CHOOSING NOT TO RETURN:
DIVERSE STUDENTS' INTAKE EXPERIENCES
AT A UNIVERSITY COUNSELING CENTER

DISSERTATION

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By

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ABSTRACT

At University counseling centers, 20% to 25% of the students who complete an initial “intake” appointment choose to not return for recommended further services. This is a significant problem that merits more research attention. Most of the extant studies have been quantitative investigations examining clinic, client, and therapist variables. For the most part, findings have been mixed; however, minority racial status, low education, and low SES have been significantly related to psychotherapy dropout. Few studies have used a qualitative approach to focus on the perspectives of clients who choose to not continue counseling following an initial “intake” appointment. Those that have been done are limited by superficial interviews and fixed-choice questions. To date, no published research has exclusively focused on using in-depth interviews to discover and understand the perspectives of these clients.

The purpose of this study was to use qualitative methods to develop a rich understanding of the perspectives and experiences of multiculturally diverse college students who sought initial services at a university counseling center. Because it was discovery oriented with a goal of capturing student perspectives, a qualitative approach was an appropriate choice. The study included students in moderate-to-high psychological distress who attended an initial “intake” session and focused on students who chose to not return for recommended individual counseling. Maximum variation sampling at a large, midwestern university made it possible to recruit a multiculturally diverse sample of nineteen students who varied widely across age, race/ethnicity, gender, and citizenship status. In addition, the nineteen student-therapist intake dyads were also quite varied due to the diverse staff at the counseling center. Nineteen initial and five follow-up individual, audiotaped interviews were completed and transcribed by the researcher.
A rigorous inductive analysis of the data yielded five major findings that are connected by a common thread: a need to better understand and appreciate student perspectives. This research facilitated an important shift in my perspective from that of an “insider” (therapist) to that of an “outsider” (student coming to the counseling center). The five major findings are grounded in these students’ experiences and reflect their perspectives on coming to counseling:

(a) It is difficult for students to come to counseling and they put off coming.
(b) “Insider” and “outsider” understandings of the intake process and counseling center practices differ. It’s important for therapists and centers to critically question unspoken assumptions about student understandings.
(c) By the time they do come in, students are ready to start the process of counseling. They want that initial “intake” visit to be a beginning, not a simple screening.
(d) Students know if they have therapist preferences and it can be empowering to let them voice those preferences.
(e) Effectively negotiating difference with cultural empathy is especially important in the initial “intake” session.

Recommendations, grounded in these findings, are offered as a guide. The underlying goal of these suggestions is to enumerate ways to enhance our practice so that all students’ initial experiences at counseling centers might be a little bit better. Quite possibly, such changes could reduce the poor return rate following intake at university counseling centers.
Dedicated to College Students Everywhere
ACKNOWLEDGMENTS

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CHAPTER 1

INTRODUCTION

At university counseling centers (UCCs), college students who come for counseling typically start off with an initial “intake” appointment that includes filling out paperwork and meeting with a therapist who screens their needs and then decides what services are most appropriate (e.g., individual, group, psychoeducational outreach, community referral). The therapist assesses the student’s level of distress based on the session and completed paperwork. Based on needs, severity of distress, therapist availability, and specified preferences (e.g., a desire to work with a female therapist), students for whom individual therapy is recommended may be immediately assigned a therapist or may have their names added to a waitlist. Eventually, all students who are appropriate for individual counseling are assigned a therapist and have a second appointment scheduled. Some students return for the second appointment (the first appointment with the assigned therapist). Other students do not return. The non-return rate hovers between 20% and 25% at UCCs (Epperson, Bushway, & Warman, 1983).

The purpose of this study was to examine college students in moderate-to-high psychological distress who sought services at the UCC but chose not to return for recommended therapy following an initial, intake session. “Premature termination”, “early dropout”, and “treatment attrition” are all terms used in the literature to describe clients who leave treatment before their therapists believe they are ready to do so. Unfortunately, these terms are laden with negative connotations. In an effort to avoid
attaching value to students’ decisions to return or not for additional, recommended UCC services, participants simply are differentiated by their choice: those who chose to return for more services and those who chose not to return.

This study examined the experiences of both types of UCC intake clients (those who chose to return and those who chose not to return) but primarily focused on developing a fuller understanding of the experience of students seen on intake who choose not to return. While some of these students may no longer be in distress by the time they are scheduled to see a therapist, research suggests many frequently remain in need of assistance (Mennicke, Lent, & Burgoyne, 1988). In these circumstances, UCCs are not meeting client needs. Additionally and secondarily, clients who choose not to return and do so by not showing for scheduled appointments tend to decrease the productivity of the counseling center staff.

Research on clients who choose to not continue counseling has been limited, but studies have consistently found high rates that typically vary from 20% to 25% (Epperson, Bushway, & Warman, 1983). The majority of these studies have been quantitative investigations of clinic/client/therapist variables. Minority racial status, low education, and low SES have been significantly related to psychotherapy dropout (Wierzbicki & Pekarik, 1993), but the results for the majority of the clinic/client/therapist variables have been mixed.

Additionally, only a few studies have focused on the perspectives of clients who choose to not continue counseling. Some have queried clients about termination using a list of possible termination reasons generated from a literature review (e.g., Hunsley, Aubry, & Verstervelt, 1999). Other studies have conducted brief telephone interviews to ask such clients why they failed to return for counseling and used this to construct a list of reasons (e.g., Freund, Russell, & Schweitzer, 1991). To date, no published research has exclusively focused on using in-depth interviews to discover and understand these clients’ perspectives.

The perspectives of UCC clients are increasingly being valued and highlighted in the research literature. “In light of the growing cultural diversity in the United States, clients’ perceptions with regard to the counseling services they receive have been
increasingly recognized as valuable and crucial” (Constantine et al., 2002, p. 408). Furthermore, “it is particularly important to use clients' perceptions of the counseling process, because these perceptions often differ from those of the counselor” (Paulson et al., 1999, p. 317). Consequently, one of the primary purposes of this study was to give voice to clients and to use their perspectives to co-construct a better understanding of their intake experiences at UCCs.

This study also had a multicultural focus, using “an inclusive definition of multiculturalism that extends beyond race and ethnicity to include nationality, social class, religion, gender, affectional orientation, age, disability, and more” (original emphasis, Pope-Davis et al., 2002, p. 360). It is not known how dimensions of difference within the intake dyad (i.e., the college student and intake therapist pair) shape the intake experience; consequently, student participants were selected so as to maximize differences across a number of dimensions. In addition, it is not known whether cultural incompetence contributes to the choice of clients not to return for counseling (Constantine et al., 2002). Thus another primary purpose of this study was to better understand these clients’ perceptions regarding effective multicultural counseling.

An extensive review of the literature has shown that research on the intake experience and the role of various dimensions of difference within the intake dyad has been minimal. Thus, the goals of this study were:

- To better understand perspectives of students seen on intake at UCCs, especially those who chose not to return for recommended counseling, and
- To better understand the role of various differences and similarities in the intake dyad for students who chose not to return for counseling.

Qualitative research methods were used to investigate the intake experience of students at a UCC with a concentration on the experiences of those who chose not to return for further counseling. A qualitative approach to this study was an appropriate choice because of its discovery-oriented nature and its focus on capturing student perspectives. Qualitative methods, which often include interviews and other means of direct observation to contextualize phenomena, allow the researcher to fully explore the experiences of participants from their own points of view and in their own words (Richie,
In their recommendations for multicultural competency research, Pope-Davis et al. (2001) recommend the use of qualitative methodology to investigate real clients in real counseling situations because qualitative methods allow clients to use their own language to describe their experiences. More specifically, a constructivist/interpretivist qualitative approach was used. Using this approach, the researcher enters the world of the participants and expresses an interest in understanding and learning about the participants’ perceptions and descriptions. During the process, the researcher attempts to suspend her socially constructed worldview while trying to understand participants’ worldviews (Ponterotto, 2002).

Because many professionals in psychology are not familiar with the philosophical and methodological frameworks of qualitative research (Fischer, 1999), an overview of qualitative research is included at the end of the literature review in the second chapter. Additionally, throughout this document an effort has been made to remain sensitive to the needs of an audience grounded in procedural and statistical analysis traditions by clarifying and explaining this study’s rationales, assumptions and techniques. Unlike quantitative research, in which specific measures are used as research instruments, the qualitative researcher serves as the research instrument as she interviews and makes observations (Janesick, 2000). Consequently, it is critical that the researcher identify her subjectivities since they strongly influence the course of the research, including research topic, inquiry paradigm, interview questions, and relationships developed with participants. Typically, researcher subjectivities are presented in the introduction.

