

Old Dominion University

ODU Digital Commons

Counseling & Human Services Theses & Dissertations

Counseling & Human Services

Spring 2009

Counselor Perceptions of Uninsured Clients

Katherine S. Moore
Old Dominion University

Follow this and additional works at: https://digitalcommons.odu.edu/chs_etds



Part of the [Counselor Education Commons](#)

Recommended Citation

Moore, Katherine S.. "Counselor Perceptions of Uninsured Clients" (2009). Doctor of Philosophy (PhD), Dissertation, Counseling & Human Services, Old Dominion University, DOI: 10.25777/6vnq-ph34
https://digitalcommons.odu.edu/chs_etds/81

This Dissertation is brought to you for free and open access by the Counseling & Human Services at ODU Digital Commons. It has been accepted for inclusion in Counseling & Human Services Theses & Dissertations by an authorized administrator of ODU Digital Commons. For more information, please contact digitalcommons@odu.edu.

COUNSELOR PERCEPTIONS OF UNINSURED CLIENTS

by

Katherine S. Moore
B.S., James Madison University, 1997
M.S.Ed., Old Dominion University, 2007

A Dissertation submitted to the Graduate Faculty of
Old Dominion University
in partial fulfillment of the
requirements for the degree of

Doctor of Philosophy
in
Counselor Education

Old Dominion University
May 2009

Approved by:

Theodore P. Remley, Jr. (Director)

Danica G. Hays (Member)

Edward E. Raspiller (Member)

ACKNOWLEDGEMENTS

To Dr. Ted Remley: You have been my mentor and guide every step of the way. I'm proud to know you and to learn from you. Thank you for everything.

To Dr. Danica Hays: Your talent is immense. Thank you for sharing it with me.

To my husband: Thank you for your endless support, and above all, thank you for your patience.

TABLE OF CONTENTS

ACKNOWLEDGEMENTS	ii
LIST OF TABLES.....	viii
LIST OF FIGURES.....	x
ABSTRACT	xi
CHAPTER ONE: INTRODUCTION.....	1
Background.....	1
Sources of Counselor Bias.....	1
Significance of the Study.....	4
Purpose of the Study.....	6
Research Questions.....	7
Limitations and Delimitations	7
Assumptions of the Study.....	8
Definition of Terms	9
CHAPTER TWO: REVIEW OF THE LITERATURE	12
Introduction	12
General Counselor Preferences	12
Attitudes toward Clients with Low Socioeconomic Status	14
Financial Concerns	15
Problem Attribution.....	17
Multicultural Competence and Comfort.....	19
Summary.....	21

CHAPTER THREE: METHODOLOGY	23
Purpose Statement	23
Overview of Research Design	25
Research Questions and Hypotheses	25
Method.....	27
Participants	27
Procedure	28
Instrumentation.....	30
Data Analysis.....	35
Internal and External Validity Threats	36
CHAPTER FOUR: RESULTS.....	39
Characteristics of the Sample	39
Data Screening and Diagnostics	44
Overall Findings	45
Tests of Hypotheses.....	47
Research Question	47
Test of Hypothesis 1	48
Test of Hypothesis 2	49
Test of Hypothesis 3	49
Test of Hypothesis 4	50
Test of Hypothesis 5	50
Other Findings	51
CHAPTER FIVE: DISCUSSION	61

Summary of Findings	61
Relationship of Findings to Prior Studies.....	64
Limitations of the Study	65
Implications for Counselors.....	70
Implications for Counselor Educators	71
Implications for Future Research	72
Conclusions	74
CHAPTER SIX: MANUSCRIPT.....	75
Abstract.....	76
Perceptions of Individuals with Low Socioeconomic Status	77
Potential Sources of Bias.....	78
Counselor Preferences and Attitudes as a Source of Bias	79
Financial Concerns as a Source of Bias.....	81
Problem Attribution as a Source of Bias	83
Multicultural Comfort as a Source of Bias.....	85
Research Objectives	87
Method.....	88
Participants	88
Procedure.....	89
Measures.....	91
Results	95
Relationship between insurance status and counselor perceptions	95
Relationship between financial concerns and counselor perceptions.....	96

Relationship between experience and exposure to counselor perceptions	96
Relationship between multicultural comfort and counselor perceptions.....	96
Other findings	97
Discussion.....	97
Implications for Mental Health Counselors.....	99
Limitations.....	100
Implications for Future Research	104
Conclusion.....	105
Table 1	107
Table 2	108
Table 3	109
REFERENCES	110
Appendix A.....	116
Human Subjects Approval.....	116
Appendix B.....	117
Personal Information Questionnaire	117
Appendix C.....	119
Case Vignette Version One	119
Appendix D.....	120
Case Vignette Version Two.....	120
Appendix E.....	121
Client Perception Rating Form (CPRF).....	121
Appendix F	123

Miville-Guzman Universality-Diversity Scale (M-GUDS)	123
Vita	127

LIST OF TABLES

Table 1	40
Frequency Distribution of Counselor Type by Survey Distribution Method.....	40
Table 2	41
Frequency Distribution by Race or Ethnic Group	41
Table 3	42
Frequency Distribution by Gender	42
Table 4	42
Frequency Distribution by Work Setting.....	42
Table 5	43
Frequency Distribution by Primary Income Type.....	43
Table 6	44
Frequency Distribution by Total Number of Years Working with Clients	44
Table 7	46
Item Loading and Possible Score Range for the CPRF.....	46
Table 8	47
Total Mean Scores for the Six Factors of the CPRF	47
Table 9	48
Mean Scores by Case Type	48
Table 10	51
Summary of Independent MANOVAs.....	51
Table 11	52

Descriptive Statistics for CPRF Factors	52
Table 12	59
Summary of Independent MANOVAs: Demographic Variables by M-GUDS	59

LIST OF FIGURES

Figure 1	53
Frequency Distribution for Social Attractiveness Scores.....	53
Figure 2.....	54
Frequency Distribution for Prognosis Scores	54
Figure 3.....	55
Frequency Distribution for Physical Attractiveness Scores	55
Figure 4.....	56
Frequency Distribution for Personal Evaluation Scores.....	56
Figure 5.....	57
Frequency Distribution for Severity Scores	57
Figure 6.....	58
Frequency Distribution for Adjustment Scores	58

Abstract

This study assessed counselor perceptions of uninsured clients. The professional literature suggests that counselor bias exists against persons with low socioeconomic status. According to United States Census Bureau, a greater percentage of individuals with income at or below the poverty level are uninsured compared to individuals with higher incomes. The professional literature also suggests that financial concerns and multicultural comfort may serve as sources of bias against individuals with low socioeconomic status. In this study, counseling professionals were surveyed to determine the relationship between counselor perceptions of type of client (insured or uninsured), and the contributing variables of work setting, counselor's income type, years of practice, and multicultural comfort. No statistically significant relationship was found between client type (insured or uninsured) and counselor perceptions. In addition, no statistically significant relationship was found among the variables of work setting, counselor's income type, years of experience, and multicultural comfort and counselor perceptions. The findings indicate that counselors perceive clients positively regardless of these external factors. The participants in this study rated the client favorably in both categories (insured and uninsured), indicating that counselors possess positive orientations toward clients regardless of insurance status. Implications for future research and considerations for other possible influences on counselor perceptions are discussed.

CHAPTER ONE

INTRODUCTION

Background

According to the United States Census Bureau (2007), in 2006 the percentage of individuals without health insurance was 15.8% which represents 47 million individuals nationwide. This figure indicates an ongoing trend of increases in the uninsured population each year. Further, people with family income below or near the poverty level in 2004 were almost three times as likely to have no health insurance coverage as those with family income twice the poverty level or higher (U.S. Department of Health and Human Services, 2006). This trend is supported by statistics that show that 24.9% of individuals from households earning less than \$25,000 are uninsured versus only 8.5% of individuals from households earning \$75,000 or more (U.S. Census Bureau, 2007). Access to mental health care can be directly linked to health insurance coverage, as most private practice settings, agencies, and hospitals require coverage in order to provide services.

Sources of Counselor Bias

In his seminal text, *Psychotherapy: The purchase of friendship*, Schofield (1964) identified what he called YAVIS Syndrome. YAVIS, an acronym standing for the qualities of *young, attractive, verbal, intelligent, and successful*, described what he believed were preferences of mental health professionals for clientele. Many have added to Schofield's (1964) paradigm by applying those preferences in contrast to individuals with low socioeconomic status. Issues have been addressed including the empathic disconnect between therapists and low socioeconomic status (SES) clients (Auld &

Meyers, 1954), the implications for treatment for low SES clients (Goldstein, 1973), training biases against low SES clients (Siassi & Messer, 1976), assumed anti-therapeutic tendencies of low SES clients (Shen & Murray, 1981), and stereotypes of low SES clients (Schnitzer, 1996).

Several empirical studies exploring counselor preferences have also been conducted (Brown, 1970; Hillerbrand, 1988; Schrader, 1989; Sharf & Bishop, 1979; Teasdale & Hill, 2006; Wills, 1978), each of which support Schofield's proposed counselor preferences. Although these studies have explored counselor biases against low SES clients, there is currently no empirical evidence supporting counselor bias against uninsured individuals as a group (versus individuals with low socioeconomic status). Given the statistics on uninsured rates among low SES individuals (U.S. Department of Health and Human Services, 2006), however, one can draw a connection between the literature supporting counselor biases against low SES individuals and potential biases against the uninsured.

While general counselor preferences and attitudes are a central source for potential counselor bias against uninsured or low SES clients, other sources exist. One may assume that the financial implications for counselors accepting uninsured clients could be a source of bias against uninsured clients. Several empirical studies and editorial essays have broached this issue (Aldler & Gutheil, 1977; Bloch, 1987; Cerney, 1990; Johnson & Frederickson, 1968), with focuses ranging from mental health professionals' internal conflict regarding fee payment to the potential impact of fee payment on therapeutic outcomes.

Attribution of the problem is another potential source of bias toward low SES clients. Attribution of the cause of a problem has been defined as the responsibility and control one has for the origin of the problem and specifically refers to whether the individual or the environment is responsible (Burkard & Knox, 2004). Problem attribution has been explored in terms of how mental health professionals' perceptions of clients may have an impact on whether or not they hold clients responsible for their problems or whether they are open to considering external sources such as systemic and institutional factors. Tendencies toward problem attribution may be affected by counselors' exposure to certain types of clients with little exposure to those clients' social environments (Batson, 1975), counselors' political viewpoints (Zucker & Weiner, 1993), and counselors' perceptions of the client as similar or dissimilar to them (Pearce, 1994).

Tversky and Kahneman's (1974) study of heuristics supports the notion that exposure to certain types of clients may contribute to problem attribution by affecting a counselor's ability to distinguish between individual client concerns versus attributing the same types of issues to all clients in a similar group. The concept of heuristics includes representativeness and availability heuristics. With the representativeness heuristic, probabilities are evaluated by the degree to which an individual is representative of a group (Tversky & Kahneman, 1974). Therefore a counselor, having worked with one or more unmotivated uninsured clients might assume that the next uninsured client will also be unmotivated. With the availability heuristic, people assess the probability of an event by the ease with which instances or occurrences can be brought to mind (Tversky & Kahneman, 1974). In this case, counselors, having had one or more negative experiences with uninsured clients, might assume that there is a high probability that all interactions

with uninsured clients will be negative because those are the experiences that the counselors can most easily recall. The concept of heuristics suggests that counselors with fewer years of experience or less exposure to certain types of clients may have fewer examples to produce representative or availability heuristics.

A fourth potential source of bias toward individuals with low socioeconomic status is counselors' competency and comfort with multicultural differences. As Liu et al. (2001) note, along with race and gender, social class is regarded as one of the three important cultural cornerstones in multicultural theory and research. Not only should social class, in and of itself, be considered as a potential cultural difference between counselors and uninsured clients, but also, given the statistics on distributions of uninsured rates along racial and ethnic lines (U.S. Department of Health and Human Services, 2006), it should be noted that many counselors may differ from their clients in terms of social class as well as race or ethnicity. Given these potential differences, there is a need for counselors to increase their competency for and comfort with working with culturally different clients.

Significance of the Study

Forty-seven million individuals lack health insurance in the United States and trends indicate that this number is growing each year (U.S. Census Bureau, 2007). Furthermore, there is a link between socioeconomic status and insurance status in that there are a disproportionate number of individuals with low socioeconomic status without coverage.

The implications of counselor bias toward uninsured individuals include lack of access to mental health care and potentially negative therapeutic outcomes when mental

health care is provided. Not only is there a financial issue concerning access, but for many counselors, there exists a divide between their ideal clients and those clients who fall into the uninsured or low socioeconomic categories. Given that research has shown a higher prevalence of depression, anxiety, substance abuse, and aggression among members of lower socioeconomic groups (Black & Krishnakumar, 1998; Grant & Mackie, 2007), access to mental health care for low SES and uninsured individuals is an important issue.

The link between socioeconomic status and insurance status has been made. Given this link, it is important to consider Goldstein's (1973) noted implications for lower class patients. Goldstein (1973) noted that these patients were be found to

be deemed unacceptable for treatment, spend considerable time on the clinic's waiting list, drop out (or be dropped out) after initial screening, receive a socially less desirable formal diagnosis, be assigned to the least experienced staff members, hold prognostic and role expectations incongruent with those held by the therapist, form a poor-quality relationship with the psychotherapist, terminate or be terminated earlier, and improve significantly less from either his own or his therapist's perspective. (p. 102)

Goldstein's (1973) implications appear to conflict with the American Counseling Association's (ACA) Code of Ethics (2005), which encourages counselors to respect the dignity and promote the welfare of clients (A.1.a.) and, when appropriate, advocate examination of potential barriers and obstacles that inhibit access or the growth and development of clients (A.5.a.). However, the literature suggests that inherent biases

against individuals with low socioeconomic status still exists, and thus, the risk of Goldstein's implications still exist.

The American Counseling Association's (ACA, 2005) Code of Ethics encourages counselors to recognize the need for continuing education to acquire and maintain a reasonable level of awareness of current scientific and professional information in their fields of activity and to take steps to keep current with the diverse populations and specific populations with whom they work (C.2.f). Further, ACA Code C.5 (2005) states that counselors do not condone or engage in discrimination based on a variety of cultural factors including socioeconomic status. Results from this study may be used to open a dialog within the counseling profession regarding the ethical implications of counselor bias.

Purpose of the Study

The purpose of this study was to explore counselors' perceptions of uninsured clients. The relationship between counselor bias and four potential sources of counselor bias (multicultural comfort, financial concerns, work setting, and years of experience) was explored. Bias was determined by counselors' responses on the Client Perception Rating Form (CPRF; Mercer, Andrews, & Mercer, 1983) as they relate to an analog case study involving an uninsured or insured client. General counselor preferences were reflected by this measure of bias. The relationship between counselor bias and financial concerns were explored via relationships between work setting (i.e., private practice, community agency, school, etc.) as well as counselor income type (i.e., salary, hourly, or fee-for-service) and scores on the CPRF. The relationship between counselor bias and multicultural comfort with culturally similar and dissimilar clients was

explored via the relationship between participants' scores on the Miville-Guzman Universality-Diversity Scale (M-GUDS; Miville et al., 1999) and scores on the CPRF.

Using Tversky and Kahneman's (1974) heuristics model, the potential exists for counselors with fewer years of experience to have fewer examples on which to base representative generalizations and availability recollections. Therefore, a potential relationship between counselor bias and years of experience was explored as a possible source of bias via problem attribution.

Research Questions

This study investigated the following broad research question: What is the relationship among counselor bias (as evidenced by counselor perception of the client), type of client (insured versus uninsured), and the contributing variables of work setting, income type, years of counselor experience, and multicultural comfort with culturally different clients?

Specific research questions developed from the broad research question included the following: (1) What is the relationship between client type (insured or uninsured) and counselor bias? (2) What is the relationship between counselors' work setting (private practice versus other) and counselor bias? (3) What is the relationship of counselor's income type (salary, hourly, private practice) and counselor bias? (4) What is the relationship between counselors' multicultural comfort level and counselor bias? (5) What is the relationship between counselors' years of experience and counselor bias?

Limitations and Delimitations

The participants in this study were recruited primarily from the seven cities that make up the Hampton Roads area of Virginia, located in the southeastern tip of Virginia.

Participants from these seven cities may not generalize to other areas of the state or the country. In addition, convenience sampling was used which also may limit generalizability.

Social Desirability has been defined as the need of participants to obtain approval by responding in a culturally appropriate and acceptable manner (Crowne & Marlowe, 1960). Consideration was given to the potential for participants in this study to respond in a socially desirable manner to both the Client Perception Rating Form (Mercer et al., 1983) and the Miville-Guzman Universality-Diversity Scale (Miville et al., 1999).

The Client Perception Rating Form (Mercer et al., 1983) asks participants to categorize a client on 22 semantic differential scales, which include adjectives such as *dirty/clean* and *likeable/unlikeable*. Due to social desirability, as well as the potential influence of the Rogerian tenet of unconditional positive regard (Corey, 2005), some participants may have found it difficult to indicate their honest impressions.

The Miville-Guzman Universality-Diversity Scale (M-GUDS; Miville et al., 1999) was designed to assess participants' relativistic appreciation of themselves and others, their commitment to seeking a diversity of contact with others, and their sense of connection with the larger society or humanity as a whole (Miville et al.). Social desirability may have influenced participants to rate themselves higher on these constructs than they actually should.

Assumptions of the Study

It is assumed that the instruments used were understandable to all of the participants and that participants answered the questions honestly with little influence from social desirability. It is further assumed that, given current statistics on uninsured rates among individuals with low socioeconomic status (U.S. Census Bureau, 2007; U.S.

Department of Health and Human Services, 2006), a realistic connection may be made between existing literature pertaining to counselor perceptions of individuals with low socioeconomic status and uninsured individuals.

Definition of Terms

- Bias: An inclination of temperament or outlook; *especially*: a personal and sometimes unreasoned judgment (Merriam-Webster, 2008); An operational signification of bias in this study will be based on responses to the Client Perception Rating Form. Low scores will indicate a more negative perception of the client. High scores will indicate a more positive perception of the client. Scores based on the uninsured client case study will be compared to scores based on the insured client case study to illuminate bias.
- Counselor Preferences: Counselors' ideas about the types of clients with whom they would like to work.
- Counselor Type: The educational background or licensure held by the counselor. Distinctions will be made between mental health/community agency counselors, school counselors, social workers, and psychologists, and between licensed versus non-licensed individuals in these categories.
- Insured Clients: Clients who have health insurance (public or private) that reimburses for mental health services.

<u>Income Type:</u>	Participants' primary source of financial income (i.e., salary, hourly, fee-for-service, etc.)
<u>Multicultural Comfort:</u>	Evidenced by scores on the Miville-Guzman Universality-Diversity Scale (M-GUDS; Miville et al., 1999). The M-GUDS was designed to assess participants' relativistic appreciation of themselves and others, their commitment to seeking a diversity of contact with others, and their sense of connection with the larger society or humanity as a whole (Miville et al.).
<u>Number of Years of Experience:</u>	Indicated free responses to the statements: "Number of years since earning your first counseling-related professional degree." and "Number of years of experience working with clients."
<u>Problem Attribution:</u>	The responsibility and control one has for the origin of the problem; specifically refers to whether the individual or the environment is responsible (Burkard & Knox, 2004).
<u>Socioeconomic Status:</u>	"typically a composite of occupation, education, income, location of residence, and certain amenities in the home (e.g. telephone, T.V., stereo, books, newspapers, etc.; Jenson, 1998). In this study SES is not specifically defined for participants, but inferences may be made based on the case study client's type of job.

Uninsured Clients:

Clients who do not have health insurance (public or private) that reimburses for mental health services

Work Setting:

Indicated by participants' selection of one of the following work settings: private practice, community agency (city or state agency), community agency (non-profit agency), school, hospital, or other (free response).

