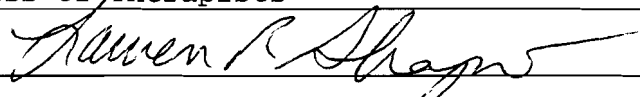


AN ABSTRACT OF THE THESIS OF

Heather M. Walden for the Master of Science

In Psychology presented on July 5, 2001

Title: The Influence of Gender and Therapy Type on the Perceived Effectiveness of Therapists

Abstract approved: 

This study investigated the effects of counselor gender, participant gender, and type of therapy on the perceived effectiveness of therapists. Participants were 110 male and female college students from a southern university. Participants were given one of four possible therapy scenarios to read and then evaluate using the Therapist Effectiveness Questionnaire. The scenarios differed in treatment type (cognitive-behavioral vs. client-centered) and therapist gender (male vs. female). Results indicated no interaction effects between therapy type, gender of therapist and gender of participant. However, women rated therapists significantly higher on trustworthiness than did men and all participants rated client-centered therapists as more understanding than cognitive-behavioral therapists.

THE INFLUENCE OF GENDER AND THERAPY TYPE
ON THE PERCEIVED EFFECTIVENESS OF THERAPISTS

A Thesis

Presented to

the Department of Psychology and Special Education

EMPORIA STATE UNIVERSITY

In Partial Fulfillment

of the Requirements for the Degree

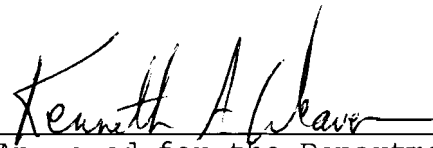
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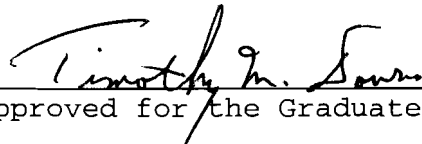
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CHAPTER 1

INTRODUCTION

The number of people with mental illness is higher than the number of clients being helped with psychotherapy (Sexton & Whinston, 1991). Why are people not getting help? One reason is that clients must be comfortable with both the therapist and the prescribed therapy. Several factors can influence a client's perception of a therapist and the therapy process (Luborsky, 1987; Kazdin, 1986; Lambert, Shapiro, & Bergin, 1986), and therefore, will play a role in the client's decision to seek and/or continue therapy. There is research on everything from décor of the office (Bloom, Weigel, & Trautt, 1977) to status of the counselor (Beutler, Cargo, & Arizmendi, 1986; Luborsky, Crits-Christoph, Mintz, & Auerbach, 1988).

The fields of Clinical Psychology and Counseling Psychology present a wide array of therapy approaches. Some of these therapy approaches are based upon particular theories, whereas others are patterned after a more eclectic style. Many researchers have focused on how clients with various disorders respond to specific types of therapy. As a result, some treatments have been found to be more effective than others for certain diagnoses (Brewin, 1996), such as depression (Miller, Norman, & Keitner, 1989; Meyer, 1981).

Ultimately, however, it is the responsibility of therapists to determine which approaches they will use in their practices. The question of what types of therapy are generally preferred and

considered effective by clients is an ongoing question. Consequently, research is needed to help clinicians ascertain what factors affect clients' perceptions of therapists and treatment effectiveness. When clients judge their therapists and therapies to be effective, they respond well to and benefit from the counseling sessions (Ponterotto & Furlong, 1985). The amount of research available on client preferences is limited (e.g., Holen & Kinsey, 1975; Uhlemann, Lee, & Hett, 1984), therefore making further research necessary.

For purposes of the present study, two very different therapy techniques were presented. These two techniques are cognitive-behavioral and client-centered therapy. Cognitive-behavioral and client-centered therapies have quite different approaches to the therapy process. Cognitive-behavioral therapy presents as an active, goal-oriented type of therapy (Andrews, 1996), whereas client-centered therapy presents as a more empathetic type of therapy (Kramer, 1995). Cognitive-behavioral and client-centered therapies will be examined in conjunction with the sex of the therapist applying these therapies. Although type of therapy and sex of therapist have been studied in the past (e.g. Bernstein & Figioli, 1983; Kelly & Byrne, 1977), research investigating the effects that one has on the other is sparse.

This investigation not only added to the body of research available, but served as an aid in helping therapists to select efficient therapies. The results clarified what it is the clients

want out of the therapy process and what biases they may have before the session even starts. These biases become integrated into clients' decisions to continue therapy. Therefore, an awareness of these potential biases, may allow therapists to avoid or to address client biases during therapy. In the next section, the two therapies selected for this study are described along with the role of sex in client perception of the counselor, factors that affect client's evaluation of therapy, and finally, the present study.

Therapy Techniques

The two therapies of interest for the present study are cognitive-behavioral and client-centered. These two therapy techniques were chosen due to their proven effectiveness with depression (Miller et al., 1989; Kramer, 1995), which will be the client's presenting problem in the current study. These two approaches were also chosen because of differences in the manifestation of techniques used in each therapy. A description of each type of therapy will be provided.

Cognitive-behavioral therapy. Cognitive-behavioral therapy combines behavioral techniques with cognitive techniques to show a reduction in dysfunctional behavior and emotions by altering both thinking patterns and behavior. Therefore, this therapy approach draws from both cognitive theory and behavioral theory, applying methods from each of them. This approach is based on an assumption that current problems are the result of prior

learning. By changing what has been learned and providing new learning experiences, positive change can occur (Brewin, 1996).

