreeableness and deference to authority. Therapists may characterize these clients as uncooperative or passive (Malgady, Rogler, & Constantino, 1987; Sue et al, 2007).

Religious bias. Further challenges arise when clients' religious observances differ from the definitions of normative as described in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). O'Connor and Vandenberg (2005) noted that "the mental health field has a long history of considering religious beliefs and experiences as pathological" (p. 610) because diagnostic criteria in the DSM are based upon secular, scientific, predominantly Western perspectives. For example, clients experiencing spiritual visions that are common in many non-Western cultures and religions may be assessed as "delusional" (p. 611) or psychotic based upon Western definitions of acceptable observances.

Additionally, although current professional guidelines require therapists to have knowledge of a variety of religious beliefs and sufficient training in assessing whether such beliefs are maladaptive, some therapists may not. O'Connor and Vandenberg (2005) found evidence of this in their study of 112 master's and doctoral level mental health workers of varying religious beliefs. Participants were asked to read vignettes describing the presenting problems of three fictional clients. In one version of the vignettes the clients were identified as Catholic, Mormon, or Muslim. In another version the fictional clients' religions were not identified. In each vignette the clients expressed normative beliefs that were consistent with their own respective religions, and these beliefs were central to their presenting problems. Participants were then asked to assess the pathology of each client. Regardless of participants' religion or whether the religions of the clients were identified, the Muslim client was assessed as significantly more pathological and dangerous than the Catholic or Mormon client. The researchers posited that participants' lack of familiarity with Muslim religious beliefs and their favorable bias toward more familiar Western religious beliefs may have contributed to the results.

Sex bias. Evidence of sex bias in assessment has been noted in the literature for decades. Researchers have found evidence of negative opinions toward both men and women, and issues with equitable and accurate diagnostic procedures. Stiver (1986) was among the first to identify biased terms that have been used to describe women:

> Such terms as manipulative, seductive, controlling, needy, devouring, frigid, castrating, masochistic and hysterical have been used… with the clear implications that such patients are hard to tolerate, almost impossible to treat, and

> if one does not manage them carefully, one will be taken over, fused with, devoured, and so on. (p. 222)

In his literature review, Garb (1997) found that clinicians initially characterized male clients as violent more frequently than female clients; however, resulting client behaviors revealed that female clients were at least as violent as male clients and, in one study, considerably more. Garb also found evidence of a subtle bias in prognostic ratings, indicating that males received poorer prognoses than females even when case histories were identical.

In addition to negative opinions, biased application of diagnostic criteria may cause assessment issues. Ford and Widiger (1989) examined the assessment abilities of 266 psychologists. Participants were asked to read the case history of a male, female, or sex-unspecified fictional client with histrionic, antisocial, or sub-clinical symptoms and assess the client for both clinical symptoms and diagnosis. The researchers found significant differences in the resulting diagnoses of male and female clients. Specifically, participants were significantly less likely to diagnose the male client with Histrionic Personality Disorder than the female client, despite the fact that the symptoms described in the case history directly matched diagnostic criteria for Histrionic Personality Disorder. Participants were also significantly less likely to diagnose the female client with Antisocial Personality Disorder than the male client, despite a direct symptomatic match to that disorder, and instead were likely to diagnose her with Histrionic Personality Disorder. The researchers posited that participants may have ultimately conformed to sex-typical "stereotypic expectations" (p. 304) of the diagnostic labels rather than evaluating clients based upon individual symptoms.

Further evidence of sex bias in diagnostic procedures was noted by Boggs and colleagues (2009) in their study of men and women diagnosed with Borderline Personality Disorder. The researchers found that women diagnosed with the disorder were given higher Global Assessment of Functioning scores than were men, despite that "men and women were functioning at similar [diagnostic criterion] levels in the sample as a whole" (p. 67). The researchers hypothesized that some "gender-specific expressions" of the disorder that are not addressed in the DSM may have caused the incongruence and cautioned that "DSM-IV criteria that function differently for men and women can systematically overpathologize or underrepresent mental illness in a particular gender" (p. 67).

Gender role stereotypes and bias. Therapists may also exhibit belief in gender role stereotypes when assessing clients and pathologize clients who violate those stereotypes. This was observed by Seem and Johnson (1998) in their study involving male and female counselor trainees' case conceptualizations. The trainees were asked to read two fictional clients' presenting problems. In one scenario, a female client was considering long term career plans that may have prevented her from having children several years in the future. In the other, a male client was considering a homemaker role. The trainees were tasked with asking further questions about the client, assessing the client's presenting problem, and formulating treatment goals to be pursued. The researchers found evidence of a "motherhood mandate" whereby the participants held beliefs that "women must be mothers." Specifically, trainees' questions about the female client focused primarily on her role as a future parent over any other potential subject. Trainees' responses included such phrases as "The client needs to decide whether or not

she wants to risk not having children," and "Her real issue is having children." The researchers explained that the female client's career choice did not elicit bias, "but to choose against parenthood did." Trainees also expressed bias and doubt regarding the male client's wishes to be a homemaker, relaying concerns such as "Possible loss of power to wife in househusband role," and believing his decision to be a homemaker may have been due to "Fears of not being able to succeed in his chosen profession." Overall, trainees "seemed skeptical that a man could genuinely want to be a househusband" (p. 263).

Brown (1990) hypothesized that gender biases in assessment may result less from therapists' personal biases and more from "androcentric norms" inherent in the diagnostic criteria of many disorders in the DSM that pathologize non-masculine behaviors (p. 13). Knudson-Martin (2003) concurs that the DSM is "based on research that did not consider the impacts of gender and typically only studied men" (p. 52). Therefore, therapists who base their assessments on both the diagnostic criteria of the DSM and their own traditional beliefs about appropriate gender role behavior may misdiagnose clients who deviate from traditional gender norms.