CHAPTER TWO

REVIEW OF THE LITERATURE

Introduction

Four potential sources of influence on counselors' perceptions of individuals who do not have health insurance that covers mental health services (the uninsured) will be discussed. Existing literature regarding counselor preferences and attitudes toward low socioeconomic clients will be reviewed. The connection between individuals with low SES and the uninsured is supported by statistics on uninsured rates among individuals with low SES (U.S. Department of Health and Human Services, 2006). Existing literature regarding financial concerns, problem attribution, and multicultural competence and comfort will also be discussed as supporting evidence that these issues are potential sources of influence on counselors' perceptions of the uninsured.

General Counselor Preferences

General counselor preferences encompass those preferences that fall under the category of a counselor's desired client characteristics. When considering who they would and would not like to take on as a client, counselors tap into their preferences. In 1964 Schofield introduced the concept of YAVIS Syndrome. YAVIS, an acronym standing for the qualities of *young, attractive, verbal, intelligent, and successful*, described what he believed were preferences of mental health professionals.

When considering YAVIS syndrome (Schofield, 1964), one might consider the underlying reason for these preferences. Many of these characteristics describe mental health professionals. Given the education requirements and the professional status of licensed counselors, one might argue that the desire of a counselor to have a YAVIS

client is really the desire to have a client who mirrors one's own self image. Teasdale and Hill (2006) supported this notion with their study of preferences of therapists-in-training. Their findings indicated that psychological mindedness and similarity in attitudes and values were the two most preferred client characteristics.

Another consideration of counselor preferences involves the desire to feel successful. When selecting a client, counselors size up the client's potential for success and treatability. It is not uncommon for counselors to internalize a client's lack of success as the result of some failing on their own part. Wills (1978) found that counselors prefer the more potentially successful, more treatable clients. In addition, Brown (1970) found that counselors' personal liking for clients related especially to their assessment of the clients' potential for change. A successful client makes the counselor feel successful.

In terms of clients' potential for success, another consideration is a client's motivation for change. Sharf and Bishop (1979) found that counselors' feelings toward clients are related to their perceptions of the clients' motivation as well as the realism of the clients' stated goals. Without client motivation or realistic client goals, a counselor might harbor concern that the client will not be successful, which conflicts with the counselor's drive to be successful. A counselor, perceiving a client as having low motivation or unrealistic goals, may elect to not work with that client due to that client's low potential for success.

General counselor preferences are encompassed by three emerging themes. First, counselors seek clients who are similar to themselves. Second, counselors seek clients for whom they perceive a potential for success. Potential success is indicated by factors

such as realism of client goals and treatability. Finally, counselors seek clients who are motivated for change.

Attitudes toward Clients with Low Socioeconomic Status

In addition to general counselor preferences, counselors' attitudes toward clients with low SES are another potential source of influence on counselors' perceptions of low SES as well as uninsured clients. Auld and Myers (1954) posited that the life of a client with low socioeconomic status has little to offer to reinforce a change in behavior. In other words, counselors may believe that a low SES client is unmotivated to change or even if motivated to change, unlikely to sustain change due to cultural factors or systemic limitations.

Another general attitude regarding clients with low SES is that they do not possess the appropriate attitude or beliefs about counseling necessary for a successful relationship. Shen and Murray (1981) suggested several characteristics of clients with low SES that are antithetical to the counseling process which include having little faith that talking can help, a tendency toward action rather than observation and awareness, and a general sense of distrust.

In addition, counselors may have internalized stereotypes of clients with low SES including beliefs that they are unreliable, disorganized, irresponsible, and less likely to follow through in counseling (Schnitzer, 1996). Counselors are not immune to stereotypes. As Sue (2003) noted, mental health professionals are no more insulated [than non-mental health professionals] from internalizing and perpetuating biases.

Counselor attitudes toward low SES or uninsured clients are encompassed by three emerging themes. First, counselors may harbor the belief that low SES or

uninsured clients have low potential for change or low potential to sustain change. Second, counselors may perceive low SES or uninsured clients to be unreliable, and lacking the ability to follow through with counseling goals or even to keep appointments. Finally, counselors may believe that a low SES or uninsured client's attitudes and beliefs do not support the counseling process.

Financial Concerns

Financial concerns are the second potential source of influence on counselors' perceptions of uninsured clients. As professionals, counselors certainly must consider their bottom line in terms of fee schedules and client load, however, most of the literature regarding financial concerns relates to the impact of fees on the client rather than the counselor. The impact of fee payment on the client was explored by both Bloch (1987) and Cerney (1990.) In her research of social workers, Bloch (1987) found that a majority of respondents believed that clients who pay fees tend to have better treatment outcomes than clients who do not pay fees, and that those fees have more therapeutic value when clients view them as requiring some financial sacrifice. Similarly, Cerney (1990) noted that charging a fee emphasizes that therapy is not a personal friendship but a business relationship and thus there is work to do.

While the impact of fee payment on the client is an important consideration in terms of client attitude and potential outcomes, one cannot ignore the personal impact that fee collection has on counselors. Counselors, especially those in private practice, must consider the impact of sliding scales or pro bono work on their personal income and their ability to successfully maintain their practice. In addition, counselors who work in

agencies in which fees are collected by clients are aware that the funds generated by client fees are used, in part, to pay their salaries.

Furthermore, counselors should consider how fee collection supports their identity as professionals. As Tudor (1998) notes, setting a fee not only sets a value on the service that counselors provide, but also sets a value on themselves as counselors.

In light of counselors' potential reactions to fee setting and fee payment, Johnson and Frederickson (1968) support the idea that counselors may be more motivated to work with clients who can offer financial reward. In their study of the impact of financial remuneration on counselor performance, they found that the knowledge of reward (payment) in direct proportion to performance motivated student counselors to establish more effective relationships with their clients. This study suggests that counselors may be more invested in their clients who are able to pay for their services.

The emerging themes regarding financial concerns include both the impact of fee payment on the client as well as on the counselor. These themes may best be summarized by Aldler and Gutheil (1997):

Though fee setting and fee charging are all too often perfunctorily performed transactions, the issues that emerge around the meaning of money, for both therapist and patient, are of far more central significance than is usually acknowledged, as regards both to the process of therapy and the identity of the therapist (p. 70).

Problem Attribution

Problem attribution is a third potential source of influence on counselors' perceptions of uninsured clients. The construct of problem attribution essentially defines one's perception of the root of the problem. In other words, problem attribution points to whom or what is causing the problem. In terms of clients with low SES, the potential exists for counselors to attribute a client's problems to his or her own actions rather than some other factor such as systemic limitations or institutional injustice. Research from several authors has indicated a potential for this source of bias. Batson (1975), for example, found that clients seeking help in dealing with problems they attributed to their social environments tended to be perceived as having personal problems. Similarly, Zucker and Weiner (1993) found that conservatives tend to see poverty in individualistic terms, that is, as failures of personal initiative.

The similarity of counselors to their clients also seems to have an impact on the tendencies of counselors toward problem attribution. In terms of multicultural differences, Burkard and Knox (2004) found that color-blind racial attitudes may interfere with counselors' ability to accurately discern the differences between internal (e.g., depression) and external (e.g., racism) causes for a client's problems. In addition, in her investigation of counselor bias, Pearce (1994) found that subjects showed a more favorable pattern of attribution for similar clients (in-group) than for dissimilar clients (out-group). For example, Pearce (1994) found that White client respondents (counselors) presented with a White client's case history rated the client's problem to be caused, to a greater extent than a non-White client, by her situation. Further, Toporek and Pope-Davis (2005) support the notion that multicultural awareness (or lack thereof)

may affect problem attribution, as their research indicated that counselor trainees who had completed more multicultural workshops were more likely to endorse external and structural causes of poverty.

Tversky and Kahneman's (1974) study of heuristics supports the notion that exposure to certain types of clients may contribute to problem attribution by have a negative impact on a counselor's ability to distinguish between individual concerns versus attributing the same types of issues to all clients in a similar group. The concept of heuristics includes representativeness and availability heuristics. With the representativeness heuristic, probabilities are evaluated by the degree to which an individual is representative of a group (Tversky & Kahneman, 1974). Therefore a counselor, having worked with one or more unmotivated uninsured clients, might assume that the next uninsured client will also be unmotivated. With the availability heuristic, one assesses the probability of an event by the ease with which instances or occurrences can be brought to mind (Tversky & Kahneman, 1974). In this case, a counselor, having had one or more negative experiences with an uninsured client, might assume that there is a high probability that all interactions with uninsured clients will be negative because those are the experiences that he or she can most easily recall.

The tendency to attribute problems to clients, without consideration of other factors, may cause counselors to develop unrealistic negative perceptions of their clients (Wills, 1978). Emerging themes from problem attribution as a potential source influence on counselors' perceptions of uninsured individuals include tendencies to attribute problems to personal failures and tendencies to ignore external factors which may be influencing the problem. Counselors' level of exposure to certain types of clients may

have an impact on these tendencies. The research indicates that these tendencies are also affected by the personal attitudes of counselors as well as their multicultural awareness.

Multicultural Competence and Comfort

Multicultural competence and comfort is a fourth potential source of influence on counselors' perceptions of the uninsured. As Grant and Mackie (2007) noted, "until now the counseling profession has failed to substantively focus on the disparity between counselors' own middle class/professional culture and the varied class cultures of their clients" (p. 410). This disparity may lead to counselors having difficulty relating to or empathizing with uninsured clients. Auld and Myers (1954) proposed that the middle class therapist, unfamiliar with the conditions of life of the lower class patient, may find it harder to be genuinely interested and to have empathic reactions to what the client tells him or her.

Researchers have suggested that biases and certain stereotypes of low-income clients are reinforced in graduate training programs (Schnitzer, 1996; Siassi & Messer, 1976) including expectations that these clients are unreliable, disorganized, irresponsible, and less likely to follow through in counseling. Further, Schnitzer (1996) noted that "where class, racial, or ethnic differences between therapist and client exist, a discourse of 'otherness' may invade the therapist's formulations, according to which the client is perceived predominately in terms of qualities antithetical to successful treatment outcomes" (p. 576).

Sue and Sue (1990) defined three characteristics of the culturally skilled counselor. These characteristics are:

(1) one who is actively in the process of becoming aware of his or her own assumptions about human behavior, values, biases, preconceived notions, personal limitations and so forth, (2) one who actively attempts to understand the worldview of his or her culturally different client without negative judgments, and (3) one who is in the process of actively developing and practicing appropriate, relevant, and sensitive intervention strategies and skills in working with his or her culturally different clients (p. 481).

In addition to multicultural competence, a counselor's comfort with working with a culturally different client may also affect his or her perception of that client. Miville et. al.'s (1999) construct of Universal-Diverse Orientation (UDO) is defined as "an attitude toward all other persons which is inclusive yet differentiating in that similarities and differences are both recognized and accepted; the shared experience of being human results in a sense of connection with people and is associated with a plurality or diversity of interactions with others" (p. 292). Fuentes, Miville, Mohr, Sedlacek, and Gretchen (2000) have explained that the UDO is conceptualized as an awareness and potential acceptance of both similarities and differences in others that is characterized by interrelated cognitive, behavioral, and affective components.

Multicultural competence and comfort as it relates to counselors' perceptions of the uninsured is encompassed by four emerging themes. First a counselor's sense of "otherness" may inhibit his or her ability to empathize with an uninsured client. Second, counselors' internalized stereotypes may affect their objectivity toward uninsured clients.

Third, a counselor lacking the characteristics of a culturally skilled counselor may not be able to work effectively with uninsured clients. Lastly, a counselor's multicultural comfort level or Universal-Diverse Orientation (Miville et. al., 1999) may affect his or her willingness to work with uninsured clients.

Summary

Four potential sources of influence on counselors' perceptions of uninsured clients have been discussed. These sources are general counselor preferences and attitudes toward low SES or uninsured clients, financial concerns, problem attribution, and multicultural competence and comfort. General counselor preferences are encompassed by three emerging themes. First, counselors seek clients who are similar to themselves. Second, counselors seek clients for whom they perceive a potential for success, which is indicated by factors such as realism of client goals and treatability. Finally, counselors seek clients who are motivated for change.

Three themes emerge from the literature on counselor attitudes toward low SES or uninsured clients. First, counselors may harbor the belief that low SES or uninsured clients have low potential for change or low potential to sustain change. Second, counselors may perceive low SES or uninsured clients to be unreliable, lacking the ability to follow through with counseling goals or even to keep appointments. Finally, counselors may believe that a low SES or uninsured client's attitudes and beliefs do not support the counseling process.

Emerging themes from problem attribution as a potential source of influence on counselors' perceptions of low SES or uninsured individuals include tendencies to attribute problems to personal failures and tendencies to ignore external factors which

may be influencing the problem. Counselors' level of exposure to certain types of clients may affect these tendencies. The research indicates that these tendencies are also affected by a counselor's personal attitudes as well as his or her multicultural awareness.

Multicultural competence and comfort as it relates to counselors' potential perceptions of the uninsured is encompassed by four emerging themes. First a counselor's sense of "otherness" may inhibit his or her ability to empathize with an uninsured client. Second, counselors' internalized stereotypes may negatively affect their objectivity toward uninsured clients. Third, a counselor lacking the characteristics of a culturally skilled counselor may not be able to work effectively with uninsured clients. Lastly, a counselor's multicultural comfort level or Universal-Diverse Orientation (Miville et. al., 1999) may have an impact on his or her willingness to work with uninsured clients.

CHAPTER THREE

METHODOLOGY

Purpose Statement

The purpose of this study was to investigate counselors' perceptions of uninsured clients. An operational definition of counselors' perceptions in this study was participants' perceptions of a client presented in a case study (herein "counselors' perceptions of client"). After reading a case study, counselors' perceptions of client were captured using the Client Perception Rating Form (CPRF; Mercer et al., 1983), which indicates a counselor's impression of a client on six factors. These six factors represented the dependent variables. Counselors' perceptions of client were determined by identifying significant directional effects for the independent variables on the six factors of the CPRF.

There were five independent variables in this study. The first independent variable was type of client (insured or uninsured). Insured clients were defined as clients who have health insurance coverage that includes coverage of mental health services. Types of insurance may include private insurance, Medicare, Medicaid, and military-provided insurance (i.e., TRICARE). Uninsured clients were defined as clients who do not have health insurance coverage for mental health services and therefore would have to pay out of pocket for counseling services. Counselors' multicultural comfort level, as evidenced by scores on the Miville-Guzman Universality-Diversity Scale (M-GUDS; Miville et. al., 1999), was the second independent variable. The M-GUDS consists of three subscales that assess the respective cognitive, behavioral, and affective components of (a) relativistic appreciation of oneself and others, (b) seeking a diversity of contact

with others, and (c) a sense of connection with the larger society or humanity as a whole (Miville et. al.). The M-GUDS provides a total score for multicultural comfort, thus a total score was used for this independent variable.

Counselors' work setting was the third independent variable. Work setting was defined as private practice, community agency (city or state agency or non-profit agency), school, hospital or "other." Private practice work settings include settings in which one or more professional counselors provide services to individuals on a fee-for-service basis. In these settings, counselors are paid per session rather than paid via a salary arrangement. Private practice settings exclude government agencies, clinics, non-profit agencies, hospitals, and any other setting in which clinicians typically receive a salary rather than payment per session.

Counselors' income type was the fourth independent variable. Income type was defined as salary, hourly (not private practice), private practice (fee for service), or "other." This independent variable differentiated between counselors whose incomes are and are not directly affected by reimbursement from an insurance company. While all counseling professionals are ultimately affected by fee payment (that is, all operations must have a revenue source), it was assumed in this study that salaried and hourly-paid counselors are less likely to experience a direct impact from non-payment than private practice counselors whose primary revenue source is fee-for-service counseling sessions.

The fifth independent variable was counselors' years of experience. Years of experience was defined by "number of years working with clients." For this study, more years of experience represented greater potential exposure to different types of clients, which may have an impact on participants' preconceived notions. A second experience-

related demographic question, “number of years since earning first counseling-related professional degree,” was included as a validity check for years of experience.

Overview of Research Design

An analog study using a quasi-experimental design was conducted. Participants were systematically assigned to one of two groups by distributing packets with the insured case study to every other participant and distributing packets with the uninsured case study to the remaining participants. Each group received one of two packets with a client description. The client description in the two packets differed only by the insurance status of the client. Sixty-five participants received packet A, which included a description of a client who was insured (had health insurance that reimburses for mental health services). The remaining 72 participants received packet B, which included a description of a client identical to that in packet A, except that she was described as uninsured. Both packets included identical survey instruments, including a demographic questionnaire, the Miville-Guzman Universality-Diversity Scale (M-GUDS; Miville et al., 1999), and the Client Perception Rating Form (CPRF; Mercer et al., 1983).

Research Questions and Hypotheses

This study investigated the following broad research question: What is the relationship among counselors’ perceptions of client, type of client (insured versus uninsured), and the contributing variables of work setting, years of experience, and multicultural comfort?

Specific research questions included

Research Question #1: What is the relationship between client type (insured or uninsured) and counselors’ perceptions of client?

Research Question #2: What is the relationship between counselors' multicultural comfort level and counselors' perceptions of client?

Research Question #3: What is the relationship between counselors' work setting and counselors' perceptions of client?

Research Question #4: What is the relationship between counselor's income type and counselors' perceptions of client?

Research Question #5: What is the relationship between counselors' years of experience and counselors' perceptions of client?

The hypotheses included the following:

Hypothesis #1: The mean scores on the CPRF subscales will be significantly lower for participants reacting to uninsured clients versus insured clients.

Hypothesis #2: There will be a significant interaction effect between counselors' multicultural comfort (as evidenced by their total score on the M-GUDS) and client's insurance status for counselors' perceptions.

Hypothesis #3: There will be a significant interaction effect between counselors' work setting and client's insurance status for counselors' perceptions. CPRF scores from participants in private practice reacting to uninsured clients will be significantly less favorable than CPRF scores from non-private practice participants reacting to uninsured clients.

Hypothesis #4: There will be a significant interaction effect between counselors' income type and client's insurance status for counselors' perceptions. CPRF scores from participants with hourly or private practice income reacting to uninsured clients will be

significantly less favorable than CPRF scores from salaried participants reacting to uninsured clients.

Hypothesis #5: There will be a significant relationship between counselors' years of experience and client's insurance status. CPRF scores from participants with more experience reacting to uninsured clients will be significantly less favorable than CPRF scores from participants with less experience reacting to uninsured clients.

Method

Participants

Convenience sampling was used to identify community and mental health counselors working in private practice and other settings (e.g., community agencies, hospitals). Utilizing existing relationships with local community agency leadership, the researcher conducted an on-site seminar within the Norfolk Community Services Board and distributed an on-line survey to the full staff of the Chesapeake Community Services Board.

Access to counselors was also gained by conducting the study during continuing education seminars held at Old Dominion University during the summer and fall of 2008. These seminars netted 83 completed survey packets, with a mix of counselor types (e.g., licensed professional counselors, licensed clinical social workers, licensed school counselors, non-licensed, master's-level counselors, etc.).

In addition to solicitation at continuing education seminars, access to counselors was gained by hosting an on-line version of the survey packet using the website www.surveymonkey.com. The survey packet was translated to an on-line version with all key elements intact (e.g., ordering of instrumentation, instrument style). The only

addition to the on-line version was a question asking participants to indicate their birth month. This question served as a redirect that allowed for participants with birthdays in the months January through June to see the insured client case and participants with birthdays in the months July through December to see the uninsured client case. The link to the on-line survey was distributed via a variety of email lists including local agencies and local counseling organizations. Approximately 200 individuals were sent the link for the survey. A total of 45 surveys were completed via the on-line version.

Using a statistical power table and assuming a moderate effect size (Cohen, 1988), a minimum of 100 participants was required in order to have an 86% chance of detecting a statistical difference. A total of 147 surveys were completed, thus meeting sample size requirements. Post-hoc effect size estimates are provided for each research question in Chapter 4.