Cognitive-behavioral therapy can be described as an active therapeutic process. This type of therapy assumes a directive, skill training approach (Haaga, Rabois, & Brody, 1999). Some of the characteristics of cognitive-behavioral therapy include devotion to aspects of behavior that are well defined and which can be measured. Cognitive-behavioral practitioners focus on the reasons that a behavioral or thinking pattern is persisting, not how or why it came to be. Likewise, therapy sessions are well planned and structured, with homework often being assigned to the client (Goisman, 1997).

This type of therapy has been classified as "masculine" in its therapeutic style because it is very directive, assertive, and highly structured. These characteristics are generally associated with men (Six & Eckes, 1991). According to Tinsley and Harris (1976), because men have a greater expectancy for directiveness from their therapists, a counseling approach that is more "directive" in nature should be preferred more by men than by women.

One of the most notable differences between cognitive-behavioral therapy and other therapy approaches is that cognitive-behavioral therapy is very structured and results are measurable. In fact, many cognitive-behavioral therapy programs come with procedure manuals, which clinicians follow throughout the course of treatment. Due to these factors, cognitive-

behavioral therapy has been proven through data analysis to be effective for depression, as well as for other psychological disorders (Andrews, 1996).

Cognitive-behavioralists assume that certain thought processes can cause depression. These broad thought patterns, or schemes, can influence one's thoughts through misinterpretations of everyday events in the form of automatic thoughts. These schemes and automatic thoughts are a result of what Beck calls the "cognitive triad," or negative views of oneself, the world, and the future. The overall aim of cognitive-behavioral therapy in treating depression is to recognize these thoughts and misconceptions and correct them (Goisman, 1997).

Enright (1997) discusses in detail the process of cognitive-behavioral therapy for treating depression. In this process, the client and the therapist work together to identify any patterns of thinking that may be creating distortions in the client's thoughts concerning everyday events. Homework assignments are given to monitor and challenge specific thinking patterns and to implement behavioral change.

Cognitive-behavioral therapy results in long-term effects. Depressed inpatient clients who received cognitive-behavior therapy as a part of their inpatient treatment of depression were more likely to be well and stable at a 12-month follow-up (Miller et al., 1989), and at a four-year follow-up (Fava, Grandi, Zielezny, Rafanelli, & Canestrari, 1996), than were those who did not receive cognitive-behavioral therapy. These studies validated

the use of cognitive-behavior therapy as an effective treatment for depression.

Client-centered therapy. Developed by Carl Rogers, client-centered therapy is a therapeutic approach designed to emphasize the relationship between the client and the therapist. This type of therapy is based on client-centered theory. Emphasis during therapy is placed on the presenting needs of the client and ways in which the therapist can assist the client with those needs. The main focus for client-centered therapy is in helping the client to recognize a particular problem and to discern what needs are present due to that problem, rather than merely trying to solve the problem (Kramer, 1995).

Client-centered therapy can be described as a discovery-oriented type of therapy. The approach taken during therapy is very person-centered, with a focus on the therapeutic relationship as the core in client development. This technique is based on the assumption that through the client-therapist relationship, a new awareness and a generation of new meaning will provide a basis for change in the client (Greenburg, Elliott, & Lietnar, 1994).

Client-centered therapy has also been described as "feminine" due to its empathetic, warm, understanding style. These attributes are generally associated more with women (Six & Eckes, 1991). Using an experimenter-generated expectancy scale, Tinsley and Harris (1976) reported that an approach that is more "client-centered" should be preferred more by women than by men

because women have a greater expectancy for acceptance and understanding from their therapists.

Studies have shown that client-centered therapy is just as effective, and sometimes more effective than other therapies in treating depression. For instance, Meyer (1981) compared psychodynamic therapy with client-centered therapy with respect to outcome variables, such as reduction in symptoms, and found that depression was reduced for both groups, but was more significant for the group of participants who had received client-centered therapy. The use of client-centered therapy for reducing depression has been replicated by other researchers (e.g., Meyer, Stuhr, Wirth, & Ruester, 1988). Additionally, Wexler and Butler (1976) found that clients suffering from depression showed an increase in client expressiveness when client-centered therapy techniques were applied during treatment.

Consistent with the idea that therapeutic techniques have been perceived as either masculine or feminine, one area to examine would be how sex of both the therapist and the client can play a role in determining counselor effectiveness. Past research in this area has been explored and is discussed in further detail below.

The Role of Gender in Client Perception of the Counselor

The client's first impression of the therapist will help to determine whether the client will make the decision to continue with the therapy process. Consequently, it would be advantageous for therapists to be cognizant of clients' beliefs about therapy.

Research has been conducted on clients' preferences for counselors and therapies.

Several studies have shown that female clients preferred female counselors over male counselors. Pikus and Heavey (1996) and Dancey, Dryden, and Cook (1992) reported similar findings. They stated that when asked for counselor preference, most women preferred female counselors. Participants for these studies were new clients seeking therapy from a student counseling center. A questionnaire designed to assess clients' preference for sex of therapist was used. Although most men in these studies stated no particular preference, when a preference was given it tended to be for a female counselor rather than for a male counselor.

Stamler, Christiansen, Staley, & Macagno-Shang (1991) examined the intake interviews of 495 clients who wanted individual therapy in a university setting. They found that those clients who expressed a preference for the sex of the counselor during intake tended to prefer female counselors over male counselors. This study also revealed that clients were more likely to express desire for a specific sex when initially interviewed by a woman.

Strickler and Shafran (1983) also noted a shift in the preference of counselor sex from male to female. They suggested that one reason for this preference may be due to clients' expectations of their counselor to be warm, understanding, and empathetic. These traits are considered feminine because they are typically associated more as belonging to women than to men. Six

and Eckes (1991) specifically investigated characteristics associated with both men and women. They found that male and female undergraduate students did rate certain characteristics as being masculine or feminine, showing that stereotypes do exist, though they did not investigate whether these students would act on these stereotypes when assessing counselors.

