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THE EFFECTS OF COUNSELOR DISABILITY STATUS AND REPUTATION ON PERCEPTIONS OF COUNSELOR EXPERTNESS, ATTRACTIVENESS, AND TRUSTWORTHINESS

Contents

A study examined the influence of counselor disability status and counselor reputation on participant's perceptions of counselors. A sample of 60 adults with disabilities viewed one of two videotaped vignettes (counselor with or without a disability) portraying a client-counselor interaction. The vignette was crossed with three levels of counselor reputation. Participants rated the counselor's attractiveness, expertness, and trustworthiness, using the Counselor Rating Form-Short. A significant effect was found for counselor disability status. Counselors without a disability received consistently higher ratings. There was no effect for counselor reputation, and no interaction was found between disability status and reputation. Implications for theory, practice, and future research are discussed.

The simple incontrovertible truth, it seems to me, is that if you are anxious or depressed or if you are experiencing difficulties with significant people in your life, chances are that you will feel better if you talk to someone you can trust. Such conversations . . . may be conducted by people who have been assigned special roles by society (e.g., shamans) or, as is true of the present time, by specially trained professionals who charge a fee for their services. This fact raises the highly controversial question of the kind of training that might be required or whether training is expendable. (Strupp, 1996, p. 1017)

Strong (1968) suggested in his social influence theory of counseling that counseling is a social influence process. Counselors employ such techniques as interpretation, suggestion, advice, information, homework assignments, reinforcement, role play, modeling, and behavioral enactment to help clients make changes in their behavior or cognitive framework.

Drawing heavily from Leon Festinger's theory of cognitive dissonance (Festinger, 1957), Strong suggested that these techniques are likely to place clients in a state of cognitive dissonance, which they must resolve to regain cognitive equilibrium. Clients can reduce this dissonance in a number of ways, including changing their behavior or cognitive framework in a way consistent with their counselor's input, or discounting their counselor's input by devaluing the counselor's credibility. An important tenet of social influence theory is that counselors who are perceived as attractive (i.e., likable, or compatible with clients), expert (i.e., as a valid source of

assertions), and trustworthy (i.e., having no devious or selfish intentions) will be more effective in promoting client change because it will be difficult for clients to discount counselor credibility.

Of particular interest to rehabilitation counselors are the studies that have examined the extent to which counselors' disability status influences clients' perceptions of counselors with and without disabilities. The basic assumption in these studies has been that counselors with disabilities may have an advantage in terms of favorable client perceptions, and thus have greater influence potential. Research in this area has resulted in mixed and sometimes counterintuitive findings. The research reported in this article represents an attempt to explicate this relationship further by examining the relationship of counselor-client group membership similarity and counselor reputation to client perceptions of counselor credibility.

Client perceptions of a counselor's expertness, attractiveness, and trustworthiness are in reality inferences that clients make about the counselor based on certain cues that they perceive about that person (Corrigan, Dell, Lewis, & Schmidt, 1980; Heppner & Claiborn, 1989). According to Strong (1968), there are three categories of cues--behavioral, evidential, and reputational--that affect counselor credibility.

Behavioral cues consist of the counselor's verbal or nonverbal behavior, such as manner of speaking, body movement, and body placement. For example, attending skills have proven to be powerful cues of counselor credibility (see, for example, ***Leierer***, Strohmer, Leclere, Cornwell, & Whitten, 1996). Evidential cues include nonbehavioral aspects of the counselor, such as appearance and attire or situational and setting characteristics. Evidential cues may be introduced to clients by stimuli such as the presence or absence of a disability (Freeman & Conoley, 1986; Nosek, Fuhrer, & Hughes, 1991, Strohmer & Biggs, 1983), counselor attire (Roll & Roll, 1984), or the presence of counselor's diplomas and certificates in the clinical setting.

One type of evidential cue particularly relevant to rehabilitation counseling that has yielded inconsistent and sometimes counterintuitive research findings is counselor and client shared group membership similarity. Although it has seemed intuitively reasonable that counselor and client shared group membership similarity should result in enhanced perceptions of counselor credibility, research has not supported this position. Some research has suggested that counselors without a disability may in fact have a fairly strong advantage among clients with disabilities (e.g., Strohmer & Biggs, 1983), whereas other research has reported a small advantage for counselors with a disability (e.g., ***Leierer*** et al., 1996). Still others report that counselor disability status promotes counselor influence (e.g., Nosek et al., 1991).