**Introduction To The Researcher**

As the author and interpreter of these students’ experiences, it is important for me to reveal the subjectivities and experiences that I bring to this research. I am an unpartnered, 46-year-old female of Scottish/English descent from a family with recent roots in central Texas. Currently, I am a fifth year student in the Counseling Psychology PhD program at a large midwestern university. I strongly identify with feminism, value multicultural diversity, and actively support the GLBTQ community. I have a background in the “hard” sciences (BA in Biochemistry, MA in Computer Sciences) and come to psychology after an eleven-year career as a software engineer.
As a therapist, I use an integrative approach that is strongly influenced by person-centered, constructivist, and feminist therapies. My feminist beliefs influence my approach to all relationships, including therapeutic and interview relationships. I highly value collaboration and egalitarianism, consciously consider the power dynamics at play in different relationships, and try to find ways to empower oppressed others (e.g., therapy clients and research participants). Consequently, I view myself as a co-investigator with research participants and have emphasized collaboration throughout the study.

At the counseling center where the research was conducted, I have completed over 100 intake interviews, spent six months serving on the intake disposition committee, and an additional two months serving on the clinical services committee. Prior to beginning this qualitative research, I completed a three-course sequence on qualitative research. The second course in the sequence required me to complete a “mini” qualitative research project during which I conducted my first qualitative interviews with a counseling client. That “mini” project was independent of the current research. Throughout this research, I have repeatedly collaborated with an expert in the theory and practice of qualitative research. From him, I have received extremely helpful advice, suggestions and guidance.

Throughout the process, I endeavored to highlight the voices, experiences, and perspectives of these students and to minimize my voice. I continue to believe that they are the experts on their intake experiences at the UCC. My job as the researcher has been to construct an understanding and interpretation that, as best as possible, is congruent with and accurately reflective of their lived experiences. Staying close to students’ voices and experiences has remained important throughout data collection, analysis, and writing.

It was important that involvement in this study be beneficial to participants. Participation was compensated at a rate of $10 per interview. Furthermore, the research interviews themselves may have been helpful to some extent because (a) counseling is actually a specialized form of interviewing, and (b) interviews are “negotiated accomplishments of both interviewers and respondents” (Fontana & Frey, 2000), thus capable of shaping both. In addition, the process of developing rapport and trust may have helped participants construct an understanding about what future counseling could offer since I am a therapist-in-training. Thus, students may view the counseling process
more favorably as a result of their interviews. Additionally, this study’s focus on students’ experiences and perspectives conveys the message that they are important to the counseling center by virtue of its endorsement of this research. Finally, conversations about how the center might improve its intake practice may have conveyed to students that the center values their input.

This study will also benefit UCCs and the field of psychology. The results are directly applicable to the UCC where this study was conducted¹ and it is likely the results are extendible to other UCCs, especially those with similar intake procedures. In a more general way, these results can heighten the awareness of therapists and counseling centers about the special challenges that accompany a student’s initial contact with a UCC. Perhaps the results will encourage and guide UCCs to make minor adjustments to better accommodate college student needs. Finally, given the rich multicultural diversity of the students I interviewed, the results provide useful insights into the experiences of students who vary widely on dimensions of difference and who are different from and similar to their intake therapists in numerous ways. As such, this is an important addition to the multicultural counseling and competency literature.

¹ During the spring of 2004, several steps were taken to educate staff members about this study’s findings and to suggest concrete changes to help students have more positive initial experiences at the center.
CHAPTER 2

LITERATURE REVIEW

Introduction

This literature review covers a number of different topic areas. Since the research explicitly studied client perspectives of the initial “intake” process, a brief review of the literature base examining client perspectives is presented. This section is immediately followed by a review of the literature on premature termination from psychotherapy. Additionally, a review of the multicultural counseling competency literature is presented because this perspective is an important one to consider given the rich multicultural diversity of the sample of students who participated in this research. Finally, a detailed overview of qualitative methodology is presented at the end of this chapter because many professionals in psychology are not familiar with the philosophical and methodological frameworks of qualitative research (Fischer, 1999),

Research on Client Perspectives

“Although traditionally it has been the counselor’s or investigator’s point of view that has informed understanding of counseling process and outcome, increasingly the client’s perspective is being recognized as valuable, if not essential” (Paulson, Truscott, & Stuart, 1999). Research on client perspectives is neither new nor uncommon, although it has become increasingly common over time. For example, a computer search of PsycINFO (1967-2002), the online database of the American Psychological Association

Another important trend in the research on client perspectives is the increasing use of qualitative methodology. When the PsycINFO search described above was narrowed to focus on qualitative investigations (by narrowing the search criteria to include only articles with an abstract that uses the words “qualitative”, “ethnographic”, “naturalistic”, or “grounded theory”), 25 articles are identified. With a single exception (published in 1975), all were published since 1990. Furthermore, since 1996, qualitative research on client perceptions has regularly appeared in the published journals, with an average of three articles included every year. While this undoubtedly reflects the increased openness of psychology to qualitative methodology in general, it also reflects the growing interest in using qualitative methods to better understand client perspectives.

Premature Termination

Overview. Psychotherapy can be prematurely terminated at a number of different points in the counseling process. At the earliest stage, a client may fail to return following an initial intake session. At the other end of the spectrum, the decision to discontinue may be made unilaterally after some number of sessions by either the client or the therapist. Premature termination is a serious problem that interferes with the effective delivery of counseling services. In a meta-analysis of 125 studies of psychotherapy dropout that covered the period from 1974 to 1990, Wierzbicki and Pekarik (1993) reported an average outpatient psychotherapy dropout rate of 47%. Furthermore, premature termination is problematic across different settings. “Approximately 40% of clients in community mental health centers and 20% in private settings terminate therapy within 2 visits” (Richmond, 1992, p. 123). Mennicke, Lent, and Burgoyne (1988) reported that “in college counseling centers specifically, ‘no-show’ rates immediately after intake often hover between 20% and 25%” (p. 458). For example, at university counseling centers,
Betz and Shullman (1979) found a 24% rate and Kokotovic and Tracey (1987) found a 22% rate, while Richmond (1992) found a 19% rate at a private, nonprofit outpatient mental health clinic.

There is no standard terminology in the research literature used to refer to clients who drop out following a single intake session (e.g., *dropouts, refusers, defectors, and no-shows*). Matters are further complicated by the fact that the same term is used differentially across studies. For example, in one study *dropout* may refer to a client who fails to return after intake, while another study may use *dropout* to refer to clients who complete fewer than four therapy sessions. This is unfortunate because factors influencing early termination from counseling may differ between individuals who do not return following an intake session and those who leave counseling at later points in the counseling process (Betz & Shullman, 1979; Garfield, 1994). For example, Richmond (1992) divided therapy into three phases: (a) intake – the first session, (b) evaluation – the second and third sessions, and (c) therapy proper – the remaining sessions. In his study of 624 clients at a training clinic that used a specific domestic violence program, 19% discontinued at the intake phase, 17.5% discontinued at the evaluation phase, and 22.5% discontinued by the end of the 10th session (Richmond, 1992). In his analyses, Richmond was able to significantly distinguish between dropouts and non-dropouts in each of the three phases based on client characteristics, although some characteristics were common to all dropouts (higher tension, racial minority, low education, and lower levels of guilt feelings).

Predictors of Premature Termination. While there is general agreement that the factors contributing to termination immediately following intake may differ from other types of premature termination, it is informative to review the predictors of premature termination that have been examined in the literature. These have been categorized into four broad classes: (a) clinic variables, (b) client variables, (c) therapist variables, and (d) client/therapist interaction variables. Unfortunately, research findings regarding effects of particular variables vary across studies with few consistently significant results.

In terms of clinic variables, May (1991) reviewed the effects of waiting for university counseling services by examining thirteen studies conducted between 1963 and
1990. Based on his review, May (1991) concluded that waiting clients have relatively low levels of dissatisfaction, and that length of wait appears to be unrelated to attrition. Variations in client assignment is another clinic variable. The assigned therapist may or may not be the intake therapist. The intake client may or may not know who the assigned therapist will be, although preferences for therapist characteristics (e.g., gender or race/ethnicity) may be specified at intake. Mennicke et al. (1988) report inconsistent results in studies on intake variations.