A few studies have examined the relationship between the sex of the client and the client's preference for certain types of counseling. Apfelbaum (1958) and Tinsley and Harris (1976) found that the sex of the client made a difference in therapy preference. The researchers reported that men preferred directive types of counseling, such as cognitive-behavioral therapy, whereas women preferred acceptance oriented therapy, such as client-centered therapy. In contrast, Cashen (1979) found that both men and women preferred the behavioral approach over the client-centered approach due to its overall structure.

As can already be determined by the above-mentioned research, sex typically appears as a variable of interest when determining clients' preferences. This may be the case because of the strong influence of sex stereotyping. Sex stereotyping and sex-role orientation can be integrated into, and possibly confused with, the counselor's therapeutic techniques. Of the therapeutic techniques one can prescribe to, many seem to possess either masculine or feminine characteristics and may be perceived by the client accordingly. In looking solely at men's perceptions of counselor characteristics, Shelton (1973) found that male

clients tend to rate highly both masculine male counselors and feminine female counselors. A masculine male counselor was identified as "more gregarious, less afraid of criticism, more inclined to experiment with life, and more tolerant of inconvenience" (p. 133). Feminine counselors were seen to be "more submissive, accommodating, trusting, tolerant, and adaptable" (p. 133).

Furthermore, perception is influenced not only by sex stereotyping, but also by sex-role orientation of the client and/or counselor. Spence, Helmreich, and Stapp (1975) define sex-role orientation as the extent to which a person's self-ratings reflect characteristics judged as stereotypically masculine or as stereotypically feminine. Masculine characteristics are seen to be assertive, whereas feminine characteristics are interpersonal and expressive.

Studies have found that sex-role orientation does make a difference in counselor ratings. Highlen and Russell (1980) and Feldstein (1982) found that regardless of actual sex, androgynous and feminine counselors tended to be rated higher than were masculine counselors. Their explanation for this is that feminine roles are more congruent with a layperson's stereotypes of characteristics that counselors should possess. Counselor characteristics are only one part of clients' consideration when evaluating treatment effectiveness.

Factors that Affect Clients' Evaluation of Therapy

Some researchers indicate that clients preferred behavioral therapies over other types of therapy for depression. For example, Dancey et al., (1992) examined clients' ratings for four different therapeutic approaches (psychoanalytic, cognitive-behavioral, humanistic, and a common sense approach). Their most favored type of therapy, regardless of the sex of the therapist, was cognitive-behavioral therapy. The second most preferred, however, was humanistic therapy. Holen and Kinsey (1975) examined perceptions of counselor effectiveness by college students using behavioral, client-centered, and psychoanalytic therapies. They also found behavioral therapy to be the most favored.

Yet other researchers indicated that client-centered therapies were perceived as more effective for depression (Kelly & Byrne, 1977; Woodard, Burck, & Sweeney, 1975). Kelly and Byrne (1977) examined perceptions of counselor effectiveness with client-centered, Gestalt, and rational-emotive therapies. They reported that client-centered was the most favored by college students.

Lastly, Schroeder and Bloom (1979) investigated perceived differences in psychoanalytic, behavioral, client-centered, and Gestalt approaches. They had college students comment on the aspects of the different approaches and the personal qualities they thought each therapist exhibited, after viewing 5-minute videotaped analogues that simulated the four approaches to therapy. Those comments centered on the involvement of the

therapist, empathy, warmth, and sensitivity. The results of this study were interesting because the psychoanalytic therapist and the Gestalt therapist elicited more positive ratings than did the behavioral or the client-centered therapists.

Consequently, the findings on perceived therapy effectiveness is somewhat contradictory. This inconsistency may be due to the lack of control for extraneous variables, such as, the sex of the therapist applying the therapeutic approach, the sex of the participants used in the studies, and the stereotyping of some therapy characteristics as being either masculine or feminine.

The Present Study

In summary, clients' preferences, stereotypes, and expectations of the counseling process can generate certain biases to therapy. Past researchers have tried to determine what preferences, stereotypes, and expectations exist in the client in order to facilitate productive counseling. Research in this area has spanned several decades and has examined multiple factors making it difficult to generalize any results. In the past, researchers have examined characteristics of the counselor, characteristics of the client, and clients' expectations and preferences for the approach to counseling. The present study differs from previous studies in that its focus was on whether preference of therapy type is dependent upon the sex of the therapist and sex of the rater. When considering expectancies of men and women in general, one might wonder whether therapy

ratings could differ due to the sex of the counselor. The present study sought to explore this intention using two therapy approaches that could be labeled as either masculine (cognitive-behavioral), or feminine (client-centered). These findings may help to explain past discrepancies in this area.

The purpose of this study was to test whether sex related/oriented therapy techniques differed in perceived effectiveness depending on the sex of the therapist applying the technique. Of interest, especially, was what variables determined the clients' perceived effectiveness of a therapist. The differences in perceived effectiveness of the therapist were compared in four different situations (a) a female therapist using cognitive-behavioral therapy, (b) a female therapist using client-centered therapy, (c) a male therapist using cognitive-behavioral therapy, and (d) a male therapist using client-centered therapy.

This study examined whether the sex of the counselor and of the client is a factor in clients' perceived effectiveness of two different therapeutic approaches. It was proposed that counselors will be rated higher if their sex was consistent with their approach to counseling. That is, female counselors would be rated higher if they approached counseling in a stereotypically feminine manner, whereas male counselors would be rated higher if they approached counseling in a stereotypically masculine manner.

Therefore, this research can not only make therapists satisfied that they are serving their clients effectively, but

can also provide a better understanding of what the clients are perceiving. The results of this study, specifically, have helped us to understand what biases clients can have, and what therapy techniques are preferred.