Procedure

Access to counselors was gained by conducting the study during continuing education seminars held at Old Dominion University during the summer and fall of 2008. These seminars netted 83 completed survey packets, with a mix of counselor types (e.g., licensed professional counselors, licensed clinical social workers, licensed school counselors, non-licensed, master's-level counselors, etc.). The seminars took place in July, September, October and November of 2008. These seminars featured three nationally recognized leaders in the counseling field.

All individuals attending a seminar were invited to complete the survey at each seminar, however, in order to avoid duplication, at the second, third, and fourth seminars, participants were asked to refrain from completing the survey if they had already

participated in the study at a previous seminar. Neither the speakers nor the participants had a personal interest in outcome of the study. To minimize coercion, the researcher announced that participation in the study was voluntary and participants were instructed to return blank copies of the survey packet if they did not wish to participate. Survey packets were bundled by table when collected by the researcher so that participants could remain anonymous if they did not elect to complete their packets.

Research packets were distributed at the mid-point of the program, as participants returned from a lunch break. The researcher distributed the research packets, allowed sufficient time for the participants to complete their packets, and collected the packets.

Participants were systematically assigned to one of two groups. Each group received one of two packets with a client description. The client description in the packets differed only by the insured status of the client. Participants who received packet A received a description of a client who was insured. Participants, who received packet B, received a description of a client identical to that in packets A, except that she was described as uninsured. The packets were collated in “A” then “B” order prior to the seminars. Therefore, while passing out packets, every other participant was given packet “A” and the person next to that participant was given packet “B.”

It took seminar participants approximately 20 minutes to complete the demographic questionnaire, read the case vignette, and complete the two instruments. Research packets also included an informed consent document. The informed consent document was placed at the top of the packet and participants were asked to review the document prior to completing the packet. To ensure confidentiality, participants were not asked to sign a consent form. Completing the research packet served as consent.

Participants were permitted to opt out of the research study if they did not consent. A total of 83 survey packets were completed at these continuing education seminars.

In addition to the continuing education seminars held at Old Dominion University, existing relationships with the leadership at the Norfolk Community Services Board (CSB) provided an opportunity to conduct an on-site continuing education seminar for their staff. Identical survey packets and distribution methodology to that used at the ODU seminars was used at the Norfolk CSB seminar. A total of 19 survey packets were completed at this on-site continuing education seminar. It took approximately 20 minutes for the CSB participants to complete their packets.

In addition to solicitation at continuing education seminars, some counselors completed an on-line version of the survey packet using the website www.surveymonkey.com. The survey packet was translated to an on-line version with all key elements intact (e.g., ordering of instrumentation, instrument style). The link to the on-line survey was distributed via a variety of email address lists including local agencies and local counseling organizations. A total of 45 surveys were completed via the on-line version.

Instrumentation

Personal Information Questionnaire. Participants were asked initially to complete a personal information questionnaire which included a question about the type of setting in which they worked and the number of years of counseling experience they had. Other items included counselor type (counselor, social worker, psychologist, and licensed or unlicensed) as well as primary income type (salary, hourly, private practice, other), race/ethnicity, and gender (Appendix A). Categories for race/ethnicity were taken

from the U.S. Census Bureau (2006) and included American Indian or Alaska Native, Asian, Black, Hispanic Origin, Native Hawaiian or Other Pacific Islander, and White (not Hispanic). The category, Multiracial, was added.

Case vignette. The participants in this study received a case vignette of a client. The client was identical in every way except for whether or not she had health insurance that covered mental health services status (i.e., insured vs. uninsured.) The vignette included information such as the client's presenting problem, her appearance, her race, her vocation, her affect, and her goals for treatment. The vignette was developed for this study to address some of the semantic differential adjectives included on the Client Perception Rating Form (CPRF, Mercer et al., 1983). It was assessed by two reviewers for appropriate coverage of included adjectives. For example, the CPRF references the client's appearance via the adjectives *clean/dirty*. Therefore, the vignette was assessed to ensure that some notation regarding client's appearance was included. Both reviewers were doctoral-level counselor educators with a minimum of five years of experience with quantitative research (Appendix B).

Client Perception Rating Form. Participants were asked to complete the Client Perception Rating Form (Mercer et al., 1983; Appendix C). Mercer et al. developed the Client Perception Rating Form (CPRF) to assess participants' overall rating of the client on six factors: social attractiveness, prognosis, physical attractiveness, personal evaluation, severity of the presenting problem, and adjustment. The CPRF is composed of 22 bipolar adjectives on a semantic differential scale of 1 to 7.

Social attractiveness is defined by four bipolar descriptions (i.e., *easy to get along with/hard to get along with*, *cooperative/uncooperative*, *employable/unemployable*,

friendly/unfriendly.) Prognosis is defined by five bipolar descriptions (i.e., *have few problems/have many problems, be improved/be worse, will require no counseling/will require counseling, be very happy/be very unhappy, dangerous/not dangerous.*) Physical attractiveness is defined by four bipolar adjectives (i.e., *clean/dirty, neat/sloppy, tasteful/distasteful, very attractive/very unattractive.*) Personal evaluation is defined by six bipolar descriptions (i.e., *very motivated for help/not motivated for help, valuable/worthless, warm/cold, deep/shallow, not dangerous/dangerous, reliable/unreliable.*) Adjustment is defined by three bipolar descriptions (i.e., *well-adjusted/maladjusted, self-reliant/dependent, not dangerous/dangerous.*) Severity of presenting problem is defined with one bipolar adjective (i.e., *mild/severe.*)

Four items were adapted from the Psychological Effectiveness Scale cited by Cash, Kehr, Polysen, and Freeman (as cited by Mercer et. al., 1983) to assess a one-year prognosis. These items are have few problems-have many problems, be improved-be worse, require no counseling-require much counseling, and be very happy-be very unhappy.

The poles of the dimensions were randomly reversed to reduce the possibility of a negative or positive set (Mercer et. al., 1983). Mercer et. al. performed a factor analysis as a reliability check for the CPRF. Six orthogonal factors emerged, including social attractiveness, prognosis, physical attractiveness, personal evaluation, severity of the presenting problem, and adjustment, which together accounted for 66% of the total variance. A total score for each of the six factors was produced by the survey. Each factor score served as a separate dependent variable, thus creating 6 dependent variables.

According to Presley (1969), for factor scoring, it is usually assumed that if scales (items on the semantic differential) have high loadings on a factor extracted across a number of concepts, then it is legitimate to sum the scores on these scales to obtain an evaluative factor score for each concept. For this study, using the CPRF instrument, the two concepts were the participants' client type (insured versus uninsured.)

Presley (1969) further noted that when factor structure is not necessarily the same across concepts, analysis must be completed separately for each of the concepts one wishes to study. To address this issue, in this study, factor scores were determined by a summation of the scores on the scales relating to each factor (e.g., factor one = social attractiveness.) Each participant was assigned a mean score for each of the six factors of the CPRF. An overall mean factor score was then calculated by concept (e.g., a mean score for the social attractiveness factor across all participants responding to the uninsured client). Overall mean factor scores for each factor were then compared between the two concepts (uninsured client versus insured client.) Higher mean factor scores served as an indication of negative perceptions of the client, as the negative adjectives were found on the right pole of the semantic differential instrument.

A limitation to this method that should be considered is the unequal loadings on the six factors of the CPRF. According to Presley (1969), simple summation procedures can be justified when the scales all have high loadings on the factor, but they unequally weight those with proportionately lower loadings. Mercer et al. (1983) noted that 11 of the items were found to load as an evaluative factor with internal consistencies ranging from .73 to .84., however loadings for the remaining items were not disclosed. Mercer et al. did note that a factor analysis identified that the six orthogonal factors together

accounted for 66% of the total variance. The results of this study produced alphas ranging from .55 for the Adjustment factor to .66 for the Personal Evaluation factor. Alphas were produced for only five of the six factors, as one of the factors, Severity of Presenting Problem, included only one item.

Miville-Guzman Universality-Diversity Scale. Participants were asked to complete the Miville-Guzman Universality-Diversity Scale (Miville et al., 1999; Appendix D). Miville et. al. developed the Miville-Guzman Universality-Diversity Scale (M-GUDS) to assess the construct of UDO. Miville et. al.'s construct of Universal-Diverse Orientation (UDO) is defined as "an attitude toward all other persons which is inclusive yet differentiating in that similarities and differences are both recognized and accepted; the shared experience of being human results in a sense of connection with people and is associated with a plurality or diversity of interactions with others" (p. 292). Fuertes, Miville, Mohr, Sedlacek, and Gretchen (2000) explained that the UDO is conceptualized as an awareness and potential acceptance of both similarities and differences in others that is characterized by interrelated cognitive, behavioral, and affective components. The M-GUDS consists of three subscales that assess the respective cognitive, behavioral, and affective components of UDO: (a) relativistic appreciation of oneself and others, (b) seeking a diversity of contact with others, and (c) a sense of connection with the larger society or humanity as a whole (as cited in Fuertes et al., 2000).

Reliability of the M-GUDS was assessed by Miville et al. (1999) in two ways: internal consistency, measured by the alpha coefficient, and stability, measured by the Pearson product-moment correlation coefficient in a test-retest procedure. Alphas were

obtained for the overall scale in both the pilot and larger studies. An alpha of .92 was obtained for the revised or final version of the M-GUDS. In addition, construct validity was evidenced in the pattern of correlations between the M-GUDS and a number of other scales. Specifically, the M-GUDS correlated positively with racial identity (for both Blacks and Whites), healthy narcissism, empathy, feminism, and androgyny and correlated negatively with dogmatism and homophobia (Miville et al.). A total score on the M-GUDS was recorded for each participant. Higher total scores indicate greater Universal-Diverse Orientation (UDO) and were used in this study to indicate greater multicultural comfort.

Data Analysis

Data analysis was conducted using the SPSS Data Analysis System, Version 15. The dependent variables for all analyses conducted were the counselor ratings on the six factors of the Client Perception Rating Form (CPRF). The six factors are social attractiveness, prognosis, physical attractiveness, personal evaluation, severity of the presenting problem, and adjustment. The ratings on the six factors were continuous variables. Each participant was assigned a mean score for each of the six factors of the CPRF.

To explore the main effect of the categorical independent variable of insurance status (insured or uninsured) on the six factors of the CPRF, which make up the dependent variables, a one-way multivariate analysis of variance (MANOVA) was conducted comparing the six mean factor scores for the two insurance status concepts. As no significant differences for case type on any of the six subscales of the CPRF were found, case type was not included as a fixed variable for the analyses of the remaining

four independent variables (multicultural comfort, counselors' work setting, counselors' income type, and counselors' years of experience.) Rather, for these independent variables, aggregate mean scores (including scores from both case vignette survey packets) were compared against each independent variable to assess for significant interaction effects between general bias toward the client in the case vignette and the independent variables. These possible interaction effects were measured by conducting independent one-way multivariate analyses of variance (MANOVA) for the six dependent variables.

All analyses included Levene's Test of Equality of Error Variances. The criteria for rejecting the null hypothesis was set at alpha level $p = .05$ (Stevens, 1999).

Internal and External Validity Threats

Internal validity asks the question, did the experimental treatments make a difference in this specific experimental instance? Conversely, external validity asks the question of generalizability, or to what populations, settings, treatment variables, and measurement variables can this effect be generalized (Campbell & Stanley, 1963)?

Threats to internal and external validity include extraneous variables that, if not controlled in the experimental design, might produce effects confounded with the effect of the experimental stimulus (Campbell & Stanley).

Internal validity threats that were considered in this study included history, instrumentation, selection, diffusion of treatment, and experimenter effect (Campbell & Stanley, 1963). In terms of history, participants' experiences (beyond those accounted for by the independent variables) may have confounded their responses. Not only did participants' personal and professional histories differ, but since the study took place over

several months, external circumstances could have posed a history threat for one group and not another. For example, if changes in health insurance legislation had occurred between the first and second seminars, participants in the second seminar would potentially have had different perspectives than participants in the first session.

Instrumentation threats may have resulted from two sources. First, the case vignette utilized in this study was created specifically for the study. The creation of the vignette was subject to the researcher's own bias, thus creating an instrumentation threat. In addition, there is limited psychometric data provided for the Client Perception Rating Form (Mercer et al., 1983). Internal consistencies were provided for only 11 of the 22 semantic differential items.

The threat of selection must also be considered as the participants were not randomly sampled. Participants included individuals attending one of four continuing education seminars in the summer and fall of 2008. The four seminars covered three different topics. Therefore, differences may have existed among individuals electing to attend one seminar versus another. For example, one of the seminar topics was multicultural counseling. One might assume that individuals electing to attend that seminar may have scored higher on the M-GUDs instrument compared to individuals who elected to attend a different seminar.

Like the history threat, the diffusion of treatment threat resulted from the seminars being offered over a five month period. The potential existed that participants who attended the first session may have discussed the survey with participants of later sessions.

The experimenter effect threat resulted from the potential that participants were acquainted with the researcher. As the researcher lives and works in the community in which the seminars were held, participants may have had previous interaction with the researcher or have name recognition of the researcher. The potential existed that participants may have consciously or unconsciously adjusted their responses as a reaction to their acquaintance with the researcher.

External validity threats should also be considered a limitation to this study. The participants in this study were recruited primarily from the seven cities that make up the Hampton Roads area of Virginia, located in the southeastern tip of Virginia. These seven cities vary only slightly from each other and their populations may not generalize to other areas of the state or the country. In addition, as noted by Campbell and Stanley (1963), all internal validity threats should be considered as potential threats to the potential to generalize the study to a wider population.

CHAPTER FOUR

RESULTS

The purpose of this study was to explore counselors' perceptions of clients based on whether the clients had health insurance that would reimburse them for counseling services. The relationship between three potential sources of counselor bias (i.e., multicultural comfort, financial concerns, and years of experience) was explored. Bias was determined by counselors' responses on the Client Perception Rating Form (CPRF; Mercer, Andrews & Mercer, 1983) related to an analog case study involving an uninsured or insured client. General counselor preferences were reflected by this measure of bias. The relationship between counselor bias and financial concerns was explored via relationships between work setting (e.g., private practice, community agency, school) as well as counselor income type (i.e., salary, hourly, or fee-for-service) and scores on the CPRF. The relationship between counselor bias and multicultural comfort was explored via the relationship between participants' scores on the Miville-Guzman Universality-Diversity Scale (M-GUDS; Miville et al., 1999) and scores on the CPRF. The relationship between counselor bias and years of experience was explored via relationships between counselors' number of years of experience and scores on the CPRF.

Characteristics of the Sample

Convenience sampling was used to identify community and mental health counselors working in a variety of settings (e.g., private practice, community agencies, and hospitals). Survey packets were distributed via two channels, live distribution at continuing education seminars held at a local Community Services Board and at a local

university and web-based distribution via the Internet tool www.surveymonkey.com .

The link to the on-line survey was distributed via a variety of email lists including local agencies and local counseling organizations.

Distribution at the continuing education seminars yielded 102 completed survey packets, and 45 completed survey packets were obtained through the web-based distribution. Both distribution methods provided access to a variety of counselor types. Descriptive data displaying the counselor types by distribution channel are displayed in Table 1.

Table 1

<i>Frequency Distribution of Counselor Type by Survey Distribution Method</i>				
Counselor Type	ODU Continuing Education Workshops	Norfolk CSB Continuing Education Workshop	Web-based Distribution (surveymonkey.com)	Total
Licensed Professional Counselor	24	2	20	46
Licensed Clinical Social Worker	9	3	1	13
Licensed Clinical Psychologist	1	0	0	1
Licensed Marriage & Family Therapist	1	0	0	1
Licensed School Counselor	9	0	1	10
Non-Licensed masters-level Counselor	14	3	17	34
Non-Licensed masters-level Social Worker	3	2	0	5

Bachelor's degree in related human services field	20	7	4	31
Other	2	2	2	6
Total	83	19	45	147

Participants were also asked to indicate their race or ethnic group. Descriptive data for participants' responses are in Table 2.

Table 2

Frequency Distribution by Race or Ethnic Group

Race or Ethnic Group	Frequency of Participants	Percent of Participants
American Indian	2	1.4%
Asian	3	2.0%
Black	24	16.3%
Hispanic Origin	1	0.7%
White not Hispanic	110	74.8%
Multiracial	7	4.8%
Total	<i>N</i> = 147	100.0%

Categories for race/ethnicity were taken from the U.S. Census Bureau (2006) and included American Indian or Alaska Native, Asian, Black, Hispanic Origin, Native Hawaiian or Other Pacific Islander, and White (not Hispanic). The category Multiracial was added. Most of the participants (almost 75%) were White without Hispanic origin, which meant that only 25% of the participants were representative of minority groups.

In addition to racial or ethnic group, participants were asked to indicate their gender. Descriptive data for participants' gender is displayed in Table 3.

Table 3

<i>Frequency Distribution by Gender</i>		
Gender	Frequency of Participants	Percent of Participants
Male	25	17.1%
Female	121	82.3%
No Response	1	0.6%
Total	<i>N</i> = 147	100.0%

This study included three demographic-oriented independent variables. These independent variables were work setting, income type, and years of experience. Descriptive data for participants' work setting are displayed in Table 4. Participants were asked to indicate their primary work setting.

Table 4

<i>Frequency Distribution by Work Setting</i>		
Work Setting	Frequency of Participants	Percent of Participants
Private Practice	27	18.4%
Community Agency, City or State	49	33.3%
Community Agency, Non-Profit	25	17.0%
School	24	16.3%
Hospital	2	1.4%
Other	20	13.6%
Total	<i>N</i> = 147	100.0%

The frequency distribution for work setting indicates that several work settings were represented; with no one work setting representing a majority of the respondents. Participants from a city or state community agency were the most frequently represented with 49 respondents which made up one-third of the participants.

Descriptive data for income type are displayed in Table 5. Participants were asked to indicate their primary income type.

Table 5

<i>Frequency Distribution by Primary Income Type</i>		
	Frequency of Participants	Percent of Participants
Salary	107	72.8%
Hourly, not Private Practice	15	10.2%
Private Practice, Fee for Service	18	12.2%
Other	6	4.1%
No Response	1	0.7%
Total	<i>N</i> = 147	100.0%

The frequency distribution for primary income type indicates that for the majority of the respondents (almost 73%), salary was their primary income type. Respondents with hourly and private practice income types represented only 10% and 12%, respectively.

Descriptive data for participants' reported years of experience are displayed in Table 6. Respondents were asked to indicate the total number of years that they had been working with clients.

Table 6

Frequency Distribution by Total Number of Years Working with Clients

	Frequency of Participants	Percent of Participants
0 to 5	46	31.2%
6 to 10	28	19.0%
11 to 15	20	13.6%
16 to 20	19	13.7%
21 to 25	11	7.5%
26 to 30	9	6.1%
31 to 35	7	4.9%
36 to 40	3	2.0%
41 to 45	1	0.7%
Missing	3	2.0%
	<i>N</i> = 147	100.0%

Participants' years of experience ranged from less than one year to 43 years. The mean response to total number of years working with clients was 13.1 years (*SD* 10.5), skewness was 0.84.

Data Screening and Diagnostics

Before conducting analyses of the five research questions, data screening, including recoding and diagnostics, was conducted. For the Client Perception Rating Form (CPRF; Mercer et al., 1983), 11 items required reverse scoring. After reverse scoring those items, the six factors of the CPRF (i.e., Social Attractiveness, Prognosis, Physical Attractiveness, Personal Evaluation, and Adjustment) were coded by summing

the scores of the items that loaded significantly on those factors. Thus, six variables representing the six factors were created.

A new variable to represent participants' total score on the Miville-Guzman Universality-Diversity Scale (M-GUDS; Miville et al., 1999) was also created by summing the scores from the 45 items of the M-GUDS. The M-GUDS is not designed to produce subscales; therefore, participants' total scores were utilized to reflect multicultural comfort for this study.