In terms of client variables, Wierzbicki and Pekarik’s (1993) meta-analysis of 125 studies determined that (a) racial minority status, (b) low education, and (c) low SES were all significantly related to dropout. Self-referrals have been found to prematurely terminate less frequently than involuntary clients, and substance abusers have been found to terminate more frequently than non-substance abusers (Reis & Brown, 1999). The majority of other demographic characteristics (e.g., age, gender, and marital status) have proven to be inconsistent predictors across studies (Garfield (1994), Mennicke et al. (1988), Reis & Brown (1999)). While these are fairly easy variables to study, the identification of particular demographic variables that are associated with premature termination is of limited usefulness for practitioners since they are relatively permanent attributes.

A wide range of other, more promising client variables have been considered in the literature. The focus of this review is on studies of university counseling center clients. For example, Kokotovic and Tracey (1987) found that client satisfaction and perceptions of the counselor as expert and trustworthy were related to continuing past intake. No differences were found with respect to client perceptions of counselor attractiveness or client-counselor agreement on problem identification. In another study, Longo, Lent and Brown (1992) examined the role of self-efficacy and outcome expectations in the prediction of client attrition. They found that self-efficacy and outcome expectations accounted for significant unique variance in motivation (above and beyond client gender, problem severity, and therapist experience), and that self-efficacy and motivation contributed to the client return following intake.
An earlier study by Hardin, Subich, and Holvey (1988) examined the relationship between counseling expectancies but found no relationship between pre-counseling expectations and premature termination. Smith, Subich, and Kalodner (1995) investigated the relationship between premature termination and client readiness, as reflected in the stages and processes of change proposed in the transtheoretical model of change (Prochaska & DiClemente, 1982). Their results showed that failure to return for a second appointment was distinguishable by the client’s stage of change upon entering therapy. In a related but more recent and broader based study, Brogan, Prochaska, and Prochaska (1999) found that client characteristics were not significant predictors but transtheoretical variables of stages of change, processes of change, and decisional balance for therapy were excellent predictors of premature termination. Their results showed that premature terminators were more oriented toward changing their environment as opposed to changing themselves.

These studies are representative of the wide range of client variables that have been studied in the literature. The remaining two categories of predictors of premature termination are therapist variables and client/therapist interaction variables. Research on these has not yielded conclusive findings. Therapist variables that have been examined include therapist gender, experience level, problem recognition, social influence, and facilitative conditions. Research findings on therapist variables do not permit definite conclusions or implications for practice (Mennicke et al., 1988).

Similarly, client-therapist demographic relationships have not yielded consistent findings. Nonetheless, this is an important area of research. For example, the effect of a therapist’s race/ethnicity on the client’s perception of the counseling process is receiving increased attention in the literature (Wade & Bernstein, 1991). As with other predictors, mixed results have been obtained. For example, in terms of racial balance, “Gibbs (1975) results indicated that Black clients averaged more sessions with Black counselors than with White counselors, but other findings suggest that dropping out is not related to client-counselor racial balance (Proctor & Rosen, 1981)” (Mennicke et al., 1988). For established and working counseling relationships, Vera, Speight, Mildner, and Carlson (1999) found that clients rated both similarities and differences as having
primarily positive effects on the counseling relationship and that clients perceived similarities as having the stronger effect. The influence of similarities and differences in premature termination has not been examined.

In summary, although a number of different predictors of premature termination have been examined, findings are largely inconclusive with conflicting findings and studies that are fraught with methodological problems (Mennicke, Lent, & Burgoyne, 1988).

Research Specific to Client Perspectives of Premature Termination

Research specific to client perspectives regarding premature termination is very sparse. One such study was done by Freund, Russell, and Schweitzer (1991) who used telephone interviews to talk to 18 clients who didn’t return for counseling after an intake session at a university-affiliated counselor training agency. The telephone interview included an open-ended question about the client’s decision not to return for counseling. Using this methodology, Freund et al. (1991) compiled the following list of reasons with the number of responses for each included parenthetically: (a) discomfort with videotaping/camera (10), (b) problem resolved (5), (c) received counseling from another professional (4), (d) wait too long (3), (e) still interested in counseling (2), (f) disappointed in intake (2), (g) moved from area (2), (h) too young for services (2), (i) lack of time (1), and (j) illness (1). A limitation of this study is that the interviews used were single, telephone-based encounters. Multiple, longer length, face-to-face interviews would allow the development of rapport and trust, thus increasing the trustworthiness of responses and reducing the influence of social desirability in responses.

Hunsley, Aubry, Vestervelt, and Vito (1999) compared client and therapist perspectives on reasons for psychotherapy termination at a university clinical psychology training clinic. Like Freund et al. (1991), they conducted telephone interviews with former clients about their services (both premature terminators and therapy completers). But, instead of using open-ended questions, Hunsley et al. (1999) developed a list of 10 possible reasons for termination, from the perspective of the client, based on the literature. In the phone interview, clients were asked to rate the importance of each reason in their decision to end therapy. Consistent with previous research, Hunsley et al. (1999)
found little agreement between the therapists’ and clients’ perspectives regarding the termination of therapy. The limitations of this study are similar to those of the Freund et al. (1991) study in that client perspectives were tapped at a very superficial level. In fact, this study was even more limited because client perceptions were assessed via a fixed set of choices rather than through open-ended questions.

Although Parsons and Srsic (1999) excluded clients who failed to return following an intake session from their study, they completed 73 telephone interviews with clients who terminated therapy within the first three sessions at a university counseling center. Interviewers posed closed ended questions and possible reasons for termination were grouped into four categories (clinic, client, therapist, and client-therapist interaction). The clinic category included items like excessive wait for service and inability to accommodate the client’s schedule. The client category included items like client got better, client was too busy, and client decided to go elsewhere for services. The therapist category included reasons why the therapist was not a good fit (e.g., race and age) and that the therapist didn’t have enough expertise. Finally, the client-therapist interaction category included things like differing expectations about counseling length, goals, and topics. Participants were allowed to identify multiple reasons for choosing to discontinue counseling. Each of the four categories was endorsed by percentages of interviewees as follows: clinic (33%), client (86%), therapist (41%), and client-therapist interaction (33%). Parsons and Srsic (1999) concluded that poor fit with the therapist is one of the major reasons contributing to premature termination. This study suffers from the same limitations as previously discussed: superficial interviews and fixed-choice interview questions.

The significant problem of client termination following intake has yet to be fully explored. No study has qualitatively approached the question and attempted to develop an understanding of clients’ perspectives regarding their experience during the intake session. This problem can’t be fully understood in the absence of the rich and elaborate data generated by qualitative research techniques. For example, clients’ experiences need to be elicited through open-ended questioning in one-on-one interviews, which are subsequently transcribed and interpreted using qualitative data analytic techniques.
Multicultural Counseling Competency (MCC)

Conceptualization of MCC. The study of multiculturalism in counseling is rooted in the racial civil rights movement (Helms, 1994), and discussions of multiculturalism have been largely from racial and ethnic perspectives. However, a more inclusive and pluralistic definition of multiculturalism is becoming widely accepted. At the January 1999 National Multicultural Conference and Summit meeting, as reported by Sue, Bingham, Porché-Burke, and Vasquez (1999), it became apparent “that the term multiculturalism must include the broad range of significant differences (race, gender, sexual orientation, ability and disability, religion, class, etc.) that so often hinder communication and understanding among people” (p. 1063, original emphasis).

Some multicultural experts have argued against such inclusiveness because of fears that the concept of multiculturalism will become diluted to the point of uselessness. For example, Helms (1994) worries that the inclusive definition will cause attention to shift away from the analysis of the influence of racial factors on the therapeutic process. Additionally, there is some concern that an all-inclusive definition would at some point degenerate into a study of individual differences (Sue et al., 1999). Nonetheless, many current multicultural researchers (e.g., Constantine & Ladany, 2001; Ponterotto, Fuertes, & Chen, 2000; Pope-Davis, Toporek, Orgeta-Villalobos, Ligiero, Brittan-Powell, Liu, Bashsur, Codrington, & Liang, 2002) conceptualize multiculturalism as extending beyond race and ethnicity. This dissertation uses ‘multiculturalism’ and ‘multicultural diversity’ in reference to the more inclusive and pluralistic definition adopted in 1999 (Sue et al., 1999).