Sexual orientation bias. Emergent research has also revealed evidence of therapists' sexual orientation biases. In their study on the therapy experiences of self-identified lesbian, gay, bisexual, and queer (LGBQ) clients, Shelton and Delgado-Romero (2011) documented statements made by heterosexual therapists as recalled by LGBQ clients. The researchers found that heterosexual therapists expressed their biases openly to clients by making "direct statements that suggested a conscious awareness of bias and negative attitudes" (p. 217) such as "the problem is that you are gay," and "you

are too pretty to be gay" (p. 216). Therapists also verbalized belief in stereotypes of lesbians as being codependent, gay males as being promiscuous, and both as having conflicts with family and religion. Additionally, therapists "infer[red] that participants' sexual orientation was the cause of all of their presenting issues" (p. 214). Finally, therapists pressured clients to stay in treatment even when clients' presenting problems had been resolved. The researchers concluded that this reflected therapists' beliefs "that LGBQ individuals are flawed and abnormal individuals who need to be in psychotherapeutic treatment" (p. 216).

Socioeconomic status bias. Clients' socioeconomic status (SES) may also affect therapists' opinions. According to Liu, Pickett, and Ivey (2007), the nature of modern therapy wherein a client seeks out an educated expert to resolve personal concerns is "derived from middle class and upper middle class White societal norms" (p. 197). These norms tend to place importance on wealth and social status, thus clients who do not subscribe to these values may be labeled "lazy, deviant, or unmotivated" (p. 197). Therapists may also assume a paternalistic role or characterize these clients as "victims [of their circumstances], without agency" (p. 198).

Symptom severity bias. Symptom severity is also closely associated with therapists' negative opinion. Accounts of negative attitudes toward acutely symptomatic clients pervade psychological literature, with many studies reporting therapists' negative opinions about these clients and/or reluctance to provide care. For example, Robbins, Beck, Mueller, and Mizener (1988) cited numerous adjectives that have been used to describe these clients, including "demanding, unreachable, help-rejecting, dangerous, poor[ly] fit," "entitled, stubborn, manipulative, hostile, and attention-seeking" (p. 490).

Calicchia's (1981) survey of psychiatrists, psychologists, and social workers revealed their opinions that the mentally ill were "somewhat dangerous, very ineffectual, and extremely undesirable" (p. 365). Since the acuity of this population's symptoms can persist for many years, negative attitudes toward these clients may be perpetuated throughout their lives.

Cognitive Errors and Their Impact on Assessment

Therapists' cognitive errors may also influence assessment. Attributional errors, or incorrect assumptions that clients' behaviors occur as a result of systemic flaws in clients' personhood and not environmental influences, may cause therapists to blame clients for their behaviors while ignoring other potential casual factors (Morrow & Deidan, 1992). As previously discussed, attributional errors may occur as a result of negative opinions about specific clients or a categorization of clients who conform to a certain diagnosis (e.g., clients with acute diagnoses or substance abuse issues). Attributional errors may also occur when therapists fail to collect complete information about their clients (Batson, 1975). Failure to assess the full scope of clients' presenting problems, including their histories and environmental factors that are outside of their locus of control, can result in negative regard toward clients.

Additionally, use of invalid heuristics, or mental shortcuts used to bridge gaps between known information and new information, can lead to inaccurate assessment (Morrow & Deidan, 1992). Therapists may use heuristics based upon experiences with prior clients or make inaccurate assumptions about the relationship between clients' past behaviors and their current presenting problems. Use of these erroneous assumptions and shortcuts, whether done consciously or not, "blinds one to the complexity of the human

being and the real meaning of the behavior in question" (Salzman, 1995, p. 185). Therapists may also be unlikely to change their negative opinions about clients once these cognitive errors are in place, resulting in therapists focusing on resolving the symptoms that are associated with their "label" and not on the personhood of the client (Malcus & Kline, 2001).

Emotional biases and their impact on assessment

Therapists also experience emotional reactions when assessing clients, which can lead to bias in assessment. Emotional exhaustion, or burnout, can challenge therapists' ability to accurately and ethically assess clients. Burnout can occur as a result of adverse workplace conditions, heavy client caseload, personal stress, and working with acutely symptomatic clients. Therapists suffering from burnout may become indifferent to client concerns or use hostility and sarcasm with clients (Watkins, 1983). In Brody and Farber's (1996) study, therapists reported feelings of anxiety, hopelessness, and frustration toward clients diagnosed with schizophrenia, and were likely to want to refer them elsewhere for therapy. Brody and Farber also found that therapists reported feelings of anger, irritation, and frustration toward clients diagnosed with borderline personality disorder. Further issues such as the nature of clients' criminal history can augment negative attitudes toward clients. For example, therapists of sex offenders can experience a broad range of negative feelings toward their clients including emotional hardening, shock, anger, cynicism, and helplessness (Farrenkopf, 1992, p. 217). Additionally, therapists who work with high-risk populations such as trauma survivors may suffer from vicarious traumatization while attempting to fully process clients' experiences. Therapists may

emotionally distance themselves from these clients in order to avoid negative feelings and minimize their own emotional distress.

Therapists may also feel anger or frustration toward clients who do not progress quickly through treatment or for whom therapeutic techniques are ineffective. To protect themselves against feelings of inadequacy they may associate "the failure of an interaction or an unsuccessful methodology or motivational strategy [with] supposed deficits and deficiencies within [the client]" (Salzman, 1995, p. 184). Such clients are "likely to be labeled as 'uncooperative' or 'hostile'" (Knudson-Martin, 2003, p. 53) by therapists in an effort to externalize accountability for these failures. For example, in her study of 39 male and female therapists and therapist trainees who had difficulties in their relationships with clients, Fisher (1989) found that male participants took less responsibility for the difficulties than their female colleagues, and more often characterized their female clients as unlikely to change.

Communication between therapists: Evidence of influence

While current research is sparse, there is some compelling evidence that therapists' assessments may have the effect of persuading subsequent readers. In their study involving 27 therapists with varying levels of expertise, Lange, De Beurs, Hanewald, and Koppelaar (1991) examined the effects of negative language used to describe clients in a family therapy session. In one scenario, negative information about the parents and positive information about the son was given; in another, neutral information was given about the family; and in another, negative information about the son and positive information about the parents was given. Therapists were then asked to view a videotape of a family therapy session, document their perceptions, and

recommended interventions. The researchers found a direct relationship between negative information given prior to viewing and resulting negative attitudes and interventions towards the clients. They found this effect was particularly strong when negative prior information was given about the mother. The researchers cautioned that "even a subjective and incorrect opinion conveyed by the person who referred the clients may distort the therapist's perception… and influence the therapist's behavior in a negative way" (p. 33).