Participants were systematically assigned to each group (e.g, one group receiving the case vignette with the insured client and another group receiving the case vignette with the uninsured client). Prior to the seminars, the researcher collated the packets in "A" then "B" order. Therefore, while passing out the packets, the researcher was able to give every other participant packet "A" and the next person next packet "B." Similarly, the online version included a question asking participants to indicate their birth month. This question served as a redirect device that allowed for participants with birthdays in the months January through June to view the insured client case, and participants with birthdays in the months July through December to view the uninsured client case. To ensure that the participants receiving both case types were similar across the independent variables, independent t-tests were conducted and revealed non-significant findings. Specifically, the groups did not differ significantly for work setting, income type, and number of years of experience.

Overall Findings

Scores on the six factors of the CPRF were utilized in this study to measure participants' perceptions of the client illustrated in the case vignette. Based on the

scoring rubric for the CPRF, higher scores represent more negative perceptions, as for each semantic differential item, participants ranked the client on a scale of one to seven, with one representing the positive pole and seven representing the negative pole. Variances in scores were then assessed to determine bias against the client (i.e., higher scores reflected greater negative bias).

Each of the six CPRF factors varied by the number of items included in that factor, which affected the potential range of scores for each factor. Descriptive data, including item loading and range of scores for each CPRF factor is displayed in Table 7.

Table 7

Item Loading and Possible Score Range for the CPRF

	Number of Items Included in Factor	Minimum Possible Score	Maximum Possible Score
Social Attractiveness	4	4	28
Prognosis	5	5	35
Physical Attractiveness	4	4	28
Personal Evaluation	6	6	42
Severity	1	1	7
Adjustment	3	3	21

The total mean scores for each of the six CPRF factors are displayed in Table 8. These mean scores include responses from participants receiving both versions of the case vignette.

Table 8

Total Mean Scores for the Six Factors of the CPRF

	Possible Range of Scores	<i>M</i>	<i>SD</i>
CPRF Social Attractiveness	4 to 28	10.74	3.66
CPRF Prognosis	5 to 35	14.83	4.14
CPRF Physical Attractiveness	4 to 28	9.90	2.97
CPRF Personal Evaluation	6 to 42	15.85	4.54
CPRF Severity	1 to 7	4.58	1.08
CPRF Adjustment	3 to 21	10.17	3.23

Note: The left pole of the CPRF item scales (i.e., lower scores) represent more favorable ratings.

It is noteworthy that responses from participants receiving both case vignettes yielded favorable mean scores (i.e., scores that were at or below the midpoint for the possible range of scores) for all of the CPRF factors except the severity factor. These mean scores indicate that the participants rated their case vignette client favorably, regardless of insurance status. Low standard deviations provide evidence that these favorable ratings were consistent across all participants.

Tests of Hypotheses

Research Question

This study investigated the following broad research question: What is the relationship among counselors' perceptions, type of client (insured versus uninsured), and the contributing variables of multicultural comfort, work setting, income type, and years of experience?

Test of Hypothesis 1

Hypothesis 1 stated that the mean scores on the CPRF subscales would be significantly lower for participants reacting to uninsured clients versus insured clients.

To explore the main effect of the categorical independent variable of insurance status (insured or uninsured) on the six factors of the CPRF, which make up the dependent variables, a multivariate analysis of variance (MANOVA) was conducted comparing the six mean factor scores for the two insurance status concepts. Levine's Test of Equality of Error Variances was not statistically significant ($p > .05$), indicating an assumed homogeneity of variance, that is, variance for all dependent variables was normality distributed.

There was not a significant difference for case type (insured or uninsured) for the six subscales of the CPRF. (Wilk's $\Lambda = .921$, $F_{6,130} = 1.87$, $p = .09$, $\eta^2 = .08$). The mean scores for the six factors of the CPRF in relation to case type are displayed in Table 9.

Table 9

Mean Scores by Case Type

	Case assigned to Participant	<i>M</i>	<i>SD</i>
Social Attractiveness	Uninsured	10.49	0.43
	Insured	10.95	0.46
Prognosis	Uninsured	14.00	0.47
	Insured	15.94	0.50
Physical Attractiveness	Uninsured	9.56	0.35
	Insured	10.32	0.37
Personal Evaluation	Uninsured	15.33	0.53

	Insured	16.59	0.56
Severity	Uninsured	4.44	0.13
	Insured	4.74	0.13
Adjustment	Uninsured	9.60	0.37
	Insured	10.71	0.39

As no significant differences for case type on any of the six subscales of the CPRF were found while testing hypothesis 1, case type was not included as a fixed variable for the analyses of the remaining hypotheses. Rather, aggregate mean scores (scores from both case vignette survey packets) for the independent variables multicultural comfort, work setting, income type and years of experience to assess for significant interaction effects between general bias toward the client in the case vignette and these independent variables. The possible interaction effect was measured by conducting independent MANOVAs for the six dependent variables.

Test of Hypothesis 2

Hypothesis 2 stated that there would be a significant interaction effect between counselors' multicultural comfort (as evidenced by their total score on the M-GUDS) and client's insurance status for counselors' perceptions. The MANOVA reflected no significant relationship between multicultural comfort and bias ratings, as evidenced by scores on the six factors of the CPRF (Wilk's $\Lambda = .008$, $F_{396,338} = 1.07$, $p = .25$, $\eta^2 = .56$).

Test of Hypothesis 3

Hypothesis 3 stated that there would be a significant interaction effect between counselors' work setting and client's insurance status for counselors' perceptions, and that CPRF scores from participants in private practice reacting to uninsured clients would

be significantly less favorable than CPRF scores from non-private practice participants reacting to uninsured clients. The independent one-way multivariate analysis of variance (MANOVA) reflected no significant relationship between counselors' work setting and bias ratings (Wilk's $\Lambda = .791$, $F_{30,506} = 1.02$, $p = .44$, $\eta^2 = .05$).

Test of Hypothesis 4

Hypothesis 4 stated that there would be a significant interaction effect between counselors' income type and client's insurance status for counselors' perceptions, and that CPRF scores from participants with hourly or private practice income reacting to uninsured clients would be significantly lower than CPRF scores from salaried participants reacting to uninsured clients. The MANOVA reflected no significant relationship between counselors' income type and general bias (Wilk's $\Lambda = .836$, $F_{18,360} = 1.31$, $p = .18$, $\eta^2 = .06$).

Test of Hypothesis 5

Hypothesis 5 stated that there would be a significant relationship between counselors' years of experience and client's insurance status, and that CPRF scores from participants with more experience reacting to uninsured clients would be significantly lower than CPRF scores from participants with less experience reacting to uninsured clients. The MANOVA reflected no significant relationship between counselors' years of experience and general bias (Wilk's $\Lambda = .151$, $F_{210,560} = 1.0$, $p = .49$, $\eta^2 = .27$).

The results of these hypotheses tests indicate that, using the CPRF as an indicator of general bias, counselor bias is not affected by client type, multicultural comfort, work setting, income type, or years of experience. A summary of the results of the independent

one-way multivariate analyses of variance (MANOVA) for the five hypotheses is displayed in Table 10.

Table 10

<i>Summary of independent MANOVAs</i>		
	Wilk's Λ	
	<i>F</i>	<i>p</i>
Case Type (Insured vs. Uninsured)	1.87	0.09
M-GUDS Total	1.07	0.25
Work Setting	1.02	0.44
Income Type	1.31	0.18
Years of Experience	1.00	0.49

Other Findings

It is noteworthy that participants' scores on the six factors of the CPRF, except severity, were normally distributed, with kurtosis values for each factor falling within an acceptable range of +/- 0.5 (Runyon, Coleman, & Pittenger, 2000). A summary of the descriptive statistics for the six CPRF factors is displayed in Table 11.

Table 11

Descriptive Statistics for CPRF Factors

	<i>N</i>	Range of Actual Scores	Mean	Median	Mode	Std. Deviation	Kurtosis
Social Attractiveness	145	18	10.74	10.00	10.00	3.66	0.08
Prognosis	145	23	14.83	14.00	14.00	4.14	0.40
Physical Attractiveness	143	13	9.90	10.00	10.00	2.97	-0.42
Personal Evaluation	141	20	15.85	16.00	16.00	4.54	-0.31
Severity	147	6	4.58	5.00	5.00	1.08	0.40
Adjustment	145	16	10.17	10.00	10.00	3.23	0.02

Note: Multiple modes exist for prognosis; the smallest value is shown.

The normal distribution for five of the six CPRF factors indicates participants did not follow a specific trend in their responses (e.g., responses were not clustered on either pole of each factor scale.) Frequency distributions for each CPRF factor are displayed in Figures 1 through 7.

Figure 1

Frequency Distribution for Social Attractiveness Scores

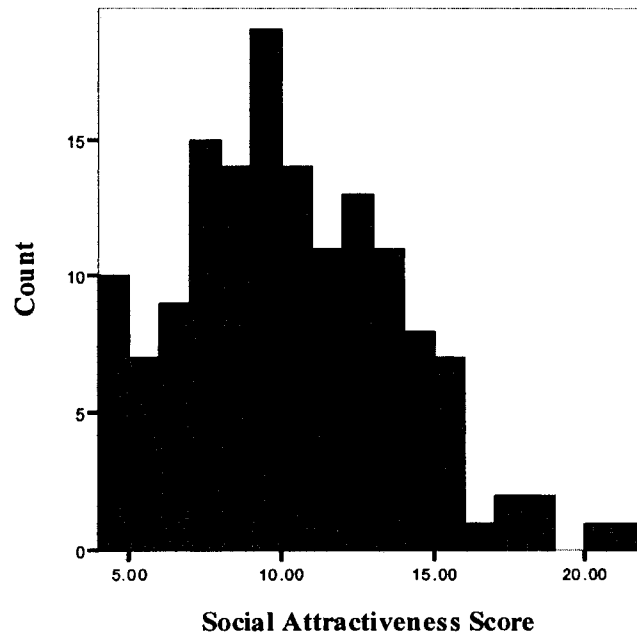


Figure 2

Frequency Distribution for Prognosis Scores

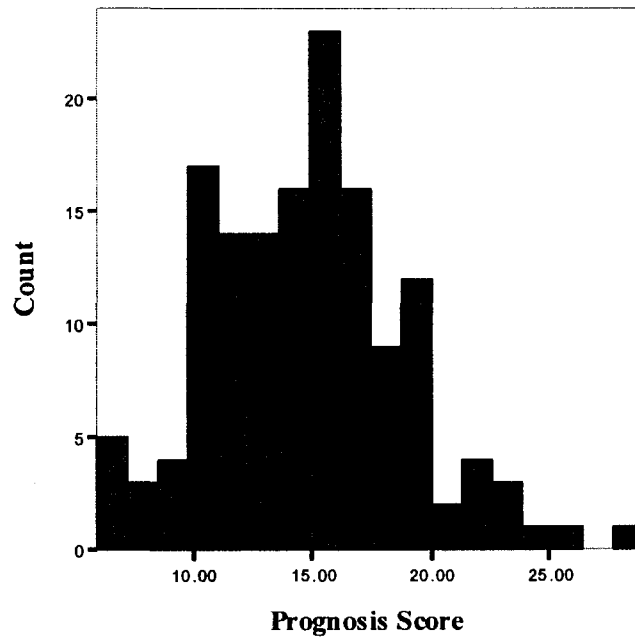


Figure 3

Frequency Distribution for Physical Attractiveness Scores

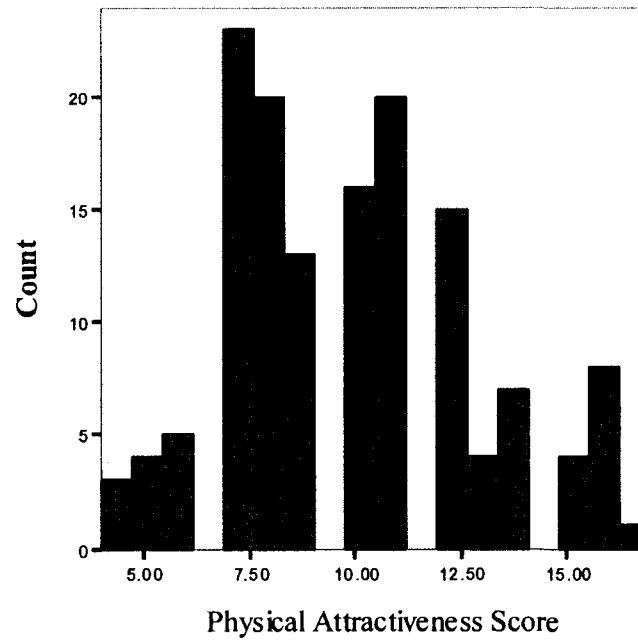


Figure 4

Frequency Distribution for Personal Evaluation Scores

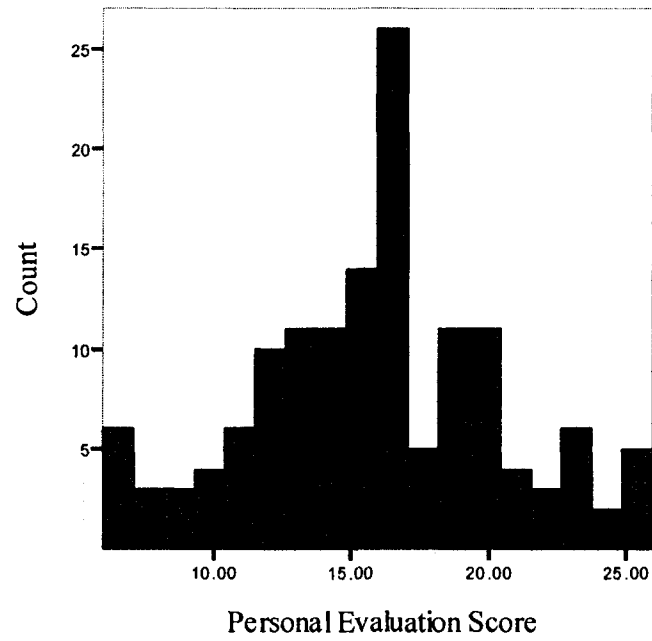


Figure 5

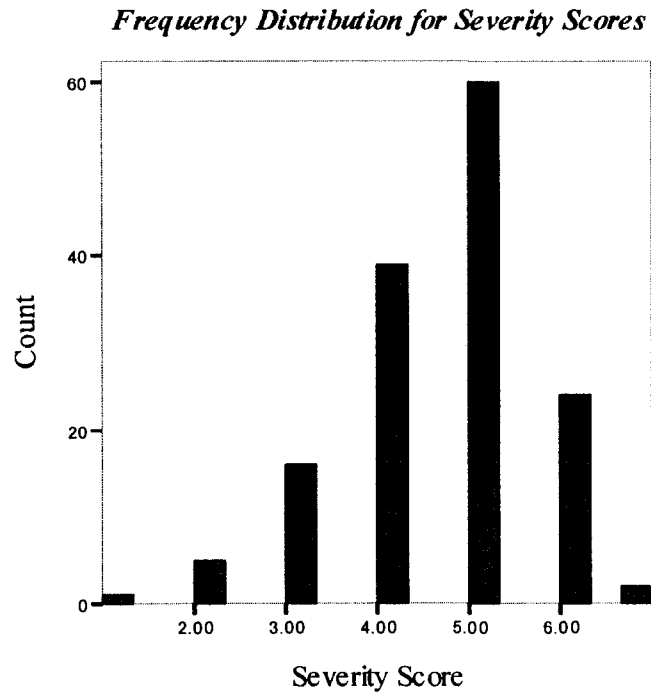
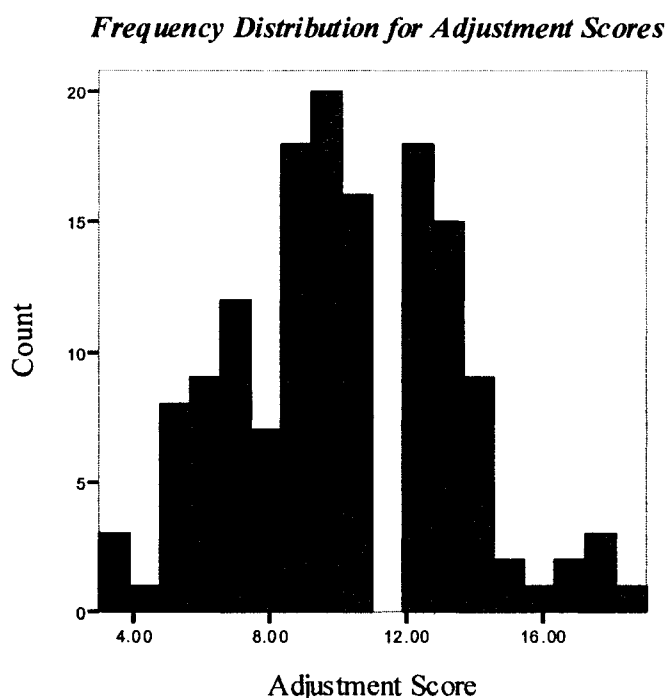


Figure 6



In addition to the five research questions and the analysis of general participant scores on the CPRF, other trends in the data were explored. For example, independent one-way multivariate analyses of variance (MANOVA) were conducted for the three demographic independent variables, work setting, income type, and years of experience, with participants' M-GUDS total score as the dependent variable. This analysis was conducted to explore a possible interaction effect between multicultural comfort and the independent variables, work setting, income type, and years of experience to determine any possible confounding effects of multicultural comfort on these variables. The independent one-way multivariate analyses of variance (MANOVA) reflected no significant relationships between participants' M-GUDS total scores and the demographic independent variables. A summary of the results of the independent one-

way multivariate analyses of variance (MANOVA) for the three demographic variables with participants' M-GUDS total scores is displayed in Table 12.

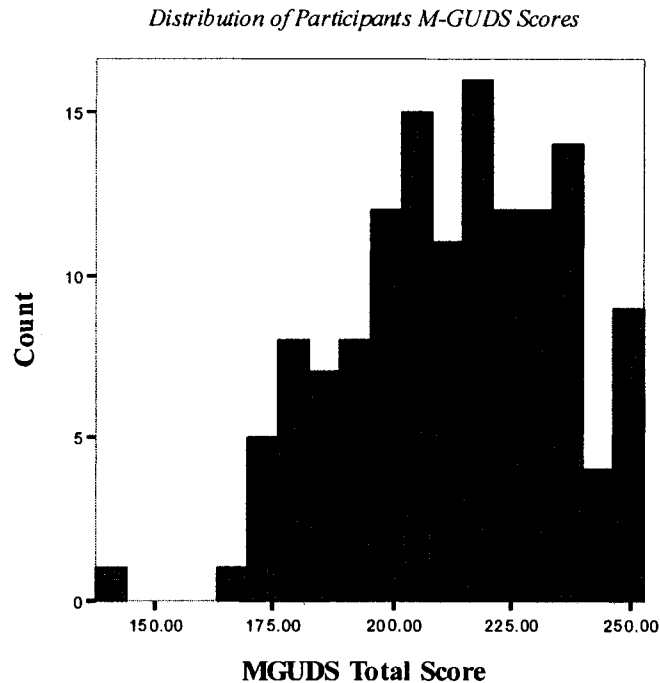
Table 12

Summary of Independent MANOVAs: Demographic Variables by M-GUDS

	Wilk's Λ	
	<i>F</i>	<i>p</i>
Work Setting	1.51	0.19
Income Type	1.14	0.34
Years of Experience	1.16	0.28

Further exploring participants' M-GUDS total scores; it was evident that participants' scores were skewed toward higher M-GUDS scores, indicating greater multicultural comfort across the sample. Participants' mean total score on the M-GUDS was 212.70, with an actual range of participant scores of 115.0 and standard deviation of 22.35. Distribution of participants' scores is displayed in Figure 7.

Figure 7



The results of this study indicated three main findings. First, there was no significant difference between participants' ratings of the insured and the uninsured client. This indicates that a bias against the uninsured client was not supported. Second, there were no significant differences between participants' ratings of the client based on participants' multicultural comfort, work setting, income type or years of experience. Third, both case vignettes yielded favorable mean scores (i.e., scores that were at or below the midpoint for the possible range of scores) for all of the CPRF factors except the severity factor and low standard deviations provided evidence that these positive ratings were consistent across all participants. These finding indicate that participants' overall client perceptions were positive, suggesting that counselors in this sample generally regard their clients positively regardless of possible influences.