The concept of MCC has been defined as “counselors’ attitudes/beliefs, knowledge, and skills in working with individuals from a variety of cultural (e.g., racial, ethnic, gender, social class, and sexual orientation) groups” (Constantine & Ladany, 2001, p. 482). Currently, MCC is conceived of as having four dimensions: skills, cultural self-awareness and other-awareness (or beliefs/attitudes), knowledge, and multicultural counseling relationship (Sodowsky, 1996b).
Two seminal papers had a significant impact on the understanding of MCC. The first was a position paper (Sue, Bernier, Curran, Feinberg, Pedersen, Smith, & Vasquez-Nuttall, 1982) that listed 11 multicultural counseling competencies that were subsumed under three dimensions: (a) beliefs/attitudes, (b) knowledge, and (c) skills. The beliefs/attitudes dimension included both self-awareness and other-awareness in cultural, racial, and sociopolitical terms. The knowledge dimension included knowing underlying theory, research, and approaches. The skills dimension included active participation in multicultural clinical work and with diverse populations.

Ten years later, a second paper (Sue, Arredondo, & McDavis, 1992) offered a revised and expanded list of multicultural competencies organized in a 3x3 matrix. One side of the matrix included the three dimensions described in Sue et al. (1982), that is, beliefs, knowledge, and skills. The other side of the 3x3 matrix included three dimensions of counselor characteristics: (a) counselor awareness of own worldview (assumptions, values, and biases), (b) counselor understanding of clients’ worldviews, and (c) culturally appropriate intervention strategies (Atkinson, Bui, & Mori, 2001). Sue et al. (1992) included 31 multicultural competences distributed among the nine quadrants of the 3x3 matrix. For example, “culturally self-aware” is included in the beliefs/counselor awareness quadrant of the matrix (Sodowsky, Kuo-Jackson, & Loya, 1997). Sodowsky, Taffe, Gutkin, and Wise (1994) proposed adding a fourth dimension, the multicultural counseling relationship, which included competencies like comfort level with minority clients and making non-normative comparisons (Sodowsky et al., 1997).

Assessment of MCC and Limitations. Several methods of multicultural counseling competency assessment have been developed to evaluate therapists, including self-report, portfolio, and observer-ratings (Constantine & Ladany, 2001). Each of these methods is briefly explored and critiqued below.

Constantine and Ladany (2001) describe three self-report measures in their review of the assessment of MCC. The first is the Multi-cultural Awareness/Knowledge/Skills Survey (MAKSS) developed by D’Andrea, Daniels, and Heck (1991). The MAKSS is a 60-item self-report measure that uses a 4-point rating scale to assess three subscales:
Awareness – awareness of personal attitudes toward people of color, Knowledge – knowledge of people of color, and Skills – cross-cultural communication skills.

The second self-report measure described by Constantine and Ladany (2001) is the Multicultural Counseling Inventory (MCI) developed by Sodowsky, Taffe, Gutkin, and Wise (1994). The MCI is a 40-item self-report measure that uses 4-point Likert-style responses to assess four subscales: Awareness – multicultural sensitivity, interactions, experiences, understanding, and advocacy, Knowledge – multicultural information, case conceptualization, and treatment strategies, Skills – multicultural and general counseling skills, and Relationship – therapist interpersonal process with racial/ethnic minority clients.

Finally, Constantine and Ladany (2001) discuss the Multicultural Counseling Knowledge and Awareness Scale (MCKAS) developed by Ponterotto, Gretchen, Utsey, Rieger, and Austin (2000, as cited by Constantine & Ladany, 2001). The MCKAS is a 32-item self-report measure that uses 7-point Likert-style responses to assess two factors: Knowledge – knowledge related to multicultural counseling, and Awareness – subtle Eurocentric worldview bias.

Several limitations regarding self-report measures of MCC have been noted in the literature (e.g., Constantine & Ladany, 2000; Ladany et al., 1997; Pope-Davis & Dings, 1995; Sue 1996). Pope-Davis et al. (2001) summarize the limitations as follows:

In summary, the problem with much of the research on counselor multicultural competency has been the reliance on self-report measures. There were several problems with these self-report measures. For instance, the self-report measures (a) used counselors' self-perceived efficacy in multicultural issues that may have been positively or negatively biased (i.e., counselors may often over- or underrate themselves on their multicultural competency); (b) were a snapshot measure of competencies with no baseline for comparison; (c) did not take into consideration that people with little multicultural training tend to be less aware of their lack of knowledge, and thus less able to make an adequate assessment of their cultural competence (i.e., overreporting their competencies); and (d) did not take into account social desirability, self-enhancement motives, and misinterpretation of items on the instruments. (p. 124)

Another important limitation of multicultural counseling competency assessment, based on a review of the measures’ items, is that “the perceived ability to work
effectively with people of color seems to be the primary construct measured” (Constantine & Ladany, 2000, p. 162). Thus current self-report assessment tools are very limited, especially when the definition of multiculturalism is extended to include a broader set of cultural dimensions, for example, social class, gender, and sexual orientation.

In addition to self-report measures, Constantine and Ladany (2001) discuss portfolio, and observer-rating methods. Two methods that allow the assessment of training programs are: (a) the Multicultural Competency Checklist (Ponterotto, Alexander, & Grieger, 1995) and (b) the Multicultural Environmental Inventory-Revised (MEI-R; Pope-Davis, Liu, Nevitt, & Toporek, 2000). The Multicultural Competency Checklist focuses on racial/ethnic diversity in training programs as assessed by program administrators and/or faculty. The MEI-R focuses on graduate students’ perceptions of their training program’s environment.

Observer ratings also have been used to assess MCC (Constantine & Ladany, 2001). The Cross-Cultural Counseling Inventory-Revised (CCCI-R; LaFromboise, Coleman, & Hernandez, 1991) is a 20-item scale that uses Likert-style responses for observers. The CCCI-R was developed for the assessment of trainees by supervisors. Unfortunately, its use is only meaningful if the supervisor is multiculturally competent. Multicultural case conceptualization, the ability of counselors to integrate and differentiate multicultural issues in client conceptualization, is another type of observer rating scale. “However, it is important to note that an ‘academic’ multicultural conceptualization is still removed from specific multicultural performance skills” (Constantine & Ladany, 2001, p. 489).

Finally, portfolio approaches can be used to assess MCC (Constantine & Ladany, 2001). A “portfolio” is a collection of work that illustrates a person’s achievements, for example, an artist’s portfolio includes samples of the artist’s work that illustrate artistic talent. Coleman (1996) discusses the use of portfolios for the assessment of multicultural counseling competency. An advantage of portfolios is their depth and breadth, which
makes them useful for assessing mastery of specific concepts and other things; disadvantages of portfolios include that they are time-consuming to develop and review, and that they lack reliability (Constantine & Ladany, 2001).

**Client Perspectives: A Missing Piece of MCC.** Until recently, MCC research has not examined clients’ experiences of multicultural counseling. Pope-Davis et al. (2002) reported finding no published empirical studies that examined how therapy clients experience a multiculturally competent counselor. The closest literature Pope-Davis et al. (2002) found was the client-matching literature, where matching is the process of asking clients if they would prefer a culturally similar or different counselor. The two dominant cultural variables used in client-matching studies are race and gender. Unfortunately, the client-matching literature largely focuses on anticipated outcomes of pseudoclients in pseudotherapy or nontherapy situations, however, that body of literature does suggest that clients prefer therapists who are similar in values and worldviews (Coleman, Wampold, & Casali, 1995).

In their review of what is missing from multicultural competency research, Pope-Davis, Liu, Toporek, and Brittan-Powell (2001) assert that client experiences in multicultural counseling situations have been given little attention. As a result, it is not known how clients conceptualize MCC and how similar that conceptualization is to psychology’s current conceptualization of MCC. Pope-Davis et al. (2001) conclude with four recommendations for future MCC research:

1. MCC research should examine real clients in real therapeutic relationships.
2. MCC research should use qualitative research methods to establish a basis for understanding the client experience.
3. MCC research should explore the different helper roles held by therapists, including non-traditional roles like advocate and change agent.
4. MCC research should examine other unexamined perspectives, like the therapist-in-training’s perception of supervisors’ multicultural competencies.

