Are Two Unmatched Minority Statuses Worse Than One? The Impact of Social Status Similarities on Alliance in a Mock Clinical Interview

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Are Two Unmatched Minority Statuses Worse Than One?
The Impact of Social Status Similarities on Alliance in a Mock Clinical Interview

A thesis submitted in partial fulfillment of the requirements for the degree of Master of Arts in Psychology

by

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Marquette University
Bachelor of Arts in Psychology, 2017

December 2019
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This thesis is approved for recommendation to the Graduate Council.

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Abstract

Strengthening therapeutic alliance through social identity matching has been a strategy used to reduce psychotherapy dropout among racial/ethnic and sexual minority clients. Limited research has examined social identity match by manipulating social identity (e.g., race/ethnicity, sexual orientation) in an analogue therapy setting. This study (1) assessed whether self-reported alliance was positively associated with theoretical proxies of alliance and (2) examined the effects of racial/ethnic and sexual orientation match on therapeutic alliance (self-reported) and proxies of alliance (perceived similarity, liking, blame, empathy, closeness, microaggression proxies, verbal validation, and open body language). Participants \((N = 71)\) were heterosexual White women interested in a mental health career. They were recruited for a study that ostensibly involved evaluating the impact of a brief training on clinical interviewing skills. All participants conducted a pre-training interview with a confederate who identified as either White (racial/ethnic match) or Latinx (racial/ethnic mismatch) and either heterosexual (sexual orientation match) or lesbian (sexual orientation mismatch). After the interview, participants completed self-report measures assessing perceived similarity, liking, therapeutic alliance, blame, empathy, and closeness. All interviews were video recorded, transcribed, and coded for participant behaviors (microaggression proxies, validation, and open body language). Results revealed only liking and empathy were associated with self-reported therapeutic alliance. There was a significant main effect of racial/ethnic match for three of nine analyses. Participants validated the confederate’s problems and demonstrated more open body language when the confederate identified as White instead of Latinx. Participants asked the confederate, “Where are you from?” more often when she identified as Latinx instead of White. There was also a main effect of sexual orientation match for three of nine analyses. Specifically, participants perceived
the confederate as more similar and liked her more when she identified as heterosexual instead of lesbian. Participants discussed the confederate’s romantic relationship more when she identified as lesbian instead of heterosexual. There were no statistically significant interaction effects to suggest endorsing two unmatched identities was worse for therapeutic alliance than one unmatched identity. Findings suggest therapists may be engaging in biased behaviors when they interact with clients of diverse social identities.
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Introduction

Are Two Unmatched Minority Statuses Worse Than One? The Impact of Social Status Similarities on Alliance in a Mock Clinical Interview

Premature dropout from therapy is common; however, minorities drop out of therapy more often than majority group members (Maramba & Nagayama, 2002; Anderson, Bautista, & Hope, 2019). A strong therapeutic alliance can help prevent drop-out. However, therapist biases can interfere with building a strong therapeutic alliance with minority clients and these biases can show up in many ways, including lower levels of liking, attributions of blame, less empathy, microaggressions, less verbal validation, or closed body language (Vasquez, 2007). One important factor that contributes to lack of alliance is low perceived similarity and the extent which therapists experience low perceived similarity with their minority clients may show more biases that interfere with alliance and result in premature drop-out. The assumption that perceived similarity enhances alliance is one rationale for trying to increase treatment engagement by matching clients and therapists on variables such as race/ethnicity (Maramba & Nagayama, 2002) or sexual orientation (Stracuzzi, Mohr, & Fuertes, 2011). Whether matching increases perceived similarity is debatable and little experimental work has been done in this area. Therefore, this study sought to fill this gap.

There are many empirically supported treatments for specific psychological disorders (Chambless et al., 1998). Empirically supported treatments yield positive therapeutic outcomes (APA Presidential Task Force on Evidence-Based Practice, 2006) and therapeutic benefits are associated the amount of treatment received (Howard, Kopta, Krause, & Orlinsky, 1986). Although precise estimates are debatable, it is clear clients need to remain in treatment for positive benefits; however, premature termination of psychotherapy is, unfortunately, quite
common. According to Wierzbicki and Pekarik’s (1993) meta-analysis of psychotherapy dropout rates, about 47% of people dropout of therapy. A subsequent meta-analysis reported a decrease in psychotherapy dropout rates; however, premature termination continues to persist (Swift & Greenberg, 2012).

People of underrepresented social groups experience higher rates of psychotherapy dropout than people who hold social identities with social privilege (i.e., White, heterosexual). There are documented differential psychotherapy dropout rates for racial/ethnic minority (Leong & Lau, 2001; Wierzbicki & Pekarik, 1993) and sexual minority (e.g., lesbian, gay, bisexual) clients (Israel, Gorcheva, Walther, Sulzner, & Cohen, 2008; Anderson et al., 2019). Differential dropout rates and apprehension to seek mental health treatment contribute to larger health disparities experienced by racial/ethnic and sexual minority populations (Alegría et al., 2002; Atdjian & Vega, 2005; Burgess, Lee, Tran, & Van Ryn, 2008; Fredriksen-Goldsen, Kim, Barkan, Muraco, & Hoy-Ellis, 2013). Therefore, addressing psychotherapy dropout rates is one way to attempt to reduce mental health disparities.

A promising way to increase treatment retention and decrease dropout rates is by strengthening therapeutic alliance. Therapeutic alliance is focused on the quality of the social interaction between the therapist and client, especially in their ability to establish rapport, work together, and agree on goals for psychotherapy (Vasquez, 2007). Validation of client’s experiences and problems is another component of therapeutic alliance (Howard, 2017). Therapeutic alliance develops during initial interactions between the therapist and client (Flicker, Turner, Waldron, Brody, & Ozechowski, 2008). Research suggests this is an essential factor in positive psychotherapy outcomes because it allows for a stronger and more trusting relationship, aiding clients’ disclosure (Chang & Berk, 2009; Vasquez, 2007). Unsurprisingly, strong
therapeutic alliance is associated with decreased dropout rates (Ogrodniczuk, Joyce, & Piper, 2005; Samstag, Batchelder, Muran, Safran, & Winston, 1998; Sharf, Primavera, & Diener, 2010). Addressing factors that facilitate or hinder client therapeutic alliance can help increase psychotherapy retention. Therefore, it is particularly important to attend to the therapeutic alliance of therapists with racial/ethnic and sexual minority clients (i.e., people who are not part of the majority/privileged culture).

Unintentional bias on behalf of therapists can interfere with therapeutic alliance and increase psychotherapy dropout rates for racial/ethnic minority clients (Vasquez, 2007). Threats to therapeutic alliance include the therapist engaging in microaggressions toward the client, negative body language, and conveying a lack of empathic understanding (Vasquez, 2007). Microaggressions are brief intentional or unintentional slights by people with social power/privilege toward people with less privileged social identities, such as racial/ethnic and sexual minorities (Sue et al., 2007; Vasquez, 2007). Microaggressions occur daily and across multiple settings for people outside the dominant/privileged group (Sue et al., 2007). For example, asking a person of color where they are from can send the message of being perceived as a foreigner, especially if that question would not be asked to a White person. Microaggressions are also experienced by people who hold other underprivileged identities, such as sexual minorities. Microaggressions can take place anywhere, including psychotherapeutic settings, and negatively impact therapeutic alliance (Shelton, & Delgado-Romero, 2011). Therapeutic alliance can also be weakened by subtle and unintentional expressions of racism, such as negative body language (e.g., closed body posture and lack of eye contact; Vasquez, 2007). Furthermore, lack of empathy and blame toward the client and their problem’s may also weaken therapeutic alliance (Vasquez, 2007). Although these constructs are associated with
weakened therapeutic alliance, there has been limited work to assess how these constructs relate to self-reported therapeutic alliance.

In fact, some research suggests lack of perceived similarity, shared experiences, or interpersonal closeness can contribute to difficulties with therapeutic alliance (Vasquez, 2007). Research on psychotherapy with racial/ethnic minority clients has focused on matching therapists and clients by race/ethnicity to strengthen therapeutic alliance. This work has yielded mixed findings, where matching may strengthen therapeutic alliance or have no effect (Flicker et al., 2008; Thompson & Alexander, 2006; Wintersteen, Mensinger, & Diamond, 2005). Furthermore, racial/ethnic matching of therapists and clients is often unfeasible, overlooks within-group differences (e.g., gender and sexual identity), and by itself does not guarantee a strong therapeutic alliance (Vasquez, 2007). Additionally, people differ in the relevance and significance of particular social identities (e.g., salience of ethnic identity; Douglass, Wang, & Yip, 2016). Therefore, people with similar identification may differ in personal experiences that influence their perspectives. For example, a Spanish-speaking Cuban immigrant therapist may identify as Latinx and their non-Spanish speaking Mexican American client may also identify as Latinx. The therapist and client share a Latinx ethnic identity, yet they have different experiences and may not perceive each other as similar. Since identity is complex, simply matching by one identity does not guarantee a better social interaction or a stronger therapeutic alliance (Maramba & Nagayama, 2002).

Research on identity matching assumes people who share a social identity perceive each other as similar (Launay & Dunbar, 2015; Montoya, Horton, & Kirchner, 2008). Perceived similarity has been studied extensively outside of clinical psychology. This research demonstrates perceived similarity is strongly associated with increased ratings of likability and
attraction (Carli, Ganley, & Pierce-Otay, 1991; Launay & Dunbar, 2015; Montoya et al., 2008; Sprecher, 2014). This mechanism has been used when matching therapists and clients by identity because there is an assumption that sharing an identity may increase perceived similarity, likability, and closeness. However, little psychological research has manipulated perceived similarity based on social identities (i.e., race/ethnicity, sexual orientation) and evaluated theoretical components of therapeutic alliance through an experimental paradigm.

**Purpose**

This study contributes to the larger scientific question about the role of racial/ethnic and sexual orientation matching on therapeutic alliance in mock clinical interviews. This study had two aims: (1) to assess whether theoretical therapeutic alliance proxies were positively associated with self-reported therapeutic alliance and (2) whether the theoretical therapeutic alliance proxies varied by racial/ethnic and sexual orientation match. I expected a main effect of sexual orientation match and a main effect of race/ethnicity match such that participants matched by race/ethnicity or sexual orientation would report greater perceived similarity, liking, stronger therapeutic alliance, less blame, more empathy, greater closeness, less microaggression proxies, more verbal validation, and more open body language. I also explored the interaction of the two mismatched identities and therapeutic alliance proxies.

**Method**

**Participants**

Participants were 75 White heterosexual women enrolled in introductory psychology courses. Inclusion criteria included self-identification as a White heterosexual woman interested in pursuing a career as a mental health professional (e.g., psychologist, counselor, social worker). The study was advertised to students enrolled in introductory psychology courses as an
evaluation of a brief training on therapeutic interviewing skills (Appendix A) on Sona, the department's online psychology experiment management system. The experimenter (study author) ran the study and a female undergraduate research assistant (RA) was the confederate who interacted with participants. There was only one confederate to minimize differences (e.g., friendliness, attractiveness, mood, etc.) across racial/ethnic and sexual orientation matching. Only participants who meet eligibility requirements had access to the study description. All participants received research credit for participating.

**Procedures**

**Experimental procedure.** The experimenter followed her script (Appendix B), met the participant and confederate in the experimental waiting area, and led them to a lab room to conduct the study. The experimenter reviewed the consent form (Appendix C) with the confederate and participant and explained the interaction would be video recorded to help researchers evaluate therapeutic-interviewing skills. Then the experimenter described the study procedures (i.e., baseline interview, measures, skills training, follow-up interview; Appendix D) and told the participant and confederate they would take turns being the interviewer and mock client. The experimenter allowed the confederate and participant to select their ‘role’ from a black mason jar. The selected role determined who would be conducting the first interview. Both laminated pieces of paper were labeled *Interviewer*; however, the confederate read her role as *Mock Client*. The participant was the only person who conducted the interview during the study, so the confederate was always the mock client who shared her roommate problem (Appendix E).

Then experimenter reviewed an article, *The Unstructured Clinical Interview* (Jones, 2010), describing the purpose of clinical interviewing and topics to discuss (i.e., identifying information, presenting problem, history of presenting problem) during an initial clinical
The experimenter told the confederate and participant they had up to 15 minutes to complete the interview. During the interview, the experimenter stepped out of the room, timed the interaction, and prepared post-interview materials. If they took 15 minutes, the experimenter knocked on the door to let them know their time is up, otherwise, they would open the door and let the experimenter know they were done.