Research questions. The first research question addressed the issue "Which therapy and therapist sex combination is perceived to be the most effective?" The second research question addressed the concern "Does participant sex influence perceived effectiveness of each therapy and therapist sex combination?"

Hypotheses

To answer the research questions, the present study investigated the following hypotheses:

Hypothesis 1a: Male therapists will be rated as significantly more effective when using cognitive-behavioral techniques than when using client-centered techniques.

Hypothesis 1b: Female therapists will be rated as significantly more effective when using client-centered techniques than when using cognitive-behavioral techniques.

Hypothesis 2a: Male participants will rate cognitive-behavioral techniques as significantly more effective for both male and female therapists.

Hypothesis 2b: Female participants will rate client-centered techniques as significantly more effective for both male and female therapists.

CHAPTER 2

METHOD

Participants

The total sample for this study consisted of 110 participants (56 men and 54 women; M age = 20.9 years; range = 18 to 24 years). The participants consisted of 68 European Americans, 26 African Americans, 5 Asian Americans, and 11 from other ethnic backgrounds. The socioeconomic status of the participants included 17% from lower/working class, 66% from middle class, and 17% from upper class. Participants for this study were obtained using an on-line site accessible to students that would post the current research studies needing volunteers. A brief description of the study and the length of time necessary for participation were included in the posting. Students were given five available time slots on different days to sign up. Additional time slots were added until a sufficient number of students had volunteered.

Design

The group design was a 2 x 2 factorial model, which was the same for both male and female respondents. There were two types of therapy and two sexes for therapist yielding four groups. Group #1 read about a male therapist who used client-centered therapy ($n = 28$). Group #2 read about the same male therapist who used cognitive-behavioral therapy ($n = 27$). Group #3 read about a female therapist who used client-centered therapy ($n = 27$). Group #4 read about the same female therapist who used

cognitive-behavioral therapy ($n = 28$). Thus, there were 14 male and 14 female participants in each group except there were only 13 female participants for female client-centered therapists.

Materials

Stimuli. The two scenarios designed for use in this study served as the stimuli. Each scenario corresponded to one of the two types of therapy sessions (client-centered vs. cognitive-behavioral). Scenario scripts (see Appendix A and B) that were approved by several licensed therapists as representative of client-centered and cognitive-behavioral techniques were used to ensure an accurate depiction of each therapy. The client verbalizations were identical in each script. Each script portrayed the same client with the same presenting problem, which was mild depression. This disorder was selected because both cognitive-behavioral and client-centered therapy techniques are considered to be beneficial in treating depression.

Therapist Effectiveness Questionnaire. The Therapist Effectiveness Questionnaire (TEQ) was employed to measure participant response to exposure to the therapy scripts. The instrument (see Appendix C) consisted of 12 seven-point Likert-type, conceptually independent items. In particular, the TEQ was constructed to measure a variety of qualities therapists should possess. These characteristics were similar to those contained in Holmes and Post's (1986) Therapist Rating Scale. The reliability alpha of .96 verifies that the items were not related to each other.

Procedure

The participants participated in groups. For each of the five time slots that were posted, a maximum of 28 people were allowed to sign up. The number of participants present for each time slot varied. The group sizes averaged around 10-15 participants per time slot. Each time slot consisted of all male or all female participants. Participants were given an informed consent document (Appendix D) prior to participation in the study. A demographic sheet (Appendix E) was also used to gather information about students' demographics. They were randomly assigned to one of four groups. Students were asked (see experimenter instructions, Appendix F) to read one of two sets of instructions and given one type of therapist with a description of the therapist as a man or woman (see Appendix G). The material packets were arranged to ensure that someone represented each of the four groups up to seven times for each of the five data collection periods. Once the participants read the description of the therapist and the scenario, they filled out the Therapist Effectiveness Questionnaire.

A debriefing of the study followed completion of the packets and consisted of an oral explanation of what the study was investigating. Questionnaires were reviewed before any participant left and if the questionnaire was not complete, the participant was asked to complete it. A complete copy of the IRB request form can be found in Appendix H.

CHAPTER 3

RESULTS

The purpose of this study was to examine whether sex of therapist or client was a factor in clients' perceived effectiveness of a "feminine" therapeutic approach and a "masculine" therapeutic approach. The twelve items of the TEQ were analyzed using a 2 (Sex of respondent) x 2 (Sex of therapist) X 2 (Type of Therapy) multivariate analysis of variance (MANOVA). The ratings were reversed for items 2, 4, 5, 9, and 11 because the wording of the statement was negative.

The MANOVA revealed two main effects, but these will be discussed later given that the hypotheses focused on the two-way interactions. The MANOVA results of the Treatment x Sex of therapist effect for each item are shown in Table 1. Because there was not a significant type of treatment by sex of therapist effect, Hypothesis 1 was not confirmed. Thus, people did not perceive male therapists who practiced cognitive-behavioral therapy as more effective than those who practiced client-centered therapy (Hypothesis 1a). In addition, people did not perceive female therapists who practiced client-centered therapy as more effective than those who practiced cognitive-behavioral therapy (Hypothesis 1b).