CHAPTER FIVE

DISCUSSION

Summary of Findings

The purpose of this study was to explore counselors' perceptions of clients as they relate to whether or not clients possess an insurance policy that will reimburse counselors for their services. Convenience sampling was used to identify community and mental health counselors working in a variety of settings (e.g., private practice, community agencies, hospitals, etc.). Survey packets were distributed via two channels: live distribution at continuing education seminars held at a local Community Services Board and a local university and web-based distribution via the Internet tool www.surveymonkey.com. A total of 147 survey packets were completed via these two distribution channels. Distribution at the continuing education seminars yielded 102 completed survey packets. Individuals attending the seminars were asked to voluntarily complete the survey packet. Neither the seminar speakers nor the participants had a personal interest in the outcome of the study. To minimize coercion, the researcher announced that participation in the study was voluntary and participants were instructed to return blank copies of the survey packet if they did not wish to participate. Survey packets were bundled by table when collected by the researcher so that participants could remain anonymous if they did not elect to complete their packets. The web-based distribution yielded 45 completed survey packets. The link to the online survey was distributed via a variety of email address lists including local agencies and local counseling organizations.

Both distribution methods provided access to a variety of counselor types including licensed professional counselors, licensed clinical social workers, licensed school counselors, and non-licensed master's-level counselors. Several work settings were represented including private practices, community agencies, schools, and hospitals. For the majority of the participants (almost 73%), salary was their primary income type. Participants with hourly and private practice income types represented only 10% and 12% respectively. Participants work experience ranged from zero to five years (31% of sample) to over 40 years (0.7% of sample). Over 75% of the sample had 20 or fewer years of experience. The majority of the participants (nearly 75%) were White without Hispanic origin, leaving only 25% of the participants representing minority groups. Over 82% of the participants were female.

To ensure that the participants receiving both case types were similar across the independent variables, independent t-tests were conducted and revealed non-significant findings. Specifically, the groups did not differ significantly for work setting, income type, and number of years of experience.

The results of this study indicate that counselors in this sample do not possess a bias against clients who do not have health insurance policies that would reimburse them for counseling services. The findings of this study demonstrated that participants did not rate an uninsured client significantly more negatively than an insured client. Perception rating scores for the client identified in both case vignettes (insured and uninsured) did not differ significantly. This finding indicates that participants' perceptions of the client were not influenced by the client's insurance status.

In addition, responses from participants receiving both the insured and uninsured case vignettes yielded favorable mean scores (i.e., scores that were at or below the midpoint for the possible range of scores) for each of the CPRF factors except the Severity factor. These favorable mean scores indicate that the participants rated their case vignette client positively. The low standard deviations provide evidence that these positive ratings were consistent across all participants. A possible interpretation of these results is that mental health professionals, in general, have favorable views of their clients. This interpretation is supported by the tenet proposed by Carl Rogers of unconditional positive regard (Corey, 2005).

This study also explored the possible influence of multicultural comfort on counselors' perceptions of a client. The results of the study reflected no significant relationship between multicultural comfort, as evidenced by participants' scores on the M-GUDS, and bias ratings, as evidenced by perception rating scores on the CPRF. This outcome indicates counselors' perceptions of clients are not significantly influenced by their level of multicultural comfort.

In addition to the effects of insurance status and multicultural comfort on counselors' perceptions of clients, this study explored the influence of three demographic variables: work setting, income type, and years of experience on counselors' perceptions of clients. The findings from this study indicated counselors' perceptions of clients do not significantly differ based on their work setting, income type, or years of experience. Given participants receiving both case types rated their client favorably, which suggested generally positive perceptions of clients, it is not surprising that significant differences were not found based on work setting, income type, or years of experience.

Relationship of Findings to Prior Studies

As discussed in Chapters 1 and 2, much empirical evidence exists to support the hypothesis that counselors would demonstrate a bias against low socioeconomic clients (Aldler & Gutheil, 1977; Auld & Meyers, 1954; Brown, 1970; Grant & Mackie, 2007; Hillerbrand, 1988; Johnson & Frederickson, 1968; Schrader, 1989; Sharf & Bishop, 1979; Shen & Murray, 1981; Siassi & Messer, 1976; Teasdale & Hill, 2006; Wills, 1978) due to a variety of influences including financial concerns, lack of understanding or sense of “otherness” toward culturally different clients, and general counselor preferences such as Schofield’s (1964) YAVIS (young, attractive, verbal, intelligent, and successful) client. Using government statistics on insurance coverage trends (U.S. Department of Health and Human Services, 2006) which demonstrate that individuals with low socioeconomic status are more likely to be uninsured, the implications from these previous studies were applied as potential sources of bias toward the uninsured as well.

However, the results of this study indicated no statistically significant measures of bias toward clients based on whether they had insurance. Furthermore, factoring in financial concerns, as examined by participants’ income type, did not result in statistically significant different responses toward the client included in the case vignette. That is, the potential financial implications of the client’s having to pay out of pocket for services or have services reimbursed by her health insurance policy did not have a statistically significant impact on participants’ ratings of the client in the case vignettes.

In addition to general counselor preferences supported by previous studies and financial concerns, this study explored the implications of exposure to uninsured clients, as evidenced by work setting and years of experience, as a possible source of bias. Using

Tversky and Kahneman's (1974) study of heuristics, which supports the notion that exposure to certain types of clients may contribute to problem attribution, this study explored the impact of exposure to a variety of client types on counselor perceptions of clients. This study did not find statistically significant differences in counselor perceptions of clients with and without insurance based on participants' years of experience or work setting.

Overall, the CPRF mean scores were favorable (i.e., scores that were at or below the midpoint for the possible range of scores) and low standard deviations provided evidence that these positive ratings were consistent across all participants. These findings indicate that participants' generally rated the client in both case vignettes in similarly positive ways. Given these similar ratings, external variables, such as work setting and multicultural comfort, failed to have a significant impact on participant perceptions.

The results of this study stand in contrast to previous empirical studies focused on counselor perceptions of low socioeconomic or culturally different clients. Various limitations of this study must be explored as potential reasons for the contrast.

Limitations of the Study

Several types of limitations were identified in this study. These limitation types include instrumentation limitations, sample limitations and social desirability limitations.

Instrumentation limitations

The instrumentation selected for this study, specifically the Client Perception Rating Form (CPRF; Mercer et al., 1983), may have contributed to the lack of statistically significant findings of differences in this study. There are four specific

limitations pertaining to the CPRF. First, the reported alpha levels for this instrument are low, making attenuation a major concern when interpreting findings. Mercer et al. (1983) noted that 11 of the items were found to load as an evaluative factor with internal consistencies ranging from .73 to .84; however loadings for the remaining items were not disclosed. Mercer et al. (1983) did note that a factor analysis identified that the six orthogonal factors together accounted for 66% of the total variance. The results of this study produced alphas ranging from .55 for the Adjustment factor to .66 for the Personal Evaluation factor. According to Ponterotto and Ruckdeschel (2007), when examining subscales with items with six or fewer items, a fair internal consistency coefficient for sample sizes of 100 – 300 is .65, while .70 is moderate, .75 is good, and .80 is excellent. In this study, all but one of the alpha values for the CPRF factors fell below the .65 level. These internal consistency ratings suggest that the CPRF factors may not have appropriately or consistently captured participants' genuine perceptions of the client in the case vignette.

In addition to reliability limitations, Mercer et al. did not provide validity data for the CPRF. Without this data, it is difficult to determine whether the CPRF is fully capturing counselors' perceptions of the case vignette client. Moreover, the CPRF may not capture all aspects of bias.

In addition to the limitations pertaining to reliability and validity, the CPRF does not include culturally-based rating items. Of the 22 items included in the CPRF, there are no items that allow the participant to indicate a cultural perception of the client, neither in terms of the client's sameness or difference to the participant, nor in terms of cultural attributions that the participant may apply to the client.

In addition to lack of cultural items, the CPRF does not allow for those completing the instrument to indicate their perceptions based on clinically significant attributions such as assessment of client's motivation to work and perceived likelihood of client to consistently return for counseling services. There are two items on the CPRF that relate to these types of perceptions. They include item 16 *very motivated for help/not motivated for help* and item 17 *cooperative/uncooperative*. Item 16 is not included for scoring of any of the factors of the CPRF, while item 17 is included in the Social Attractiveness factor. The lack of items related to clinical judgment does not result in the instrument being able to assess any possible confounding effects of attribution. For example, with regard to the uninsured case vignette, participants may have attributed greater motivation to this client due to the fact that she was willing to pay out of pocket for her counseling services.

Furthermore, the case vignette utilized in this study did not include any cultural references other than the clients' insurance status, which implies a socioeconomic difference. While participants may have attributed cultural differences to the client in the case vignette (e.g., the client referenced poor job skills which one may infer to mean that she is uneducated), specific cultural cues were not included. In addition, participants may not have interpreted the client's insurance status as a cultural cue. Part of this study examined the interaction effect of multicultural comfort, as evidenced by scores on the Miville-Guzman Universality-Diversity Scale (Miville et al., 1999). As no statistically significant differences were found based on insurance status during the initial analysis, that variable was not included in the analysis of interaction effects with multicultural comfort. Therefore, in essence, the only cultural cue (insurance status) was not

controlled prior to this analysis. This lack of cultural cues may have been a limitation to finding statistically significant interaction effects with multicultural comfort.

The case vignette in this study was written by the author for the purposes of this study. It was assessed by two reviewers for appropriate coverage of adjectives included on the CPRF. A potential limitation to this study is that the case vignette may not have included the information necessary to cue sources of participants' bias. As insurance status was the primary independent variable for this study, the two versions of the case vignette were designed to be identical except for the mention of insurance status.

Another possible limitation of this study may have been that the mention of insurance status was too minimal and thus overlooked by participants.

Sample limitations

There are three possible limitations related to the sample. First, 13.6% of the sample (or 20 out of 147 participants) listed their work setting as "other." By selecting "other," these participants indicated that their work setting was not represented by the choices: private practice, community agency-city or state, community agency-non-profit, school, or hospital. It is possible that these participants may represent a type of work setting not considered. If these other work settings had been identified and examined, they might have had a significant impact on the research question focused on the relationship between work setting and counselor bias.

The second possible limitation related to the sample is the possible selection threat based on income type. Nearly 73% of the sample listed "salary" as their income type. As income type was an independent variable, the large majority of participants with a salary income type may have decreased the likelihood of finding a significant

difference within the population for income type. In addition, given the low number of participants who indicated that their income was based on private practice (18 participants or 12.2% of the sample), it was impossible to compare CPRF scores of those with private practice income types to CPRF scores of those with salary income types.

A third possible limitation related to the sample is that participants were asked to indicate only their primary work setting. This format did not allow participants to identify a secondary work setting. It is possible that some participants had secondary work settings and were influenced by their experiences in those work settings. Without data on secondary work settings, it is not possible to attribute accurately the possible influence those work settings on their responses.

External validity threats

External validity threats should also be considered a limitation to this study. The participants in this study were recruited primarily from the seven cities that make up the Hampton Roads area of Virginia, located in the southeastern tip of Virginia. These seven cities vary only slightly from each other and their populations may not generalize to other areas of the state or the country.

Social desirability limitations

The effects of social desirability are another possible limitation of this study. Social Desirability has been defined as the need of participants to obtain approval by responding in a culturally appropriate and acceptable manner (Crowne & Marlowe, 1960). It is possible that participants in this study responded in a socially desirable manner to both the CPRF and the M-GUDS.

The CPRF asked participants to categorize a client on 22 semantic differential scales, which included adjectives such as *dirty/clean* and *likeable/unlikeable*. Due to social desirability, as well as the potential influence of the Rogerian tenet of unconditional positive regard (Corey, 2005), some participants may have found it difficult to indicate their honest impressions.

The M-GUDS was designed to assess participants' relativistic appreciation of themselves and others, their commitment to seeking a diversity of contact with others, and their sense of connection with the larger society or humanity as a whole (Miville et al., 1999). Social desirability may have influenced participants to rate themselves higher on these constructs than their actual beliefs or actions might represent.

Implications for Counselors

While the findings of this study did not indicate a bias toward uninsured clients or an interaction effect for work setting, income type or years of experience and general bias, counselors must consider their own general preferences for client types and how those preferences influence their perceptions of clients. Although this study does not support Schofield's (1964) YAVIS Syndrome, which suggested that mental health professionals prefer to counsel young, attractive, verbal, intelligent, and successful clients, each counselor should consider which attributes he or she does prefer in a client. Perhaps insurance status is not as much of an influence as other factors such as the client's motivation and reliability. Wills (1978) found that counselors prefer the more potentially successful, more treatable clients. In addition, Brown (1970) found that counselors' personal liking for clients related especially to their assessment of the clients' potential for change. A successful client makes the counselor feel successful. Perhaps a

stronger influence on counselors' perceptions of clients is their belief that clients will be successful. A variety of influences on this perception should be considered.

Implications for Counselor Educators

Much research has been conducted to support the need for multicultural training in counselor education programs (Grant & Mackie, 2007; Schnitzer, 1996; Siassi & Messer, 1976; Sue & Sue, 1990). Furthermore, the Council for Accreditation of Counseling and Related Educational Programs (CACREP) 2009 guidelines mandate specific core curriculum requirements including multicultural and pluralistic trends, including characteristics and concerns within and among diverse groups nationally and internationally (2a), and counselors' roles in eliminating biases, prejudices, and processes of intentional and unintentional oppression and discrimination (2f).

While much focus on minority groups has garnered attention in counseling research and education, Grant and Makie (2007) note that the counseling profession has failed to focus on the differences between counselors' middle class cultures and the varied class cultures of their clients. Although this study did not identify a specific bias toward the uninsured, much has been written to support the existence of biases against low socioeconomic status individuals (Auld & Myers, 1954; Schnitzer, 1996; Shen & Murray, 1981). Research from the U.S. Department of Health and Human Services (2006) and the U.S. Census Bureau (2006) indicates that individuals with low socioeconomic status are nearly three times more likely to be uninsured than individuals with higher economic status. These statistics suggest that, like many cultural groupings, socioeconomic status includes a variety of sub-groups, such as insurance status, and issues related to such subgroups need to be addressed as potential contributors to clients'

presenting issues as well as clients' perceptions of the counseling process. Counselor educators when teaching multicultural counseling courses need to help their students to deconstruct various cultural groups to consider the variety of cultural forces influencing that client, such as insurance status.

In addition, given the current economic slowdown in the United States, trends indicate that employers are cutting costs through job cuts and benefit cuts (Goldman, 2009; Lehman, 2009; Taenzler, 2009). These cuts will likely lead to separate sub-cultures which include newly unemployed (or "laid off") individuals and working individuals without access to health insurance benefits. These individuals may or may not fall into the low socioeconomic status culture, but will face many of the same barriers in terms of access to mental health care. Counselor educators should help trainees explore the dynamics of these sub-groups as well, and ask students to consider how they may contribute to the issue of access to mental health care. Trainees should explore advocacy issues as well as their own preferences and ideas about the types of clients with whom they expect to work.

Implications for Future Research

There are many avenues for future research that stem from this study. A primary goal for future research would be to develop a more effective perception rating instrument, given the low reliability scores associated with the Client Perception Rating Form (CPRF; Mercer et al., 1983) used in this study. Additional perception rating tools should be developed to be more reflective of cultural perceptions as well as clinical attributions such as client motivation and counselors' perceptions of problem attribution (i.e., perceptions of internal or external locus of control).

Following the notion of counselors' clinical attributions, a qualitative, or Delphi, study would be appropriate to explore those client attributes that counselors most readily and frequently perceive and how those perceptions affect counselors' opinions about clients and their willingness to work with specific client types.

Another qualitative study that would further our understanding of cultural perceptions would be a study focused on counselors' understanding of the variety of sub-cultures that make up each client. A qualitative study would allow counselors to explore their initial perceptions about clients based on readily identifiable cultural attributes (e.g., racial or ethnic group, age, gender) and then explore to what extent counselors also consider the contributing factors of sub-cultural issues such as insurance status, education level, and verbal ability. A follow up to this study could include a study to identify current client attributes most sought after by counselors, which may offer an update to Schofield's (1964) idealized YAVIS client.

To further explore the impact of clients' insurance status on counselor perceptions, a qualitative study designed to identify counselors' perceptions of third party payment, in general, should be explored. For example, do counselors feel positively or negatively about third party payment? Do they feel that it's reliable and easy to use? Do they feel that managed-care limits their ability to provide appropriate treatment? Exploring these perceptions of health insurance in general may better illuminate counselors' perceptions of clients with and without insurance. Perhaps counselors prefer to work with self-pay clients, as it is more convenient or indicative of motivation. This exploration should focus on counselors' who rely on fee-for-service income, as

counselors working for a salary are less likely to be impacted by these types of financial concerns.

Finally, given the changing face of the United States economy and employer trends (Goldman, 2009; Lehman, 2009; Taenzler, 2009), a variety of program evaluation and needs assessment studies should be conducted in local communities to address if or how access to mental health care is being addressed for uninsured and underinsured individuals.

Conclusions

The purpose of this study was to explore counselors' perceptions of uninsured clients. The relationship between four potential sources of counselor bias (multicultural comfort, financial concerns, work setting and years of experience) was explored. This study did not indicate an existing bias against uninsured individuals; nor did it indicate a statistically significant interaction effect for work setting, income type, and years of experience on general counselor bias. In addition, this study explored a possible interaction effect for multicultural comfort on general counselor bias, and did not indicate a statistically significant effect.

Future research, including additional quantitative studies utilizing an updated counselor perception instrument and possible qualitative studies to explore counselor perceptions are recommended to further explore counselor perceptions and possible sources of counselor bias.

Counselor Perceptions of Uninsured Clients

Katherine S. Moore, Theodore P. Remley Jr., & Danica G. Hays

Old Dominion University

Address: 1096 Warner Hall Drive
Virginia Beach, VA 23464
Phone: 757-406-7078
Email: ksmoore@odu.edu

Submitted to:
Journal of Mental Health Counseling
c/o James R. Rogers, Ph.D.; Editor, JMHC
The University of Akron
Carroll Hall 127
Akron, OH 44325-5007

Abstract

This study assessed counselor perceptions of uninsured clients. The professional literature suggests counselor bias exists against persons with low socioeconomic status. According to United States Census Bureau, a greater percentage of individuals with income at or below the poverty level are uninsured compared to individuals with higher incomes. The professional literature also suggests financial concerns and multicultural comfort may serve as sources of bias against individuals with low socioeconomic status. In this study, counseling professionals were surveyed to determine the relationship between counselor perceptions of type of client (insured or uninsured), and the contributing variables of work setting, counselor's income type, years of practice, and multicultural comfort. No statistically significant relationship was found between client type (insured or uninsured) and counselor perceptions. In addition, no statistically significant relationship was found among the variables of work setting, counselor's income type, years of experience, and multicultural comfort and counselor perceptions. The findings indicate counselors perceive clients positively regardless of these external factors. The participants in this study rated the client favorably in both categories (insured and uninsured), indicating counselors possess positive orientations toward clients regardless of insurance status. Implications for future research and considerations for other possible influences on counselor perceptions are discussed.

Health insurance coverage is an important issue in the United States today. Uninsured and underinsured rates are climbing as the country's economic slowdown progresses (Lehman, 2009; Taenzler, 2009). In addition to climbing rates of newly uninsured and underinsured individuals affected by current economic conditions, socioeconomic status has traditionally been a predictor of insurance status. According to the U.S. Department of Health and Human Services (2006), people with family income below or near the poverty level in 2004 were almost three times as likely to have no health insurance coverage as those with family income twice the poverty level or higher. This trend is supported by the U.S. Census Bureau's survey statistics for 2006 that show that 24.9% of individuals from households earning less than \$25,000 were uninsured versus only 8.5% of individuals from households earning \$75,000 or more. Access to mental health care can be directly linked to health insurance coverage. Mental Health providers must consider their perceptions of the uninsured and how those perceptions may or may not contribute to access to care.