The experimenter then told them they would complete post-interview measures in separate rooms and walk the participant to a separate room. The confederate waited in the room where the interview was recorded while the experimenter gave the participant a packet of measures where they were asked to describe the mock client’s presenting problem (Appendix G) and complete various measures about perceived similarity (Appendix H), liking (Appendix I and J), therapeutic alliance (Appendix K), blame (Appendix L), empathy (Appendix M), closeness (Appendix N), a manipulation check asking for a summary of the mock client’s demographic information (Appendix O), and a demographic form (Appendix P). After the participant completed the measures, she was debriefed (Appendix Q), and received tips for clinical interviewing as well as information about improving interactions with people of diverse backgrounds (Appendix R). At the end of each semester of data collection, participants received a second debriefing via email which described the manipulation of race/ethnicity and sexual orientation (Appendix S).

**Manipulation of independent variables.** This study manipulated the confederate’s race/ethnicity (Latinx or White) and sexual orientation (lesbian or heterosexual). Only females who identified as White and heterosexual could sign up for the study, which resulted in a 2x2 matrix of social status match (racial/ethnic match: yes/no and sexual orientation match: yes/no). Participants were randomly assigned to one of the four conditions which were based on
racial/ethnic and sexual orientation match: White/heterosexual (match/match), White/lesbian (match/mismatch), Latinx/heterosexual (mismatch/match), and Latinx/lesbian (mismatch/mismatch). To manipulate social statuses, the confederate wore different graphic t-shirts (i.e., pink Disney shirt, rainbow Disney shirt, pink Latinx shirt, rainbow Latinx shirt) which varied by racial/ethnic and sexual orientation match (Appendix T) and described her roommate problems which incorporated her social identities (Appendix E).

The confederate described problems with her roommate that differed in the details highlighting the confederate’s social identities. For instance, in the Latinx (mismatched) condition, the confederate mentioned her roommate does not like when she listens to bachata or reggaetón, heats up “smelly” food (e.g., rice and beans), or talks to her mom in Mexico. In the White (matched) condition, the music is described as indie rock or pop, the food was macaroni and cheese, and her mom lived in Little Rock. For the lesbian (mismatched) condition, the confederate mentioned her roommate makes hostile and snarky comments when the confederate’s girlfriend is in the dorm room. In the heterosexual (matched) condition the confederate mentions the same comments toward her boyfriend.

**Measures**

**Demographic information.** Participants completed a demographic form assessing gender, race/ethnicity, age, sexual orientation, relationship status, language use, university major, and year in school (Appendix P). Relationship status was coded as single, partnered, and other. Single was defined as not seeing anyone or casually dating, partnered included people who identified with being in a committed relationship or married, and other was for people who did not identify with the previous options.
**Racism.** The Symbolic Racism Scale (SRS; Henry & Sears, 2002) is a 16-item self-report measure designed to measure racism attitudes (Appendix V). Items 1, 2, 5, and 12 were scored on a 6-point Likert scale ranging from 1 (strongly disagree) to 6 (strongly agree). Items 3, 4, 6, 10, 13, 15, and 16 were scored on a 4-point Likert scale ranging from 1 (strongly disagree) to 4 (strongly agree). Items 7 and 8 were scored on a 3-point Likert scale ranging from 1 (going too slowly) to 3 (trying to push too fast). Items 9 and 14 were scored on a 4-point Likert scale ranging from 1 (not much at all) to 4 (all of it). Item 11 was scored on a 3-point Likert scale ranging from 1 (a lot) to 4 (just a little). Items 3, 10, 11, 12, and 15 were all reversed scored. Item 14 was excluded from the total score calculation because it was unclear which anchor was explicitly more racist. Anchors ranged from 3-point to 6-point scales, so the total composite scores were created by recoding all scores to a 0 to 1 scale and then calculating a total mean score. Higher scores represent greater racism. Predictive validity has been established by correlating the SRS with political conservativism, $r = .46$ and preferring racialized policy, $r = .58$ (Henry & Sears, 2002). Reliability of this measure was assessed among White community members and students in Los Angeles; internal consistency across these samples ranged from .59 to .79 (Henry & Sears, 2002). In the current sample, internal reliability was assessed and yielded a Cronbach alpha of .89.

**Homophobia.** The Modern Homophobia Scale (MHS) attitudes toward Lesbians subscale was used to assess homophobia (Raja & Stokes, 1998, Appendix W). This is a self-report 24-item measure. Items are rated on a 5-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree), where higher scores represent greater homophobia. Items 1, 2, 3, 5, 6, 7, 12, 13, 14, 15, 16, 18, 19, 20, and 21 were reverse coded and mean scores were computed. Higher scores represent greater homophobia. In a previous study interrater reliability
yielded a Cronbach alpha of .95 (Raja & Stokes, 1998). Convergent validity was established for this measure by correlating the MHS attitudes towards lesbian subscales with the Index of Homophobia scale, $r = .80$ (Raja & Stokes, 1998). In the current sample, internal reliability was assessed and yielded a Cronbach alpha of .93.

**Perceived similarity.** Although perceived similarity was manipulated in this experiment through identity matching, participants also answered a two-item self-report measure after the interaction to assess how similar they perceive the confederate (Sprecher, 2014; Appendix H). The first item, “How much do you think you have in common with the other person?” is rated on a 7-point Likert scale ranging from 1 (*nothing or almost nothing*) to 7 (*a great deal*). The second item, “How similar do you think you and the Other are likely to be?” is rated on a 7-point Likert scale ranging from 1 (*not at all*) to 7 (*a great deal*). Higher scores represent greater perceived similarity. Sprecher (2014) used these questions in a similar study on perceived similarity and likability of dyads; in her study reliability yielded a Cronbach’s alpha of 0.91. Criterion validity was established in a study with 118 participants who self-disclosed or listening to a disclosure (Sprecher, Treger, & Wondra, 2013). In the current sample, an average perceived similarity score was computed, and internal reliability yielded a Cronbach alpha of .83.

**Liking.** Participants completed the Liking-subscale from the Measurement of Romantic Love to assess how much they liked the confederate (Rubin, 1970; Appendix I). This is a 13 item self-report measure with a 9-point Likert scale ranging from 1 (*not at all true*) to 9 (*definitely true*), where higher scores represent greater liking. Sample items included in this study are, “I think that ________ and I are quite similar to each other” and “I think that ________ is one of those people who quickly wins respect.” The current study excluded one item because it alluded to multiple interactions; however, study participants only interact with the confederate once
(“When I am with ________, we are almost always in the same mood”). Previous studies assessed internal consistency based on responses of 158 dating couples at the University of Michigan and results yielded a Cronbach’s alpha of .81 for women and .83 for men (Rubin, 1970). In the current sample, an average liking score was computed and internal reliability was assessed for the 12 items and yielded a Cronbach alpha of .94.

Participants also completed the Interpersonal Liking measure (IL-6; Veksler & Eden, 2017; Appendix J); a self-report scale with six items on a 9-point Likert scale ranging from 1 (not at all true) to 9 (definitely true). Sample items include, “I think that future interactions with this person would be pleasurable” and “I would like to get to know this person better.” This measure evaluates positive attitudes toward interactions with someone else, where higher scores represent greater liking. In a previous study, reliability was assessed in a sample of 446 undergraduate students attending a large university in the Southwest region of the United States; Cronbach’s alpha was .91 (Veksler & Eden, 2017). Previous studies assessed convergent validity by administering this measure and Rubin’s (1970) measure of liking to a sample of 925 undergraduate students attending large universities in the Midwest and Northeast regions of the United States; results revealed a strong association, r = .83 (Veksler & Eden, 2017). In the current sample, an average liking score was computed and internal reliability was assessed and yielded a Cronbach alpha of .91.

Therapeutic alliance. Participants completed the Working Alliance Inventory – Short Revised – Therapist to assess self-reported therapeutic alliance (WAI-SRT; Horvath & Greenberg, 1989; Appendix K). This is a self-report measure composed of 10-items on a 9-point Likert scale ranging from 1 (seldom) to 9 (always). The WAI is based on Bordin’s (1979) conceptualization of working alliance as an integrated relationship involving tasks, bond, and
goals, which explain the collaboration and concordance between therapists and clients. Sample questions include, “We are working towards mutually agreed upon goals” and “___ and I both feel confident about the usefulness of our current activity in therapy.” A previous study estimated reliability to yield a Cronbach alpha of .87 for the therapist version and convergent validity was established with the three components of this measure and Empathy scale of the Relationship Inventory, $r = .74$ Bond, $r = .49$ Task, $r = .60$ Goal (Horvath & Greenberg, 1989). This measure has three subscales, bond, task, and goal; however, in this study the measure yielded one score because researchers did not have theoretical reasons to further break down alliance into more specific processes. Items 2, 5, 6, 8, and 10 were reverse coded. A total mean score was computed, where higher scores reflected greater therapeutic alliance. In the current sample, internal reliability was assessed for all 10 items and yielded a Cronbach alpha of .82.

**Blame.** The Causal Dimension Scale (Russell, 1982; Appendix L) a self-report measure composed of nine items on a 9-point Likert scale. A tenth item was added to assess how much someone is to blame for the cause of their problems. This item had been added to this scale in a previous study (Villalobos & Bridges, 2016). The Causal Dimension Scale is based on Weiner’s (1979) three causal dimensions, locus of causality (e.g., internal, external attributor), stability (e.g., stable, unstable), and controllability. Items correspond to each subscale and are scored on a 9-point Likert scale with varied anchored responses. Sample items include, “Is the cause something for which” 1 (*no one is responsible*) to 9 (*someone is responsible*) and “Is the cause something that” 1 (*reflects an aspect of yourself*) to 9 (*reflects an aspect of the situation*). Items 1, 2, 3, 4, and 7 were reverse coded and mean scores were computed for each subscale and for the total measure. Higher scores represent more internal, stable, and controllable causes. A previous study assessed reliability for the 9-item scale in a sample of 189 undergraduate students
and results yielded a Cronbach alpha of .88 (Russell, 1982). In the current sample, reliability was assessed for the nine item scale and yielded a Cronbach alpha of .46. The following are the Cronbach alphas for each subscale: locus of control $\alpha = .70$, stability $\alpha = .36$, and controllable $\alpha = .53$. The Cronbach alpha for the 10-items was .50. Both reliability estimates were unacceptable, and the researchers decided to use the single item to measure blame directly because amount of blame placed on the confederate for her problems was the construct this study was focused on assessing. The single item assessing blame was used in the analyses, where higher scores reflected greater blame placed on the confederate for her problems.

**Empathy.** Eight items assessed emotional reactions (i.e., compassion, sympathy, warmth, concern, frustration, anger, hostility, indifference) of the participant toward the confederate (Villalobos & Bridges, 2016; Appendix M). Items were rated on a 9-point Likert scale ranging from 1 (not at all) to 9 (totally) where higher scores represent more positive affect. Negatively valanced emotion items (i.e., frustration, anger, indifference, hostility) were reverse scored and a total mean positive affect index score was calculated. In the current sample, internal reliability was assessed and yielded a Cronbach alpha of .73.

**Closeness.** Closeness was assessed with the one-item Inclusion of Other in Self (IOS) Venn diagram (Aron, Aron, & Smollan, 1992; Appendix N). Participants were presented with seven Venn diagrams ranging from two separate circles to two overlapping circles and they were instructed to select the set of circles that best described their relationship with the confederate. Higher scores represent greater closeness. Convergent validity has been established by correlating scores with the Relationship Closeness Inventory, $r = .22$ (Berscheid, Snyder, Omoto, 1989). Several studies have used this measure to assess closeness in dyad interactions (Fraley & Aron, 2004; Sprecher et al., 2013).
**Microaggressions.** Microaggression proxies were coded by trained coders who read transcriptions of the video-recorded interviews. Training consisted of reviewing Sue et al. (2007) and Shelton & Delgado-Romero’s (2011) work on racial/ethnic and sexual orientation microaggressions, respectively (Appendix X and Y). Codes were dichotomized where 0 = no and 1 = yes and the following were the behavioral proxies for racial/ethnic microaggressions: (1) participant discussing the confederate’s race/ethnicity and (2) participant asking confederate, “Where are you from?” The following were behavioral proxies for sexual orientation microaggressions: (1) participant discussing confederate’s boyfriend/girlfriend and (2) participant referring to confederate’s boyfriend/girlfriend as “friend?”

Each interview was coded by two research assistants. The first coder coded sexual orientation microaggression proxies in all sexual orientation mismatch (i.e., lesbian) conditions as well as racial/ethnic microaggression proxies in all racial/ethnic match (i.e., White) conditions. The second coder coded for sexual orientation microaggression proxies in the sexual orientation match (i.e., heterosexual) conditions and the racial/ethnic microaggression proxies in the racial/ethnic mismatch (i.e., Latinx) conditions. For the analyses the two behavioral proxies were not combined because the two variables for each construct were not correlated with one another; therefore, they were analyzed as distinct variables. The correlation between discussing race/ethnicity and “Where are you from?” was \( r = .13 \) and the correlation between discussing boyfriend/girlfriend and referring to them as a “friend” was \( r = .11 \).