The MANOVA results of the Treatment x Sex of respondent for each category are shown in Table 2. There was not a significant type of treatment by sex of respondent effect, thereby

Table 1

Summary Table of Multivariate Analysis of Variance for Treatment
x Sex of Therapist for each TEQ item

Source	<u>df</u>	<u>MS</u>	<u>F</u>
Willing to help	1	.15	.06
Recommend therapist	1	4.34	.00
Go to this therapist	1	.32	.12
Know what they're doing	1	.69	.37
Easy to talk to	1	3.42	1.60
Effective therapist	1	9.10	.05
Fits well with idea	1	1.15	.44
Effective way to help	1	.24	.11
Treatment of client	1	.12	.04
Personality fits well	1	6.93	.00
Seems Understanding	1	2.71	.00
Therapist is trustworthy	1	.17	.09
Error	102		

p > .05 for all items (non-significant)

Table 2

Summary Table of Multivariate Analysis of Variance for Treatment
x Sex of Respondent for Each TEQ item

Source	<u>df</u>	<u>MS</u>	<u>F</u>
Willing to help	1	9.43	.00
Recommend therapist	1	3.01	.00
Go to this therapist	1	3.36	1.32
Know what they're doing	1	3.64	.02
Easy to talk to	1	2.09	.98
Effective therapist	1	7.89	.04
Fits well with idea	1	.25	.09
Effective way to help	1	.47	.22
Treatment of client	1	2.37	.86
Personality fits well	1	1.01	.01
Seems Understanding	1	3.48	1.71
Therapist is trustworthy	1	9.96	.05
Error	102		

p > .05 (non-significant)

disconfirming Hypothesis 2. Thus, men did not rate cognitive-behavioral therapy as significantly more effective than client-centered therapy (Hypothesis 2a). Also, women did not rate client-centered therapy as significantly more effective than cognitive-behavioral therapy (Hypothesis 2b).

Although expected interactions were not found, there were main effects for treatment and for sex of respondent. Table 3 shows the means and standard deviations for each item by treatment type. A main effect was only found for understanding, $F(1, 102) = 4.277$, $p < .05$. Respondents perceived client-centered therapists to be significantly more "understanding" than cognitive-behavioral therapists. Table 4 shows the means and standard deviations for each item by sex of respondent. A sex effect was only found for trustworthiness, $F(1, 102) = 4.488$, $p < .05$. Women perceived the therapists to be more trustworthy than did men. No other main effects or interaction effects were found.

Table 3

Summary of Mean Ratings and Standard Deviations of TEQ Item by Treatment Type

TEQ Question	Client-Centered		Cognitive-Behavioral	
	<u>M</u>	<u>SD</u>	<u>M</u>	<u>SD</u>
Willing to help	4.53	1.48	4.51	1.66
Recommend therapist	3.74	1.53	3.56	1.63
Go to this therapist	3.65	1.52	3.42	1.67
Know what they're doing	4.34	1.26	4.34	1.44
Easy to talk to	4.27	1.32	4.11	1.58
Effective therapist	4.05	1.31	4.11	1.37
Fits well with idea	3.74	1.45	4.02	1.76
Effective way to help	3.87	1.25	4.04	1.64
Treatment of client	3.93	1.58	3.78	1.72
Personality fits well	4.09	1.22	4.04	1.39
Seems Understanding*	4.51	1.32	3.94	1.53
Therapist is trustworthy	4.51	1.23	4.20	1.47

*p < .05

Table 4

Summary of Mean Ratings and Standard Deviations of TEQ Item by Sex of Respondent

TEQ Item	Male		Female	
	<u>M</u>	<u>SD</u>	<u>M</u>	<u>SD</u>
Willing to help	4.50	1.58	4.54	1.56
Recommend therapist	3.55	1.56	3.76	1.60
Go to this therapist	3.41	1.46	3.67	1.73
Know what they're doing	4.23	1.37	4.46	1.33
Easy to talk to	4.05	1.42	4.33	1.49
Effective therapist	4.05	1.26	4.11	1.42
Fits well with idea	3.91	1.53	3.85	1.71
Effective way to help	3.91	1.43	4.00	1.49
Treatment of client	3.86	1.62	3.85	1.69
Personality fits well	3.98	1.12	4.15	1.47
Seems Understanding	4.11	1.40	4.35	1.51
Therapist is trustworthy*	4.09	1.35	4.63	1.32

*p < .05

CHAPTER 4

DISCUSSION

Different therapies have been developed to help clients cope with factors in their lives that may have lead them to become depressed. The author was interested in whether raters' perceptions of counselor effectiveness was mediated by counselor sex, client sex, and type of therapy. The results did not support the contention that people would differentially rate male and female therapists who practiced dissimilar therapies (Hypothesis 1). The findings also did not endorse the idea that men and women would differentially rate the two types of therapies (Hypothesis 2). Thus, based on a therapy transcript people did not evaluate effectiveness using information about the sex of the therapist and the therapy. Nor did male and female raters indicate a preference for therapy type as had been found by Apfelbaum (1958) or by Tinsley and Harris (1976).

One explanation for past researchers to indicate preferences by men and women for certain therapies may be due to a change in therapy expectations over time. It is also possible that the measures and stimuli differences in past studies and the present one contributed to inconsistency in the findings. Specifically, Apfelbaum (1958) had college students complete a questionnaire about their expectations of counseling, whereas Tinsley and Harris (1976) used an experimenter-generated expectancy scale. Items on the scale were concerned with counseling procedures, experience, genuineness, expertness,

acceptance, understanding, and directiveness. Participants were asked to complete the scale about their expectations of counseling. No stimuli was presented before doing this. This may be the reason why the results of this study differed from the present study.

Although the combined factors did not influence ratings, two individual factors did. College students in this study saw the client-centered style of therapy as more "understanding" than the cognitive-behavioral style of therapy. This finding is consistent with past research indicating that client-centered therapy is seen as an "understanding" type of therapy (Six and Eckes (1991)). Thus, clients who want their therapists to have this quality may prefer client-centered therapy over more directive, less empathetic types. Tinsley and Harris (1976) reported that understanding was an important expectancy, although this was not rated as one of the higher rated expectancies.

Interestingly, women rated the therapist in each scenario as more "trustworthy" than did men. It is possible that women may value trustworthiness in their therapist more than men do, regardless of therapist sex or therapy style. Tinsley and Harris (1976) did report that trust was an important factor, although the differences in the importance of this factor between men and women was not investigated. Although this finding was statistically significant, the actual difference between the means was low suggesting that it may not be useful for practical

purposes. Thus, future researchers may fail to find a sex difference for trustworthiness.