In a recent research review, Strohmer, ***Leierer***, Cochran, & Arokiasamy (1996) suggested that the findings in this area are at best inconclusive, and called for additional research examining this issue. In an effort to explore this relationship further, we tested two rival hypotheses reflective of the current findings in the area: Hypothesis 1A, counselors without a disability will be perceived as more expert, attractive, and trustworthy than counselors with a disability; and Hypothesis 1B, counselors with a disability will be perceived as more expert, attractive, and trustworthy than counselors without a disability.

Another important cue of counselor credibility is counselor reputation. Reputational cues include indications of the counselor's professional or social role made known by introductions or inferred from information made available about the counselor's background, accomplishments, or theoretical-philosophical orientation (Corrigan et al., 1980). Factors such as counselor experience and status (e.g., licensure, certification, or peer counselor training) have been proven to have a reliable effect on clients' perceptions (Corrigan et al., 1980; Strong, Welsh, Corcoran, & Hoyt, 1992).

Research studies have examined reputational cues such as counselor introduction (e.g., Bernstein & Figioli, 1983; Freeman & Conoley, 1986; McCarthy, 1982; McKee & Smouse, 1983), level of training (e.g., Freeman & Conoley, 1986; Nosek et al., 1991), and level of experience (e.g., Nosek et al., 1991; Strohmer & Biggs, 1983). Specifically, in rehabilitation counseling, attainment of Certified Rehabilitation Counselor (CRC) status seems to be a probable cue that clients might use to infer counselor credibility. As Thomas (1993) suggests, however, although the intended inference to be made from scores on the Commission on Rehabilitation Counselor Certification (CRCC) examination is that people who attain a passing score are more competent to practice rehabilitation counseling than are those who do not pass, little or no empirical evidence documents the types of inferences that are drawn about those who have passed the exam. Furthermore, it could be argued that status as either a licensed mental health counselor (LMHC) or a peer counselor may be an equal or even superior cue

of counselor credibility. Clients are likely to be more familiar with the notion of a licensed rather than a certified professional (e.g., licensed physician, licensed social worker, licensed physical therapist).

Nosek and her colleagues (Nosek et al., 1991) argued, "persons with disability will relate more readily to a counselor with a disability than to one who is able-bodied." To understand the importance of counselor reputation in client perceptions, we tested the following hypothesis: H2, there will be a difference among the rating of expertness, attractiveness, and trustworthiness given to certified, licensed, and peer counselors by individuals with disabilities.

In addition to the main effects of disability status and counselor reputation on perceived counselor attractiveness, expertness, and trustworthiness, we were curious about the interaction of counselors' disability status and reputation. Because researchers have not analyzed the effect of the disability status by reputational cue interaction on client perceptions of counselors, we chose to examine this interaction as a research question rather than a research hypothesis.

METHOD

Participants

The 60 participants, 27 male and 33 female, were recruited by a flyer distributed through the office of students with disabilities at five large state universities. The majority of the sample was composed of White (77%) and Black (15%) participants. Hispanic, Pacific Islander, Native American, and Asian American groups were each represented by 1 (1.7%) participant. One participant's ethnic background was not specified. The disabilities reported included neuromuscular (n = 15), cerebral palsy (n = 10), spinal cord (n = 11), mobility limitations not related to a spinal cord injury (n = 11), cardiorespiratory (n = 5), traumatic brain injury (n = 3), neurological (n = 4), chronic pain (n = 2), psychological (n = 3), and other types of disabilities (n = 3). The number of disabilities recorded by the participants was greater than the number of participants, because 6 participants reported having two different disabilities, and one participant reported having three different disabilities. Participants' ages ranged between 18 and 63 years (M = 32.19, SD = 11.49). Each participant was paid $10 for participating in the study.