Additional research found evidence that therapists rely heavily on prior assessments to inform their opinions. In a study conducted in Jerusalem, Ben-Shakhar, Bar-Hillel, Bilu, and Shefler (1998) gave two versions of a brief background assessment to psychologists, either paired with psychodiagnostic tests or not. Another group was given psychodiagnostic tests only. One assessment suggested features of Paranoid Personality Disorder, and the other suggested features of Borderline Personality Disorder. Participants were asked to prepare their own assessments based upon materials provided and diagnose the client described in the assessment. The researchers found that the background information given had a strong influence on subsequent diagnoses, and that diagnoses were "highly similar [to the background information] regardless of which test battery, if any, was combined with it" (p. 243). In a second phase of the study, the brief background assessments were replaced with only a short paragraph indicating a suggestion of a diagnosis. The researchers found that the groups who received this suggestion were likely to diagnose the client similarly to the suggestion, whereas the groups who received only the test batteries were not. Years later, Shefler, Ben-Shakhar, and Bilu (2009) performed a similar study. The researchers again found that the

participants' resulting assessments were "profoundly biased by the background suggestions" (p. 349).

These studies were conducted outside of the United States; therefore, the results may not be generalizable to the United States. Nevertheless, they provide evidence that therapists can be influenced by prior information about clients.

Current practices versus best practices in assessment

The rise of managed care in mental health has led to changes in traditional assessment procedures. These changes emphasize increased accessibility to mental health services through healthcare providers, brief therapeutic approaches, finite timelines for therapy, and concrete diagnoses to make healthcare billing clear. In their survey of therapists' current assessment methods, Piotrowski, Belter, and Keller (1998) found that 72% of the 137 service providers they surveyed "are relying more on short, brief self-report measures that tap target symptoms or problem areas, and less on tests that demand considerable clinicians' time," because of "managed care directives" (p. 441).

In addition to time constraints, therapists cite issues with billing for clients' presenting problems. In his survey of therapists who serve primarily Native American clients, Thomason (2011) found that many therapists wanted to diagnose clients with culture-bound syndromes when appropriate, but felt unable to do so because of current insurance billing practices. The therapists gave responses such as: "What insurance company would reimburse a clinician for susto or soul loss?", "If we can't bill for V-codes we're unlikely to use them", and "If clients have soul loss or spiritual intrusions, we use 'standard' diagnoses" (p. 29).

Meyer et al. (2001) discouraged the use of pared-down assessment practices, arguing that doing so can be detrimental to treatment:

> …many patients may be misunderstood or improperly treated when they do not receive thorough assessments. Errors of misappraisal and mistreatment are most likely when administrative efforts to save money restrict clinicians to very brief and circumscribed evaluations. (p. 151)

Meyer et al. further emphasized that multimethod assessment procedures must be used because they "provide a powerful antidote to the normal judgment biases that are inherent in clinical work" (p. 151). As the use of psychological testing decreases in favor of less time-constraining, more cost-effective basic assessments, the information communicated about clients may become more subjective. With more potential for error, then, it becomes even more important to focus on the content of assessments and the accuracy of their language.

Summary and Purpose of This Study

This review of literature has identified that therapists can communicate internalized biases, prejudices, and emotional reactions in the language they use to describe clients. It also emphasized the importance of using diagnostically accurate, unbiased language in psychological assessments and described evidence of therapists' failure to do so. Decades of consciousness-raising in psychological literature, restructuring of counseling program curricula to include competency courses, and mandates from licensing and professional organizations have all helped therapists to identify and correct their biases and emotional conflicts. However, therapists' labelling of clients is still noted in the literature and is still an issue in assessment practices.

Therapy frequently requires coordination of care between numerous professionals including therapists, clinical supervisors, and other members of treatment teams. Therapists rely upon psychological assessments written by these professionals to inform their initial opinions about clients. Some research suggests that the language used in psychological assessments may influence the opinions of subsequent readers, but the participants were not American. More studies using American participants are needed. The current study addresses that need.

This study investigated the influence of three different types of clinical assessments on counselor trainees' opinions about a client: one using positive, strengths-based language; one using neutral language; and one using negative, deficit-based language. The following research question was posed: Does the type of language used in specific clinical assessments influence counselor trainees' opinions about a client? It was predicted that the trainees would generalize from the assessments and believe that the client had characteristics consistent with the language used to describe the client. Specifically, it was predicted that trainees would believe that a client described with positive, strength-based language would have positive characteristics; that a client described with negative, deficit-based language would have negative characteristics; and that a client described using neutral language would have neither overtly positive or overtly negative characteristics.

CHAPTER 2

METHOD

Participants

The directory on the website for the Council for Accreditation of Counseling and Related Educational Programs (CACREP) was used to search for all Clinical Mental Health Counseling programs in the United States, and 174 unique universities were listed. Of these, four were excluded from this study due to missing contact information for their Program Directors and faculty. The university from which this study was conducted was also excluded because many students eligible for participation were recruited to be consultants and raters for this study. Thus, Program Directors of 169 CACREP-accredited Master of Clinical Mental Health Counseling programs throughout the U.S. were contacted via e-mail with an introduction to the study, a web link to the online survey, and a request to forward the e-mail to students in their programs. Participants were required to indicate their agreement on the survey's 'Introduction and Informed Consent' webpage prior to beginning the survey. Participation was voluntary. Participants were not offered financial reimbursement, but were given the option to submit their e-mail addresses upon completion of the survey to be entered into a drawing to win a US$50 Visa gift card. E-mail addresses were not attached to or associated with the online survey in order to maintain confidentiality. No demographic or identifying information was requested. The survey was made available to participants for a three week time period. In total, 139 respondents consented to participate. However, 23 did not complete the adjective selection task, leaving 116 participants as the final sample size.

Independent Variable

Similar to the Lange et al. (1991) study, three versions of a psychological assessment were used (see Appendices A, B, & C). The outline of the assessments was based upon the Standard Assessment form used at the Counselor Training Center at Arizona State University (ASU). Content for the assessments consisted of a synthesis of data obtained from the assessments of two real clients with similar diagnoses and demographics. To protect the clients' anonymity, specific details about their identities and histories were excluded or altered. The profile of one fictional client was created from this synthesis and three versions of assessments were drafted.