**Validation.** Participant’s affirmation of the confederate’s problem was coded by the study author. The study author listened to the audio-recorded videos and coded for instances where the participant agreed with or provided validation for the confederate’s problem. This code was dichotomized, where 0 = no validation and 1 = validation of the confederate’s problem.
Body language. Open body language was coded based on a modified six item version of
the 25-item Conversational Skills Rating Scale (CSRS; Spitzberg & Adams, 2007; Appendix Z).
During the interview, one video camera only faced the participant, so the coder could not see the
confederate’s shirt. Additionally, all videos were coded without audio to ensure the coder did not
know the condition. The following participant behaviors were coded on a 5-point Likert scale:
posture, leaning toward the confederate, fidgeting, active listening, smiling, and eye contact.
Higher scores represent more open and comfortable body posture (i.e., open posture, appropriate
leaning, less fidgeting, active listening, more smiling, and greater eye contact).

Analytic Approach

To assess adequacy of random assignment, levels of racism and homophobia were
evaluated across racial/ethnic and sexual orientation matching. To test the first aim, I conducted
bivariate correlations between self-reported therapeutic alliance and theoretical aspects of
therapeutic alliance (i.e., perceived similarity, liking, blame, empathy, closeness,
macroaggression proxies, validation, and body language). To test the second aim, I conducted
two-way analyses of variance (ANOVA) assessing group differences in racial/ethnic match
(IV1) and sexual orientation match (IV2) on perceived similarity, liking, therapeutic alliance,
blame, empathy, closeness, and body language. I also conducted chi-square tests of
independence to assess the percentage of participants who engaged in microaggression proxy
behaviors and validated the confederate across racial/ethnic and sexual orientation match.

Power Analyses

An a priori power analysis was conducted to evaluate sample size for a two-way
ANOVA. A meta-analysis on perceived similarity and interpersonal attraction yielded a
correlation of $r = .39$ (Montoya et al., 2008). Pearson’s $r$ was converted to Cohen’s $f$, which
yielded an effect size of .42. This meta-analysis was selected because it differentiated between actual and perceived similarity and included 313 studies conducted between 1861 and 2004. Of the studies evaluated, 54 effect sizes for perceived similarity and interpersonal attraction were included in the analyses. A power analysis using the G-Power computer program indicated a total sample of 68 would be needed to detect large effects \( (f = .42) \) with 80% power for a two-way ANOVA with one numerator degree of freedom, four groups, and an alpha of .05.

**Results**

The total sample size was 75 people; however, four participants were excluded from the analyses, leaving a sample of 71. Twenty people interacted with the White heterosexual confederate, 15 with the White lesbian confederate, 18 with the Latinx heterosexual confederate, and 18 with the Latinx lesbian confederate. Two participants were excluded because they identified as biracial and did not meet inclusion criteria (White, heterosexual, female). These participants were able to sign up for the study because there was an issue with the online prescreener. Two other participants were excluded from the analyses because their age was two standard deviations greater than the mean. One of the participants excluded for her age also reported she did not believe the manipulation and thought the confederate was part of the study.

**Descriptive Statistics**

Characteristics of the overall sample and across racial/ethnic and sexual orientation match are presented in Table 1. The average age for the total sample was 18.54 \( (SD = 0.79) \), 81.7% of participants were college freshman, and 50.7% reported their relationship status as single. Participants completed racism \( (M = 0.40, SD = 0.15) \) and homophobia \( (M = 2.01, SD = 0.66) \) measures before signing up for the study and these scores were used to evaluate the adequacy of random assignment. There were no significant differences in racism, \( F(3,69) = 0.14, \)
scores across racial/ethnic and sexual orientation match. Correlations among study variables are presented in Table 2. Means and standard deviations for all dependent variables are presented in Table 3.

Aim 1

**Self-reported therapeutic alliance.** Bivariate correlations assessed whether self-reported alliance was positively associated with theoretical alliance proxies, including perceived similarity, liking, blame, empathy, closeness, microaggression proxies, verbal validation, and open body language (Table 4). There was a significant positive correlation for between alliance, both liking scales (Rubin, 1970 $r = .40$, Veksler & Eden, 2017 $r = .42$), and empathy ($r = .49$). However, there was no significant correlation between therapeutic alliance and perceived similarity, blame, closeness, microaggression proxies, verbal validation, or open body language.

Aim 2

**Perceived similarity.** A two-way ANOVA was conducted to explore the impact of racial/ethnic and sexual orientation match on perceived similarity (Table 5). There was a marginally significant main effect of sexual orientation match, $F(1,66) = 3.79$, $p = .06$, $\eta^2_p = .05$. These findings revealed participants perceived the heterosexual confederate as more similar to them than the lesbian confederate (Figure 3). There was not a statistically significant main effect of racial/ethnic match or interaction match.

**Liking.** A two-way ANOVA was conducted to explore the impact of racial/ethnic and sexual orientation match on liking as measured by Rubin (1970) and Veksler and Eden (2017). For Rubin (1970; Table 6) there was not a statistically significant main effect for racial/ethnic match, sexual orientation match, or interaction match (Figure 4). For Veksler and Eden (2017; Table 7), there was a statistically significant main effect for sexual orientation match, $F(1,67) =
2.99, \( p = .09 \), \( \eta^2_p = .04 \) (Figure 5). These results revealed participants liked the heterosexual confederate more than the lesbian confederate. There was not a statistically significant main effect for racial/ethnic match or interaction match.

**Therapeutic alliance.** A two-way ANOVA was conducted to explore the impact of racial/ethnic and sexual orientation match on therapeutic alliance. There was not a statistically significant main effect for racial/ethnic match, sexual orientation match, or interaction match (Table 8). Results suggest self-reported therapeutic alliance did not differ across matched identities (Figure 6).

**Blame.** A two-way ANOVA was conducted to explore the impact of racial/ethnic and sexual orientation match on blame. There was not a statistically significant main effect for racial/ethnic match, sexual orientation match, or interaction match (Table 9). Results suggest levels of blaming the confederate for her problems did not differ across matched identities (Figure 7).

**Empathy.** A two-way ANOVA was conducted to explore the impact of racial/ethnic and sexual orientation match on empathy. There was not a statistically significant main effect for racial/ethnic match, sexual orientation match, or interaction match (Table 10). Results suggest levels of empathy toward the confederate for her problems did not differ across matched identities (Figure 8).

**Closeness.** A two-way ANOVA was conducted to explore the impact of racial/ethnic and sexual orientation match on closeness. There was not a statistically significant main effect for racial/ethnic match, sexual orientation match, or interaction match (Table 11). Results suggest levels of empathy toward the confederate did not differ across matched identities (Figure 9).
**Microaggressions.** Chi-squared tests of independence were conducted for the two racial/ethnic microaggression proxies. One chi-squared test of independence explored the percentage of participants who discussed race/ethnicity across racial/ethnic match, $\chi^2 (1, N = 71) = 2.13, p = .15$ (Figure 10). Results revealed no statistically significant differences in the percentage of discussions about race/ethnicity. A second chi-squared test of independence explored the percentage of participants who asked the confederate, “Where are you from?” across racial/ethnic match, $\chi^2 (1, N = 71) = 3.24, p = .07$ (Figure 11). Results revealed a marginally significant difference suggesting the confederate was asked, “Where are you from?” more when she identified as Latinx instead of White.

Chi-squared tests of independence were also conducted for the two sexual orientation microaggression proxies. One chi-squared test of independence explored the percentage of participants who discussed the confederate’s boyfriend/girlfriend across sexual orientation match, $\chi^2 (1, N = 71) = 6.16, p = .01$ (Figure 12). Results revealed a statistically significant difference suggesting participants discussed the confederate’s boyfriend/girlfriend more when she identified as lesbian instead of heterosexual. A second chi-squared test of independence was conducted to explore the percentage of participants who referred to the confederate’s boyfriend/girlfriend as her “friend” across sexual orientation match, $\chi^2 (1, N = 71) = 2.37, p = .12$ (Figure 13). There were no statistically significant differences in the percentage of participants referred to the confederate’s romantic partner as her “friend.” This occurred twice when the confederate identified as lesbian and this did not happen when she identified as heterosexual.

**Verbal validation.** A chi-squared test of independence was conducted to explore the percentage of participants who validated the confederate across racial/ethnic and sexual orientation match. There was a statistically significant difference in the participant’s verbal
validation of the confederate across racial/ethnic match, $\chi^2(1, N = 71) = 4.44, p = .04$ (Figure 14). These results revealed the confederate was validated more when she identified as White instead of Latinx. There was not a statistically significant difference in the participant’s verbal validation of the confederate across sexual orientation match (Figure 15).

**Body language.** A two-way ANOVA was conducted to explore the impact of racial/ethnic and sexual orientation match on open body language. There was a statistically significant main effect for racial/ethnic match, $F(1,67) = 4.75, p = .03, \eta^2_p = .07$ (Table 12). Results revealed participants engaged in more open body language when the participant identified as White in comparison to when she identified as Latinx (Figure 16). There was not a statistically significant sexual orientation match or interaction match.

In summary, for the second aim of the study, racial/ethnic matching was significantly associated with three of nine outcome variables. Specifically, racial/ethnic match was associated with increased verbal validation and open body language. Participants also asked the confederate, “Where are you from?” more often when she identified as Latinx instead of White. Sexual orientation matching was significantly associated with three of nine outcome variables. Specifically, sexual orientation match was associated with greater perceived similarity and likability. Participants also discussed the confederate’s romantic relationship more often when she identified as lesbian instead of heterosexual. There was no evidence of an interaction effect on any variables.

**Discussion**

In this study, self-reported therapeutic alliance was only related to liking and empathy and no other theoretical proxies of alliance including perceived similarity, blame, closeness, microaggression proxies, verbal validation, or open body language. Most research on
racial/ethnic and sexual orientation matching suggests perceived similarity between the therapist and client can help strengthen therapeutic alliance and therefore, identity matching has been encouraged and yielded mixed findings (Maramba & Nagayama, 2002; Anderson et al., 2019). However, these findings suggest perceived similarity is not associated with a stronger therapeutic alliance and instead levels of liking and empathy toward the client are most indicative of a strong therapeutic alliance. To build a strong therapeutic alliance the focus should not be on perceived similarity, blame, closeness, or even behaviors (e.g., what they said to validate the client or how they carried their body). Alliance building to decrease psychotherapy dropout should consider how much the therapist likes the client and how much empathy they have for them. Furthermore, therapeutic alliance should not solely focus on the therapist’s perceptions, but also the client’s perceptions and experiences of alliance. One study assessed therapeutic alliance from the perspective of both clients and therapists and found only client’s perceptions were predictive of treatment outcomes (Howard, 2017).

In this study, three theoretical alliance proxies varied by racial/ethnic match including microaggression proxies, verbal validation, and open body language. Three theoretical proxies of alliance varied by sexual orientation match including perceived similarity, likability, and microaggression proxies. Racial/ethnic matching did not increase perceived similarity, but it did increase verbal validation, open body language, and was related to microaggression proxies. These findings do not support research that has focused on racial/ethnic matching to increase perceived similarity and thus strengthen therapeutic alliance. Decades of work suggested similar racial/ethnic backgrounds between the therapist and client could be related to a stronger therapeutic alliance; however, these findings suggest other factors should be explored. Some research has assessed therapist’s commitment to diversity and therapeutic alliance. Commitment
to diversity was operationalized by therapist’s interest in participating in diverse social and cultural activities, comfort with people of different backgrounds, and valuing the impact of diversity on personal growth (Fuertes, Miville, Mohr, Sedlacek, & Gretchen, 2000). One study found a positive association between therapists who reported commitment to diversity and client ratings of therapeutic alliance (Stracuzzi et al., 2011). Assessing therapist’s commitment to diversity should continue to be explored as a way to improve therapeutic alliance and retain clients of marginalized backgrounds in psychotherapy.