Design

The design of the experiment was a 2 (counselor disability status) x 3 (counselor reputation) factorial. Counselor disability status (seated in a wheelchair or not seated in a wheelchair) and counselor reputation (CRC, LMHC, and peer counselor) were between-subjects variables. Participants were randomly assigned to one of six counselor licensure conditions:

1. CRC with a disability
2. LMHC with a disability
3. Peer counselor with a disability
4. CRC without a disability
5. LMHC without a disability
6. Peer counselor without a disability

Procedure

Each participant was randomly assigned to view one of the six counselor conditions. After completing consent and demographic sheets, participants read a 100-word description of either a certified rehabilitation counselor, a licensed mental health counselor, or a peer counselor. When all the participants in the room had read the descriptions, the experimenter played a videotape of one counseling session. Each participant watched a scenario with the counselor in a wheelchair or the counselor seated in a desk chair. Immediately after watching the videotape, participants noted their perceptions of the counselor using the Counselor Rating Form-Short (CRF-S; Corrigan & Schmidt, 1983).

Counselor Reputation Descriptions

Three different descriptions of the counselor's reputation were developed for this study. The CRC description

was based on the one provided in the test registration materials of the CRCC; the LMHC description was developed from the American Counseling Association (ACA) Code of Ethics and Standards of Practice (1995): Section A.1, Client Welfare, and Section C, Professional Responsibility. The peer counselor description was developed by synthesizing descriptions created by several universities and independent-living peer counseling programs in the southeastern United States.

Counseling Scenarios

The researchers recorded two different tapes (one with the counselor in a wheelchair, and the other with a counselor seated in a desk chair) that crossed the two independent variables: (a) counselor disability status (evidential cue), and (b) counselor reputation (reputational cue). Each participant evaluated either a counselor with a disability or one without a disability. Two female rehabilitation counseling graduate students played the roles of the counselor and client in the taped vignettes. The counselor and client discussed a disability-relevant interpersonal problem (the client's not having a boyfriend because of her disability).

The script was composed of 9 client disclosures and 10 counselor responses. These disclosures reached strong levels of intensity (Carkhuff & Anthony, 1979), and the counselor responses consisted of Level III empathic responses and Level III genuineness responses (Carkhuff, 1969).

After the counseling script was written, it was recorded on a videotape and was shown to master's-level rehabilitation counseling students for feedback. Suggestions were noted, the script was revised and polished, and then the two versions of the counseling session were rerecorded. Each vignette was videotaped over the client's right shoulder with the counselor facing the camera.

Instruments

A critical issue in experimental studies is whether the data are gathered under appropriate conditions of measurement (i.e., whether the data were gathered using a procedure appropriate to the theory under question). Initially, experimenters who examined the social influence of counselors on clients used the Counselor Rating Form (CRF; Barak & LaCrosse, 1975; LaCrosse & Barak, 1976). More recently (Corrigan & Schmidt, 1983), researchers developed the shorter CRF-S to expedite data collection among populations who may have difficulty completing the full CRF in a timely manner.

The CRF-S is a brief, 12-adjective instrument that asks respondents to rate their perceptions of counselors (e.g., friendly, expert, sincere) by using a 7-point scale with anchors 1 (not very) and 7 (very; Corrigan & Schmidt, 1983). Summing the items yields three separate 4-item subscale scores: (a) Attractiveness, (b) Expertness, and (c) Trustworthiness. Subscale scores can range from 4 to 28.

When Corrigan and Schmidt (1983) developed the CRF-S, they found reliabilities for Attractiveness, Expertness, and Trustworthiness to range from .89 to .93, .85 to .94, and .82 to .91. With a similar sample to that used in this study, ***Leierer*** and his colleagues (1996) found that the reliabilities of the CRF-S subscales ranged between .88 and .94 for Attractiveness, .90 and .96 for Expertness, and .84 and .93 for Trustworthiness. We felt confident that these reliabilities were sufficient for conducting our experimental research (see Churchill, 1983; Nunnally, 1967).

RESULTS

Data Analyses

A 2 (disability status) x 3 (reputation) multivariate analysis of variance (MANOVA) was used to test the hypotheses of this experiment. Only those effects that were relevant to the test of the experimental hypotheses were considered. Significant multivariate main effects and interactions were followed by univariate analyses (Bray & Maxwell, 1985; Stevens, 1996).