The first assessment described the client's history and current presentation using neutral language without interpretation. This assessment was the core set of neutral characteristics upon which the second and third assessments were built. The second assessment described the client using negative language that emphasized client deficits and interpreted the client's behaviors as maladaptive. The third assessment described the client using positive language that emphasized client strengths and interpreted the client's behaviors as adaptive. Each sentence or phrase in the neutral assessment was reframed to describe the client from a negative perspective for the deficit-based assessment and a positive perspective for the strength-based assessment. The core set of characteristics was maintained across all three assessments. For example, the phrase "She reports feeling 'Great! Really great! So ready!' today" from the neutral assessment was written as "She also presents with elevated, expansive mood inappropriate to setting and circumstances" for the deficit-based assessment, and as "She reports being in a 'Great!' mood and seems enthusiastic about beginning treatment" for the strength-based assessment. The deficit-

based version of the phrase was written to connote the assessing therapist's opinion that the client's "great" mood may be indicative of the client cycling into a manic episode. The strength-based version was written to connote the therapist's opinion that the client's mood was indicative of her readiness for change.

Prior to the study, three advanced graduate student consultants from ASU's Master of Counseling program and one from the Doctorate of Counseling Psychology program read each assessment. The consultants were first asked to improve each assessment on two dimensions: accuracy and believability, based upon a similar scale utilized by Wisch and Mahalik (1999). The dimension of accuracy related to how well the fictional client's symptoms represented the diagnosis. The dimension of believability related to how realistic the client's symptoms were based upon consultants' knowledge and/or experience. Consultants were also asked to perform a sentence-by-sentence matching of all assessments and provide written correction and/or oral feedback on the language to ensure that each assessment was clearly neutral, deficit-based, or strength-based. Consultants met as a group with the Principal Investigator to provide oral feedback and also communicated via e-mail. Consultants' suggestions were incorporated into the final drafts if at least two raters agreed that a correction was needed.

Two expert raters, a graduate from the Master of Counseling program and another from the Doctorate of Counseling Psychology program, were then recruited to rate the revised assessments on their Accuracy, Believability, and polarity of their language by using the Assessment Rating Sheet (see Appendix F). The Sheet consisted of two parts, both with six-point Likert scales. In Part 1, raters used the scale to rate the assessments' Accuracy and Believability from "Not at all" (a rating of 1) to "A great deal" (a rating of

6). Ratings of at least 4 for both Accuracy and Believability were considered acceptable. In Part 2, raters used the scale to rate the polarity of the language in the assessments from "Mostly negative, deficit-based verbiage" (a rating of 1) to "Mostly positive, strength-based verbiage" (a rating of 6). Mean ratings of 5 and 6 were acceptable for the strength-based assessment, mean ratings of 3 and 4 were acceptable for the neutral assessment, and ratings of 1 and 2 were acceptable for the deficit-based assessment. Written feedback was also obtained. Criterion was not reached on the dimension of Accuracy for one rater. Additional revisions to the assessments were completed based upon both raters' feedback. Finally, the rating process was repeated sans feedback with five new raters from the Master of Counseling program. Criterion was reached for Parts 1 and 2. In all, 11 consultants and raters were utilized to produce the final versions of the assessments. Consultants and raters were offered their choice of lunch or an equivalent Amazon.com gift card for their assistance.

Dependent Variable

The consultants were also asked to provide assistance with selecting the adjectives used to describe the fictional client. The adjectives originated from a master list conceived by Dorre (2003, p. 56) of commonly-used clinical adjectives. In her study, 104 counselors and counseling psychologists used a seven-point Likert scale to rate 40 adjectives commonly used to describe clients. Participants in Dorre's study rated each adjective from -3 to +3 on how "respectful" they were, and mean ratings for the adjectives were obtained. Means and standard deviations for the adjectives are listed in Appendix D. Dorre's study reported factor loadings of ±.40 for 37 adjectives, classified into three categories: "Informal Negative Descriptors," "Informal Positive Descriptors,"

and “Clinical Diagnoses and Descriptors.” Each of the 37 adjectives loaded on only one of the three factors, except “Compliant.” Two adjectives were dropped for insufficient factor loadings.

Consultants for this study were asked to select adjectives from Dorre’s list that were general, clear, and relevant to the client. Fourteen adjectives were selected from Dorre’s list that represented a range from disrespectful to respectful (see Appendix E). Seven from the “Informal Negative Descriptors” and five from the “Informal Positive Descriptors,” were selected. The adjective “Compliant” was dual-loaded as both a positive and negative descriptor. However, Dorre interpreted it as generally positive, as did the consultants for this study. One term, “Helpless,” was excluded by Dorre due to insufficient factor loadings but was selected by the consultants of this study due to its relevance to the client. These fourteen adjectives comprised the final list used in this study.

Participants were asked to select at least two adjectives from the final list that they would use to describe the client, based upon their own clinical judgment. Selection of at least two adjectives was recommended by an expert statistician to ensure that participants could sufficiently express their view about the client (S.B. Green, personal communication, October 30, 2014). Ratings for the adjectives selected by each participant were obtained from Dorre’s list and were summed to produce a mean score for each participant. For example, the mean score of “Withdrawn,” “In Denial,” and “Dependent,” with respective adjective ratings of .41, -.41, and -.25, was obtained by summing the ratings and dividing by the number of adjectives selected, resulting in a mean score of -.25.

Procedure

Participants were recruited via e-mail through their respective Program Directors. Students who chose to participate followed a web link in the e-mail to an online survey. After reading the first webpage, 'Introduction and Informed Consent,' participants could select the "Yes" button to proceed with the study, or "No" and exit the study. Participants were informed that the purpose of the study was to analyze counselor trainees' opinions about a fictional client. Participants were randomly assigned by the online survey program to one of three assessments describing the same fictional client in either neutral language; negative, deficit-based language; or positive, strengths-based language. On the second page, participants were asked to read the assessment shown. On the final page, participants were asked to select at least two adjectives that they believed best described the client, based upon their own clinical judgment. The adjectives were presented in random order. Once completed, the online survey was concluded and participants were provided with an e-mail address to contact in order to be entered into the study's drawing.