Findings for this study suggested the confederate was treated more positively (i.e., seen as more similar, likable, received more verbal validation, open body language, and experienced less microaggression proxies when she endorsed a majority identity (i.e., White or heterosexual). These findings are consistent with research on in-group favoritism, where people favor those who share their social identities instead of engaging in out-group discrimination (Abbink & Harris, 2019). Findings also revealed engaging in more open body language toward people of matched identities can represent a form of bias toward people of unmatched identities, in this case racial/ethnic and sexual minorities. Studies on body language during interracial interactions between Whites and racial/ethnic minorities have found that White people engage in less warm body language with racial/ethnic minorities (Dovidio, Kawakami, & Gaertner, 2002) and even organize chairs to be farther away if they know they will be interacting with a person of a different racial/ethnic background (Amodio & Devine, 2006). Regardless of the motive driving these interactions, either in-group favoritism or out-group discrimination, there is still differential treatment influenced by prejudice and bias that ultimately affects interpersonal communication in psychotherapy (Vasquez, 2007).
This study also added to the literature by using behavioral proxies to measure microaggressions in a mock therapy setting. The participant asking the confederate, “Where are you from?” was used as a behavioral proxy for microaggressions. This question is from Sue et al.’s (2007) list of microaggressions that sends the message that racial/ethnic minorities in the United States are perceived to be foreigners and are not assumed to be “American.” In this study, the confederate was asked, “Where are you from?” more often when she identified as Latinx instead of White. The confederate was the same across conditions, so she did not have different characteristics (e.g., accent, skin tone) that may have contributed to differences in this question being asked. Other situational factors may contribute to this question being asked; however, these findings may also suggest potential therapist bias. Regarding sexual orientation microaggression proxies, this study revealed the participant discussed the confederate’s romantic partner more often when she identified as lesbian instead of heterosexual. Discussing a romantic relationship is not a microaggression by itself. However, I then examined the content of these conversations and noticed when the participant discussed the confederate’s girlfriend, the participant would also insinuate the confederate was experiencing roommate problems due to her sexual orientation. This is considered a microaggression based on Shelton and Delgado-Romero’s (2011) work on sexual orientation microaggressions in psychotherapy where the therapist assumes the client’s sexual orientation is the cause of the presenting issues even if it may not be the case.

There are a couple reasons why I may not have found significant differences in therapeutic alliance, blame, empathy, or closeness across racial/ethnic match, sexual orientation match, or interaction match. One reason may be related to this sample being more comfortable with interacting with racial/ethnic and sexual minorities in comparison to other marginalized
groups such as people who identify as transgender or non-binary. Furthermore, mean scores for racism and homophobia were low, suggesting less bias toward both identities. There may have also been a self-selection bias because the sample was composed of students who expressed interest in pursuing a mental health career; therefore, most participants were psychology and social work majors. Prior research suggests people in these majors tend to be more empathic and engage in more perspective taking than non-Psychology majors (Harton & Lyons, 2003).

Another reason for low variability in scores may be related to the limited interview length. The average interview lasted about 7 minutes and 5 seconds ($SD = 3$ minutes and 10 seconds). This was a short amount of time, which gave limited opportunity for behaviors to occur. Perhaps with more time, such as a traditional 50-minute therapy session, there would have been a greater possibility for variability in ratings of similarity, liking, therapeutic alliance, blame, empathy, closeness, microaggression proxies, verbal validation, or open body language.

**Clinical Implications**

Although this study was conducted with undergraduate students interested in pursuing a mental health career and not graduate students in this field or trained mental health professionals, there are several clinical implications. First, is the importance of acknowledging personal biases play a role in interactions with clients. This study demonstrated how therapists who hold privileged identities may validate certain clients more often, engage in more eye contact, or smiling with clients who share their background. Even clinicians who value the role of culture and nuanced identities, can still work on their cultural humility. More clinicians and training programs should invest time, courses, performance evaluations, provide workshops, or conference funding to support students, faculty, and staff as they learn about how they can improve their interactions with people of marginalized identities. For many this may mean
starting to learn about our own social identities, social power, privilege, and how our identities shape our personal experiences and interactions with others.

**Limitations and Future Directions**

This study was underpowered given the observed effect sizes even though an *a priori* power analysis suggested the sample would yield large effect sizes. For the predicted effect size, I used a correlation from a meta-analysis on perceived similarity and interpersonal attraction (Montoya et al., 2008); however, this study focused on a more specific effect (i.e., perceived similarity and therapeutic alliance) in a therapy context. Therefore, future studies should consider replicating this study and increasing the sample size.

The present study utilized a novel design to emulate a therapy scenario with undergraduate students interested in pursuing a mental health career. Having undergraduate students act as therapists is a limitation because they may be less familiar with clinical interviewing in comparison to more advanced students such as graduate-level therapists or therapists in the community. Perhaps trained therapists may engage in more inclusive behaviors with their clients. Future studies can maximize external validity by assessing therapy interactions with therapists at various training levels and include an opportunity for training on addressing biases in psychotherapy.

This study examined therapeutic alliance only from the perspective of the therapist and not the client. Studies have demonstrated that the subjective experience of the client is often the perspective that is predictive of treatment outcomes (Howard, 2017). Therefore, future studies should assess therapist and client’s experiences in psychotherapy. Furthermore, the present study attempted to incorporate an intersectionality framework by assessing the impact of multiple marginalized identities on therapeutic alliance. However, I only focused on a few social
identities (i.e., race/ethnicity, sexual orientation, gender) so it does not speak to the complexities of other dimensions of identity (e.g., ability, documentation status, socioeconomic status, skin tone, etc.). Future studies should consider how multiple aspects of identity inform interpersonal interactions, including psychotherapy experiences.

**Conclusion**

Overall, this study assessed (1) whether self-reported therapeutic alliance was positively associated with theoretical proxies of alliance and (2) examined the effects of racial/ethnic and sexual orientation match on therapeutic alliance (self-reported) and proxies of alliance (i.e., perceived similarity, liking, blame, empathy, closeness, microaggression proxies, verbal validation, and open body language). Self-reported alliance was only positively associated with liking and empathy. Racial/ethnic match was associated with verbal validation, open body language, and lower occurrence of microaggressions. Sexual orientation match was associated with greater perceived similarity, liking, and less instances of microaggressions. This study assessed differences across racial/ethnic match and sexual orientation match to capture the experiences of people from marginalized identities in psychotherapy. There were differences in the treatment of the confederate based on her social identities, which helped highlight biased behaviors therapists may be engaging in during therapy. Awareness of these experiences is a critical first step in educating people about the biases they hold so they can eventually treat people who hold different social identities a more equitable and inclusive manner.
References


Fredriksen-Goldsen, K. I., Kim, H. J., Barkan, S. E., Muraco, A., & Hoy-Ellis, C. P. (2013). Health disparities among lesbian, gay, and bisexual older adults: Results from a


Table 1

**Characteristics of Overall Sample and Across Racial/Ethnic and Sexual Orientation Match**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Total Sample</th>
<th>White heterosexual</th>
<th>White lesbian</th>
<th>Latinx heterosexual</th>
<th>Latinx lesbian</th>
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<tr>
<td></td>
<td>(N = 71)</td>
<td>(n = 20)</td>
<td>(n = 15)</td>
<td>(n = 18)</td>
<td>(n = 18)</td>
</tr>
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<td>Age</td>
<td>18.54 (0.79, 18-21)</td>
<td>18.60 (0.85)</td>
<td>18.93 (1.10)</td>
<td>18.44 (0.78)</td>
<td>18.50 (0.71)</td>
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<td>Year in school</td>
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</tr>
<tr>
<td>Freshman</td>
<td>58 (81.7%)</td>
<td>19 (95%)</td>
<td>10 (66.7%)</td>
<td>15 (83.3%)</td>
<td>14 (77.8%)</td>
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<td>Sophomore</td>
<td>10 (14.1%)</td>
<td>1 (5%)</td>
<td>3 (20%)</td>
<td>3 (16.7%)</td>
<td>3 (16.7%)</td>
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<td>Junior</td>
<td>2 (2.8%)</td>
<td>0 (0%)</td>
<td>1 (6.7%)</td>
<td>0 (0%)</td>
<td>1 (5.6%)</td>
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<td>Senior</td>
<td>1 (1.4%)</td>
<td>0 (0%)</td>
<td>1 (6.7%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
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<td>Relationship status</td>
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<td>Single</td>
<td>36 (50.7%)</td>
<td>12 (60%)</td>
<td>8 (53.3%)</td>
<td>9 (50.0%)</td>
<td>7 (38.9%)</td>
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<td>Partnered</td>
<td>34 (47.9%)</td>
<td>8 (40%)</td>
<td>7 (46.7%)</td>
<td>9 (50.0%)</td>
<td>10 (55.6%)</td>
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<td>Other</td>
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<td>1 (5.6%)</td>
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<td>Racism</td>
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<td>n = 15</td>
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<td>0.40 (0.15)</td>
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<td>0.42 (0.15)</td>
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<td>Homophobia</td>
<td>2.01 (0.66)</td>
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<td>n = 15</td>
<td>n = 18</td>
<td>n = 18</td>
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<td>2.16 (0.74)</td>
<td>1.79 (0.50)</td>
<td>1.99 (0.73)</td>
<td>2.05 (0.63)</td>
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Table 2

*Correlations Among Study Variables*

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<td>3. Homophobia</td>
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<td>.42</td>
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<td>8. Blame</td>
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<td>-.01</td>
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<td>9. Empathy</td>
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<td>-.35</td>
<td>.41</td>
<td>.59</td>
<td>.76</td>
<td>.49</td>
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<td>-.03</td>
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<td>.22</td>
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<td>.09</td>
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<td>11. Discuss race/ethnicity</td>
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<td>.14</td>
<td>-.12</td>
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<td>12. “Where are you from?”</td>
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<td>.03</td>
<td>-.23</td>
<td>.05</td>
<td>.08</td>
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<td>13. Discuss boyfriend/girlfriend</td>
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<td>.04</td>
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<td>-.27</td>
<td>.17</td>
<td>.06</td>
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</tbody>
</table>

*Note.* Statistically significant correlations (p < .05) in bold
Table 3

<table>
<thead>
<tr>
<th>Variable</th>
<th>Total Sample</th>
<th>White heterosexual</th>
<th>White lesbian</th>
<th>Latinx heterosexual</th>
<th>Latinx lesbian</th>
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<tbody>
<tr>
<td></td>
<td>( N = 71 )</td>
<td>( n = 20 )</td>
<td>( n = 15 )</td>
<td>( n = 18 )</td>
<td>( n = 18 )</td>
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<tr>
<td>Perceived Similarity</td>
<td>3.77 (1.17)</td>
<td>4.13 (0.97)</td>
<td>3.70 (1.28)</td>
<td>3.91 (1.42)</td>
<td>3.26 (0.89)</td>
</tr>
<tr>
<td>Liking (Rubin)</td>
<td>5.47 (1.43)</td>
<td>5.86 (1.12)</td>
<td>5.32 (1.28)</td>
<td>5.58 (1.67)</td>
<td>5.07 (1.57)</td>
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<tr>
<td>Liking (Veksler)</td>
<td>6.14 (1.60)</td>
<td>6.59 (1.11)</td>
<td>5.82 (1.54)</td>
<td>6.29 (1.91)</td>
<td>5.74 (1.76)</td>
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<td>Therapeutic Alliance</td>
<td>3.27 (0.70)</td>
<td>3.26 (0.69)</td>
<td>3.10 (0.65)</td>
<td>3.41 (0.84)</td>
<td>3.29 (0.61)</td>
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<tr>
<td>Blame</td>
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<td>6.20 (2.55)</td>
<td>6.87 (1.68)</td>
<td>7.03 (1.93)</td>
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<tr>
<td>Empathy</td>
<td>6.85 (1.18)</td>
<td>6.91 (1.03)</td>
<td>6.72 (1.14)</td>
<td>7.09 (1.37)</td>
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<tr>
<td>Closeness</td>
<td>2.34 (1.20)</td>
<td>2.50 (1.10)</td>
<td>2.14 (1.03)</td>
<td>2.28 (1.41)</td>
<td>2.39 (1.29)</td>
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<td>Body Language</td>
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<td>4.27 (0.46)</td>
<td>4.44 (0.31)</td>
<td>4.10 (0.51)</td>
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Table 4
*Correlations between Therapeutic Alliance Measure and Theoretical Components of Therapeutic Alliance*

<table>
<thead>
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<th>Theoretical Component</th>
<th>Therapeutic alliance</th>
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<tr>
<td>1. Perceived Similarity</td>
<td>.16</td>
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<tr>
<td>2. Liking (Rubin)</td>
<td>.40***</td>
</tr>
<tr>
<td>3. Liking (Veksler)</td>
<td>.42****</td>
</tr>
<tr>
<td>4. Blame</td>
<td>.18</td>
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<td>5. Empathy</td>
<td>.49****</td>
</tr>
<tr>
<td>6. Closeness</td>
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<td>7. Discuss race/ethnicity</td>
<td>-.01</td>
</tr>
<tr>
<td>8. “Where are you from?”</td>
<td>.17</td>
</tr>
<tr>
<td>9. Discuss boyfriend/girlfriend</td>
<td>.04</td>
</tr>
<tr>
<td>10. “Friend”</td>
<td>-.18</td>
</tr>
<tr>
<td>8. Validation</td>
<td>.07</td>
</tr>
<tr>
<td>9. Body language</td>
<td>-.09</td>
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*Note.* *p < .05, **p < .01, ***p < .001
Table 5
Two-Way Analysis of Variance of Perceived Similarity Across Racial/Ethnic and Sexual Orientation Match

<table>
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<tr>
<td>Interaction (White x heterosexual)</td>
<td>1</td>
<td>.17</td>
<td>.68</td>
<td>.003</td>
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<td>Error</td>
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Table 6