Despite the two main effects indicated above, the means for each of the therapist qualities were concentrated around the middle of the scale. Previous researchers using a rating scale of therapist qualities have reported similar results. For instance, the mean scores reported by Holmes and Post (1986) ranged from 3.52 - 5.0 on a 7-point scale, whereas the current study had a range of 3.41 - 4.63. The narrow range suggests that raters did not form strong opinions about the sex of the therapist or type of therapy portrayed in the video for Holmes and Post or the transcripts in the current study.

Limitations

Due to practical constraints and population accessibility, only students from one southern university were asked to participate in the study. The characteristics of the sample should be taken into consideration when generalizing the results of this study. The level of education, income, past therapy experience, age, and interest of the participants may not be reflective of the general client population. Of the participants, 7% had been treated in therapy for depression, and 12% had received psychological treatment for something other than depression. Conversely, the use of people who are already considered depressed may not be a reliable method. People who are depressed may not be in the right state of mind to make such decisions regarding what they want from their therapist.

A second limitation to the study may have been the use of written therapist descriptions and written therapy scenarios. This method, although useful in reducing extraneous variables, likely did not put enough emphasis on the sex of the therapist or the presentation of the therapy styles. A visual presentation of the scenarios may have produced stronger opinions and feelings from the participants.

A third limitation to the study may have been the length of the scenarios. Although the scenarios were shown to be representative of the therapy types, they may not have been long enough for the participants to form an opinion regarding effectiveness. This limitation can be further supported by the fact that the mean scores from the TEQ are very centralized and show very little variation (refer to Table 3).

Implications and Future Research

Because the number of people who have been evaluated with a mental illness are fewer than the number who are being helped in therapy, research that focuses on ways of closing the gap must be conducted. Specifically, it is important to learn about clients' perceptions of therapy and to ascertain the types of therapist traits they considered to be important. The end goal would be to develop an evaluation device that will allow therapists to understand the concerns clients have about therapists and therapy.

To this end, the Therapist Effectiveness Questionnaire was designed to investigate raters' perceptions of therapists. The

findings indicated that trustworthiness and understanding are two characteristics that need to be investigated further. Thus, these qualities should be ones that are included in future evaluation devices. To do this, it would be helpful to ask people in general how important the qualities of understanding and trustworthiness are when considering therapy, and to specify or evaluate which other qualities are important. It is possible that understanding and trustworthiness are the two main characteristics that clients use to judge therapists. Thus, the development of an evaluation device that included those features would help in the determination of whether someone chooses to receive or maintain therapy.

Future research should also investigate whether the diagnosis of the client is a factor in what qualities are desired in a therapist and what style of therapy is preferred. The qualities that can be regarded as desirable in a therapist may depend, in a large part, on what the client is seeking therapy for.

Lastly, based on the findings and limitations reported for this study, changes for future research would include the use of video taped sessions portraying therapy styles, or possibly the use of actual people acting out a therapy script. These methods may help to capture the interest of the participants involved in the study, and would place greater emphasis on both the sex of the therapist and the presentation style of the therapy.

In summary, therapist sex, rater sex, and type of therapy used does impact perceptions of therapists trustworthiness and understanding, although no significant interaction effects between these three variables were found. Under careful examination, the results of the present study suggest that some characteristics or attributes to the therapeutic process may be influential in a clients' decision to seek or continue therapy. While this study does not lend support to past research, differences in research designs and how to integrate these designs to produce stronger outcomes needs to be examined.

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Appendix A

Therapy Session Segment- Client Centered Therapy

Note:

The client is depicted with a "C" and the therapist with a "T."

C- Over the weekend... its hard to explain. I noticed my sadness, it was still there and I couldn't believe that I was functioning and feeling like a whole person. Even though I felt this sadness.

T- It was a new experience to have the sadness coexist with a sense of wholeness.

C- I feel like, if I don't keep this problem in mind, if I don't keep after myself...well, I might end up living with this sadness when I could have gotten rid of it. I feel, if I don't do something about it, it's going to get worse...and I'll live that way.

T- But you won't have had to, (C: Yeah) you won't have had to have that sadness continue but it will continue because you didn't do something about it.

C- Right.

T- If you don't keep vigilant.

C- And there's another thing... when I don't feel good about myself... like... I don't stand up to my expectations I'm upset about that. I was doing so well and so I decided o.k., that's it, I know I can do it, so I'm depressed that I even let myself think that, because then I fail.

T- Your thoughts and actions should be consistent, but it isn't that way and somehow you can't..

C- When I'm feeling like that or when I'm feeling like a failure or whatever, something feels, um, it feels like.... I don't know... it feels like I'm not a whole person... It's like I don't feel like a whole person when I'm like that and even though others can't tell... I feel like I'm being dishonest, Because they can't see what's really inside of me. I have a big problem with that, talking to people when I feel like this, I feel dishonest because I really don't feel like I'm me. I feel angry, I feel depressed, I feel fragmented..

T- In your appearance and your behavior, your appearance is one kind of person.... but inside you're...

C- It's that they're not together, they're different. To me that's why I can't feel like a whole person. But this weekend, I did feel like a whole person, even though I was still torn up inside, and it felt good, but, yet, it was upsetting too. Because then, I guess, I feel if I don't try to fix this, that I will never feel completely whole and happy.

T- The thing is you felt like a whole person in spite of the fact that you still have the sadness. But there was the worry that you would, in feeling whole, let the pain stay by giving up on doing your utmost to get rid of it.

C- That's it. That is how I feel.