Perceptions of Individuals with Low Socioeconomic Status

Given the link between individuals with low socioeconomic status and insurance status, one can draw a link between the literature focused on mental health providers' perceptions of individuals with low socioeconomic status and individuals without health insurance. In his seminal text, *Psychotherapy: The purchase of friendship*, Schofield (1964) identified what he called YAVIS Syndrome. YAVIS, an acronym standing for the qualities of *young, attractive, verbal, intelligent, and successful*, describes what he believed were preferences of mental health professionals. Many have contributed to Schofield's (1964) paradigm noting such issues as the empathic disconnect between

therapists and low socioeconomic status (SES) clients (Auld & Meyers, 1954), the implications for treatment for low SES clients (Goldstein, 1973), training biases against low SES clients (Siassi & Messer, 1976), assumed anti-therapeutic tendencies of low SES clients (Shen & Murray, 1981), and stereotypes of low SES clients (Schnitzer, 1996).

Potential Sources of Bias

Although general counselor preferences and attitudes are a central source for potential counselor bias against uninsured or low SES clients, other sources exist. One may assume the financial implications for counselors accepting uninsured clients could be a source of bias against uninsured clients. Several empirical studies and editorial essays have broached this issue (Aldler & Gutheil, 1977; Bloch, 1987; Cerney, 1990; Johnson & Frederickson, 1968), with focuses ranging from mental health professionals' internal conflict regarding fee payment to the potential impact of fee payment on therapeutic outcomes.

Attribution of the problem is another potential source of bias toward low SES clients. Attribution of the cause of a problem has been defined as the responsibility and control one has for the origin of the problem and specifically refers to whether the individual or the environment is responsible (Burkard & Knox, 2004). Problem attribution has been explored in terms of how mental health professionals' perceptions of clients may have an impact on whether they hold clients responsible for their problems or whether they are open to considering external sources such as systemic and institutional limitations. Tendencies toward problem attribution may be affected by counselors' exposure to certain types of clients with little exposure to those clients' social

environments (Batson, 1975), counselors' political viewpoints (Zucker & Weiner, 1993), and counselors' perceptions of the client as similar or dissimilar to them (Pearce, 1994).

A fourth potential source of bias toward individuals with low socioeconomic status is counselors' competency and comfort with multicultural differences. As Liu et al. (2001) have noted, along with race and gender, social class is regarded as one of the three important cultural cornerstones in multicultural theory and research. Not only should social class, in and of itself, be considered as a potential cultural difference between counselors and uninsured clients, but also, given the statistics on distributions of uninsured rates along racial and ethnic lines (U.S. Department of Health and Human Services, 2006), it should be noted many counselors may differ from their clients in terms of social class as well as race or ethnicity.

Counselor Preferences and Attitudes as a Source of Bias

General counselor preferences encompass those preferences that fall under the category of the ideal client. When considering who they would and would not like to take on as a client, counselors tap into their preferences. When considering Schofield's (1964) YAVIS syndrome, one might consider the underlying reason for these preferences. Many of these characteristics describe mental health professionals. Given the education requirements and the professional status of licensed counselors, one might argue that the desire to have a YAVIS client is really the desire to have a client who mirrors one's own self image. Teasdale and Hill (2006) supported this notion with their study of preferences of therapists-in-training. Their findings indicated psychological mindedness and similarity in attitudes and values were the two most preferred client characteristics.

Another consideration of counselor preferences involves the desire to feel successful. When selecting a client, counselors estimate the client's potential for success and treatability. It is not uncommon for counselors to internalize a client's lack of success as the result of some failing on their own part. Wills (1978) found counselors prefer the more potentially successful, more treatable clients. In addition, Brown (1970) found counselors' personal liking for clients related especially to their assessment of the clients' potential for change. A successful client makes the counselor feel successful.

In terms of clients' potential for success, another consideration is a client's motivation for change. Sharf and Bishop (1979) found counselors' feelings toward clients are related to their perceptions of the clients' motivation as well as the realism of the clients' stated goals. Without client motivation or realistic client goals, a counselor might harbor concern that the client will not be successful, which conflicts with the counselor's drive to be successful.

General counselor preferences are encompassed by three emerging themes. First, counselors seek clients who are similar to themselves. Second, counselors seek clients for whom they perceive a potential for success. Potential success is indicated by factors such as realism of client goals and treatability. Finally, counselors seek clients who are motivated for change.

Counselors' attitudes toward clients with low SES are another potential source of influence on counselors' perceptions of low SES as well as uninsured clients. Auld and Myers (1954) posited the lower class patient's life has little to offer to reinforce a change in behavior. In other words, counselors may believe a lower class client is unmotivated

to change or even if motivated to change, unlikely to sustain change due to cultural factors or systemic limitations.

Another general attitude regarding clients with low SES is they do not possess the appropriate attitude or beliefs about counseling necessary for a successful relationship. Shen and Murray (1981) suggested several characteristics of clients with low SES that are antithetical to the counseling process which include having little faith that talking can help, a tendency toward action rather than observation and awareness, and a general sense of distrust.

In addition, counselors may have internalized stereotypes of clients with low SES including beliefs that they are unreliable, disorganized, irresponsible, and less likely to follow through in counseling (Schnitzer, 1996). Counselors are not immune to stereotypes. As Sue (2003) noted, mental health professionals are no more insulated [than non-mental health professionals] from internalizing and perpetuating biases.

Counselor attitudes toward low SES or uninsured clients are encompassed by three emerging themes. First, counselors may harbor the belief that low SES or uninsured clients have low potential for change or low potential to sustain change. Second, counselors may perceive low SES or uninsured clients to be unreliable, and lacking the ability to follow through with counseling goals or even to keep appointments. Finally, counselors may believe that a low SES or uninsured clients' attitudes and beliefs do not support the counseling process.

Financial Concerns as a Source of Bias

Financial concerns are the second potential source of influence on counselors' perceptions of uninsured clients. As professionals, counselors certainly must consider

their bottom line in terms of fee schedules and client load, however, most of the literature regarding financial concerns relates to the impact of fees on the client rather than the counselor. The impact of fee payment on the client was explored by both Bloch (1987) and Cerney (1990.) In her research of social workers, Bloch (1987) found a majority of respondents believed clients who pay fees tend to have better treatment outcomes than clients who do not pay fees, and that those fees have more therapeutic value when clients view them as requiring some financial sacrifice. Similarly, Cerney (1990) noted charging a fee emphasizes therapy is not a personal friendship but a business relationship and thus there is work to do.

While the impact of fee payment on the client is an important consideration in terms of client attitude and potential outcomes, one cannot ignore the personal impact fee collection has on counselors. Counselors, especially those in private practice, must consider the impact of sliding scales or pro bono work on their personal income and their ability to successfully maintain their practice. In addition, counselors who work in agencies in which fees are collected by clients are aware that the funds generated by client fees are used, in part, to pay their salaries.

Furthermore, counselors should consider how fee collection supports their identity as professionals. As Tudor (1998) noted, setting a fee not only sets a value on the service we provide, but also sets a value on ourselves as counselors.

In light of counselors' potential reactions to fee setting and fee payment, research from Johnson and Frederickson (1968) supports the idea that counselors may be more motivated to work with clients who can offer financial reward. In their study of the impact of financial remuneration on counselor performance, Johnson and Frederickson

(1968) found the knowledge of reward (payment) in direct proportion to performance motivated student counselors to establish more effective relationships with their clients.

The emerging themes regarding financial concerns include both the impact of fee payment on the client as well as on the counselor. These themes may best be summarized by Aldler and Gutheil's (1997) statement:

Though fee setting and fee charging are all too often perfunctorily performed transactions, the issues that emerge around the meaning of money, for both therapist and patient, are of far more central significance than is usually acknowledged, as regards both to the process of therapy and the identity of the therapist (p. 70).

Problem Attribution as a Source of Bias

Problem attribution is a third potential source of influence on counselors' perceptions of uninsured clients. The construct of problem attribution essentially defines one's perception of the root of the problem. In other words, problem attribution points to whom or what is causing the problem. In terms of clients with low SES, the potential exists for counselors to attribute a client's problems to his or her own actions rather than some other factor such as systemic limitations or institutional injustice. Research from several authors has indicated a potential for this source of bias. Batson (1975), for example, found clients seeking help in dealing with problems they attributed to their social environments tended to be perceived as having personal problems. Similarly, Zucker and Weiner (1993) found conservatives tend to see poverty in individualistic terms, that is, as failures of personal initiative.

Tversky and Kahneman's (1974) study of heuristics supports the notion that exposure to certain types of clients may contribute to problem attribution by having a negative impact on a counselor's ability to distinguish between individual concerns versus attributing the same types of issues to all clients in a similar group. The concept of heuristics includes representativeness and availability heuristics. With the representativeness heuristic, probabilities are evaluated by the degree to which an individual is representative of a group (Tversky & Kahneman, 1974). Therefore a counselor, having worked with one or more unmotivated uninsured clients might assume that the next uninsured client will also be unmotivated. With the availability heuristic, one assesses the probability of an event by the ease with which instances or occurrences can be brought to mind (Tversky & Kahneman, 1974). In this case, a counselor, having had one or more negative experiences with an uninsured client, might assume that there is a high probability that all interactions with uninsured clients will be negative because those are the experiences that he or she can most easily recall.

The tendency to attribute problems to clients, without consideration of other factors, may cause counselors to develop unrealistic negative perceptions of their clients (Wills, 1978). Emerging themes from problem attribution as a potential source of influence on counselors' perceptions of uninsured individuals include tendencies to attribute problems to personal failures and tendencies to ignore external factors which may be influencing the problem. Counselors' level of exposure to certain types of clients may have an impact on these tendencies. The research indicates these tendencies are also affected by the personal attitudes of counselors as well as their multicultural awareness.

Multicultural Comfort as a Source of Bias

Multicultural competence or comfort is a fourth potential source of influence on counselors' perceptions of the uninsured. As Grant and Mackie (2007) note, "until now the counseling profession has failed to substantively focus on the disparity between counselors' own middle class/professional culture and the varied class cultures of their clients" (p. 410). This disparity may lead to counselors having difficulty relating to or empathizing with uninsured clients. Auld and Myers (1954) proposed that the middle class therapist, unfamiliar with the conditions of life of the lower class patient, may find it harder to be genuinely interested and to have empathic reactions to what the client tells him or her.

Researchers have suggested that biases and certain stereotypes of low-income clients are reinforced in graduate training programs (Schnitzer, 1996; Siassi & Messer, 1976) including expectations that these clients are unreliable, disorganized, irresponsible, and less likely to follow through in counseling. Further, Schnitzer (1996) noted "where class, racial, or ethnic differences between therapist and client exist, a discourse of *otherness* may invade the therapist's formulations, according to which the client is perceived predominately in terms of qualities antithetical to successful treatment outcomes" (p. 576).

Sue and Sue (1990) defined three characteristics of the culturally skilled counselor. These characteristics are

- (1) one who is actively in the process of becoming aware of his or her own assumptions about human behavior, values, biases, preconceived notions, personal limitations and so forth, (2) one

who actively attempts to understand the worldview of his or her culturally different client without negative judgments, and (3) one who is in the process of actively developing and practicing appropriate, relevant, and sensitive intervention strategies and skills in working with his or her culturally different clients (p. 481).

In addition to multicultural competence, a counselor's comfort with working with a culturally different client may also affect his or her perception of that client. Miville et. al.'s (1999) construct of Universal-Diverse Orientation (UDO) is defined as "an attitude toward all other persons which is inclusive yet differentiating in that similarities and differences are both recognized and accepted; the shared experience of being human results in a sense of connection with people and is associated with a plurality or diversity of interactions with others" (p. 292). Fuertes, Miville, Mohr, Sedlacek, and Gretchen (2000) have explained that the UDO is conceptualized as an awareness and potential acceptance of both similarities and differences in others that is characterized by interrelated cognitive, behavioral, and affective components.

Multicultural competence and comfort as it relates to counselors' perceptions of the uninsured is encompassed by four emerging themes. First a counselor's sense of *otherness* may inhibit his or her ability to empathize with an uninsured client. Second, counselors' internalized stereotypes may affect their objectivity toward uninsured clients. Third, a counselor lacking the characteristics of a culturally skilled counselor may not be able to work effectively with uninsured clients. Lastly, a counselor's multicultural

comfort level or Universal-Diverse Orientation (Miville et. al., 1999) may affect his or her willingness to work with uninsured clients.

Research Objectives

The purpose of this study was to investigate counselors' perceptions of uninsured clients. An operational definition of counselors' perceptions in this study was participants' perceptions of a client presented in a case study (herein "counselors' perception of client"). After reading a case study, counselors' perceptions of client were captured using the Client Perception Rating Form (CPRF; Mercer et al., 1983) which indicates a counselor's impression of a client on six factors. These six factors represented the dependent variables. Counselors' perceptions were determined by identifying significant directional effects for the independent variables on the six factors of the CPRF.

Using the existing literature related to counselor bias against individuals with low socioeconomic status, four independent variables were utilized to explore the possible interaction of financial concerns, experience with or exposure to clients, and multicultural comfort with client insurance status. These independent variables were income type, years of experience, work setting, and multicultural comfort, as indicated by participants' scores on the Miville-Guzman Universality-Diversity Scale (M-GUDS; Miville et. al., 1999).

It was hypothesized that the mean scores on the CPRF subscales would be significantly lower for participants reacting to uninsured clients versus insured clients. In addition, based on the four potential sources of bias (financial concerns, exposure to clients, and multicultural comfort), it was hypothesized that there would be a significant

interaction effect between client type (insured versus uninsured) and counselors' income type, work setting , years of experience, and multicultural comfort.

Directional effects were hypothesized for the independent variables income type and years of experience. Regarding income type it was hypothesized that CPRF scores from participants with hourly or private practice income reacting to uninsured clients would be significantly less favorable than CPRF scores from salaried participants reacting to uninsured clients. Regarding exposure to clients, it was hypothesized that CPRF scores from participants with more experience reacting to uninsured clients will be significantly less favorable than CPRF scores from participants with less experience reacting to uninsured clients.

METHOD

Prior to data collection, we sought and obtained approval for this research proposal from the Old Dominion University Institutional Review Board.

Participants

Convenience sampling was used to identify community and mental health counselors working in a variety of settings (e.g., private practice, community agencies, and hospitals). Survey packets were distributed via two channels, live distribution at continuing education seminars held at a local Community Services Board and a local university and web-based distribution via the Internet tool www.surveymonkey.com .

Distribution at the continuing education seminars netted 102 completed survey packets, while the web-based distribution netted 45 completed survey packets. Both distribution methods provided access to a variety of counselor types. Descriptive data displaying the counselor types by distribution channel are displayed in Table 1.

Using a statistical power table and assuming a moderate effect size (Cohen, 1988), a minimum of 100 participants was required in order to have an 86% chance of detecting a statistical difference. A total of 147 surveys were completed, thus meeting sample size requirements.

The majority of the participants (almost 75%) were European American, with only 25% of the participants representing of minority groups. The majority of the participants were female (82.3%). Participants' years of experience ranged from less than one year to 43 years. The mean response to total number of years working with clients was 13.1 years (*SD* 10.5). The primary income for the majority of the respondents (almost 73%) was salary. Respondents with hourly and private practice income types represented only 10% and 12% respectively. Descriptive data for participants' work setting are displayed in Table 2. Participants were asked to indicate their primary work setting.

Procedure

Access to counselors was gained by conducting the study during continuing education seminars held at a local university during the summer and fall of 2008. These seminars netted 83 completed survey packets, with a mix of counselor types (e.g., licensed professional counselors, licensed clinical social workers, licensed school counselors, non-licensed, master's-level counselors, etc.). The seminars took place in July, September, October and November of 2008. These seminars featured three nationally recognized leaders in the counseling field.

All individuals attending a seminar were invited to complete the survey at each seminar, however, in order to avoid duplication, at the second, third, and fourth seminars,

participants were asked to refrain from completing the survey if they have already participated in the study at a previous seminar. Neither the speakers nor the participants had a personal interest in outcome of the study. To minimize coercion, we announced that participation in the study was voluntary and participants were instructed to return blank copies of the survey packet if they did not wish to participate. Survey packets were bundled by table when collected so that participants could remain anonymous if they did not elect to complete their packets.

Research packets were distributed at the mid-point of the program, as participants returned from a lunch break. The researcher distributed the research packets, allowed sufficient time for the participants to complete their packets, and collected the packets.

Participants were systematically assigned to one of two groups. Each group received one of two packets with a client description. The client description in the packets differed only by the insured status of the client. Participants who received packet A received a description of a client who is insured. Participants, who received packet B, received a description of a client identical to that in packets A, except that she was described as uninsured.

It took seminar participants approximately 20 minutes to complete the demographic questionnaire, read the case vignette, and complete the two instruments. Research packets also included an informed consent document. The informed consent document was placed at the top of the packet and participants were asked to review the document prior to completing the packet. To ensure confidentiality, participants were not asked to sign a consent form. Completing the research packet served as consent.

Participants were permitted to opt out of the research study if they did not consent. A total of 83 survey packets were completed at these continuing education seminars.

In addition to the continuing education seminars held at a local university, existing relationships with the leadership of a local Community Services Board (CSB) provided an opportunity to conduct an on-site continuing education seminar for their staff. Identical survey packets and distribution methodology to that used at the university seminars was used at the CSB seminar. A total of 19 survey packets were completed at this on-site continuing education seminar. It took approximately 20 minutes for the CSB participants to complete their packets.

In addition to solicitation at continuing education seminars, the researcher gained access to counselors by hosting an on-line version of the survey packet using the website www.surveymonkey.com. The survey packet was translated to an on-line version with all key elements intact (e.g., ordering of instrumentation, instrument style). The only addition to the on-line version was a question asking participants to indicate their birth month. This question served as a redirect device that allowed for participants with birthdays in the months January through June to see the insured client case, and participants with birthdays in the months July through December to see the uninsured client case. The link to the on-line survey was distributed via a variety of email address lists including local agencies and local counseling organizations. A total of 45 surveys were completed via the on-line version.

Measures

Personal Information Questionnaire. Participants were asked initially to complete a personal information questionnaire which included a question about the type

of setting in which they work and the number of years of counseling experience they have. Other items included counselor type (counselor, social worker, psychologist, and licensed or unlicensed) as well as primary income type (salary, hourly, private practice, other), race/ethnicity, and gender (Appendix A).

Case vignette. The participants in this study received a case vignette of a client. The client was identical in every way except for whether she had health insurance that covers mental health services status (i.e., insured vs. uninsured.) The vignette included information such as the client's presenting problem, her appearance, her race, her vocation, her affect, and her goals for treatment. The vignette was developed for this study to address some of the semantic differential adjectives included on the Client Perception Rating Form (CPRF, Mercer et al., 1983). It was assessed by two reviewers for appropriate coverage of included adjectives. For example, the CPRF references the client's appearance via the adjectives *clean/dirty*. Therefore, the vignette was assessed to ensure that some notation regarding client's appearance was included. Both reviewers were doctoral-level counselor educators with a minimum of five years of experience with quantitative research. (Appendix B).

Client Perception Rating Form. Participants were asked to complete the Client Perception Rating Form (Mercer et al., 1983; Appendix C). Mercer et al. developed the Client Perception Rating Form (CPRF) to assess participants' overall rating of clients on six factors: social attractiveness, prognosis, physical attractiveness, personal evaluation, severity of the presenting problem, and adjustment. The CPRF is composed of 22 bipolar adjectives on a semantic differential scale of 1 to 7.