Preliminary Analyses

Some might argue that persons with different disabilities may respond differently to a counselor in a wheelchair.

Therefore, analyses were conducted to determine whether persons with various disabilities were significantly different from one another in terms of their perceptions of counselor attractiveness, expertness, and trustworthiness. We grouped the participants according to their reported primary disability. The groups included cerebral palsy, spinal cord, mobility limitations not related to spinal cord injury, neuromuscular, and other disabilities. The MANOVA we conducted revealed no significant differences among the disability groups [F(4,55) = .29, p = ns] on their ratings of the counselor attractiveness, expertness, and trustworthiness. Therefore, the specific disability of the participant did not seem to significantly influence the evaluation of the counselor.

Multivariate Analysis of Variance

The multivariate test revealed a significant main effect for counselor disability status [F(1,54) = 4.44, p = .008, Eta^2 = .85]. No significant main effect was found for counselor licensure status [F(2,54) = .30, p = ns]. Likewise, the multivariate test showed that two-way interaction between disability status and counselor licensure status was not significant [F(2,54) = .56, p = ns].

Tests of Hypotheses

Table 1 presents the means and standard deviations for the significant experimental effects.

Hypotheses 1A and lB. The tests for hypothesis H1 (the disability status hypothesis) were the univariate main effects for disability status. Our findings indicated that counselors without disabilities were perceived as more attractive [F(1,54) = 9.04, p Eta^2 .004, Eta^2 = .84], expert [F(1,54) = 6.74, p = .012, Eta^2 = .72], and trustworthy [F(1,54) = 10.78, p = .002, Eta^2 = .90] than were counselors with disabilities. Therefore, hypothesis 1A (the counselor without a disability hypothesis) was supported; hypothesis 1B (the counselor with a disability hypothesis) was not supported.

Hypothesis 2. The test for hypothesis H2 (counselor status) was not significant in the multivariate status [F(2,54) = .30, p = ns]. As a result, univariate tests on counselor attractiveness, expertness, and trustworthiness were not conducted. Therefore, hypothesis H2 (counselor status) was not supported.

Research Question 1. The counselor status X reputation interaction was not significant in the multivariate test [(F(2,54) = .58, p = ns)]. As a result, univariate t-tests on counselor attractiveness, experytness, and trustworthiness were not conducted.

DISCUSSION

A common idea in counseling is that clients from special populations may perceive counselors from similar populations as more credible and attractive because they may be seen as more similar and capable of understanding the clients' concerns (e.g., Atkinson, Maruama, & Matsui, 1978; Holland, Atkinson, & Johnson, 1986; Porche & Bakiniotes, 1982). Research examining this issue, however, has produced counterintuitive and contradictory findings (e.g., Freeman & Conoley, 1986; Nosek et al., 1991; Strohmer & Biggs, 1983; Thurer, 1983). The research reported here tested two hypotheses and one research question designed to further explicate this issue.

With the overall multivariate test, we found that counselor disability status influenced participants' perceptions of the counselor substantially, accounting for 85% of the variance. Likewise, the univariate tests of counselor disability also demonstrated the influence of counselor disability status. Specifically, disability status accounted for 84%, 72%, and 90% of the variance on the CRF-S subscales of counselor Attractiveness, Expertness, and Trustworthiness. Although these effects are substantial, it is important to note that we examined clients discussing a social-relationship issue. In another context (e.g., vocational or academic concerns), a counselor with a disability may be perceived as more effective based on the belief that he or she may have overcome various obstacles to become gainfully employed (see Mitchell & Allen, 1975; Mitchell & Frederickson, 1975; Strohmer & Phillips, 1985).

Interestingly, client perceptions of the counselor were not related to reputational cues, such as certification by a professional organization. Our results also suggest that clients with disabilities did not differentially evaluate the

attractiveness, expertness, and trustworthiness of counselors who were either CRCs, LMHCs, or peer counselors. Although lack of difference on the main effect of counselor reputation is interesting, it is not clear what caused the lack of difference among these reputational cues. Likewise, when considering the research question about the interaction effect of counselor disability status and reputational cue, we found no significant differences.