**Qualitative Research and Counseling Psychology**

**Introduction.** The purpose of this section is to provide a brief overview of qualitative research, especially as it applies to counseling psychology. Traditionally,
counseling research has relied heavily on quantitative methodologies with qualitative approaches being less common (Ponterotto, 1998), but since the mid-1980s calls for the inclusion of qualitative procedures have increased. Throughout the 1990s, increasing numbers of qualitative investigations have been published and special issues dedicated to qualitative methods have appeared in flagship counseling psychology journals like The Counseling Psychologist and Journal of Counseling Psychology (Morrow & Smith, 2000). For example, in 1994, Journal of Counseling Psychology published a special section on counseling process and outcome qualitative research (1994, 41, pp. 427-509).

Although relatively new to psychology, qualitative research has long been used by a variety of disciplines, including anthropology, sociology, and linguistics. The term ‘qualitative research’ has been given various names, including participant observation, ethnography, naturalistic research, and interpretive research (Morrow & Smith, 2000). This introduction to qualitative research provides only a brief overview of a topic that over time has evolved into a complex field. More in-depth information on qualitative methodologies can be obtained from a variety of sources, including general resources by Denzin and Lincoln (2000) and Glesne (1998), and resources specific to counseling psychology by Morrow and Smith (2000) and Kopala and Suzuki (1999).

Broadly, the purpose of qualitative research is to interpret human behavior in a particular context using multiple methods for the purpose of developing a richer and more accurate understanding of participants’ lived experiences. In his landmark chapter on “Qualitative Methods in Research On Teaching”, Erickson (1986) asserts that qualitative research “involves being unusually thorough and reflective in noticing and describing everyday events in the field setting, and in attempting to identify the significance of actions in the events from the various points of view of the actors themselves” (p. 121). Methods used in qualitative research include face-to-face interviews, participant-observation, examination of physical data like artifacts and documents, and analytic and reflexive journaling. However, it is important to note that qualitative research is not simply a matter of applying particular methods to a research problem.

From one point of view, that of the textbook, doing ethnography is establishing rapport, selecting informants, transcribing texts, taking
genealogies, mapping fields, keeping a diary, and so on. But it is not these things, techniques and received procedures, that define the enterprise. What defines it is the kind of intellectual effort it is: an elaborate venture in, to borrow a notion from Gilbert Ryle, “thick description.” (Geertz, 1973, p. 6)

Unlike the fixed design of quantitative research, qualitative research has an emergent design that evolves as the research project unfolds. The researcher always identifies research interests before entering the field, but as the research progresses the researcher alternatively uses inductive and deductive reasoning to guide the project. “The research pursues deliberate lines of inquiry while in the field, even though the specific terms of inquiry may change in response to the distinctive character of events in the field setting. The specific terms of inquiry may also be reconstructed in response to changes in the fieldworker’s perceptions and understandings of events and their organization during the time spent in the field” (Erickson, 1986, p. 121). Consequently, the research proposal identifies the research design as fully as possible, but over the course of the investigation, as the researcher gathers and begins interpreting the data, the design may be modified and adapted to more fully meet the research goals (Morrow & Smith, 2000).

Quantitative and Qualitative Research – Different Ways of Knowing. These two approaches to research have fundamentally different underlying philosophical assumptions about the nature of reality, how that reality can be known, and the methods that can be used to investigate that reality. Morrow, Rakhsha, and Castañeda (2001) differentiate between the two like this:

Each approach – one [quantitative] being more academic, structured, linear, and certain and the other [qualitative] more practical, intuitive, circular, and packed with ambiguity and discovery – complements the other, and each has its particular strengths. (p. 576)

Denzin and Lincoln (2000) contrast the two as follows:

Qualitative researchers stress the socially constructed nature of reality, the intimate relationship between the researcher and what is studied, and the situational constraints that shape inquiry. Such researchers emphasize the value-laden nature of inquiry. They seek answers to questions that stress how social experience is created and given meaning. In contrast, quantitative studies emphasize the measurement and analysis of causal relationships between variables, not processes. (p. 8)
One way to illustrate the basic differences between these two research approaches is to examine the differing roles of qualitative and quantitative investigators. Because the underlying philosophical assumptions of these two approaches are divergent, it isn’t surprising that the researcher role is also quite different. Kopala and Suzuki (1999) enumerate some of these differences, including (a) onlooker versus actor, (b) expert versus learner, and (c) detachment versus involvement. Each of these role differences is elaborated below.

In quantitative research, the researcher tends to adopt the role of an onlooker, while in qualitative research, the researcher tends be adopt the role of an involved actor. One way to understand this onlooker versus actor difference is to imagine the research problem as if it were contained within a small, windowed, one-room house. The quantitative researcher, who is strongly influenced by the desire to maintain objectivity, stands outside of the house and investigates by inconspicuously observing the research problem through one of the windows in the house. In contrast, the qualitative researcher doesn’t believe that an objective stance is possible due to her belief that every individual’s truth (including the researcher’s truth) is partial, perspectival, and situated. Consequently, the qualitative researcher deliberately enters the researcher context (i.e., the house in this example) and becomes a part of that context through participation, observation, and/or interviewing. “Qualitative researchers are on the inside, immersing themselves in the social contexts and minds of the participants as an interacting student willing to learn about the experiences and the meanings given to those experiences within the participants’ local context or culture” (Kopala & Suzuki, 1999, p. 43).

This immersion into the research context is most richly accomplished when the qualitative researcher adopts a role of learner rather than assuming the role of an expert. A quantitative researcher closely controls the research process acting as an objective and expert scientist, whereas a qualitative researcher enters the research setting as a learner and student. Adopting the learner role also means relinquishing control because “only in this fashion can they truly enter the world of another” (Kopala & Suzuki, 1999, p. 43). There are times when a qualitative researcher may adopt the role of an expert, for example, to gain entry to a research site. However, once access has been gained, the
researcher must become a learner in order to fully develop an understanding of how research participants make sense of their world. For a qualitative researcher, participants are the experts and the researcher’s task is to learn how the participants understand the research context.

A consequence of fully entering into the participants’ world is that the qualitative researcher becomes quite involved with the participants. This involvement is antithetical to the detachment deliberately sought by quantitative researchers in an effort to maintain scientific objectivity. “The qualitative research must constantly negotiate issues of closeness and intimacy because they are necessary consequences of the serious qualitative endeavor” (Kopala & Suzuki, 1999, p. 44). This indispensable involvement makes it critical for the researcher to monitor her own subjectivity and how that subjectivity might influence the research. Reflexive journaling is the primary means by which the qualitative researcher monitors the influence of her subjectivity.

**Qualitative Data Collection.** With the goal of creating a thick, rich description to allow interpretation of the situation of interest, qualitative data collection includes the use of interview, participant-observation, physical data like artifacts and documents, and analytic and reflexive journaling. Each of these four strategies is discussed below. The research has an emergent design, which is iteratively modified and adapted based on the information revealed and interpreted from the data collected (Morrow & Smith, 2000). Thus data collection methodology may vary as the study progresses. Furthermore, data collection methods differ across qualitative research projects. For example, some research studies may rely heavily on interview data, others may rely heavily on physical data, and still others may rely equally on all data collection methods. The use of multiple methods is encouraged to increase validity through “triangulation”, a term borrowed from navigation and surveying (Glesne, 1998).

The process of triangulation involves examining a phenomenon from multiple perspectives as a means of counteracting the threat to validity that is inherent in any single method. Four basic types of triangulation have been identified: (a) data – using a variety of data sources, (b) investigator – using multiple investigators or evaluators, (c)
theory – using multiple theoretical perspectives to interpret the data set, and (d) methodological – using a variety of data sources (Janesick, 2000). Triangulation increases confidence in research findings.

Interview is a common qualitative data collection strategy. Interviews can occur in formal and informal contexts; they can be structured, semi-structured, or unstructured; and one or more researchers can interview single individuals or groups (Fontana & Frey, 2000). Spradley (1979) describes ethnographic interviews “as a series of friendly conversations” (p. 58) that avoid formal interrogation and give priority to rapport building and gaining trust. Glesne (1998) describes the interviewer as establishing rapport, being non-directive and therapeutic, taking on the role of naïve learner, being aware of status differences, and probing in a warm and caring manner for more explanation, clarification, description, and evaluation.

The interviewer may take notes during the interview and may, with the participants’ permission and informed consent, record interviews using audiotape or videotape equipment. The field log or notebook maintained by the qualitative researcher includes a record of interviews conducted along with descriptive and analytic notes on each interview. Notes taken during the interview should be elaborated in the field log as soon after each interview as possible.