Analyses

This study used a one-way analysis of variance to evaluate the relationship between assessment group and the adjectives selected to characterize the client described in the assessment. The independent variable, assessment group, included three levels: neutral, deficit-based, and strength-based. The dependent variable was the participants' mean score associated with the adjectives they selected to describe the client.

An a priori power analysis was performed via G*Power to determine adequate sample size. An alpha of .05, estimated power of .80, and a moderate effect size of .25 yielded an appropriate *N* of 159 participants, though this *N* was not ultimately obtained.

CHAPTER 3

RESULTS

The ANOVA was significant, $F(2, 113) = 61.12$, $p = .000$. The strength of the relationship between assessment group and participants' scores, assessed by η^2, was strong, with assessment group accounting for 52% of the variance in participants' scores. Descriptive statistics are reported in Table 1.

Follow-up tests were conducted to evaluate mean differences between the three assessment groups. A Dunnett's *C* test for unequal variances was performed due to several considerations including small sample size, unequal Ns in each group, and a notable range of variance among the three groups. Significant mean differences were reported between all groups, which are reported in Table 2.

Table 1

Descriptive Statistics of Assessment Groups

Assessment Group	*N*	*M*	*SD*	Min/Max
Neutral	41	.41	.66	-.68 to 1.99
Deficit-Based	36	-.14	.46	-.77 to 1.54
Strength-Based	39	1.42	.71	-.40 to 2.08

Table 2

Pairwise Mean Differences and 99% Confidence Intervals of Comparisons

Assessment Group Comparison	MD	CI
Neutral with Deficit-Based	.55*	.15 to .95
Neutral with Strength-Based	-1.01*	-1.49 to -.54
Deficit-Based with Strength-Based	-1.56*	-1.98 to -1.13

*The 99% confidence interval does not contain zero. MD is significant using using Dunnett's *C* procedure.

Examination of the specific adjectives chosen by each group revealed differences in their opinions, reported in Table 3. As predicted, participants assigned to the strengths-based assessment group selected generally respectful adjectives to describe the client, reflecting their positive opinions. "Motivated" was the most frequently selected (62%), followed by "Cooperative" (54%) and "Compliant" (26%). No participants described the client as "Helpless" or "Withdrawn," and only one participant (3%) described the client as "Difficult." In contrast, participants assigned to the deficit-based group responded with generally disrespectful terms describing the client as "Withdrawn" (50%), "In Denial" (41%), and "Resistant" (39%). Further, they were highly unlikely to select any of the most respectful terms including "Motivated" (0%), "Insightful" (3%), and "Intelligent" (3%). The neutral assessment group showed a broad range of adjective selections, with most falling mid-range (see Figure 1).

Table 3

Percentage of Adjectives Selected by Assessment Groups

Adjective	Assessment Group		
	Neutral	Deficit-Based	Strength-Based
Helpless	7	19	0
Difficult	15	14	3
Aggressive	5	14	8
In Denial	41	39	10
Resistant	24	36	3
Acting Out	5	14	3
Dependent	51	33	13
Withdrawn	5	50	0
Compliant	22	8	26
Assertive	12	3	10
Cooperative	22	6	54
Motivated	17	0	62
Insightful	5	3	10
Intelligent	10	3	10