Limitations

Although the results of this study have implications for rehabilitation counseling practice, training, and future research directions, it is important to note the study's limitations. A key limitation lies in the analogue nature of the study. The traditional issues associated with laboratory research (as thoroughly laid out in works by Kazdin [1986] and Kerlinger [1986]) are operative here, and clearly there are problems associated with using such a design. Nonetheless, our design is consistent with most studies in this area, and we felt that it was important to ensure that our results would be comparable to other findings in this body of research. In addition, our use of a cross-sectional design was appropriate because the impact of a reputational cue or disability status is likely to be most noticeable in the initial stage of an interview.

A second clear limitation is that our participants were not counseling clients, nor were they seeking counseling. A strength of this research, however, was that all participants were highly independent, career-oriented adults with disabilities, and a large number of participants had had experience with counseling. In addition, we do not know what participants were thinking or feeling as they watched the video tape. Hence, our understanding of participants' internal experiences remains limited.

Third, some may believe that the treatment condition of peer counselors without a disability has little external validity because the counselor did not have a disability. Certainly, peer counselors must be able to relate to the challenges experienced by persons with disabilities. Shared experiences are not restricted to disability status; they may be established upon other characteristics (e.g., age, race, gender, and academic training). For example, in our videotaped counseling scenario, the counselor and the client shared similar characteristics (e.g., age, gender, and social experiences). Therefore, the counselor without a disability could have established a peer relationship on a variety of characteristics other than disability status.

Implications for Theory

Client perceptions of a counselor are based on assumptions about the counselor's ability and experience in managing specific problems effectively. The influence of a counselor's disability status depends upon the nature of the client's problem and the client's perception of the counselor's ability to help solve that problem. Our findings also suggest that a counselor's disability will not necessarily guarantee higher ratings on attractiveness, expertness, and trustworthiness; in fact, a client can be influenced negatively by a counselor's disability. Therefore, we propose that a client is likely to form perceptions of counselor credibility and social influence based on other characteristics, such as (a) the client's perception of the counselor competence as related to the specific counseling problem, (b) cultural stigma and negative attitudes that have been absorbed by the client, and (c) the client's identification with issues related to disability status.

Perceptions about desirable counselor characteristics to some extent determine the counselor's ability to influence a client (Strong, 1968). Adapting this principle to the counseling relationship, Strong and Matross (1973) stated that the counselor's power to influence a client depends on the client's judgment of the correspondence between his or her needs and counselor resources appropriate to those needs as perceived by the client. The influence of the counselor's disability status may be influenced by the nature of the client's problem and the client's perception of the counselor's ability to help solve that problem. For example, previous studies (Mitchell & Allen, 1975; Mitchell & Frederickson, 1975; Strohmer & Phillips, 1985) reported that counselors with disabilities were preferred over counselors without disabilities when working with academic or vocational issues. Interestingly, these studies also suggested that participants prefer counselors without disabilities when discussing personal-social problems. Our findings suggest that for counselors and clients discussing personal-social issues, disability status does not help establish group similarity or counselor credibility.

When a client's primary identification is his or her disability status, a counselor's disability may help establish

counselor credibility, because these perceptions are constructed by a client's self-defined identity. Conversely, if the client's disability status is not central to personal identity, counselor credibility must be developed upon characteristics other than disability status. Likewise, though a physical disability may be observable and readily perceived, disability status may not always be the most salient group similarity characteristic, because perceived counselor similarity is more complex than disability status. For example, although the counselor and client may have disabilities, they may live in a culture that perpetuates negative attitudes and stigma toward people with disabilities (Dion & Berscheid, 1974; Goffman, 1963; Kleck & Delong, 1981; Shontz, 1977). By internalizing these prejudicial attitudes, the social influence of a counselor with a disability will be undermined and the therapeutic relationship abated.