Development of interview questions is not simply a mechanical translation of research questions into an interview schedule, as some novice researchers naively assume (Glesne, 1998). Research questions describe the phenomena to be understood; interview questions, more contextual and specific, are designed to elicit answers that will shed light on the phenomenon of interest. In qualitative research, it is common to use pilot study interviews for the development and refinement of interview questions.

Participant observation is a second qualitative data collection strategy that involves the direct observation of human behavior in a particular context. The researcher physically enters and becomes part of the social setting of interest in order to observe and/or develop relationships with individuals within that setting. “Through participant observation … you learn firsthand how the actions of research participants correspond to their words; see patterns of behavior; experience the unexpected, as well as the expected;
and develop a quality of trust with your others that motivates them to tell you what otherwise they might know” (Glesne, 1998, p. 43). Participant observation falls on a continuum from pure observation to pure participation. Additionally, the researcher’s role is not fixed and the level of participation may fluctuate as needed by the situation. For example, in a classroom setting, the researcher may sometimes simply observe students’ behaviors, sometimes help a student with a problem, and sometimes fully participate in student activities. As a participant-observer, a researcher observes and keeps notes about the setting and the participants, events, and gestures noted within the setting. Descriptive and analytic notes are kept in a field log, which is a primary tool for the qualitative researcher (Glesne, 1998).

A third method of qualitative data collection consists of physical data and artifacts, which can include documents, photographs, archival data, and so on. This is a catchall pile that basically includes any data the investigator gets access to by means other than interviewing and observation. For example, in a qualitative study of the counseling dyad, it could include client and therapist thought listings immediately following counseling sessions, therapist session notes, data collected at the client’s intake, and the client’s personal journal kept over the course of therapy.

Because of the recursive relationship between qualitative data collection and analysis, analytic and reflexive memos written during the research often become important things to analyze. The researcher keeps an analytic journal as part of the field log that “consists of interpretive memos, sudden insights, questions to ask during follow-up interviews, hunches, informal categories or themes, and countless other ideas that occur during the course of the investigation” (Morrow & Smith, 2000). These memos are both analytic and reflexive. It is here that the researcher identifies, explores, and examines how different subjectivities might be influencing the research process. More analytic memos serve to inform data analysis and help direct the course of the research.

In summary, a wealth of information is collected and interpreted in qualitative research. This can result in vast amounts of data. Consequently, one of the challenges in
Qualitative research is to effectively manage the data without being overwhelmed and without overlooking important themes. The process of discovering and constructing meaning from data is the substance of data analysis.

**Qualitative Data Analysis.** Unlike quantitative research, which tends to proceed in a sequential fashion from data collection to analysis, in qualitative research “data collection, analysis, and writing are inseparable and integral” (Morrow & Smith, 2000, p. 213). Data analysis begins at the inception of the research project and continues throughout. Ongoing data analyses suggest modifications and additions to data collection strategies. Even the writing portion of the research is seen as co-occurring with data analysis. Richardson (2000) views writing as a form of data analysis and suggests the use of multiple writing methods as means of discovery and analysis.

A number of data analysis techniques can be used on textual data. Ryan and Bernard (2000) differentiate between techniques from a linguistic tradition that treat text as the object of the analysis (e.g., narrative analysis and discourse analysis) and techniques from a sociological tradition that treat text as a window into human experience. The textual data under consideration here is a free-flowing text derived from interviews and to be analyzed from the sociological tradition. Several forms of analysis are possible, but this discussion focuses on analyzing chunks of text, that is, coding.

The fundamental task of coding includes “sampling, identifying themes, building codebooks, marking texts, constructing models (relationships among codes), and testing these models against empirical data” (Ryan & Bernard, 2000, p. 780). Although there are multiple major coding traditions (e.g., schema analysis and content dictionaries), the only one elucidated here is grounded theory.

The task of sampling is the process of collecting data to be analyzed. Once the researcher has collected data to be analyzed, the process of identifying themes and concepts happens through searching for themes, building a codebook of themes, and marking or tagging text for later retrieval or indexing. “A good codebook should include a detailed description of each code, inclusion and exclusion criteria, and exemplars of real text for each theme” (Ryan & Bernard, 2000, p. 781). Once codes have been
developed, the researcher can begin building conceptual models. Grounded theory is one method of building a conceptual model. An alternative approach is to impose an existing conceptual model or theory onto the codes to develop an understanding.

Grounded theory methods “enable the researcher to develop theory from the experience of respondents, rather than imposing preconceived theory” (Fook, 2002, p. 83, emphasis in original). Alternatively, *a priori* theory models allow the researcher to deliberately select a particular lens with which to view the data. Much can be learned from both methods, and the use of multiple approaches greatly enriches the analysis process and can expose unexpected and interesting results.

An in-depth description of the process of grounded theory analysis helps make clear the overlap of data collection and analysis inherent in the process of qualitative research. Charmaz (2001) describes grounded theory as follows:

> Grounded theory methods consist of systematic inductive guidelines for collecting and analyzing data to build middle-range theoretical frameworks that explain the collected data. Throughout the research process, grounded theorists develop analytic interpretations of their data to focus further data collection, which they use in turn to inform and refine their developing theoretical analyses. Since Glaser and Strauss developed grounded theory methods [in 1967], qualitative researchers have claimed the use of these methods to legitimate their research. (p. 509)

The strategies of grounded theory include simultaneous data collection and analysis. Data coding or analysis “starts the chain of theory development” (Charmaz, 2001, p. 515). Data codes are developed and focused through memo writing, the intermediate step between coding and the completed analysis. “Memo writing helps researchers (a) to grapple with ideas about the data, (b) to set an analytic course, (c) to refine categories, (d) to define the relationships among various categories, and (e) to gain a sense of confidence and competence in their ability to analyze the data” (Charmaz, 2001, pp. 517-518). As the process continues, the researcher begins to use more theoretical sampling based on the emerging theory to guide the data collection process. This process is iteratively repeated; eventually allowing the researcher to sort and integrate the emergent memos into a grounded theory.
As is evident, the methods of data collection and analysis in qualitative research differ significantly from those used in quantitative research. Not surprisingly, the criteria for evaluating the research quality are also quite different.

**Evaluation of Qualitative Research.** In terms of rigor and trustworthiness, the criteria that denote quality in qualitative research are necessarily different from those of quantitative research. Morrow et al. (2001) identify and discuss some “core standards” (p. 592) in qualitative research. Their quality criteria include: (a) immersion in the field – maximizing one’s understanding of participants’ worldviews, (b) sufficient data – continuing to collect data until new data stops providing new information, (c) triangulation – using multiple data sources, for example, interview and observation data, (d) immersion in the data – becoming intimately involved with the data so that meanings are not missed or misconstrued, (e) participant checks – going back to participants to ensure that the researcher’s understanding is consistent with the participants’ realities, (f) search for disconfirming evidence – actively seeking cases that contradict emerging themes, (g) management of researcher subjectivity – managing researcher biases, assumptions, and emotions through a self-reflexive journal, (h) thick description – fully developing the context surrounding participants and phenomena, (i) an audit trail – maintaining a physical record of every bit of raw data that is part of the study, and (j) authenticity criteria – attending to voice, community, reciprocity, and sharing of power and privilege throughout the research process.

**Concluding Remarks.** It is hoped that this brief overview of qualitative research is helpful to therapists who may be strongly grounded in quantitative research methodology and not as familiar with qualitative methodology. It is recommended that such readers refer back to this section as they read the following methods discussion.
CHAPTER 3

METHODS

Research Design

A review of the literature reveals a meager understanding of the initial “intake” experience of multiculturally diverse students at university counseling centers and a poor understanding of the role of difference within multiculturally diverse “intake” dyads. Furthermore, university counseling centers typically have significantly poor return rates for students: 20% to 25% choose not to return for recommended services following an intake session (Epperson, Bushway, & Warman, 1983). Given this, the goals of this study were (a) to better understand perspectives of intake clients at university counseling centers, especially clients who chose not to return for recommended counseling, and (b) to better understand the role of various differences and similarities in the intake client/therapist dyad.