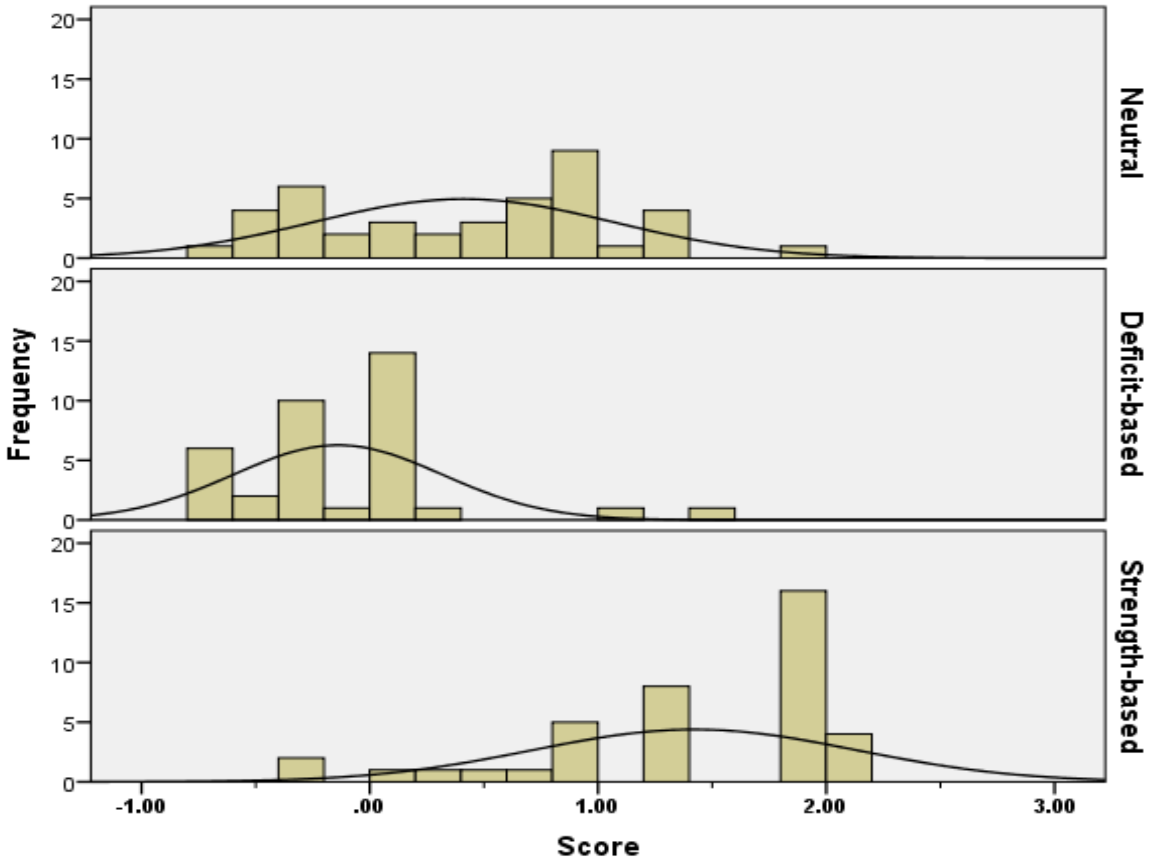

Figure 1. Frequencies of Adjectives Selected By Assessment Groups

CHAPTER 4

DISCUSSION

The purpose of this study was to determine if biased language used in psychological assessments could influence the opinions of counselor trainees. Participants read one of three assessments describing a client with neutral language, strength-based language, or deficit-based language. Results indicated that the trainees were significantly influenced by the language in the assessments in that they expressed a positive, respectful view of the client; a mixed view; or a negative, disrespectful view of the client depending on which assessment they read. A majority of the trainees who read the strength-based assessment used positive, respectful terms such as "Motivated" and "Cooperative" to describe the client. Trainees who read the deficit-based assessment used generally negative, disrespectful terms such as "Withdrawn," "In Denial," and "Resistant." Trainees who read the neutral assessment used a variety of terms ranging from positive to negative. ANOVA and post-hoc testing showed that the groups' responses were significantly different from one another, and that at least 52% of the variance between these groups was attributed to the type of assessment they read.

This study supports the existing research of Lange, DeBeurs, Hanewald, and Koppelaar (1991); Ben-Shakhar, Bar-Hillel, Bilu, and Shefler (1998); and Shefler, Ben-Shakhar, and Bilu (2009) cited earlier in this review. However, the current study may improve upon this research by strengthening and simplifying the research design. Specifically, the Lange et al. study had therapists evaluate three clients interacting with each other simultaneously, requiring therapists to evaluate them individually and as a family unit. The current study uses one client, allowing participants to focus on the

clients' presentation completely. In the Ben-Shakhar et al. study, therapists were given three different completed psychodiagnostic tests and background information for the client they were tasked to assess. However, these tests were from three different real clients unrelated to the study and were "intended to produce an essentially [ambiguous] non-diagnostic battery" (p. 238). As intended, the test batteries were found to have no effect on therapists' opinions about the client. The current study eliminated such extraneous, time intensive tasks and provided one brief source of prior information. Further, this study provides current data on a U.S. population of counselor trainees, whereas the most recent existing literature originated outside the U.S. and used mostly professional therapists.

Limitations

While the results of the ANOVA and post-hoc tests were strong, the study does have some limitations. First, the Brief Assessment used in the study was notably brief, whereas standard psychological assessments contain a much more comprehensive review of the client. Limiting the Assessment's content to one page was deemed necessary to fit it into the web-based survey program's margins and promote ease of reading. However, the decision of aesthetics over comprehensiveness may have excluded some details that the participants needed to formulate a full clinical impression, causing them to answer with limited data. This lack of details may have resulted in a small number of adjectives selected by participants, as 80% selected the minimum amount required. Second, the client described in the Brief Assessment possessed a number of characteristics that counselor trainees may have had insufficient experience with, including being a community-based client, her diagnosis of bipolar disorder, her low level of functioning

(GAF), and her unemployment status. To control for this potential confound, participants were required to have completed at least one semester of direct client contact. However, because counselor training programs throughout the U.S. vary in their contact requirements and access to client populations it is difficult to determine if participants had enough experience with clients of similar characteristics to the client in the Brief Assessment to fully understand her presentation. Therefore, it is possible that inexperienced participants were more easily influenced by the biased language used in the strengths-based and deficit-based assessments than more experienced participants were. This effect may have inflated mean scores for those groups. Additionally, participants only had fourteen adjectives to choose from, which limited how fully they could express their opinions about the client. Participants may have selected more adjectives if provided with a longer and more diverse list. Finally, the process of polarizing the deficit-based and strength-based assessments altered, omitted, or rearranged some core client characteristics on both assessments, making the characteristics somewhat qualitatively different in each assessment. It is possible that these differences in characteristics influenced participants' opinions about the client more than the language used to describe the client. The data obtained, then, should be interpreted with caution.

Implications

The results of this study have implications for several aspects of counselor training and practice. First, as the results of this study demonstrate, counselor trainees' opinions can be significantly influenced by the information given to them about their clients, and they make generalizations about their clients based upon the information.

Trainees summarily agreed with the directional bias of the language in each assessment despite that the same symptoms, history, and diagnosis were presented, and despite the instructions to use their own clinical judgment to evaluate the client. This is particularly of note for trainees in the deficit-based group as they were influenced to take a generally negative, disrespectful view of the client. Program Directors for counselor training programs should consider adding a component to their assessment courses that teaches trainees how to identify biased language in assessments and how to compose their own unbiased assessments. Program Directors should also ensure that trainees have enough confidence in their assessment skills to assert their own view when others' seem incorrect or unethical. Clinical supervisors of trainees should meet with trainees individually to help them identify their personal biases and areas for growth. Clinical supervisors of early-career counselors should also review their supervisees' assessments regularly to note signs of negative bias and meet to discuss.

Further, Program Directors and clinical supervisors should refrain from encouraging trainees to take an overtly strength-based approach to assessment. While it is important to note clients' strengths and resources, this approach could cause trainees to minimize, overlook, or incorrectly diagnose their clients' more serious symptoms and concerns. Trainees should be encouraged to take a balanced approach to assessment, noting both strengths and struggles as realistically as possible.

Future Research

The results of this study support the results of existing studies that analyzed how biased language in psychological assessments can cause subsequent readers to develop a biased view of the client. However, further research is needed. Future studies should

expand upon this research in several ways. First, since the Lange, et al. (1991) study found that age and level of expertise may influence responses, future studies should obtain demographic information such as theoretical orientation, prior relevant work experience, gender, and age to determine if these factors influence scores. Second, since the response options were both forced-choice and limited to 14 terms, future studies should provide an opportunity for participants to explain their answers or give feedback. Finally, future studies should continue to build on this study's findings by developing an effective training battery to help trainees identify their negative biases and reduce them. Ideally, this training battery could be used in counselor training programs nationwide to enhance counselor trainee competencies and ultimately improve treatment outcomes for clients.