Our findings do not support the notion that the counselor reputational cues of CRC, LMHC, or peer counselor status have a differential effect on client perceptions. In our study, the LPC and the CRC were used to represent similar educational levels, but different knowledge levels about disability. The peer counselor was chosen to represent an individual whose credibility was linked with actually going through experiences similar to the client's. Although a logical case could be made for each of these reputational cues as being the most effective, in this research there was no difference between them. Several explanations for this finding seem possible. First, it may be that each of these statuses is a legitimate source of counselor influence, each drawing on a different source of power--the CRCs drawing on their disabilityspecific training, the LMHCs drawing on their licensure status, and peer counselors drawing on the disability experience they share with the client. On the other hand, it may be that they were equally unimportant in influencing participant perceptions. It is possible that this type of status is simply not important to clients, and will only be of value to professionals and administrators. It is also possible that the participants were simply not knowledgeable about counselor training, and in particular about the CRC credential and what it embodies.

Implications for Practice

Although it seems logical that experience and training should be influential in the counselor-client relationship, our results suggest that it is important that the client understand how the counselor's experiences and training and credentials are related to positive therapeutic outcomes. Counselors who explain how their training and education will influence their therapeutic interventions and strategies may have more credibility, because their clients will understand the association between professional training and client outcome. By understanding the links among outcomes, disability status, and counselor education and training, clients are likely to perceive that the counselor is more credible.

Rather than leaving the clients' perceptions to chance, counselors can influence client perceptions of counselor credibility by using self-disclosure. Hill and her colleagues (Hill et al., 1988) found that when compared to other counselor responses, self-disclosure received the highest helpfulness ratings from the clients. When counselors self-disclose their feelings and experiences about disability status, they (a) become more human in the eyes of clients, (b) share in the universality of human struggle with clients, and (c) model effective behavior (Knox, Hess, Petersen, & Hill, 1997). In addition, when counselors explain the relationship between certification and training and therapeutic counseling outcomes, the social influence of the counselor is enhanced, because clients perceive a link between certification and a successful counseling outcome.

It is not enough for practitioners to be certified rehabilitation counselors. Likewise, merely possessing a disability will not guarantee that the counselor will be perceived as attractive, expert, and trustworthy. In fact, our findings suggest that if shared group membership similarity is to be an asset instead of liability, then it seems reasonable that counselors with disabilities will need to use techniques that inform and educate clients. For example, counselors must help clients understand how training and experience will have a positive influence on counseling sessions. By self-disclosure, counselors can help clients to become informed consumers of rehabilitation counseling services. In addition, counselors who are able to explain the impact of their training and experience on the counseling session are more likely to understand thoroughly their role in counseling and to be able to make a definitive statement about the value of the CRC in the rehabilitation process.

Future Research Directions

Our goals for future studies include (a) examining how a counselor's disability status can influence the

perceptions of clients without disabilities; (b) examining the perceptions of clients with disabilities in different counseling venues (e.g., vocational, academic, relationship) at the same time; (c) examining the relationship of clients' identities with their perceptions of counselors with disabilities; (d) examining the influence of counselor self-disclosure about coping with a disability upon the social influence; and (e) examining client perceptions over multiple counseling sessions. The latter is particularly important because there is a paucity of longitudinal studies examining changes in client perceptions over the course of the counseling relationship, especially concerning rehabilitation issues.

TABLE 1 Mean Scores for Videotaped Counseling Session

	Attractiveness	
Counseling Condition	M	SD
Disability Status		
With a disability	14.97	4.00
Without a disability	18.43[*]	4.78
Counselor Certification		
Certified rehabilitation counselor	17.50	5.63
Licensed mental health counselor	16.65	4.12
Peer counselor	15.55	4.33
	Expertness	
Counseling Condition	M	SD
Disability Status		
With a disability	13.87	5.57
Without a disability	17.80[*]	6.09
Counselor Certification		
Certified rehabilitation counselor	16.30	6.67
Licensed mental health counselor	15.65	5.40
Peer counselor	15.95	6.50
	Trustworthiness	
Counseling Condition	M	SD
Disability Status		
With a disability	15.87	2.54
Without a disability	18.77[*]	3.95
Counselor Certification		

Certified rehabilitation counselor	17.60	3.57
Licensed mental health counselor	16.90	3.70
Peer counselor	17.45	3.68

[*] p < .01.

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