This study used qualitative research methods to investigate the intake experience of college students at a university counseling center with a focus on the experiences of those who chose not to return for further counseling. A qualitative approach to this study was an appropriate choice because it is discovery-oriented and is focused on capturing perspectives of intake clients. Qualitative methods, which often include interviews and other means of direct observation to contextualize phenomena, allow the researcher to fully explore the experiences of participants from their own points of view and in their
own words (Richie, Fassinger et al., 1997). In their recommendations for multicultural competency research, Pope-Davis et al. (2001) recommend the use of qualitative methodology to investigate real clients in real counseling situations because qualitative methods allow clients to use their own language to describe their experiences. More specifically, a constructivist/interpretivist qualitative approach was used. Using this approach, the researcher enters the world of the participants and expresses an interest in understanding and learning about the participants’ perceptions and descriptions. During the process, the researcher attempts to suspend her socially constructed worldview while trying to understand the participants’ worldviews (Ponterotto, 2002).

Because many professionals in psychology are not familiar with the philosophical and methodological frameworks of qualitative research (Fischer, 1999), an overview of qualitative research is included at the end of the literature review in chapter two. Additionally, throughout this dissertation an effort has been made to remain sensitive to the needs of an audience grounded in procedural and statistical analysis traditions by clarifying and explaining this study’s rationales, assumptions and techniques. Unlike quantitative research, in which specific measures are used as research instruments, the qualitative researcher serves as the research instrument as she interviews and makes observations (Janesick, 2000). My subjectivities as a researcher were presented at the end of the introduction chapter.

Research Setting

The Counseling Center

This research was conducted at the counseling center of a large midwestern university. This particular site was selected for a number of reasons. First, the counseling center has a widely diverse staff in terms of experience (from practicum students through licensed, experienced professionals), type of degree, and licensing (LISW, LPC, CCDCIII, Ph.D., M.D.). Its staff is also multiculturally diverse on a number of dimensions, for example, age, race/ethnicity, gender, and sexual orientation. Second, the counseling center serves a large university population (university enrollment in Autumn 2003 was 50,731) of students who have some significant elements of diversity (e.g., in
terms of racial diversity, 13.7% minorities with 6.9% African American, 4.6% Asian American, 1.8% Hispanic, and 0.4% American Indian in Autumn 2003) with over 1,600 intakes in 2002-3. The large student body and multiculturally diverse, multidisciplinary staff of the counseling center made maximum variation sampling (described below) feasible. Finally, the endorsement of this research project by all levels of the counseling center staff (director, clinical director, intake therapists, and receptionists) made the research possible.

At this university, the counseling center is located with a number of other student services offices (e.g. career services, academic learning lab) in a relatively new building on campus. The counseling center occupies the fourth floor of the building. When you enter the building, a sign indicates which services are on which floors. The elevator at the fourth floor opens in the counseling center lobby. Couches, chairs, and small tables are casually arranged throughout the long, narrow lobby, which shares a side with a glass-enclosed atrium that has some art objects hanging in it. To the far right is a glass-enclosed area where the receptionists sit. Across from the receptionists is a small area that offers free coffee, hot chocolate, and hot tea to visitors. There are a variety of magazines, pamphlets, and brochures distributed throughout the lobby. One day in May 2003, I counted 41 different pamphlets with topics addressing a wide range of issues, including suicide, eating disorders, anxiety, race, addiction, self-esteem, communication skills, and other topics.

The center is a multidisciplinary training agency with licensed mental health professionals in psychiatry, psychology, social work, and counseling. The staff also includes trainees from multiple disciplines and at various stages of training. During the 2002-2003 academic year, the center’s full staff included ten psychologists, three psychiatrists, three social workers, and two counselors; and the center’s trainee staff included two social work interns, five psychology interns, seven clinical fellows, four student personnel assistants, and an average of eight practicum students over the course of the year. The counseling center staff is also multiculturally diverse across a number of dimensions, including race/ethnicity, age, sexual orientation, and gender. Table 3.1
summarizes the multicultural diversity of the staff (except for the practicum students who changed quarterly over the course of the year) across several different dimensions.

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Distribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>24 to 59 years</td>
</tr>
<tr>
<td>Gender</td>
<td>13 males and 23 females</td>
</tr>
<tr>
<td>Race/Ethnicity</td>
<td>1 American Indian, 1 Arab-American, 1 Asian-American, 3 Asian-International, 6 African American, 24 White</td>
</tr>
<tr>
<td>Sexual Orientation</td>
<td>8 gay/lesbian/bisexual, 28 heterosexual</td>
</tr>
<tr>
<td>Years Experience</td>
<td>2 to 32 years</td>
</tr>
</tbody>
</table>

Table 3.1: Summary of Therapist Multicultural Diversity

The counseling center serves a large and multiculturally diverse student population. In the fall of 2002, almost 50,000 students were enrolled at the university with 13.7% minority students and 8.7% international students. During the 2002-2003 academic year, 2,222 students came to the counseling center for a grand total of 12,730 appointments, including 8,759 individual sessions, 297 couple sessions, 1,479 group sessions, 73 group screenings, 1 family session, 1,616 intake sessions, and 334 urgent sessions. The average number of individual client sessions was 5.3 (minimum = 1, maximum = 42). There were 1,599 students who came for intake sessions (17 students attended more than one intake session), 437 students (27%) only had intake session contact with the center during the 2002-2003 academic year.

The Intake Process

When a student stops by or calls the center for any non-emergency, non-urgent concern, an intake appointment is scheduled for the student. The goal of the center is to offer an intake appointment to students within one week of initial contact. Intake appointments last one hour, which includes 30 minutes to complete intake paperwork and 30 minutes to meet with an intake therapist. Intake responsibilities are shared among

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2 These numbers do not include students who saw the psychiatrists at the counseling center.
various staff members, including many of the licensed professionals and trainees. Psychiatrists and the psychiatric resident conduct psychiatric intakes using a completely independent process.

When a student arrives for an intake appointment, a receptionist checks her in and then gives her a folder that contains intake paperwork to complete and sign. The folder contains several forms, including:

- Two copies of a three-page informed consent form. One, requiring a signature, stays in the chart and the other is offered to the student.
- A one-page, double-sided, small-print Health Insurance Portability and Accountability Act (HIPAA) notice of privacy practices.
- A one-page form on which the student acknowledges being given the opportunity to review and receive the HIPAA notice of privacy practices. This requires the student’s signature or a witness’ signature, if the student is unwilling to sign it.
- A three-page questionnaire that asks for identifying information, contact information, demographic data, previous counseling experience, a 31-item checklist of concerns (e.g., schoolwork and grades, self-esteem, and depression), a self-rating item for urgency, and the number of sessions the student estimates will be needed.
- A one-page schedule form where students mark times they are available for appointments during the week.

After completing the paperwork and returning it to the receptionist, students wait in the lobby until an intake therapist greets them and takes them back to an interview room. The therapist is scheduled to begin with the student thirty minutes into the one-hour intake appointment.

During the intake, the therapist reviews the completed paperwork, briefly screens the student’s concerns and history, and then discusses with the student how her or his needs can best be met. From intake, students may be referred to individual, group, or couples counseling, to a physician, or to some other campus or off-campus agency. Nonetheless, an overwhelming majority of the referrals are for individual counseling. For

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3 To be eligible to conduct intake sessions, trainees must have prior experience working in a university counseling center and must have completed a 2-hour intake-training module that includes didactic and experiential components.

4 Throughout this thesis, I have chosen to use the feminine pronoun, “she”, as the generic pronoun instead of the more traditional masculine pronoun, “he”. As such, the use of “she” encompasses female and male students and/or therapists. This reflects my feminist beliefs and is not intended to imply anything about students or therapists.
example, during the month of March 2003, 128 students completed intake sessions at the counseling center; of these, 2 were referred to group (1.6%), 2 were referred to couples counseling (1.6%), 3 were referred out (2.3%), and 121 were referred to individual counseling (94.5%).

Students referred to individual counseling are offered an appointment with an individual therapist at the time of intake or, if there are no available therapists, added to the end of the waitlist. The goal of the center is to assign therapists to waitlisted students within two weeks of their intake appointment. Once a student has been assigned a therapist, it may take a week or two until the therapist has an open appointment.

When the academic year begins, there is no waitlist and students seen on intake and referred for individual counseling can be immediately assigned to a therapist. Once therapist caseloads are full, students seen on intake and referred for individual counseling are put on a waitlist until they can be assigned a therapist. Within six to eight weeks of the start of the academic year, students on intake begin to be waitlisted and the waitlist has a non-zero size until the beginning of the summer session. Throughout this period, therapists are assigned cases from the waitlist as their caseloads develop openings. Periodically, the clinical director “distributes” client cases that have been on the waitlist for two weeks by directly assigning them to therapists. Unfortunately, the waitlist was not tracked during the 2002-3 academic year, so I am unable to provide any data on it.