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APPENDIX A

NEUTRAL ASSESSMENT

Directions: The following Brief Assessment was found in the file of a client who was recently transferred to your Agency for outpatient counseling. Read the Assessment, then select **AT LEAST TWO** adjectives on the next page that you believe might best describe the client. You may refer back to the Assessment during your selection.

Brief Assessment

Presenting Problem: C.J. is a 35-year-old client referred to the Agency for assistance with managing anxiety and learning coping skills. She reports experiencing anxiety, insomnia, and physical restlessness for the past two weeks, though she reports being unsure of the cause. She currently presents with toe tapping, chair shifting, and distractibility. She reports she is feeling "Great! Really great! So ready!" today.

Mental Health/Substance Abuse History: Client reports she was diagnosed with Bipolar Disorder at age 20 and has undergone inpatient and outpatient treatment since then. Client reports no history of alcohol or substance use.

Treatment Interventions: Client reports having been prescribed various antipsychotics and mood stabilizers over the past 15 years; details unspecified. Client states she prefers Ativan and that most other medications produce negative side effects. Client reports having learned several coping strategies as a result of therapy, including "thought stopping, journaling, watching TV, and talking about it." Client reports she implements these strategies with varied success.

Educational/Vocational Status: Client has a high school diploma and attended some college courses toward a culinary arts degree. Client has been unemployed since age 25 due to her symptoms. Client reports a desire to pursue work as a "veterinarian, psychologist, or CEO of a Fortune 500 company." Last year, client attended six out of 22 days of coursework in a vocational rehabilitation program. Client states she did not like the program and does not plan to complete it.

Current Living Situation: Client currently lives in an apartment located at a Supported Community Living site. Client receives assistance with taking her medications from staff at the site. Client reports a desire to live independently, but has not yet drafted an Action Plan for this goal.

Social Supports and Activities: Client reports good relationships with family and other residents of the site. Client maintains weekly contact with a friend from high school via phone. Client's mother takes client out to breakfast every few weeks. Client spends most days resting and watching TV, and attends community outings with staff and other residents when invited.

Risk Factors: Historical records indicate client initiated an altercation with her mother at age 20 during which she hit her mother. Client was subsequently hospitalized and

received her initial diagnosis. Hospital records from 2008 also indicate client once pushed another patient "without provocation."

Diagnosis:
Axis I: 296.41 Bipolar Disorder, Manic, Mild
Axis II: Deferred
Axis III: None
Axis IV: Lack of Social Support
Axis V: 65

APPENDIX B

DEFICIT-BASED ASSESSMENT

Directions: The following Brief Assessment was found in the file of a client who was recently transferred to your Agency for outpatient counseling. Read the Assessment, then select **AT LEAST TWO** adjectives on the next page that you believe might best describe the client. You may refer back to the Assessment during your selection.

Brief Assessment

Presenting Problem: C.J. is a 35-year-old female referred to the Agency for problems with managing anxiety and learning coping skills. She reports being anxious, sleepless, and physically restless for the past two weeks, though she lacks insight regarding the cause. She currently presents with an inability to sit calmly and focus. She also presents with elevated, expansive mood inappropriate to setting and circumstances.

Mental Health/Substance Abuse History: Client reports a long history of bipolar disorder, requiring revolving inpatient and outpatient treatment since age 20. Client denies any history of alcohol or substance use.

Treatment Interventions: Client reports having been prescribed numerous antipsychotics and mood stabilizers over the past 15 years but could not remember many specifics about them. Client states she only wants to take Ativan and that any other medication is "intolerable." Client has received treatment for over 15 years but was only able to identify four coping strategies: "thought-stopping, journaling, watching TV, and talking about it." Client admitted she is unable to implement these strategies consistently and effectively.

Educational/Vocational Status: Client has a high school diploma. Client dropped out of college after only a few courses. Client has not worked in over ten years. Last year, client dropped out of a vocational rehabilitation program after six days of coursework. Client stated it was "boring" and refuses to return. Despite her low level of functioning, client reports grandiose goals of being a "veterinarian, psychologist, or CEO of a Fortune 500 company."

Current Living Situation: Client is voluntarily living in an apartment located at a Supported Community Living site. Site staff monitor client to ensure she takes her medications. Client reports the desire to live independently but has taken no initiative toward doing so.

Social Supports and Activities: Though client reports good relationships with family, client's mother only visits every few weeks. Client has one friend from high school but does not visit her and only talks with her via phone once a week. Client reports amiable relations with other residents at the Community Living site. Staff at the site report that client spends most of her day in bed or watching TV. Client will attend community outings with staff and other residents when encouraged to do so.

Risk Factors: Historical records indicate client violently assaulted her mother at age 20. Client was hospitalized and diagnosed following the assault. Hospital records from 2008 also note that client once physically attacked another patient "without provocation."

Diagnosis:
Axis I: 296.41 Bipolar Disorder, Manic, Mild
Axis II: Deferred
Axis III: None
Axis IV: Lack of Social Support
Axis V: 65

APPENDIX C

STRENGTH-BASED ASSESSMENT

Directions: The following Brief Assessment was found in the file of a client who was recently transferred to your Agency for outpatient counseling. Read the Assessment, then select **AT LEAST TWO** adjectives on the next page that you believe might best describe the client. You may refer back to the Assessment during your selection.

Brief Assessment

Presenting Problem: C.J. is a 35-year-old woman referred to the Agency for support with managing anxiety and learning additional coping skills. She reports feeling anxious, sleepless, and physically restless for the past two weeks, and would like to discover the cause. She presents in office today with some excess of energy and is very attentive to her surroundings. She reports being in a "Great!" mood and seems enthusiastic about beginning treatment.

Mental Health/Substance Abuse History: C.J. has suffered from bipolar disorder since age 20. She has utilized inpatient and outpatient care for ongoing support since then. She has no history of alcohol or substance use.

Treatment Interventions: C.J. reports she has been prescribed many antipsychotics and mood stabilizers over the past 15 years but did not report details about them at this time. She identified that Ativan is particularly helpful to manage her symptoms and that most other medications cause her to suffer unpleasant side effects. She identified that "thought stopping, journaling, watching TV, and talking about it" are coping strategies she can implement.