<table>
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<th>p</th>
<th>η²_p</th>
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</thead>
<tbody>
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<td>.13</td>
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<tr>
<td>Interaction (White x heterosexual)</td>
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<td>.001</td>
<td>.97</td>
<td>&lt;.001</td>
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</table>
### Table 7

*Two-Way Analysis of Variance of Liking (Veksler & Eden, 2017) Across Racial/Ethnic and Sexual Orientation Match*

<table>
<thead>
<tr>
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</thead>
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<td>Sexual orientation match (heterosexual)</td>
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<td>2.99</td>
<td>.09</td>
<td>.04</td>
</tr>
<tr>
<td>Interaction (White x heterosexual)</td>
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<td>.08</td>
<td>.78</td>
<td>.001</td>
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<tr>
<td>Error</td>
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Table 8
Two-Way Analysis of Variance of Therapeutic Alliance Across Racial/Ethnic and Sexual Orientation Match

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</thead>
<tbody>
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<td>1.01</td>
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<td>Interaction (White x heterosexual)</td>
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Table 9

Two-Way Analysis of Variance of Blame Across Racial/Ethnic and Sexual Orientation Match

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<tbody>
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<td>.83</td>
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<tr>
<td>Sexual orientation match (heterosexual)</td>
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<td>.94</td>
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<td>Interaction (White x heterosexual)</td>
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<td>1.68</td>
<td>.20</td>
<td>.02</td>
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<td>Error</td>
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Table 10
Two-Way Analysis of Variance of Empathy Across Racial/Ethnic and Sexual Orientation Match

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</thead>
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<td>Interaction (White x heterosexual)</td>
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<td>.66</td>
<td>.003</td>
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<td>Error</td>
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</table>
Table 11
Two-Way Analysis of Variance of Closeness Across Racial/Ethnic and Sexual Orientation Match

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
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<td>Racial/ethnic match (White)</td>
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<td>.002</td>
<td>.97</td>
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<td>Sexual orientation match (heterosexual)</td>
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<td>.17</td>
<td>.68</td>
<td>.003</td>
</tr>
<tr>
<td>Interaction (White x heterosexual)</td>
<td>1</td>
<td>.63</td>
<td>.43</td>
<td>.01</td>
</tr>
<tr>
<td>Error</td>
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</tbody>
</table>
Table 12
Two-Way Analysis of Variance of Body Language Across Racial/Ethnic and Sexual Orientation Match

<table>
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<th>p</th>
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</tr>
</thead>
<tbody>
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<td>Racial/ethnic match (White)</td>
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<td>1.66</td>
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<tr>
<td>Interaction (White x heterosexual)</td>
<td>1</td>
<td>.22</td>
<td>.64</td>
<td>.003</td>
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<tr>
<td>Error</td>
<td>67</td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>
Figure 1. Mean racism scores across racial/ethnic and sexual orientation match.
Figure 2. Mean homophobia scores across racial/ethnic and sexual orientation match.
Figure 3. Mean perceived similarity scores across racial/ethnic and sexual orientation match.
Figure 4. Mean liking Rubin (1970) scores across racial/ethnic and sexual orientation match.
Figure 5. Mean liking (Veksler & Eden, 2017) scores across racial/ethnic and sexual orientation match.
Figure 6. Mean therapeutic alliance scores across racial/ethnic and sexual orientation match.
Figure 7. Mean blame scores across racial/ethnic and sexual orientation match.
Figure 8. Mean empathy scores across racial/ethnic and sexual orientation match.
Figure 9. Mean closeness scores across racial/ethnic and sexual orientation match.
Figure 10. Participant initiating discussions about the confederate’s race/ethnicity across racial/ethnic match.
Figure 11. Participant asking the confederate, “Where are you from?” across racial/ethnic match.
Figure 12. Participant initiating a discussion about the confederate’s boyfriend/girlfriend across sexual orientation match.
Figure 13. Participant referring to confederate’s boyfriend/girlfriend as her “friend” across sexual orientation match.
Figure 14. Validation of confederate’s problem across racial/ethnic match.
Figure 15. Validation of confederate’s problem across sexual orientation match.
Figure 16. Mean body language scores across racial/ethnic and sexual orientation match.
Appendices
Appendix A
Study Description

Do you want to be a mental health professional? Are you interested in learning clinical interviewing skills? This study is an opportunity to learn therapeutic interviewing skills as an undergraduate student. Research suggests there are many types of trainings to help build therapeutic interviewing skills. This study tests two types of trainings for therapeutic interviewing skills by randomly assigning participants to one of two trainings. We will examine participants’ therapeutic interviewing skills before and after the training to measure the effect of the training on your skills.
Appendix B

Procedure Script for Experimenter

- [walk into the experiment waiting area with script on clipboard] Are __________ & __________ here for the Therapeutic Interviewing Skills study?
- Awesome, thank you. You can follow me. [walk down hallway]
- We have two rooms that we will be using, but we will start here [unlock and open 116B]
- You [confederate can sit here – couch farthest from door] and you [participant] can sit here [closest to door]
- Before we get started, we will go through our consent form and if you agree to participate you can sign the form.
- [Hand each person a clipboard with a consent form]
- I will go through it with you. The purpose of this study is to test how different types of trainings affect therapeutic interviewing skills this is in the PURPOSE.
- This study will last about 1 to 1 ½ hours, which is why our slot is for 90 minutes.
- In terms of what you will be doing today, which is in the DESCRIPTION section, you will be asked to interview and be interviewed by the other participant, so you will take turns interviewing each other. First, we will need you to complete a baseline interview, which will be recorded. The video recording is to help the researchers code your skills before and after the training. You will have up to 15 minutes to interview each other. Then you will respond to some questions about the interview (these are in a packet that I will hand you both). After you complete the measures, you will receive one of two training methods. After the training, you will each interview each other again, where one of you interviews first and then the other. After the second interview (again, you will have up to 15 minutes), you will answer some additional questions about the interview. Do you have any questions?
- We do not anticipate any risks involved with your participation. Although some people may feel awkward or uncomfortable interviewing each other.
- I also want to let you know your participation is voluntary, if at any moment you want to stop or leave questions blank (on the packets) you can do so.
- All of your information will be kept confidential and your name will not be associated with any of your responses.
- If you agree, please sign at the bottom of the page [hand pens].
- [take consent forms]
- As I mentioned, during this study you will take turns interviewing each other. Right now, I will randomly assign who is the interviewer first.
- [Grab jar with two pieces of paper inside]
- This jar has two pieces of paper with the role you will be in first. Please pick a paper out of the jar and tell me what it says. [Hand jar to confederate then participant]
- What did you [participant] get? **Interviewer**.
- What did you [confederate] get? **Mock client**.
- Okay so for the first interview, you [participant] will interview her [confederate] and then we can switch.
Next, we will go over an article that describes the purpose of clinical interviewing and then each of you will fill out an intake form, similar to what a therapist receives when they will be seeing a new client.

So here is a copy of Jones’ article, *Unstructured Clinical Interview* [show laminated copy and hand a copy to participant and confederate].

I have gone through and highlighted parts that will be useful for us.

[Point to 1st page] This article explains that the first clinical interview a counselor has with a client is fundamental and is the beginning of every counseling relationship. There is not a lot of research about how training affects clinical interviewing skills, which is why we are running this study. Clinical interviews are important tools in therapy because they allow the therapist to find out what is happening in the client’s life and it can give them information about what mental health problems the person is experiencing.

This article and study are focused on unstructured interviews which means that the counselor or in this case the interviewer is asking questions that they are creating, and they do not have a list of questions they need to ask. So similarly, in this study when you interview each other, you will be able to come up with the questions you want to ask.

[Turn to page 2] Although unstructured interviews do not have a set list of questions, it can be helpful to have a general outline. This part of the article goes through three sections that are helpful to discuss during a clinical interview. The goal of the clinical interview is to gather information about the mock client’s presenting problem. One important part to discuss is identifying information (part A on article) like sex, age, race/ethnicity, relationship status, etc. Part B talks about the importance of discussing the presenting problem so you can ask something like, “what brings you in today?”

[Turn to page 3] Part C mentions gathering more information about the history of the presenting problem, like when did the problems begin? How do these problems interfere with the client’s life in terms of work, relationships, etc.?

So overall, the main goal of clinical interviewing is to gather information about the client’s identifying information (like some of the demographics we mentioned), presenting problem (what is going on?), and the history of presenting problem (so getting more details about the problem).

Do you have any questions?

So now, to help you two gather some of the identifying information and so you can each start thinking about what presenting problem you want to discuss, I will have you two fill out an intake form [SHOW intake form]

This is very similar to the information counselors receive when seeing a new client. Here is some of the demographic information we talked about in the article and on the back, you would write about your presenting concern.

Since each of you will have to discuss a problem, please pick an issue in your life that you would feel comfortable sharing. It does not have to be too personal since you will be writing the problem down, switching sheets, and talking about it out loud in the room next door while it is being recorded.

[hand out intake forms] You can go ahead and fill out both sides.

[once it looks like both are done, ask] Are both of you done?

[Take both intake forms and switch their sheets] Take a minute to read over the both sides of the form to get a sense of what kind of questions you would like to ask during the interview.
• [As they are reading, make sure 116A is unlocked and have your timer ready]
• Are you done? You can give me the clipboards, forms, and pens. [Put all of these materials on the table]. We will now go into the next room [grab keys, unlock 116A if it is not already].
• [To participant] You can sit here [point to chair] and you [confederate can sit here, point to chair].
• You [participant] will have up to 15 minutes to interview her [confederate] I will be keeping track of the time. Once you feel like you have all the information you need, please open the door and let me know that you are done since I will be in the room next door. If you go over the 15 minutes, I will knock on the door and let you know the time is up. So basically, when you are done just let me know and we can move on. After this, each of you will complete some questionnaires in separate rooms. Then we will come back in this room and you [confederate] will interview her [participant] and then answer some questions after the interview. Then we will go through the training and conduct these interviews again. Okay, I will be next door just let me know when you are done and we can move on. [close door and START TIMER].
• [while they are interviewing be sure to put the black mason jar in the hallway and out of sight, write the participant number on both intake forms and post-interview packets, put the consent and intake forms in the desk drawer and put post-interview packets on clipboards with pens, put debriefing form on your experimenter clipboard, and put confederate and participant clipboards in hallway with packets faced down]
• [Be sure to time how long the interview lasts and write it down at the top of the participant’s intake form when the study is over]
• [To participant] follow me into the next room so you can each complete the packets [walk her to 116B]. [To confederate] I will be back to turn off the cameras and give you your packet of measures.
• [In 116B with participant] Here is your packet of measures, please fill these out and I will be in the hallway, so let me know if have any questions. Just open the door when you are done and we can move on. [close the door]
• [In 116A with confederate. Give her the packet right away and she can leave so you are saying the following part to yourself] Let me go ahead and turn off the cameras so they do not keep recording while you are completing your measures. Here is your packet of measures. Please fill these out and I will be in the hallway, so let me know if have any questions. Just open the door when you are done, and we can move on. [close the door]
• [Once participant finished measures]. Thank you for filling these out. She is not done yet so I can wait in here with you. How did the first interview go?
• So earlier I said you and the other participant would be taking turn interviewing each other, but this is actually the end of the experiment. You will still earn full credit for your participation.
• [Grab debriefing sheet and hand it to participant]
• Here is a debriefing form for you to keep and I will go over it with you. When you selected your role to be interviewer, both papers in the jar said interviewer. The other participant is a confederate, so she is a fellow research assistant in our lab helping us conduct the experiment. During the experiment, she wrote and said things that were not accurate about herself. In different experimental conditions, the confederate says different things about herself, so we could see how these would impact ratings of liking, similarity, and attributions
of blame and responsibility for her problems. We are interested in how you related and empathized with the confederate after the up to 15-minute interview. You will not be conducting a second interview or receiving a training on clinical interviewing skills. We did not tell you everything about the study’s purpose is because we believed if we told you the true purpose, it would compromise the data.

- Do you have any questions? Did you think this was going to happen? [we want to know if they believed the deception piece]
- Since you will not be receiving the training, I want to give you some resources about clinical interviewing. These are on the other side of the debriefing form.
- When you are conducting a clinical interview with someone, it is important to listen to focus on what the other person is saying, instead of what your response will be. You can reflect what you hear, it is similar to a summary of what they shared so you can make sure you are understanding correctly. This form has some examples of how to do this. There is also some information about if you are interacting with people who are different than you, you want to go into the interaction thinking it will go well. Down here is a citation of a pdf you can find online with some more tips about clinical interviewing like attending to your use of eye contact and body posture.
- Do you have any final questions?
- That is all I have for you. Thank you for participating in our study and you will be awarded full credit on Sona.
Appendix C
Consent Form

CONSENT TO PARTICIPATE IN AN EXPERIMENTAL STUDY

TITLE: Efficacy of Different Training Methods on Clinical Interviewing Skills

RESEARCHERS: Roselee Ledesma, B.A.
Ana Bridges, Ph.D.
University of Arkansas
Department of Psychological Science
Fayetteville, AR 72701
rjledesm@uark.edu

COMPLIANCE CONTACT PERSON:
Ro Windwalker, IRB Coordinator
Office of Research Compliance
109 MLKG
1424 W. Martin Luther King, Jr.
Fayetteville, AR 72701
(479)575-2208
irb@uark.edu

RESTRICIONS: You must be at least 18 years old to participate in this experiment.