Appendix B

Therapy Session Segment- Cognitive Behavior Therapy

Note:

The client is depicted with a "C" and the therapist with a "T."

C- Over the weekend...it's hard to explain. I noticed my sadness, it was still there and I couldn't believe that I was functioning and feeling like a whole person. Even though I felt this sadness.

T- Why do you think, if you felt you were functioning like a whole person, that you noticed sadness? What triggered this taking notice?

C- I feel like, if I don't keep this problem in mind, if I don't keep after myself...well, I might end up living with this sadness when I could have gotten rid of it. I feel, if I don't do something about it, it's going to get worse...and I'll live that way.

T- So you recognize that you do need to do something about it, and that is what we are going to work on.

C- Right.

T- Let's do that.

C- And there's another thing...when I don't feel good about myself...like..I don't stand up to my expectations I'm upset about that. I was doing so well and so I decided o.k., that's it, I know I can do it, so I'm depressed that I even let myself think that, because then I fail.

T- What expectations do you have of yourself that you fail at? How does this failure make you feel? These thoughts of feeling like a failure will influence your actions, so we need to work on changing these thoughts.

C- When I'm feeling like a failure or whatever, something feels, um, it feels like...I don't know...it feels like I'm not a whole person...it's like I don't feel like a whole person when I'm like that and even though others can't tell...I feel like I am being dishonest, because they can't see what's really inside of me. I have a big problem with that. Talking to people when I feel like this, I feel dishonest because I really don't feel like I'm me. I feel angry, I feel depressed, I feel fragmented..

T- We need to work on making your thoughts and your actions consistent.. right now your thoughts and your actions are..

C- It's that they're not together, they're different. To me that's why I can't feel like a whole person. But this weekend, I did feel like a whole person, even though I was still torn up inside, and it felt good, but, yet, it was upsetting too. Because then, I guess, I feel if I don't try to fix this, that I will never feel completely whole and happy.

T- We are going to work on identifying what your thoughts are and what your actions are and look at how they are different. I am going to give you a homework assignment consisting of writing down your thoughts and your actions when they are different from each other. Write down how you are feeling, what you are thinking, and how you are acting and what you are doing. We will go over it together at the next session.

C- That's it. That is how I feel.

Appendix C
THERAPIST EFFECTIVENESS QUESTIONNAIRE

For each of the following questions, please circle the number that most accurately represents your level of agreement. A rating of 1 indicates that you Strongly Disagree, while a rating of 7 indicates that you Strongly Agree.

- | | Strongly
Disagree..... | | | | | | | Strongly
Agree |
|--|---------------------------|---|---|---|---|---|---|-------------------|
| 1. The therapist in this story appeared to want to help the client. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
| 2. I would NOT recommend this therapist to friends or relatives in need of help. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
| 3. I would go to see this therapist for therapy if I were seeking help for a problem or concern. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
| 4. The therapist in this story did NOT appear to know what he/she was doing. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
| 5. This therapist would NOT be easy to talk to about any problems I might have. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
| 6. In my opinion, this therapist appears to be an effective therapist. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
| 7. This therapist fits well with my idea of what a therapist should be like. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
| 8. The way in which this therapist tried to help the client appeared to be an effective way to help someone. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
| 9. This therapist did NOT treat the client how I would like to be treated in therapy. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
| 10. The personality of this therapist fits well with how a therapist should act. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
| 11. This therapist does NOT seem very understanding of people and their problems. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
| 12. This therapist could be trusted to keep our conversation confidential. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |

Appendix D



INFORMED CONSENT DOCUMENT

The Department of Psychology and Special Education at Emporia State University and Louisiana State University supports the practice of protection for human subjects participating in research and related activities. The following information is provided so that you can decide whether you wish to participate in the present study. You should be aware that even if you agree to participate, you are free to withdraw at any time, and that if you do withdraw from the study, you will not be subjected to reprimand or any other form of reproach.

Your participation in this study will consist of reading a story about a therapy session and filling out a questionnaire regarding how effective you felt the therapist was in the story. The time you should allow for this study is approximately thirty minutes.

There are no discomforts or other forms of risk involved by taking part in this study.

This study is intended to further clarify what expectations people have about therapists and what people perceive to be as effective in therapy.

"I have read the above statement and have been fully advised of the procedures to be used in this project. I have been given sufficient opportunity to ask any questions I had concerning the procedures and possible risks involved. I understand the potential risks involved and I assume them voluntarily. I likewise understand that I can withdraw from the study at any time without being subjected to reproach."

Subject Name (please print)

Subject Signature

Date

Appendix E
Demographic Sheet

Age? _____ Birth Date _____

Gender? ___Male ___Female

Select one representing your ethnic background:

_____ European American

_____ African American

_____ Asian American

_____ Other/Mixed (specify) _____

Select one representing your family's socio-economic status:

_____ Lower/Working class

_____ Middle class

_____ Upper class

Have you ever received treatment for depression? ___Yes
_____No

Have you ever received psychological treatment for anything other
than depression? ___Yes ___No

How depressed do you currently feel?

Not at all							
Depressed	1	2	3	4	5	Very	Depressed

Appendix F

EXPERIMENTER INSTRUCTIONS/SCRIPT

Each subject packet contains an informed consent form, a basic demographic sheet, a therapist description form, and the Therapist Effectiveness Questionnaire. Before subjects arrive make sure that the packets are complete and make a pile of packets to be handed out ensuring that for every four packets, each of the four therapist/therapy combinations are represented. Once subjects have arrived and are seated pass out the packets from the pile that was previously constructed. Once each subject has his or her packet instruct the group as follows:

"Each of you have just been handed a packet containing several items. The first is an informed consent form, which I would like you to read through and sign. If you read the consent form and decide not to participate, you are free to leave. By signing the consent form you are stating that you agree to participate in the study, and can then move on to the next item in your packet. This is a basic demographic sheet, it does not contain any questions that would identify you specifically and the information will only be used for purposes of data analysis. Once the demographic sheet is completed, please move on to the basic instructions of the study and proceed from there. You will be asked to read a description of a therapist, read a portion of a therapy session, and answer a questionnaire. Once you have completed everything in the packet you can turn it in to me and are free to leave. You will receive a research credit slip from me once you have completed the packet. Thank you for your participation in this study."