Social attractiveness was defined by four bipolar descriptions (i.e., *easy to get along with/hard to get along with, cooperative/uncooperative, employable/unemployable, friendly/unfriendly.*) Prognosis was defined by five bipolar descriptions (i.e., *have few problems/have many problems, be improved/be worse, will require no counseling/will require counseling, be very happy/be very unhappy, dangerous/not dangerous.*) Physical attractiveness was defined by four bipolar adjectives (i.e., *clean/dirty, neat/sloppy, tasteful/distasteful, very attractive/very unattractive.*) Personal evaluation was defined by six bipolar descriptions (i.e., *very motivated for help/not motivated for help, valuable/worthless, warm/cold, deep/shallow, not dangerous/dangerous, reliable/unreliable.*) Adjustment was defined by three bipolar descriptions (i.e., *well-adjusted/maladjusted, self-reliant/dependent, not dangerous/dangerous.*) Severity of presenting problem was defined with one bipolar adjective (i.e., *mild/severe.*)

Mercer et al. (1983) noted 11 of the items were found to load as an evaluative factor with internal consistencies ranging from .73 to .84., however loadings for the remaining items were not disclosed. Mercer et. al. did note a factor analysis identified the six orthogonal factors together accounted for 66% of the total variance. The results of this study produced alphas ranging from .55 for the Adjustment factor to .66 for the Personal Evaluation factor. Alphas were produced for only five of the six factors, as one of the factors, Severity of Presenting Problem, included only one item.

Miville-Guzman Universality-Diversity Scale. Participants were asked to complete the Miville-Guzman Universality-Diversity Scale (Miville et. al., 1999; Appendix D). Miville et. al. (1999) developed the Miville-Guzman Universality-Diversity Scale (M-GUDS) to assess the construct of universal-diverse orientation

(UDO). Miville et. al.'s construct of UDO is defined as "an attitude toward all other persons which is inclusive yet differentiating in that similarities and differences are both recognized and accepted; the shared experience of being human results in a sense of connection with people and is associated with a plurality or diversity of interactions with others" (p. 292). Fuertes, Miville, Mohr, Sedlacek, and Gretchen (2000) explained the UDO is conceptualized as an awareness and potential acceptance of both similarities and differences in others that is characterized by interrelated cognitive, behavioral, and affective components. The M-GUDS consists of three subscales that assess the respective cognitive, behavioral, and affective components of UDO: (a) relativistic appreciation of oneself and others, (b) seeking a diversity of contact with others, and (c) a sense of connection with the larger society or humanity as a whole (as cited in Fuertes et. al., 2000).

Reliability of the M-GUDS was assessed by Miville et al. (1999) in two ways: internal consistency, measured by the alpha coefficient, and stability, measured by the Pearson product-moment correlation coefficient in a test-retest procedure. Alphas were obtained for the overall scale in both the pilot and larger studies. An alpha of .92 was obtained for the revised or final version of the M-GUDS. In addition, construct validity was evidenced in the pattern of correlations between the M-GUDS and a number of other scales. Specifically, the M-GUDS correlated positively positive racial identity (for both Blacks and Whites), healthy narcissism, empathy, feminism, and androgyny and correlated negatively with dogmatism and homophobia (Miville et al.). A total score on the M-GUDS was recorded for each participant. Higher total scores indicate greater

Universal-Diverse Orientation (UDO) and were used in this study to indicate greater multicultural comfort.

RESULTS

Scores on the six factors of the CPRF were utilized in this study to measure participants' perception of the client illustrated in the case vignette. Based on the scoring rubric for the CPRF, higher scores represent more negative perceptions, as for each semantic differential item, participants ranked the client on a scale of one to seven, with the number one representing the positive pole and the number seven representing the negative pole. Variances in scores were then assessed to determine bias against the client (i.e., higher scores reflect greater negative bias.) The results of the five statistical analyses are summarized in Table 3.

Relationship between insurance status and counselor perceptions

To explore the main effect of the categorical independent variable of insurance status (insured or uninsured) on the six factors of the CPRF, which made up the dependent variables, a one-way multivariate analysis of variance (MANOVA) was conducted comparing the six mean factor scores for the two insurance status concepts. Levine's Test of Equality of Error Variances was not statistically significant ($p > .05$), indicating an assumed homogeneity of variance.

There was not a significant difference for case type (insured or uninsured) for the six subscales of the CPRF. (Wilk's $\Lambda = .921$, $F_{6,130} = 1.87$, $p = .09$, $\eta^2 = .08$).

Relationship between financial concerns and counselor perceptions

To explore the possible relationship between financial concerns and counselor perceptions, the main effect of the independent variable income type on the six factors of the CPRF was explored. The independent one-way multivariate analysis of variance (MANOVA) reflected no significant relationship between counselors' income type and general bias (Wilk's $\Lambda = .836$, $F_{18,360} = 1.31$, $p = .18$, $\eta^2 = .06$).

Relationship between experience and exposure to counselor perceptions

To explore the possible relationship between counselors' experience with and exposure to clients and counselor perceptions, the main effects of the independent variables work setting and years of experience on the six factors of the CPRF were explored. The independent one-way multivariate analyses of variance (MANOVAs) reflected no significant relationships between counselors' work setting and bias ratings (Wilk's $\Lambda = .791$, $F_{30,506} = 1.02$, $p = .44$, $\eta^2 = .05$) or counselors' years of experience and bias ratings (Wilk's $\Lambda = .151$, $F_{210,560} = 1.0$, $p = .49$, $\eta^2 = .27$).

Relationship between multicultural comfort and counselor perceptions

To explore the possible relationship between counselors' multicultural comfort and counselors' perceptions, the main effect of the multicultural comfort independent variable (as evidenced by scores on the M-GUDS) on the six factors of the CPRF was explored. No significant relationship between multicultural comfort and bias ratings (Wilk's $\Lambda = .008$, $F_{396,338} = 1.07$, $p = .25$, $\eta^2 = .56$) was found.

Other findings

Relationship between multicultural comfort and demographic factors

In addition to the four hypotheses, other trends in the data were explored. For example, independent one-way multivariate analyses of variance (MANOVA) were conducted for the three demographic independent variables, work setting, income type, and years of experience, with participants' M-GUDS total score as the dependent variable. The independent one-way multivariate analyses of variance (MANOVA) reflected no significant relationships between participants' M-GUDS total scores and the demographic independent variables.

Further exploring participants' M-GUDS total scores; it was evident that participants' scores were skewed toward higher M-GUDs scores, indicating greater multicultural comfort across the sample. Participants' mean total score on the M-GUDS was 212.70, with an actual range of participant scores of 115.0 and standard deviation of 22.35.

DISCUSSION

The purpose of this study was to explore counselors' perceptions of clients as they relate to whether clients' possess an insurance policy that will reimburse counselors for their services. The results of this study indicate counselors' do not possess a bias against clients who do not have health insurance policies that would reimburse them for counseling services. The findings of this study demonstrated counselor-participants did not rate an uninsured client significantly more negatively than an insured client. Perception rating scores for the client identified in both case vignettes (insured and

uninsured) did not differ significantly. This finding indicates participants' perceptions of the client were not influenced by the client's insurance status.

In addition, responses from participants receiving both the insured and uninsured case vignettes yielded favorable mean scores (i.e., scores that were at or below the midpoint for the possible range of scores) for each of the CPRF factors except the Severity factor. The low standard deviations provide evidence that these positive ratings were consistent across all participants. A possible interpretation of these results is mental health professionals, in general, have favorable views of their clients. This interpretation is supported by the tenet proposed by Carl Rogers of unconditional positive regard (Corey, 2005).

Although statistically significant differences were not found between ratings of the insured and uninsured client, and overall ratings were favorable regardless of insurance status, the uninsured client was rated slightly more favorably than the insured client on every CPRF factor. This result, while not statistically significant, lends itself to possible interpretation about counselors' perceptions of uninsured clients. One possible interpretation is that participants viewed the uninsured client in the case vignette as being highly motivated given her willingness to pay out-of-pocket for services.

This study also explored the possible influence of multicultural comfort on counselors' perceptions of a client. The results of the study reflected no significant relationship between multicultural comfort, as evidenced by participants' scores on the M-GUDS, and bias ratings, as evidenced by perception rating scores on the CPRF. This outcome indicates counselors' perceptions of clients are not significantly influenced by their level of multicultural comfort.

In addition to the effects of insurance status and multicultural comfort on counselors' perceptions of clients, this study explored the influence of three demographic variables: work setting, income type, and years of experience on counselors' perceptions of clients. The findings from this study indicated counselors' perceptions of clients do not significantly differ based on their work setting, income type, or years of experience. Given that participants receiving both case types rated their client favorably, which suggested generally positive perceptions of clients, it is not surprising that significant differences were not found based on work setting, income type or years of experience.

Implications for Mental Health Counselors

While the findings of this study did not indicate a bias toward uninsured clients or an interaction effect for work setting, income type or years of experience and general bias, counselors must consider their own general preferences for client types and how those preferences influence their perceptions of clients. Although this study does not support Schofield's (1964) YAVIS Syndrome, which suggested mental health professionals prefer to counsel young, attractive, verbal, intelligent, and successful clients, each counselor should consider which attributes he or she does prefer in a client.

Perhaps insurance status is not as great an influence on counselor perceptions as other factors such as the client's motivation and reliability. Wills (1978) found counselors prefer the more potentially successful, more treatable clients. In addition, Brown (1970) found counselors' personal liking for clients related especially to their assessment of the clients' potential for change. A successful client makes the counselor feel successful. Perhaps a stronger influence on counselors' perceptions of clients is their belief that clients will be successful.

Given the consistently positive ratings of the client in this study, the findings suggests counselors have generally positive views of clients regardless of external factors such as clients' insurance status, or counselors' experience with or exposure to clients, income type or multicultural comfort. These findings indicate counselors have an altruistic viewpoint. Greater consideration should be given to how mental health counselors merge this viewpoint with the challenges of operating their practice in today's environment. Perhaps this study suggests that unlike mental health professionals in Schofield's (1964) era, counselors today better understand the climate of providing mental health services. Perhaps counselors today have realistic expectations regarding the challenges created by third party payment and other systematic limitations, and choose to enter the field despite these challenges, for truly altruistic purposes.

Limitations

The instrumentation selected for this study, specifically the Client Perception Rating Form (CPRF; Mercer et al., 1983), may have contributed to the lack of statistically significant findings of differences in this study. There are three specific limitations pertaining to the CPRF. First, the reported alpha levels for this instrument are low, making attenuation a major concern when interpreting findings. Mercer et al. (1983) noted that 11 of the items were found to load as an evaluative factor with internal consistencies ranging from .73 to .84; however loadings for the remaining items were not disclosed. Mercer et al. (1983) did note that a factor analysis identified that the six orthogonal factors together accounted for 66% of the total variance. The results of this study produced alphas ranging from .55 for the Adjustment factor to .66 for the Personal Evaluation factor. According to Ponterotto and Ruckdeschel (2007), when examining

subscales with items with six or fewer items, a fair internal consistency coefficient for sample sizes of 100 – 300 is .65, while .70 is moderate, .75 is good, and .80 is excellent. In this study, all but one of the alpha values for the CPRF factors fell below the .65 level. These internal consistency ratings suggest the CPRF factors may not have appropriately or consistently captured participants' genuine perceptions of the client in the case vignette.

In addition to the limitations pertaining to internal consistencies, the CPRF does not include culturally-based rating items. Of the 22 items included in the CPRF, there are no items that allow the participant to indicate a cultural perception of the client, neither in terms of the client's sameness or difference to the participant, nor in terms of cultural attributions that the participant may apply to the client.

In addition to lack of cultural items, the CPRF does not allow for those completing the instrument to indicate their perceptions based on clinically significant attributions such as assessment of client's motivation to work and perceived likelihood of client to consistently return for counseling services. There are two items on the CPRF that relate to these types of perceptions. They include item 16 *very motivated for help/not motivated for help* and item 17 *cooperative/uncooperative*. Item 16 is not included for scoring of any of the factors of the CPRF, while item 17 is included in the Social Attractiveness factor. The lack of items related to clinical judgment does not result in the instrument being able to assess any possible confounding effects of attribution. For example, with regard to the uninsured case vignette, participants may have attributed greater motivation to this client due to the fact that she was willing to pay out of pocket for her counseling services.

Furthermore, the case vignette utilized in this study did not include any cultural references other than the clients' insurance status, which implies a socioeconomic difference. While participants may have attributed cultural differences to the client in the case vignette (e.g., the client referenced poor job skills which one may infer to mean that she is uneducated), specific cultural cues were not included. Part of this study examined the interaction effect of multicultural comfort, as evidenced by scores on the Miville-Guzman Universality-Diversity Scale (Miville et al., 1999). As no statistically significant differences were found based on insurance status during the initial analysis, that variable was not included in the analysis of interaction effects with multicultural comfort. Therefore, in essence, the only cultural cue (insurance status) was removed prior to this analysis. This lack of cultural cues may have been a limitation to finding statistically significant interaction effects with multicultural comfort.

The case vignette in this study was written by the author for the purposes of this study. It was assessed by two reviewers for appropriate coverage of adjectives included on the CPRF. A potential limitation to this study is the case vignette may not have included the information necessary to cue sources of participants' bias. As insurance status was the primary independent variable for this study, the two versions of the case vignette were designed to be identical except for the mention of insurance status. Another possible limitation of this study may have been the mention of insurance status was too minimal and thus overlooked by participants.

There are two possible limitations related to the sample. First, 13.6% of the sample (or 20 out of 147 participants) listed their work setting as *other*. By selecting *other*, these participants indicated their work setting was not represented by the choices:

private practice, community agency-city or state, community agency-non-profit, school, or hospital. It is possible these participants may represent a type of work setting not considered. If these other work settings had been identified and examined, they might have had a significant impact on the research question focused on the relationship between work setting and counselor bias.

The second possible limitation related to the sample is the possible selection threat based on income type. Nearly 73% of the sample listed *salary* as their income type. As income type was an independent variable, the large majority of participants with a salary income type may have decreased the likelihood of finding a significant difference within the population for income type. In addition, given the low number of participants who indicated their income was based on private practice (18 participants or 12.2% of the sample), it was impossible to compare CPRF scores of those with private practice income types to CPRF scores of those with salary income types.

The effects of social desirability are another possible limitation of this study. Social Desirability has been defined as the need of participants to obtain approval by responding in a culturally appropriate and acceptable manner (Crowne & Marlowe, 1960). It is possible that participants in this study responded in a socially desirable manner to both the CPRF and the M-GUDS.

The CPRF asked participants to categorize a client on 22 semantic differential scales, which included adjectives such as *dirty/clean* and *likeable/unlikeable*. Due to social desirability, as well as the potential influence of the Rogerian tenet of unconditional positive regard (Corey, 2005), some participants may have found it difficult to indicate their honest impressions.

The M-GUDS was designed to assess participants' relativistic appreciation of themselves and others, their commitment to seeking a diversity of contact with others, and their sense of connection with the larger society or humanity as a whole (Miville et al., 1999). Social desirability may have influenced participants to rate themselves higher on these constructs than their actual beliefs or actions might represent.

Implications for future research

There are many avenues for future research that stem from this study. A primary goal for future research would be to develop a more effective perception rating instrument, given the low reliability scores associated with the Client Perception Rating Form (CPRF; Mercer et al., 1983) used in this study. Additional perception rating tools should be developed to be more reflective of cultural perceptions as well as clinical attributions such as client motivation and counselors' perceptions of problem attribution (i.e., perceptions of internal or external locus of control).

Following the notion of counselors' clinical attributions, a qualitative study would be appropriate to explore those client attributes that counselors most readily and frequently perceive and how those perceptions affect counselors' opinions about clients and their willingness to work with specific client-types.

Another qualitative study that would further our understanding of cultural perceptions would be a study focused on counselors' understanding of the variety of sub-cultures that make up each client. A qualitative study would allow counselors to explore their initial perceptions about clients based on readily identifiable cultural attributes (e.g., racial or ethnic group, age, gender) and then explore to what extent counselors also consider the contributing factors of sub-cultural issues such as insurance status, education

level, and verbal ability. A follow up to this study could include a study to identify current client attributes most sought after by counselors, which may offer an update to Schofield's (1964) idealized YAVIS client.

To further explore the impact of clients' insurance status on counselor perceptions, a qualitative study designed to identify counselors' perceptions of third party payment, in general, should be explored. For example, do counselors feel positively or negatively about third party payment? Do they feel that it's reliable and easy to use? Do they feel that managed-care limits their ability to provide appropriate treatment? Exploring these perceptions of health insurance in general may better illuminate counselors' perceptions of clients with and without insurance. Perhaps counselors prefer to work with self-pay clients, as it is more convenient or indicative of motivation. This exploration should focus on counselors' who rely on fee-for-service income, as counselors working for a salary are less likely to be impacted by these types of financial concerns.

Finally, given the changing face of the United States economy and employer trends (Goldman, 2009; Lehman, 2009; Taenzler, 2009), a variety of program evaluation and needs assessment studies should be conducted in local communities to address if or how access to mental health care is being addressed for uninsured and underinsured individuals.

CONCLUSION

The purpose of this study was to explore counselors' perceptions of uninsured clients. The relationship between four potential sources of counselor bias (multicultural comfort, financial concerns, work setting and years of experience) and counselor

perceptions were explored. This study did not indicate an existing bias against uninsured individuals; nor did it indicate a statistically significant interaction effect for work setting, income type, and years of experience on general counselor bias. In addition, this study explored a possible interaction effect for multicultural comfort on general counselor bias, and did not indicate a statistically significant effect.

Future research, including additional quantitative studies utilizing an updated counselor perception instrument and possible qualitative studies to explore counselor perceptions are recommended to further explore counselor perceptions and possible sources of counselor bias.

Table 1

Frequency Distribution of Counselor Type by Survey Distribution Method

Counselor Type	ODU Continuing Education Workshops	Norfolk CSB Continuing Education Workshop	Web-based Distribution (surveymonkey.com)	Total
Licensed Professional Counselor	24	2	20	46
Licensed Clinical Social Worker	9	3	1	13
Licensed Clinical Psychologist	1	0	0	1
Licensed Marriage & Family Therapist	1	0	0	1
Licensed School Counselor	9	0	1	10
Non-Licensed masters-level Counselor	14	3	17	34
Non-Licensed masters-level Social Worker	3	2	0	5
Bachelor's degree in related human services field	20	7	4	31
Other	2	2	2	6
Total	83	19	45	147

Table 2

Frequency Distribution by Work Setting

Work Setting	Frequency of Participants	Percent of Participants
Private Practice	27	18.4%
Community Agency, City or State	49	33.3%
Community Agency, Non-Profit	25	17.0%
School	24	16.3%
Hospital	2	1.4%
Other	20	13.6%
Total	<i>N</i> = 147	100.0%

Table 3

Summary of independent MANOVAs

	Wilk's Λ	
	<i>F</i>	<i>p</i>
Case Type (Insured vs. Uninsured)	1.87	0.09
M-GUDS Total	1.07	0.25
Work Setting	1.02	0.44
Income Type	1.31	0.18
Years of Experience	1.00	0.49

References

- Aldler, J., & Gutheil, T. G. (1977). Fees in beginning private practice. *Psychiatric Annals*, 7(2), 35-46.
- American Counseling Association (2005). *ACA code of ethics*. Alexandria, VA: Author.
- Auld, F., & Myers, J. (1954). Contributions to a theory for selecting psychotherapy patients. *Journal of Clinical Psychotherapy*, 10, 56-60.
- Batson, C. D. (1975). Attribution as a mediator of bias in helping. *Journal of Personality and Social Psychology*, 32, 455-466.
- Black, M. M., & Krishnakumar, A. (1998). Children in low-income, urban settings: Interventions to promote mental health and well being. *American Psychologist*, 53, 635-646.
- Bloch, M. (1987). Paying for service: What do clinical social workers believe? *Journal of Social Service Research*, 9(4), 21-35.
- Brown, B. R. (1970). Experienced and inexperienced counselors first impressions of client and case outcomes: Are first impressions lasting? *Journal of Counseling Psychology*, 17, 550-558.
- Burkard, A., & Knox, S. (2004). Effect of therapist color-blindness on empathy and attributions in cross-cultural counseling. *Journal of Counseling Psychology*, 51, 387-397.
- Campbell, D. T., & Stanley, J. C. (1963). *Experimental and quasi-experimental designs for research*. Chicago: Rand McNally College Publishing Company.