PURPOSE: This study is about how different types of training affect therapeutic interviewing skills.

DURATION: This study should take between 1 and 1.5 hours.

DESCRIPTION: In this study, you will be asked to interview and will be interviewed by another participant. First you will complete a baseline interview, which will be video recorded. Then you will respond to several questions about the interview. You will then receive training in one of two methods of clinical interviewing. Following this training, you will each complete a second interview, which will also be video recorded. At the end of the second set of interviews, you will respond to additional questions.

RISKS AND BENEFITS: There are no anticipated risks to participating in this study; however, being video recorded, interviewed, or interviewing the other participant may feel uncomfortable or awkward. The benefits include earning research credits (½ credit per 30 minutes of participation) toward your Introductory Psychology research requirement or course extra credit. You will also be contributing to research about the impact of training on therapeutic interviewing skills.

VOLUNTARY PARTICIPATION: Your participation in this research is completely voluntary. There are other options that are available for you to complete your Introductory Psychology research requirement or course extra credit. There are no payments for participating in this study. You are not obligated to participate, and you may leave any of the questions blank or stop participating in the study at any time.

CONFIDENTIALITY: Your name will be kept separate from any materials; all of your responses will be recorded confidentially and, once data collection is complete, your name
will be removed from all of your data to render the data anonymous. All information you provide will be kept confidential to the extent allowed by law and University policy.

**RIGHT TO DISCONTINUE:** You are free to refuse to participate in the research and/or to discontinue this study at any time. If at any time you wish to discontinue your participation, just inform the experimenter and you will be excused. Your decision to discontinue will bring no negative consequences—no penalty to you. If you choose to discontinue at any point during the experiment you will be given credit for the amount of time you spent in the study.

**INFORMED CONSENT:** I have read the description, including the purpose of the study, the procedures to be used, the potential risks and benefits, the confidentiality, as well as the option to discontinue participation at any time. I believe I understand what is involved in this study. By signing below, I am indicating that I freely agree to participate in this study.

Signature: ___________________________ Date: ___________________________
Appendix D

Procedure Flow Chart

Recruitment via Sona for participants who identify as White-heterosexual females interested in a career as a mental health professional (e.g., psychologist, counselor, social worker).

Yes. Schedule for an experiment time slot.

Participant consents to participate in experiment and be videotaped.

Participant is told she will “choose” a role but will always select interviewer. Participant interviews the confederate to “assess” baseline therapeutic interviewing skills

Confederate identifies as either White/heterosexual, White/lesbian, Latinx/heterosexual, or Latinx/lesbian

Participant interviews confederate for up to 15 minutes.

Confederate steps out of the room and the participant completes measures (i.e., perceived similarity, liking, therapeutic alliance, blame, empathy, closeness, and demographic information).

Experimenter collects measures, debriefs participant, and provides a sheet of recommendations for clinical interviewing and improving interactions with diverse people.

Participant is awarded credit via Sona.
Appendix E
Procedure Script for Confederate

I am a freshman and I grew up in Little Rock. Oh, my roommate is actually from there too, but I didn’t know her until we became roommates. I live in the dorms and this is the first time I’m living away from my family. I like the University, spending time with my friends and boyfriend/girlfriend. But I guess a problem I am facing has to do with issues with my roommate. It just feels like I can’t do anything right in her eyes. So, because this is the first time I am away from my family, I call them daily. You know just to check in and let them know I am okay. I usually call my mom since she is in [Little Rock/Mexico]. Last week my roommate told me she doesn’t like when I make calls in the room because it is distracting. And that was last week, this week I noticed she is still mad. She said she wants me to stop calling when I’m in the dorm. I also like listening to [indie rock, alternative rock/ salsa, bachata, reggaetón] music and she hates that too. She said we should have “quiet study time” during the evenings, when neither of us listens to music, but I can’t do that. I can only study with my music on. If she wanted quiet time, she can just go to the library, it is always quiet there. This is my dorm too, you know? I like using her lotion because it smells really good, but she doesn’t know that. There was one time when I used a pair of her shoes, but then she saw me on campus wearing her shoes and she was so mad. It was kind of funny to see her face. She had tons of shoes, so I don’t understand why it is such a big deal. Oh and she hates my [boyfriend/girlfriend]. My [boyfriend/girlfriend] also goes to school here. We met in high school and [he/she] also lives on-campus. [He/she] come and hangs out in my dorm. We like having the room to ourselves, so I told my roommate that she needs to let me know when she is coming back to the dorm ahead of time because I don’t want her to walk in on us. I already told her which days and times she should avoid the room, but she doesn’t listen and just comes in anyways. She said it is her space too and I shouldn’t make any
restrictions because we share the space, but she really needs to be more considerate of my relationship. She is single, so she doesn’t understand. But she is also really rude to my [boyfriend/girlfriend]. There was this one time when she told [him/her], “Don’t you have another place you should be? Shouldn’t you be paying rent here?” She is a big complainer and I just feel like I can’t do anything right. I usually bring food from home and heat it up in our microwave. She also complains about the food I heat up because she doesn’t like when I heat up “smelly” food. All I was heating up was [mac and cheese/rice and beans]. I don’t know, I guess we are both really different. I am a night owl, so I like to stay up and just be on my phone. She said she hates light at night, but it is just my phone screen. I am not going to get off my phone because that is my routine. She can just get a facemask if it really bothers her. She is a lot to deal with and I don’t know what to do anymore.
Appendix F

Unstructured Clinical Interview Article

The Unstructured Clinical Interview

Karyn Dayle Jones

In mental health, family, and community counseling settings, master's-level counselors engage in unstructured clinical interviewing to develop diagnoses based on the Diagnostic and Statistical Manual of Mental Disorders (4th ed., text rev.; DSM-IV-TR, American Psychiatric Association, 2000). Although counselors receive education about diagnosis and the DSM classification system, the majority of them are not specifically trained in clinical interviewing. This article provides information about using the unstructured clinical interview to make a DSM-IV-TR diagnosis for adult clients with Axis I and Axis II disorders.

The initial interview is the most fundamental area of counselor training; it is the beginning of every counseling relationship and the cornerstone of assessment. In mental health and community counseling settings, the initial interview, using an unstructured, open-ended approach, remains the primary assessment tool for diagnosing mental disorders based on the Diagnostic and Statistical Manual of Mental Disorders (4th ed., text rev.; DSM-IV-TR; American Psychiatric Association [APA], 2000; Craig, 2003; Miller, 2003; Sommers-Flanagan & Sommers-Flanagan, 2003). When used for diagnosis, the initial interview is known as the clinical interview or diagnostic interview.

Traditionally only a psychiatrist's task, the responsibility of diagnosing now falls to almost all master's-level counselors (marriage and family, mental health, and community; Bogels, 1994; Mead, Hohenhil, & Singh, 1997). Diagnostic training in counselor education program curricula has existed for the last 15 to 20 years, and the Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2009) mandates that community and mental health counselors receive training on the use of the DSM-IV-TR (APA, 2000). Despite the emphasis in CACREP requirements for diagnostic training, the majority of counselors are trained in traditional interviewing techniques, not in clinical interviewing (Morrison, 1995; Turner, Hersen, & Heiser, 2003). Traditional interviewing techniques focus on gathering background history about the client but do not emphasize the identification of diagnostic signs and symptoms that aid in determining a diagnosis. The importance of clinical interviewing cannot be overemphasized because a client's DSM-IV-TR diagnosis is the primary basis for treatment planning. Being an effective clinical interviewer requires a broad knowledge of psychopathology and the current diagnostic system as means to properly evaluate the information obtained during the initial interview.

Information about clinical interviewing is scarce in the counseling literature or in counseling assessment textbooks. The literature that does exist on clinical interviewing is published mostly in psychiatry journals and textbooks, and much of that literature espouses the use of structured and semistructured interviews for accurate diagnosis (Basco, 2003). Despite the current emphasis on the use of structured and semistructured interviews, the unstructured clinical interview remains the most commonly used clinical assessment among psychiatrists and psychologists, as well as counselors (Craig, 2003; Miller, 2003; Sommers-Flanagan & Sommers-Flanagan, 2003).

The ability to interview for diagnosis is an important skill for counselors to develop. Counselors should know what information they need to obtain during the clinical interview and how that information is relevant to making a DSM-IV-TR (APA, 2000) diagnosis. This article provides (a) information about clinical interviewing for the purpose of making a DSM-IV-TR diagnosis, (b) the format of the unstructured clinical interview, and (c) examples of diagnostic clues and questions. This article focuses on interviewing adult clients with DSM-IV-TR Axis I and Axis II disorders. The term clinical interview is used throughout this article to describe interviewing for the purpose of developing a DSM-IV-TR diagnosis.

Clinical Interviewing

Clinical interviews may be unstructured, semistructured, or structured. Each approach has benefits and drawbacks, but the primary purpose of all three types is to obtain accurate information relevant in making a DSM-IV-TR (APA, 2000) diagnosis. Unstructured interviews consist of questions posed by the counselor with the client's responses and counselor observations recorded by the counselor. This type of interview is considered unstructured because there is no standardization of questioning or recording of client responses; it is the counselor who is “entirely responsible for deciding what questions to ask and how the resulting information is used in arriving at a diagnosis” (Summerfeldt & Antony, 2002, p. 3). The accuracy of diagnoses based on unstructured interviews depends a great deal on the counselor's ability to recognize DSM-IV-TR diagnostic symptoms. Structured interviews are a type of diagnostic interview procedure that consists of a standardized list of questions; a standardized sequence of questioning, including follow-up questions; and the system-
Appendix G

Now, please describe the mock client’s principal complaint. What is the problem he/she was discussing? Provide as many details as you can.
Instructions before Dependent Measures

Now, we are interested in learning how in your thoughts about how the interview with the other student went. On the following pages, please follow all instructions carefully and answer each question as honestly as possible. Remember, there are no right or wrong answers.
Appendix H

Perceived Similarity (Sprecher, 2014)

1. **How much do you think you have in common with the mock client?**

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<td>Nothing or almost nothing</td>
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<td>A great deal</td>
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2. **How similar do you think you and the mock client are likely to be?**

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Appendix I

Liking Subscale (Rubin, 1970)

1. I think that ______ is unusually well-adjusted.
   
   1  2  3  4  5  6  7  8  9
   Not true at all
   Definitely true

2. I would highly recommend ______ for a responsible job.
   
   1  2  3  4  5  6  7  8  9
   Not true at all
   Definitely true

3. In my opinion, ______ is an exceptionally mature person.
   
   1  2  3  4  5  6  7  8  9
   Not true at all
   Definitely true

4. I have great confidence in ______'s good judgment.
   
   1  2  3  4  5  6  7  8  9
   Not true at all
   Definitely true

5. Most people would react very favorably to ______ after a brief acquaintance.
   
   1  2  3  4  5  6  7  8  9
   Not true at all
   Definitely true

6. I think that ______ and I are quite similar to each other.
   
   1  2  3  4  5  6  7  8  9
   Not true at all
   Definitely true

7. I would vote for ______ in a class or group election.
   
   1  2  3  4  5  6  7  8  9
   Not true at all
   Definitely true
8. I think that _______ is one of those people who quickly wins respect.

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9. I feel that _______ is an extremely intelligent person.

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10. _______ is one of the most likable people I know.

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11. _______ is the sort of person whom I myself would like to be.

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12. It seems to me that it is very easy for _______ to gain admiration.

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Appendix J

Interpersonal Liking-6 (IL-6; Veksler & Eden, 2017)

1. I think that this person and I may have a lot in common.

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2. There are aspects of this person’s personality that I admire.

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3. I think that this person exhibits good judgement.

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4. I think that future interactions with this person would be pleasurable.

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5. I enjoyed interacting with this person.

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6. I would like to get to know this person better.

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Appendix K

Working Alliance Inventory-Short Revised-Therapist (WAI-SRT; Horvath & Greenberg, 1989)

**Instructions:** Below is a list of statements about experiences people might have with their client. Some items refer directly to your client with an underlined space – as you read the sentences, mentally insert your mock client in place of ___ in the text.

IMPORTANT!!! Please take your time to consider each question carefully.