Appendix G

INSTRUCTIONS TO THE SUBJECT & THERAPIST INFORMATION SHEET

Following is a description of a therapist and an introduction to a segment of a therapy session between this therapist and a client. Please read through the therapist information and then read through the therapy session. Once you have read through these materials, turn to the questionnaire on the following page and answer the questions based on the therapist and the therapy segment you just read.

Therapist information and introduction to therapy segment:

The therapist for this session is a 40-year old male (or female) with several years experience in treating patients. In the following segment, he (she) is in a session with a patient whom he (she) has seen on two previous visits. The client began therapy for help with feelings of depression and general unhappiness with life.

Appendix H



APPLICATION FOR APPROVAL TO USE HUMAN SUBJECTS

This application should be submitted, along with the Informed Consent Document, to the Institutional Review Board for Treatment of Human Subjects, Research and Grants Center, Plumb Hall 313F, Campus Box 4003.

1. Name of Principal Investigator(s) (Individual(s) administering the procedures):

Heather Walden

2. Departmental

Affiliation: Department of Psychology & Special Education-
Graduate Student

3. Person to whom notification should be sent: Heather Walden

Address: 10795 Mead Rd. Apt. 414, Baton Rouge, LA 70816

Telephone: 225-292-4298

4. Title of Project:

The Influence of Gender and Therapy Type On the
Perceived Effectiveness of Therapists.

5. Funding Agency (if applicable): N/A

6. Project Purpose(s):

The purpose of this project is to determine whether gender of therapist and type of therapy used are influencing factors when therapists are rated on effectiveness. The researcher wishes to determine (a) if stereotypically masculine therapy techniques are rated as more effective when utilized by a male therapist than by a female therapist, and (b) if stereotypically feminine therapy techniques are rated as more effective when utilized by a female therapist than by a male therapist.

7. Describe the proposed subjects: (age, sex, race, or other special characteristics, such as students in a specific class, etc.) The subjects for this project will consist of 50 male and 50 female undergraduate students ages 18 to 24 years who volunteer to participate in the study.

8. Describe how the subjects are to be selected:

The subjects will be selected by posting a request for participation on a web site accessible to students designed specifically for posting current research projects looking for volunteers. Those students who sign up for the study via the web site and who arrive for participation will be used as the participants in the study.

9. Describe the proposed procedures in the project. Any proposed experimental activities that are included in evaluation, research, development, demonstration, instruction, study, treatments, debriefing, questionnaires, and similar projects must be described here. Copies of questionnaires, survey instruments, or tests should be attached. (Use additional page if necessary.) Once students sign up for participation in the study and arrive at the stated room for the study, they will be given an informed consent document to read and sign. This document (attached) will inform the participants of a basic description of the study, what they will have to do, and approximately how long it will take. This form will also state that participation is voluntary and that they are free to leave at any time. Once participants have signed this form, they will be given one of four packets containing a description of a therapist, a script of a therapy session, and a Therapist Effectiveness Questionnaire. The participants will be asked to read the therapy description and therapy script and then fill out the questionnaire concerning how effective they felt the therapist in the script was and how they felt about the therapy session. They will then be debriefed and told they are free to leave. The participants will represent four groups due to there being four packets which are all similar except for the gender of the therapist (male or female) and the type of therapy used (cognitive-behavioral or client centered).

10. Will questionnaires, tests, or related research instruments not explained in question #9 be used?

Yes No (If yes, attach a copy to this application.)

11. Will electrical or mechanical devices be used?

Yes No (If yes, attach a detailed description of the device(s).)

12. Do the benefits of the research outweigh the risks to human subjects?

Yes No (if no, this information should be outlined here.)

13. Are there any possible emergencies which might arise in utilization of human subjects in this project?

_____ Yes X No Details of these emergencies should be provided here.

14. What provisions will you take for keeping research data private?

The researcher will be the only person to view the questionnaires. Subject numbers will be assigned to each packet of questionnaires to ensure anonymity. The name of the subject and the subject number will be kept on a master list which will remain in a locked filing cabinet. All answers will be loaded into a database by subject number. Results will be stated using the statistical analyses of the results with no single answer to any question being reported.

15. Attach a copy of the informed consent document, as it will be used for your subjects.

STATEMENT OF AGREEMENT: I have acquainted myself with the Federal Regulations and University policy regarding the use of human subjects in research and related activities and will conduct this project in accordance with those requirements. Any changes in procedures will be cleared through the Institutional Review Board for Treatment of Human Subjects.

Signature of Principal Investigator

Date

Faculty advisor/instructor
(if applicable)

Date

I, Heather M. Walden, hereby submit this thesis to Emporia State University as partial fulfillment of the requirements for an advanced degree. I agree that the Library of the University may make it available to use in accordance with its regulations governing materials of this type. I further agree that quoting, photocopying, or other reproduction of this document is allowed for private study, scholarship (including teaching) and research purposes of a nonprofit nature. No copying which involves potential financial gain will be allowed without written permission of the author.

heather m. walden
Signature of Author

Aug 07, 2001
Date

The Influence of Gender and
Therapy Type on the Perceived
Effectiveness of Therapists
Title of Thesis

Ray Lopez
Signature of
Graduate Office Staff

August 17, 2001
Date Received

Handwritten mark