Educational/Vocational Status: C.J. is a high school graduate. She passed five college courses in culinary arts. She has been unable to work since age 25 due to her symptoms. She currently has ambitious vocational goals to work as a "veterinarian, psychologist, or CEO of a Fortune 500 company." Last year, she passed six daily modules in a vocational rehabilitation program but ultimately decided the program did not meet her needs.

Current Living Situation: C.J. voluntarily resides in her own apartment located at a Supported Community Living site. She receives support from staff at the site when taking her medications. She reports a goal of living independently someday.

Social Supports and Activities: C.J. reports good relationships with her family and other residents at the site. She enjoys visiting with her mother every few weeks. She maintains a close friendship with a friend from high school and talks with her weekly via phone. Most days, C.J. enjoys relaxing at home and watching her favorite TV shows. She also attends community outings with staff and other residents when invited.

Risk Factors: Historical records indicate that C.J. was involved in a physical altercation with her mother at age 20. She was subsequently hospitalized and learned about her

initial diagnosis. More recent hospital records also indicate a single incident of hostility toward another patient many years ago.

Diagnosis:
Axis I: 296.41 Bipolar Disorder, Manic, Mild
Axis II: Deferred
Axis III: None
Axis IV: Lack of Social Support
Axis V: 65

APPENDIX D

MASTER LIST OF ADJECTIVES (DORRE, 2003)

Means and Standard Deviations of Adjective Ratings for Respectful/Disrespectful Dimension

Term	*M*	*SD*
Whiner	-2.42	.85
Anal	-1.97	1.08
Manipulative	-1.53	1.25
Immature	-1.30	1.26
Irresponsible	-1.21	1.38
Narcissistic	-1.18	1.50
Needy	-1.17	1.09
Helpless*	-1.13	1.36
Dysfunctional	-1.11	1.36
Paranoid	-1.05	1.33
Difficult*	- .96	1.35
Irrational	- .95	1.69
Negative	- .82	1.30
Unmotivated	- .74	1.42
Attention-seeking	- .71	1.41
Passive-Aggressive	- .69	1.48
Controlling	- .66	1.26
Evasive	- .60	1.23
Codependent	- .53	1.35
Borderline Personality Disorder	- .47	1.69
Aggressive*	- .46	1.41
In Denial*	- .41	1.52
Resistant*	- .40	1.42
Defensive	- .32	1.29
Acting Out*	- .25	1.47
Dependent*	- .25	1.21
Obsessive	- .14	1.22
Inappropriate	- .07	1.47
Addicted	.19	1.45
Obsessive-Compulsive Disorder	.21	1.41
Bipolar Disorder	.36	1.37
Withdrawn*	.41	1.28
Compliant*	.57	1.39
Angry	.67	1.39
Client	1.30	1.44

Appendix D, continued

Assertive*	1.83	1.01
Cooperative*	1.98	1.26
Motivated*	2.01	1.18
Insightful*	2.15	1.21
Intelligent*	2.22	1.02

Note. Means and standard deviations are ranked in order from disrespectful to respectful.
* Adjectives selected for the current study are indicated with an asterisk.

APPENDIX E

ADJECTIVE CHECKLIST

Directions: Although you may not have enough information about the client at this time to formulate a full impression, please select **AT LEAST TWO** of the following adjectives that you believe best describe this client. Use your clinical judgment to guide your impression. You may refer back to the Assessment during your selection.

___ Cooperative	___ In Denial	___ Assertive	___ Motivated
___ Withdrawn	___ Acting Out	___ Intelligent	___ Dependent
___ Compliant	___ Resistant	___ Aggressive	
___ Insightful	___ Difficult	___ Helpless	

APPENDIX F

ASSESSMENT RATING SHEET

Part 1- Directions: Read the assessments provided. Then circle the number below that best represents your rating on the following three dimensions.

	Not at all					A great deal
Accuracy: The client's symptoms and history are generally consistent with her diagnosis	1	2	3	4	5	6
Believability: The client's symptoms and history seem generally realistic	1	2	3	4	5	6

Part 2- Directions: Rate each assessment on the overall type of verbiage used to describe the client. Circle your rating below.

	Mostly negative, deficit-based verbiage		Mostly neutral verbiage			Mostly positive, strengths-based verbiage
Assessment 1:	1	2	3	4	5	6
Assessment 2:	1	2	3	4	5	6
Assessment 3:	1	2	3	4	5	6

APPENDIX G

INTRODUCTION AND INFORMED CONSENT FORM

Thank you for your interest in participating in this study. This study is being conducted to analyze counselor trainees' opinions about a fictional client. Your participation will involve reading a Brief Psychological Assessment and responding to a question about the client. It may take approximately 10 minutes to complete. No identifying information will be requested. Your participation in this study is voluntary. If you choose not to participate or to withdraw from the study at any time, you may do so without penalty by closing your web browser window. You must be 18 or older and have completed at least one semester of direct client contact in a Master of Clinical Mental Health Counseling program in order to participate in this study.

Even though there are no direct benefits for participating in the study, your participation will provide valuable information that may ultimately help counselor training programs. Upon completing the questionnaire, you will be invited to provide your email address for an opportunity to win one of two US$50 Visa gift cards in a drawing. You may decline the invitation by not clicking on the link to provide your email address. A random drawing will be completed at the end of the study, and the winner will be notified by email. Your email will NOT be linked to any materials in the study. Completion of the questionnaire in full will be considered your consent to participate in this study.

Data will be collected and stored within this survey-based program, as well as in a secured hard drive in the office of Dr. Richard Kinnier, advisor to the principal investigator, at Arizona State University. Data will be kept for at least five years. All data within the survey-based program will be password protected. Only Dr. Kinnier and the principal investigator will have access to the data. The results of this study may be used in reports, presentations, or publications only in the aggregate form.

This research has been reviewed and approved by the Social Behavioral Institutional Review Board at Arizona State University. If you have any questions concerning the study, please contact Angela Scott, principal investigator, at anscott2@asu.edu, or Dr. Richard Kinnier at kinnier@asu.edu. If you have any questions about your rights as a participant in this research, or if you feel you have been placed at risk, you can contact the Institutional Review Board at (480) 965-6788 or by email at research.integrity@asu.edu.