1. ___ and I agree about the steps to be taken to improve her/his situation.
   1. Seldom
   2. Sometimes
   3. Fairly Often
   4. Very Often
   5. Always

2. I am genuinely concerned for ___’s welfare.
   1. Always
   2. Very Often
   3. Fairly Often
   4. Sometimes
   5. Seldom

3. We are working towards mutually agreed upon goals.
   1. Seldom
   2. Sometimes
   3. Fairly Often
   4. Very Often
   5. Always

4. ___ and I both feel confident about the usefulness of our current activity in therapy.
   1. Seldom
   2. Sometimes
   3. Fairly Often
   4. Very Often
   5. Always

5. I appreciate ___ as a person.
   1. Always
   2. Very Often
   3. Fairly Often
   4. Sometimes
   5. Seldom

6. We have established a good understanding of the kind of changes that would be good for ___.
   1. Always
   2. Very Often
   3. Fairly Often
   4. Sometimes
   5. Seldom

7. ___ and I respect each other.
   1. Seldom
   2. Sometimes
   3. Fairly Often
   4. Very Often
   5. Always

8. ___ and I have a common perception of her/his goals.
9. I respect ___ even when he/she does things that I do not approve of.

Seldom  Sometimes  Fairly Often  Very Often  Always

10. We agree on what is important for ___ to work on.

Always  Very Often  Fairly Often  Sometimes  Seldom
Appendix L

The Causal Dimension Scale (Russell, 1982)

Instructions: Think about the reason or reasons you have written above. The items below concern your impressions or opinions of this cause or causes of your outcome. Circle one number for each of the following scales.

1. Is the cause(s) something that:

9  8  7  6  5  4  3  2  1
Reflects an aspect of herself/himself

2. Is the cause(s):

9  8  7  6  5  4  3  2  1
Controllable by her/him or other people

3. Is the cause(s) something that is:

9  8  7  6  5  4  3  2  1
Permanent

4. Is the cause(s) something:

9  8  7  6  5  4  3  2  1
Intended by her/him or other people

5. Is the cause(s) something that is:

9  8  7  6  5  4  3  2  1
Outside of her/him

6. Is the cause(s) something that is:

9  8  7  6  5  4  3  2  1
Reflects an aspect of the situation

Uncontrollable by her/him or other people

Temporary

Unintended by her/him or other people

Inside of her/him
7. **Is the cause(s):**

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<th>1</th>
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<tr>
<td>Something about herself/himself</td>
<td>Something about others</td>
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8. **Is the cause(s) something that is:**

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<td>Changeable</td>
<td>Unchanging</td>
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9. **Is the cause(s) something for which:**

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<tr>
<td>No one is responsible</td>
<td>Someone is responsible</td>
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Appendix M

Emotions Measure (Villalobos & Bridges, 2016)

INSTRUCTIONS: Record your answers in response to the scenario for each question using the scales provided (1 = not at all to 9 = totally). Please circle only one number per question.

1. **How much compassion do you feel toward your [mock client]?**

   1  2  3  4  5  6  7  8  9
   Not at all          Totally

2. **How much frustration do you feel toward your [mock client]?**

   1  2  3  4  5  6  7  8  9
   Not at all          Totally

3. **How much sympathy do you feel toward your [mock client]?**

   1  2  3  4  5  6  7  8  9
   Not at all          Totally

4. **How much anger do you feel toward your [mock client]?**

   1  2  3  4  5  6  7  8  9
   Not at all          Totally

5. **How much warmth do you feel toward your [mock client]?**

   1  2  3  4  5  6  7  8  9
   Not at all          Totally

6. **How much indifference do you feel toward your [mock client]?**

   1  2  3  4  5  6  7  8  9
   Not at all          Totally

7. **How much concern do you feel toward your [mock client]?**

   1  2  3  4  5  6  7  8  9
8. How much hostility do you feel toward your \textit{mock client}?

\begin{tabular}{cccccccccc}
1 & 2 & 3 & 4 & 5 & 6 & 7 & 8 & 9 & \text{Totally} \\
Not at all & & & & & & & & & \text{Totally} \\
\end{tabular}
Appendix N

Closeness Self-Other Overlap

Please circle the picture below which best describes your relationship with the mock client.
Appendix O

Participant Completing Confederate’s Demographic Measure

Please describe the mock client’s identifying information by doing your best to answer the following questions about the mock client.

What is their sex? (Male/Female/Transgender)

What is their race/ethnicity? (choose all that apply)
- Black/African American
- Hispanic/Latinx
- Asian/Pacific Islander
- American Indian/Native American/Alaskan Native
- White/Caucasian/European American

What is their sexual orientation?
- Heterosexual
- Lesbian
- Gay
- Bisexual
- Asexual
- Pansexual

What is their relationship status?
- In a relationship
- Single

What languages do they speak?

What music genres do they listen to?

What year are they in?
- Freshman/First year
- Sophomore/Second year
- Junior/Third year
- Senior/Fourth year
- Fifth year
Appendix P

Participant Demographic Measure

Please answer the following questions about yourself.

What is your age?

What is your sex? (Male/Female/Transgender)

What is your race/ethnicity? (choose all that apply)
  • Black/African American
  • Hispanic/Latinx
  • Asian/Pacific Islander
  • American Indian/Native American/Alaskan Native
  • White/Caucasian/European American

What is your sexual orientation?
  • Heterosexual
  • Lesbian
  • Gay
  • Bisexual
  • Asexual
  • Pansexual

What is your relationship status?
  • In a relationship
  • Single

What languages do you speak?

What year are you in?
  • Freshman/First year
  • Sophomore/Second year
  • Junior/Third year
  • Senior/Fourth year
  • Fifth year

What is your academic major?

Are you interested in being a mental health professional (e.g., psychologist, counselor, social worker)?
  Yes
  If yes, what career? ________________________.
  No
Appendix Q

First Debriefing Form

In the beginning of the study, you were told this study was investigating two therapeutic interviewing skills trainings and your clinical interviewing skills would be tested before and after the training. You selected your role for the first interview and chose interviewer. Both of the papers in the jar actually said interviewer. The other participant is a confederate, so she is a fellow research assistant helping us conduct the experiment. During the experiment, the confederate wrote and said things that were not accurate about herself. In the different experimental conditions, we had the confederate say different things about herself so we could see how these would impact ratings of liking, similarity, and attributions of blame and responsibility for her problems. We are interested in how you related and empathized with the confederate after the 15-minute interview. You will not be conducting a second interview or receiving a training on clinical interviewing skills. We did not tell you everything about the study’s purpose because we believed if we told you the true purpose, it would compromise the data.

Thank you for participating in the study. If you have any questions or concerns following this study, please contact Roselee Ledesma at rjledesm@email.uark.edu.

_________________________________________  ________________
Name                                           Date
Appendix R

Tips for Clinical Interviewing and Improving Interactions with Diverse People

- Focus on what the other person is saying, not what you want to say next.
- Reflect what you heard to make sure you understood correctly.
  - E.g., “It sounds like…”, “I get the sense this has been difficult”
- Listen to the other person instead of offering solutions.
- Ask open-ended questions, not questions that will result in yes/no answers.
  - E.g., “What brought you here today?”, “What was that like for you?”
- Affirm by supporting, encouraging, and recognizing the person’s difficulties.
  - E.g., Therapist: “It sounds like you are still struggling with making these changes, but you have made some changes. How do you think you might reduce your drinking even further?” [The second sentence is an open-ended question]
  - E.g. Therapist: “You showed a lot of strength and determination by doing that.”
- Go into interactions thinking they will go well, especially if the person you will interact with is different from you.
- Interact with people who are different from you.


- Attend to your use of eye contact, body posture, voice tone, silence, paraphrasing, reflection of listening, and summarization.
- Have an open body posture by not crossing your arm
Appendix S

Second Debriefing Form

This semester you participated in a study where you were told you would learn therapeutic interviewing skills through a set of interviews and a training. However, the study was actually focused on how you related and empathized with the confederate. Throughout the course of the semester we conducted the same interaction between participants and the confederate but changed the race and sexual orientation of the confederate to see if these social identities affected the 15-minute interaction. We did not tell you everything about the study’s conditions because we believed if we told you, it would compromise the data. If you would like to withdraw your data, please contact Roselee Ledesma (rjledesm@email.uark.edu). Thank you again for participating in the study. Your information will be anonymous and will not be tied to you in any way. If you have any questions or concerns following this study, please contact Roselee Ledesma at rjledesm@email.uark.edu.
Appendix T

Shirts for Racial/Ethnic and Sexual Orientation Match

<table>
<thead>
<tr>
<th>Latinx/lesbian</th>
<th>Latinx/heterosexual</th>
</tr>
</thead>
<tbody>
<tr>
<td>(mismatch/mismatch):</td>
<td>(mismatch/match):</td>
</tr>
<tr>
<td>Rainbow Latinx shirt</td>
<td>Pink Latinx shirt</td>
</tr>
</tbody>
</table>

White/lesbian
(match/mismatch):
Rainbow Disney shirt

White/heterosexual
(match/match):
Pink Disney shirt
Appendix U

Symbolic Racism 2000 Scale (Henry & Sears, 2002)

Please read the following statements carefully and select your answer based on the scale provided.

1. **It’s really a matter of some people not trying hard enough; if Blacks would only try harder they could be just as well off as Whites.**

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly disagree</td>
<td>Disagree</td>
<td>Somewhat disagree</td>
<td>Somewhat agree</td>
<td>Agree</td>
<td>Strongly agree</td>
</tr>
</tbody>
</table>

2. **Irish, Italian, Jewish, and many other minorities overcame prejudice and worked their way up/ Blacks should do the same.**

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly disagree</td>
<td>Disagree</td>
<td>Somewhat disagree</td>
<td>Somewhat agree</td>
<td>Agree</td>
<td>Strongly agree</td>
</tr>
</tbody>
</table>

3. **Blacks work just as hard to get ahead as most other Americans.**

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly disagree</td>
<td>Disagree</td>
<td>Agree</td>
<td>Strongly Agree</td>
</tr>
</tbody>
</table>

4. **How responsible, in general, do you hold Blacks in this country for their outcomes in life?**

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not responsible at all</td>
<td>A little responsible</td>
<td>Somewhat responsible</td>
<td>Very responsible</td>
</tr>
</tbody>
</table>

5. **Blacks are getting too demanding in their push for equal rights.**

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly disagree</td>
<td>Disagree</td>
<td>Somewhat disagree</td>
<td>Somewhat agree</td>
<td>Agree</td>
<td>Strongly agree</td>
</tr>
</tbody>
</table>

6. **Blacks are demanding too much from the rest of society.**

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly disagree</td>
<td>Disagree</td>
<td>Agree</td>
<td>Strongly Agree</td>
</tr>
</tbody>
</table>

7. **Some say Black leaders have been trying to push too fast. Others feel that they haven’t pushed fast enough. What do you think?**
1. Going too slowly
2. Moving at about the right speed
3. Trying to push too fast

8. Some say that the civil rights people have been trying to push too fast. Others feel they haven’t pushed fast enough. What do you think?

1. Going too slowly
2. Moving at about the right speed
3. Trying to push too fast

9. How much of the racial tension that exists in the United States today do you think Blacks are responsible for creating?

1. Not much at all
2. Some
3. Most
4. All of it

10. Blacks generally do not complain as much as they should about their situation in society.

1. Strongly disagree
2. Disagree
3. Agree
4. Strongly Agree

11. How much discrimination against Blacks do you feel there is in the United States today, limiting their chances to get ahead?

1. Strongly disagree
2. Disagree
3. Agree
4. Strongly Agree

12. Generations of slavery and discrimination have created condition that make it difficult for blacks to work their way our of the lower class.

1. Strongly disagree
2. Disagree
3. Somewhat agree
4. Agree
5. Strongly agree

13. Discrimination against Blacks is no longer a problem in the United States.

1. Strongly disagree
2. Disagree
3. Agree
4. Strongly Agree

14. Has there been a lot of real change in the position of Black people in the past few years, only some, not much at all?

1. Not much at all
2. Only some
3. A lot
15. Over the past few years, Blacks have gotten less than they deserve.

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
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<th></th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>Disagree</td>
<td>Agree</td>
<td>Strongly Agree</td>
</tr>
</tbody>
</table>

16. Over the past few years, Blacks have gotten more economically than they deserve.

<p>| | | | |</p>
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>Disagree</td>
<td>Agree</td>
<td>Strongly Agree</td>
</tr>
</tbody>
</table>
Appendix V

Modern Homophobia Scale-Lesbians (Raja & Stokes, 1998)

Please read the following statements carefully and select your answer based on the scale provided.