- Cerney, M. (1990). Reduced fee or free psychotherapy: Uncovering the hidden issues. *Psychotherapy Patient*, 7(1-2,) 53-65.
- Cohen, J. (1988). *Statistical power analysis for the behavioral sciences*, New York: Lawrence Erlbaum Associates.
- Corey, G. (2005). *Theory and practice of counseling and psychotherapy*. Belmont, CA: Brooks/Cole – Thompson Learning.
- Council for Accreditation of Counseling and Related Educational Programs (2008). *2009 Standards*. Retrieved February 10, 2009 from <http://www.cacrep.org/2009standards.html>
- Crowne, D. P., & Marlowe, D. (1960). A new scale of social desirability independent of psychopathology. *Journal of Consulting Psychology*, 24, 349 – 354.
- DeNavas-Walt, C., Proctor, B. D., & Smith, J. (2007). *Income, poverty, and health Insurance coverage in the United States: 2006*. Retrieved March 3, 2008 from <http://www.census.gov/prod/2007pubs/p60-233.pdf>
- Fuertes, J. N., Miville, M. L., Mohr, J. J., Sedlacek, W. E., & Gretchen, D. (2000). Factor structure and short form of the Miville-Guzman Universality-Diversity Scale. *Measurement and Evaluation in Counseling and Development*, 33, 157 – 169.
- Goldman, David (2009). Economists: Recession getting worse. Retrieved February 10, 2009 from http://money.cnn.com/2009/01/26/news/economy/nabe_survey/
- Goldstein, A. P. (1973). *Structured learning therapy: Toward a psychotherapy of the poor*. Oxford, England: Academic Press.

- Grant, P. G., & Mackie, K. L. (2007). Social class. In G. McAuliffe (Ed.), *Culturally alert counseling: A comprehensive introduction* (pp. 390-428). Thousand Oaks, CA: Sage Publications.
- Hillerbrand, E. (1988). The relationship between socioeconomic status and counseling variables at a university counseling center. *Journal of College Student Development, 29*, 250 – 254.
- Jensen, A. R. (1998) *The g factor: The science of mental ability*. Westport, CT: Praeger.
- Johnson, R. W., & Fredrickson, R. H. (1968). Effect of financial remuneration and case description on counselor performance. *Journal of Counseling Psychology, 15*, 130-135.
- Lehman, M. B. (2009). Report: 4 million Americans lost health insurance since recession began. Retrieved February 16, 2009 from <http://www.bizjournals.com/portland/stories/2009/02/16/daily42.html?t=printable>
- Liu, W. M., Ali, S. R., Soleck, G., Hopps, J., Dunston, K., & Pickett, Jr. T. (2004). Using social class in counseling psychology research. *Journal of Counseling Psychology, 51*, 3 – 18.
- Mercer, J., Andrews, H., & Mercer, A. (1983). The effects of physical attractiveness and disability on client ratings by helping professionals. *Journal of Applied Rehabilitation Counseling, 14*(4), 41 – 45.
- Merriam-Webster's Online Dictionary. (2008). Retrieved March 10, 2008 from <http://www.merriam-webster.com/dictionary/bias>

- Miville, M. L., Gelso, C. J., Pannu, R., Liu, W., Touradji, P., Holloway, P., & Fuertes, J. N. (1999). Appreciating similarities and valuing differences: The Miville-Guzman Universality-Diversity Scale. *Journal of Counseling Psychology, 46*, 291-307.
- Pearce, A. (1994). Investigating biases in trainee counsellors' attitudes to clients from different cultures. *British Journal of Guidance and Counselling, 22*, 417-428.
- Ponterotto, J. G. & Ruckdeschel, D. E. (2007). An overview of coefficient alpha and a Reliability matrix for estimating adequacy of internal consistency coefficients with psychological research measures. *Perceptual and Motor Skills, 105*(3), 997-1014.
- Presly, A. S. (1969). Concept-scale interaction in the semantic differential and its Implications for factor scores. *British Journal of Psychology, 60*(1), 109 – 113.
- Runyon, R. P., Coleman, K. A., & Pittenger, D. J. (2000). *Fundamentals of behavioral statistics* (9th ed.). Boston: McGraw-Hill.
- Schnitzer, P. K. (1996). "They don't come in!" Stories told, lessons taught about poor families in therapy. *American Journal of Orthopsychiatry, 66*, 572-582.
- Schofield, W. (1964). *Psychotherapy: The purchase of friendship*. New Brunswick, NJ: Transaction Publishers.
- Schrader, M. K. (1989) Willingness of counselors in training to accept low Socioeconomic statues and ethnic clients (Doctoral dissertation, Purdue University, 1989). Dissertation Abstracts International, 51, 02A.
- Sharf, R. R., & Bishop, J. B. (1979). Counselors' feelings toward clients as related to intake judgments and outcome variables. *Journal of Counseling Psychology, 26*,

267-269.

Shen, J., & Murray, J. (1981). Psychotherapy with the disadvantaged. *American Journal of Psychotherapy*, 35, 268-275.

Siassi, I., & Messer, S. B. (1976). Psychotherapy with patients from lower socioeconomic groups. *American Journal of Psychotherapy*, 30(1), 29 – 40.

Stevens, J. (1999). *Intermediate statistics: A modern approach*. Mahway, NJ: Lawrence Erlbaum Associates.

Sue, D. W., & Sue, D. (1990). *Counseling the culturally different: Theory and practice*. New York: Wiley.

Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Counseling and Development*, 70, 477 – 486.

Sue, D. W. (2003). *Overcoming our racism: The journey to liberation*. San Francisco: Jossey-Bass.

Taenzler, J. (2009). Study: 14K losing H.C. insurance a day. Retrieved February 19, 2009 from <http://firstread.msnbc.msn.com/archive/2009/02/19/1801786.aspx>

Toporek, R., & Pope-Davis, D. B. (2005). Exploring the relationships between Multicultural training, racial attitudes, and attributions of poverty among graduate counseling trainees. *Cultural Diversity and Ethnic Minority Psychology*, 11, 259-271.

Tuder, K. (1998). Value for money? Issues of fees in counselling and psychotherapy. *British Journal of Guidance and Counselling*, 26, 477-493.

- Tversky, A., & Kahneman, D. (1974). Judgement under uncertainty: Heuristics and biases. *Science*, 185(4157), 1124 - 1131
- Teasdale, A. C., & Hill, C. E. (2006). Preferences of therapists-in-training for client characteristics. *Psychotherapy: Theory, Research, Practice, Training*, 43, 111-118.
- U.S. Census Bureau Housing and Household Economic Statistics Division (2007). *Health insurance coverage: 2006*. Retrieved March 3, 2008 from <http://www.census.gov/hhes/www/hlthins/hlthin06/hlth06asc.html>
- U.S. Department of Health and Human Services (2006) *National Center for Health Statistics, Health, United States, 2006 with chartbook on trends in the health of Americans*. Retrieved March 3, 2008 from <http://www.cdc.gov/nchs/data/hus/hus06.pdf>
- Wills, T. A. (1978). Perceptions of clients by professional helpers. *Psychological Bulletin*, 85, 968-1000.
- Zucker, G. S., & Weiner, B. (1993). Conservatism and perceptions of poverty: An Attributional analysis. *Journal of Applied Social Psychology*, 23, 925-943.

Appendix A

Human Subjects Application and Approval

Appendix B

Personal Information Questionnaire

Please provide the personal information requested below.

1. Work Setting (check one):

- ☐ Private Practice
- ☐ Community Agency (City or State agency)
- ☐ Community Agency (Non-profit agency)
- ☐ School
- ☐ Hospital
- ☐ Other, please list: _____

2. Counselor Type (check primary credential):

- ☐ Licensed Professional Counselor
- ☐ Licensed Clinical Social Worker
- ☐ Licensed Clinical Psychologist
- ☐ Licensed School Counselor
- ☐ Master's in Counseling (non-licensed)
- ☐ Master's in Social Work (non-licensed)
- ☐ Bachelor's Degree in related human services field
- ☐ Other, please list: _____

3. Number of years since earning your first counseling-related professional degree (e.g., master's degree in counseling or social work): _____

4. Number of years working with clients: _____

5. Primary Income Type (check one):

- ☐ Salary
- ☐ Hourly (may include Independent Contractors; Not Private Practice)
- ☐ Private Practice (Fee for Service)
- ☐ Other, please list: _____

6. If primary income type is Private Practice, (check one):

- ☐ I accept insurance
- ☐ I operate on a cash only basis

7. Race/Ethnicity (check one):

(U.S. Census Bureau, 2006)

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black
- ☐ Hispanic Origin
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White (not Hispanic)

8. Gender (check one):

- ☐ Male
- ☐ Female

Please now read the case vignette on the following page.

Appendix C

Case Vignette – Version One

Please read the following case vignette:

Kelly is a 33-year-old, white, mother of three children, ages 5, 7, and 11. She presents for counseling services stating that she has been depressed and anxious for the past two months.

She states that she has recently ended a relationship and has had difficulty sleeping since then. She notes that her lack of sleep and her feelings of depression have made it hard for her to get up and go to work in the morning. She has missed 15 days of work over the past two months. She notes that she cannot continue to miss work, as she is already at risk of losing her job.

Kelly reports that she is employed as a customer service phone representative at a local company. She notes that although “the pay is not great,” she is fairly satisfied with her job. She further notes that lately she has been unable to concentrate and she worries that her boss has noticed her drop in performance. She notes that she is fearful of losing her job because she’s “not qualified to do anything else.”

Kelly reports that she drinks about 1 – 2 alcoholic drinks per evening, most evenings of the week. She notes that she tries to wait until her children go to bed before pouring her first drink. She explains that she hopes the drinks will help her sleep better.

When asked about the nature of her insomnia, Kelly states that she “just lays awake and worries about everything.” When asked what she worries about, she states that she worries about whether or not she’s a good mother, she worries about her job, and she worries that she’ll “never have a good relationship.”

Kelly is clean and dressed appropriately and is oriented to the session. Her eyes are cast downward for much of the session, making only occasional eye contact. She requires minimal encouragement to speak. She becomes tearful a few times during the session.

Kelly states that she is hoping that counseling will help her “worry less, stop feeling depressed, and sleep better.”

Kelly states that she was referred to your services by her health insurance carrier and notes that her plan covers 8 counseling visits per year.

Please now respond to the 2 instruments on the following pages:

1 – Client Perception Rating Form

2 – Miville-Guzman Universality-Diversity Scale

Appendix D

Case Vignette – Version Two

Please read the following case vignette:

Kelly is a 33-year-old, white, mother of three children, ages 5, 7, and 11. She presents for counseling services stating that she has been depressed and anxious for the past two months.

She states that she has recently ended a relationship and has had difficulty sleeping since then. She notes that her lack of sleep and her feelings of depression have made it hard for her to get up and go to work in the morning. She has missed 15 days of work over the past two months. She notes that she cannot continue to miss work, as she is already at risk of losing her job.

Kelly reports that she is employed as a customer service phone representative at a local company. She notes that although “the pay is not great,” she is fairly satisfied with her job. She further notes that lately she has been unable to concentrate and she worries that her boss has noticed her drop in performance. She notes that she is fearful of losing her job because she’s “not qualified to do anything else.”

Kelly reports that she drinks about 1 – 2 alcoholic drinks per evening, most evenings of the week. She notes that she tries to wait until her children go to bed before pouring her first drink. She explains that she hopes the drinks will help her sleep better.

When asked about the nature of her insomnia, Kelly states that she “just lays awake and worries about everything.” When asked what she worries about, she states that she worries about whether or not she’s a good mother, she worries about her job, and she worries that she’ll “never have a good relationship.”

Kelly is clean and dressed appropriately and is oriented to the session. Her eyes are cast downward for much of the session, making only occasional eye contact. She requires minimal encouragement to speak. She becomes tearful a few times during the session.

Kelly states that she is hoping that counseling will help her “worry less, stop feeling depressed, and sleep better.”

Kelly notes that her job does not offer health insurance benefits, so she will have to pay out-of-pocket for your services. She asks if you provide any type of sliding scale or free sessions.

Please now respond to the 2 instruments on the following pages:

1 – Client Perception Rating Form

2 – Miville-Guzman Universality-Diversity Scale

Appendix E

Client Perception Rating Form (Mercer, Andrews, & Mercer, 1983)

(Reprinted with permission from the *Journal of Applied Rehabilitation Counseling*)

Please circle the "X" on the continuum **for each item** that most closely reflects your perception of Kelly

1	Valuable	X	X	X	X	X	X	X	Worthless
2	Dirty	X	X	X	X	X	X	X	Clean
3	Tasteful	X	X	X	X	X	X	X	Distasteful
4	Cold	X	X	X	X	X	X	X	Warm
5	Shallow	X	X	X	X	X	X	X	Deep
6	Easy to get along with	X	X	X	X	X	X	X	Hard to get along with
7	Self-reliant	X	X	X	X	X	X	X	Dependent
8	Unreliable	X	X	X	X	X	X	X	Reliable
9	Neat	X	X	X	X	X	X	X	Sloppy
10	Dangerous	X	X	X	X	X	X	X	Not Dangerous
11	Unemployable	X	X	X	X	X	X	X	Employable
12	Friendly	X	X	X	X	X	X	X	Unfriendly
13	Likable	X	X	X	X	X	X	X	Unlikeable
14	Well-adjusted	X	X	X	X	X	X	X	Maladjusted
15	Very unattractive	X	X	X	X	X	X	X	Very attractive
16	Not motivated for help	X	X	X	X	X	X	X	Very motivated for help
17	Cooperative	X	X	X	X	X	X	X	Uncooperative

Description of presenting problem:

18	Mild	X	X	X	X	X	X	X	Severe
----	------	---	---	---	---	---	---	---	--------

Prognosis after one year:

19	Have few problems	X	X	X	X	X	X	X	Have many problems
20	Be worse	X	X	X	X	X	X	X	Be improved
21	Require counseling	X	X	X	X	X	X	X	Require no counseling
22	Be very unhappy	X	X	X	X	X	X	X	Be very happy

(Continued on next page)

As a counselor, would you choose to work with this client?

☐ Yes ☐ No

Appendix F

Miville-Guzman Universality-Diversity Scale (M-GUDS)

The following items are made up of statements using several terms which are defined below for you. Please refer to them throughout the rest of the questionnaire.

Culture refers to the beliefs, values, traditions, ways of behaving, language of any social group. A social group may be racial, ethnic, religious, etc.

Race or racial background refers to a sub-group of people possessing common physical or genetic characteristics. Examples include White, Black, American Indian.

Ethnicity or ethnic group refers to specific social group sharing a unique cultural heritage (i.e., customs, beliefs, language, etc.). Two people can be of the same race (e.g., White), but be from different ethnic groups (e.g., Irish-American, Italian American).

Country refers to groups that have been politically defined; people from these groups belong to the same government (e.g., France, Ethiopia, United States). People of different races (White, Black, Asian) or ethnicities (Italian, Japanese) can be from the same country (United States).

Instructions: Please indicate how descriptive each statement is of you by filling in the number corresponding to your response. This is not a test, so there are no right or wrong, good or bad answers. All responses are anonymous and confidential.

1	2	3	4	5	6
Strongly Disagree	Disagree	Disagree a little bit	Agree a little bit	Agree	Strongly Agree
1. _____	I am interested in knowing people who speak more than one language.				
2. _____	It deeply affects me to hear persons from other countries describe their struggles of adapting to living here.				
3. _____	I attend events where I might get to know people from different racial backgrounds.				
4. _____	I feel a sense of connection with people from different countries.				
5. _____	I am not very interested in reading books translated from another language.				
6. _____	Knowing about the experiences of people of different races increases my self understanding.				

	1	2	3	4	5	6
	Strongly Disagree	Disagree	Disagree a little bit	Agree a little bit	Agree	Strongly Agree
7. _____	I sometimes am annoyed at people who call attention to racism in this country.					
8. _____	Knowing someone from a different ethnic group broadens my understanding of myself.					
9. _____	Knowing how a person differs from me greatly enhances our friendship.					
10. _____	I don't know too many people from other countries.					
11. _____	I place a high value on being deeply tolerant of others' viewpoints.					
12. _____	It's really hard for me to feel close to a person from another race.					
13. _____	It grieves me to know that many people in the Third World are not able to live as they would choose.					
14. _____	I would like to join an organization that emphasizes getting to know people from different countries					
15. _____	In getting to know someone, I try to find out how I am like that person as much as how that person is like me.					
16. _____	When I hear about an important event (e.g., tragedy) that occurs in another country, I often feel as strongly about it as if it had occurred here.					
17. _____	It's hard to understand the problems that people face in other countries.					
18. _____	I can best understand someone after I get to know how he/she is <u>both</u> similar and different from me.					
19. _____	I often feel irritated by persons of a different race.					
20. _____	It does not upset me if someone is unlike myself.					
21. _____	I would like to know more about the beliefs and customs of ethnic groups who live in this country.					
22. _____	It's often hard to find things in common with people from another					

generation.

	1	2	3	4	5	6
	Strongly Disagree	Disagree	Disagree a little bit	Agree a little bit	Agree	Strongly Agree
23. ____	When I listen to people of a different race describe their experiences in this country, I am moved.					
24. ____	I often feel a sense of kinship with persons from different ethnic groups.					
25. ____	I would be interested in participating in activities involving people with disabilities.					
26. ____	Knowing about the different experiences of other people helps me understand my own problems better.					
27. ____	Persons with disabilities can teach me things I could not learn elsewhere.					
28. ____	I am often embarrassed when I see a person with disabilities.					
29. ____	I am only at ease with people of my race.					
30. ____	I would like to go to dances that feature music from other countries.					
31. ____	For the most part, events around the world do not affect me emotionally.					
32. ____	Placing myself in the shoes of a person from another race is usually too tough to do.					
33. ____	I often listen to the music of other cultures.					
34. ____	If given another chance, I would travel to different countries to study what other cultures are like.					
35. ____	I have friends of differing ethnic origins.					
36. ____	Knowing how a person is similar to me is the most important part of being good friends.					
37. ____	It is important that a friend agrees with me on most issues.					
38. ____	In getting to know someone, I like knowing <u>both</u> how he/she differs from me and is similar to me.					

	1	2	3	4	5	6
	Strongly Disagree	Disagree	Disagree a little bit	Agree a little bit	Agree	Strongly Agree
39. _____	Getting to know someone of another race is generally an uncomfortable experience for me.					
40. _____	I would be interested in taking a course dealing with race relations in the United States.					
41. _____	Becoming aware of experiences of people from different ethnic groups is very important to me.					
42. _____	I am interested in learning about the many cultures that have existed in this world.					
43. _____	I am interested in going to exhibits featuring the work of artists from different minority groups.					
44. _____	I feel comfortable getting to know people from different countries.					
45. _____	I have <u>not</u> seen many foreign films.					

© 1992 Marie L. Miville

Permission is granted for research and clinical use of the scale. Further permission must be obtained before any modification or revision of the scale can be made.

VITA

Katherine S. Moore earned a Bachelor's of Science degree in Speech Communication in 1997 from James Madison University and a Master's of Education degree in Counseling from Old Dominion University in 2007. She is a national certified counselor and is currently completing her residency requirements for licensure as a professional counselor.

Ms. Moore is currently the Director of a partnership counseling center between Old Dominion University and the Norfolk Community Services Board. In addition, she specializes in counseling children and adolescents and has worked in both a shelter setting and as a home-based counselor.

Ms. Moore is an active member of several national professional organizations including the American Counseling Association (ACA), the American Mental Health Counselors Association (AMHCA), and Chi Sigma Iota (CSI). Ms. Moore was awarded the Chi Sigma Iota national Fellow award in 2008. At the state level, she serves on the board of the Virginia Association of Clinical Counselors.

Ms. Moore is a member of the book review board for The Family Journal, has contributed editorials for state and national journals, and has presented at state and national conferences.

Ms. Moore has 10 years of experience in both fundraising and sales prior to joining the counseling field.