1. **Employers should provide health care benefits to the partners of their lesbian employees.**
   
   1  2  3  4  5  
   Strongly disagree Disagree Neither agree nor disagree Agree Strongly agree

2. **Teachers should try to reduce their student's prejudice toward lesbians.**
   
   1  2  3  4  5  
   Strongly disagree Disagree Neither agree nor disagree Agree Strongly agree

3. **Lesbians who adopt children do not need to be monitored more closely than heterosexual parents.**
   
   1  2  3  4  5  
   Strongly disagree Disagree Neither agree nor disagree Agree Strongly agree

4. **Lesbians should be allowed to be leaders in religious organizations.**
   
   1  2  3  4  5  
   Strongly disagree Disagree Neither agree nor disagree Agree Strongly agree

5. **Lesbians are as capable as heterosexuals of forming long-term romantic relationships.**
   
   1  2  3  4  5  
   Strongly disagree Disagree Neither agree nor disagree Agree Strongly agree

6. **School curricula should include positive discussion of lesbian topics.**
   
   1  2  3  4  5  
   Strongly disagree Disagree Neither agree nor disagree Agree Strongly agree

7. **Marriages between two lesbians should be legal.**
   
   1  2  3  4  5  
   Strongly disagree Disagree Neither agree nor disagree Agree Strongly agree

8. **Lesbians should not be allowed to join the military.**
   
   1  2  3  4  5
<p>| | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Strongly disagree</td>
<td>Disagree</td>
<td>Neither agree nor disagree</td>
<td>Agree</td>
<td>Strongly agree</td>
</tr>
<tr>
<td>9.</td>
<td>I would not vote for a political candidate who was openly lesbian.</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10.</td>
<td>Lesbians are incapable of being good parents.</td>
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<td></td>
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<tr>
<td></td>
<td>1</td>
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<tr>
<td>11.</td>
<td>I am tired of hearing about lesbians' problems.</td>
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<td></td>
<td>1</td>
<td>2</td>
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<tr>
<td>12.</td>
<td>I wouldn't mind going to a party that included lesbians.</td>
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<td></td>
<td></td>
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<tr>
<td></td>
<td>1</td>
<td>2</td>
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<td>4</td>
<td>5</td>
</tr>
<tr>
<td>13.</td>
<td>I wouldn't mind working with a lesbian.</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>14.</td>
<td>I am comfortable with the thought of two women being romantically involved.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>15.</td>
<td>It's all rights with me if I see two women holding hands.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>16.</td>
<td>If my best female friend was dating a woman, it would not upset me.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>17.</td>
<td>Movies that approve of female homosexuality bother me.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Question</td>
<td>Strongly disagree</td>
<td>Disagree</td>
<td>Neither agree nor disagree</td>
<td>Agree</td>
<td>Strongly agree</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
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<td>-----------------------------</td>
<td>-------</td>
<td>----------------</td>
</tr>
<tr>
<td>18. I welcome new friends who are lesbian.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>19. I don't mind companies using openly lesbian celebrities to advertise their products.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>20. I would be sure to invite the same-sex partner of my lesbian friend to my party.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>21. I don't think it would negatively affect our relationship if I learned that one of my close relatives was a lesbian.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>22. Physicians and psychologists should strive to find a cure for female homosexuality.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>23. Lesbians should undergo therapy to change their sexual orientation.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>24. Female homosexuality is a psychological disease.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
# Appendix W

## Racial Microaggressions (Sue et al., 2007)

<table>
<thead>
<tr>
<th>Theme</th>
<th>Microaggression</th>
<th>Message</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Alien in own land</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>When Asian Americans and</td>
<td>“Where are you from?”</td>
<td>You are not American</td>
</tr>
<tr>
<td>Latino Americans are</td>
<td>“Where were you born?”</td>
<td></td>
</tr>
<tr>
<td>assumed to be foreign-born</td>
<td>“You speak good English.”</td>
<td></td>
</tr>
<tr>
<td>A person asking an Asian</td>
<td></td>
<td></td>
</tr>
<tr>
<td>American or Latinx to teach</td>
<td></td>
<td></td>
</tr>
<tr>
<td>them words in their native</td>
<td>You are a foreigner</td>
<td></td>
</tr>
<tr>
<td>language</td>
<td></td>
<td></td>
</tr>
<tr>
<td>“You people . . . ”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>You don’t belong. You are a</td>
<td></td>
<td></td>
</tr>
<tr>
<td>lesser being.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Ascription of intelligence</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assigning intelligence to a</td>
<td>“You are a credit to your race.”</td>
<td>People of color are generally</td>
</tr>
<tr>
<td>person of color on the basis</td>
<td></td>
<td>not as intelligent as Whites.</td>
</tr>
<tr>
<td>of their race.</td>
<td>“You are so articulate.”</td>
<td>It is unusual for someone of</td>
</tr>
<tr>
<td></td>
<td></td>
<td>your race to be intelligent.</td>
</tr>
<tr>
<td><strong>Color blindness</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Statements that indicate that a</td>
<td>“When I look at you, I don’t see color.”</td>
<td>Denying a person of color’s</td>
</tr>
<tr>
<td>White person does not want</td>
<td></td>
<td>racial/ethnic experiences.</td>
</tr>
<tr>
<td>to acknowledge race</td>
<td>“America is a melting pot.”</td>
<td>Assimilate/acculturate to the</td>
</tr>
<tr>
<td></td>
<td>“There is only one race, the human race.”</td>
<td>dominant culture.</td>
</tr>
<tr>
<td><strong>Denial of individual racism</strong></td>
<td></td>
<td>Denying the individual as a</td>
</tr>
<tr>
<td>A statement made when</td>
<td>“I’m not racist. I have several Black friends.”</td>
<td>racial/cultural being.</td>
</tr>
<tr>
<td>Whites deny their racial</td>
<td></td>
<td></td>
</tr>
<tr>
<td>biases</td>
<td>“As a woman, I know what you go through as a racial minority.”</td>
<td></td>
</tr>
<tr>
<td><strong>Myth of meritocracy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Statements which assert that</td>
<td>“Everyone can succeed in this society, if they work hard</td>
<td>People of color are lazy</td>
</tr>
<tr>
<td>race does not play a role in</td>
<td>enough.”</td>
<td>and/or incompetent and need</td>
</tr>
<tr>
<td>life successes</td>
<td></td>
<td>to work harder.</td>
</tr>
<tr>
<td><strong>Pathologizing cultural values/communication styles</strong></td>
<td>Asking a person of color:</td>
<td>Assimilate to dominant</td>
</tr>
<tr>
<td>The notion that the values and</td>
<td>“Why do you have to be so loud/animated? Just calm down” or “Why are you so</td>
<td>culture.</td>
</tr>
<tr>
<td>communication styles of the</td>
<td>quiet? We want to know what</td>
<td></td>
</tr>
<tr>
<td>dominant/White culture are</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ideal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>you think. Be more verbal.”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>“Speak up more.”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dismissing an individual who brings up race/culture in work/school setting</td>
<td>Leave your cultural baggage outside</td>
<td></td>
</tr>
</tbody>
</table>
# Appendix X

## Sexual Orientation Microaggressions in Psychotherapy (Shelton, & Delgado-Romero, 2011)

<table>
<thead>
<tr>
<th>Theme</th>
<th>Microaggression</th>
<th>Message</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assumption that sexual orientation is the cause of all presenting issues</td>
<td>A therapist says to a client, “I know what the problem is, you are gay.”</td>
<td></td>
</tr>
<tr>
<td></td>
<td>When a client discusses academic issues, a therapist interjects, “What do you think this issue has to do with your sexuality?”</td>
<td>Your sexual orientation is the problem.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Your sexual orientation needs to be treated.</td>
</tr>
<tr>
<td>Avoidance and minimizing of sexual orientation</td>
<td>A therapist says to the client, “You don’t have to worry about that [sexual orientation] right now, let’s talk about this other issue.”</td>
<td>You should feel uncomfortable talking about your sexual orientation.</td>
</tr>
<tr>
<td>Attempts to overidentify with LGBQ clients</td>
<td>A therapist makes frequent references to distant family members who are LGBQ.</td>
<td>I understand your issues because I know someone who is LGBQ.</td>
</tr>
<tr>
<td>Making stereotypical assumptions about LGBQ clients</td>
<td>A gay male client describes his weekend and the therapist says, “You were in a hardware store?!”</td>
<td>All LGBQ people are alike.</td>
</tr>
<tr>
<td></td>
<td>A therapist tells an attractive lesbian woman, “You don’t look like a lesbian.”</td>
<td>I don’t need to make an effort to get to know you as an individual.</td>
</tr>
<tr>
<td>Expressions of heteronormative bias</td>
<td>After a client discloses their sexual orientation, a therapist states, “I am not gay!”</td>
<td>It is insulting for you to think I am gay.</td>
</tr>
<tr>
<td>Assumption that LGBQ individuals need psychotherapeutic treatment</td>
<td>A therapist encourages a client to stay in treatment against the client’s wishes.</td>
<td>You need to change or conform.</td>
</tr>
<tr>
<td>Warnings about the dangers of identifying as LGBQ</td>
<td>A therapist asks a client, “Are you sure you want to enter this lifestyle?” or “Have you really thought this through?”</td>
<td>You are incapable of making rational decisions.</td>
</tr>
<tr>
<td></td>
<td>When a client discusses experiencing discrimination, the therapist says, “This lifestyle brings certain problems with it.”</td>
<td>Any problems you face are your own fault for choosing an LGBQ identity.</td>
</tr>
</tbody>
</table>

*Note. LGBQ = lesbian, gay, bisexual, queer*
Appendix Y

Conversational Skills Rating Scale

<table>
<thead>
<tr>
<th>Name</th>
<th>Start Time</th>
<th>Video Number</th>
<th>End Time</th>
<th>Date</th>
<th>Guess Condition</th>
<th>Actual Condition</th>
</tr>
</thead>
</table>

Select the single most accurate response for each behavior.

**Posture**

1. Closed off all the time
2. Closed/open about half the time
3. Open the entire time

**Lean toward partner**

1. Awkward (too far forward/back) all the time
2. Occasionally awkward about half the time
3. Appropriate leaning in all the time

**Unmotivated movements/fidgeting (e.g., tapping feet, fingers, hair twirling, etc.)**

1. Unmotivated movements all the time
2. Unmotivated movements about half the time
3. No/few unmotivated movements

**Active listening (e.g., nodding of head in agreement, etc)**

1. No nodding/agreement
2. Nodding/agreement about half the time
3. Nodding/agreement all the time

**Smiling/laughing**

1. No smiling/laughing evident
2. Smiling/laughing about half the time
3. Frequent smiling/laughing
<table>
<thead>
<tr>
<th>Eye contact</th>
<th>No eye contact</th>
<th>Eye contact about half the time</th>
<th>Consistent eye contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>


Appendix Z

Institutional Review Board Approval Letter

<table>
<thead>
<tr>
<th>To:</th>
<th>Roselee J Ledesma</th>
</tr>
</thead>
<tbody>
<tr>
<td>From:</td>
<td>Douglas James Adams, Chair</td>
</tr>
<tr>
<td></td>
<td>IRB Committee</td>
</tr>
<tr>
<td>Date:</td>
<td>05/30/2018</td>
</tr>
<tr>
<td>Action:</td>
<td>Expedited Approval</td>
</tr>
<tr>
<td>Action Date:</td>
<td>05/30/2018</td>
</tr>
<tr>
<td>Protocol #:</td>
<td>1804119833</td>
</tr>
<tr>
<td>Study Title:</td>
<td>Efficacy of Different Training Methods on Clinical Interviewing Skills</td>
</tr>
<tr>
<td>Expiration Date:</td>
<td>05/03/2019</td>
</tr>
<tr>
<td>Last Approval Date:</td>
<td></td>
</tr>
</tbody>
</table>

The above-referenced protocol has been approved following expedited review by the IRB Committee that oversees research with human subjects.

If the research involves collaboration with another institution then the research cannot commence until the Committee receives written notification of approval from the collaborating institution’s IRB.

It is the Principal Investigator’s responsibility to obtain review and continued approval before the expiration date.

Protocols are approved for a maximum period of one year. You may not continue any research activity beyond the expiration date without Committee approval. Please submit continuation requests early enough to allow sufficient time for review. Failure to receive approval for continuation before the expiration date will result in the automatic suspension of the approval of this protocol. Information collected following suspension is unapproved research and cannot be reported or published as research data. If you do not wish continued approval, please notify the Committee of the study closure.

Adverse Events: Any serious or unexpected adverse event must be reported to the IRB Committee within 48 hours. All other adverse events should be reported within 10 working days.

Amendments: If you wish to change any aspect of this study, such as the procedures, the consent forms, study personnel, or number of participants, please submit an amendment to the IRB. All changes must be approved by the IRB Committee before they can be initiated.

You must maintain a research file for at least 3 years after completion of the study. This file should include all correspondence with the IRB Committee, original signed consent forms, and study data.

cc: Rebeca Irma Zapata, Investigator
    Ana Julia Bridges, Key Personnel