Research Participants

Initial Recruitment

A pool of potential participants was generated through initial recruiting. Students coming to the center for an intake appointment had a single additional sheet added to their intake paperwork (see Appendix A). The top two lines of this sheet announced “Paid Research Opportunity” and “Intake Research Study”. The names of students who (a) indicated an interest in participating, (b) were referred for individual counseling, and
(c) were in moderate-to-severe distress as indicated by self-assessment or therapist-assessment were added to the pool of potential participants.

This method of initial recruitment was selected in an effort to minimize the intrusiveness of the research at the counseling center. As Spindler (1982) suggests, every attempt was made to “disturb as little as possible the process of interaction and communication” (p. 7). This minimal intrusiveness was chosen to increase the trustworthiness, reliability, and extendibility of the research findings.

An important goal of this research was to examine multiculturally diverse intake client/therapist dyads. Consequently, an intentional sample was drawn from the pool of potential participants. In qualitative research, it is common to use intentionally drawn samples to address particular questions (Richie, Fassinger et al., 1997). Maximum variation sampling was the selected strategy. Patton (1990) offers the following description of maximum variation sampling:

This strategy … aims at capturing and describing the central themes or principal outcomes that cut across a great deal of participant or program variation. For small samples a great deal of heterogeneity can be a problem because individual cases are so different from each other. The maximum variation sampling strategy turns that apparent weakness into a strength by applying the following logic: Any common patterns that emerge from great variation are of particular interest and value in capturing the core experiences and central, shared aspects or impacts of a program. (Patton, 1990, p. 172)

Initial recruitment began in October 2002 and continued until August 2003. During this period, 1341 clients had intake sessions at the counseling center. Of those 1341, 374 (28%) indicated an interest in participating in the study at the time of their intake appointment and were added to the pool of potential participants. This pool of 374 potential participants self-identified across dimensions of diversity as follows:

- Age – 18 to 52 years (average = 23, standard deviation = 4.9)
- Citizenship – 94% United States, 4% International, 1% Domestic
- Disability – 100% able-bodied
- Gender – 70% female and 30% male

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5 Throughout most of the recruitment period, the researcher did conduct intakes at the counseling center. Intake clients of the researcher who met the study criteria (n = 12) were not included in the pool of potential participants.
- Marital status – 60% single, 9% never married, 14% parented, 8% married, 4% divorced, 2% separated
- Race/Ethnicity – 76% white, 5% African American, 5% Asian/Pacific Islander, 4% Hispanic/Latino/Latina, 3% biracial, 2% other, 2% multiracial, 2% Appalachian
- Sexual identification – 85% heterosexual, 4% bisexual, 4% gay, 2% lesbian, 2% questioning, 1% other, <1% transgendered
- Urgency (1-7 self-rating of distress with 7 indicating an emergency level) – 1 to 7 (average = 4, standard deviation = 1.2)

Although greater diversity in terms of disability/ability, citizenship, race/ethnicity, and sexual identification would have been desirable, the size and multicultural diversity of this pool of potential participants made maximum variation sampling feasible.

**Participant Selection and Final Recruitment**

Three criteria were used to select participants from the pool. The goal of the first criterion was to maximize demographic differences among the selected participants. The second criterion was based on demographics as well, but this criterion focused on comparisons of demographics within client-intake therapist dyads. Selection was designed to maximize variation across various dimensions of difference, such as age, race/ethnicity, and gender. The third selection criterion was based on the student’s choice to return or not return for recommended individual counseling. Selection was designed to favor potential participants who had chosen not to return for counseling, however, a few who did return were included so that the voices of both could be included in the analysis.

Selected individuals were contacted and approached for participation in the study. (Appendix B details the telephone recruitment script.) Telephone was the preferred method of contact. To guard confidentiality, telephone messages were not left. Initial interviews were arranged with telephone-recruited individuals who were still interested in participating. In a few cases, phone contact was not possible and email contact was attempted. A very simple email reminded individuals about the study in which they had indicated an interest and requested they reply to the email if they were still interested.

From March 2003 to August 2003, 58 individuals were selected for contact. In three cases, contact through email was attempted. Of the 58 selected, 30 (52%) were
successfully contacted. Of the 30 contacted, 6 (20%) were no longer interested in participating, 1 (3%) was already scheduled for a return appointment, and 23 (79%) agreed to be interviewed. A total of 20 initial interviews were completed (3 of the 23 individuals lost interest in participating). One interview audiotape was inadvertently taped over, bringing the final count of initial interviews to 19. These 19 individuals (33% of the 58 selected for contact) comprise the final group of research participants.

Three phases of selection occurred. An initial phase from mid-February and early March 2003 recruited eight individuals into the study. These individuals were predominantly of European descent (six of European descent, one of African descent, and one of biracial descent). During the second phase of selection in May 2003, an additional five participants were added to the study. These individuals were also predominantly of European descent (four of European descent and one of African descent). At this point, the study had 10 participants. While a more ethnically diverse sample was desired and sought by the researcher, potential participants who chose not to return for counseling were overwhelmingly individuals of European descent who identified as heterosexual.

The third and final phase of selection occurred between the middle of July and the beginning of August 2003. During this period, selection was strictly limited to non-European descent and non-heterosexual individuals. During this period, there was a marked shift in the nature of the pool of potential participants. Whereas previous pools had only rarely included international students who had chosen not to return for individual counseling, suddenly the pool included several international students and a single domestic student. Each of these with whom contact was established (four international students and one domestic student) agreed to participate in initial interviews. Another individual of African descent was also successfully contacted and interviewed during this phase.

The goal to select and recruit individuals who identified as non-heterosexual was not met. Over the entire period of selection, a single individual who identified as “gay” was successfully contacted. He was no longer interested in participating. The final sample does include a woman who identifies as “heterobisexual” but she that was an identification that she adopted during our interview. In her intake paperwork, she
identified as heterosexual. Selection for diversity in sexual identification turned out to be quite difficult as a result of having a very small number of individuals in the potential participant pool who identified as non-heterosexual in their intake paperwork.

Final Sample

The final sample of 19 participants was diverse across a number of dimensions of difference, including age, gender, race/ethnicity, citizenship, level of distress, and status of returning for individual counseling. Table 3.2 summarizes participant diversity across these dimensions. The 19 participant-intake therapist dyads also were notably diverse, especially across the dimensions of age, gender, and race/ethnicity. Table 3.3 summarizes the multicultural diversity in the 19 dyads across these dimensions.

Data Collection Methods

Ethical Issues

All of the participants in this study provided informed consent, and no deception was used. The collected data have been managed and reported in such a way as to protect the privacy and confidentiality of participants. Counseling center intake therapists were not informed of the identities of research participants. To further guard participant confidentiality, interviews were conducted at a building on campus that is located three to four blocks from the counseling center.

Throughout the process, member checking\(^6\) was offered to participants in order to help guarantee that their experiences were accurately reflected. Final member checks of the written results were voluntary and not compensated. Any disagreements that arose through member checking and could not be resolved by agreed-upon modifications been clearly noted. (For example, in the introduction to each participant, I describe Trooper’s desire to use a pseudonym that was not reflective of his ethnic background and my desire that Trooper’s pseudonym choice reflect his heritage.) Member-checks occurred at two points: (a) during initial and follow-up interviews and (b) near the end of the writing.

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\(^6\) Going back to participants to ensure that the researcher’s understanding is consistent with the participants’ realities.
### Dimension Distribution

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Distribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>18 to 49 years (mean = 24, standard deviation = 7)</td>
</tr>
<tr>
<td>Gender</td>
<td>8 males and 11 females</td>
</tr>
<tr>
<td>Race/Ethnicity</td>
<td>2 African Americans, 2 Biracial Americans, 2 Middle Eastern, 3 Asian (2 from India, 1 from Taiwan), 10 European Americans</td>
</tr>
<tr>
<td>Sexual Orientation</td>
<td>18 heterosexual and 1 heterobisexual</td>
</tr>
<tr>
<td>Citizenship</td>
<td>14 United States citizens, 4 international students, 1 domestic student</td>
</tr>
<tr>
<td>Urgency/Severity</td>
<td>3 to 6 (Note, this is student-rated on 1-7 scale with 7=emergency.)</td>
</tr>
<tr>
<td>Severity</td>
<td>1 to 3 (Note, this is therapist-rated on 1-3 scale with 4=emergency.)</td>
</tr>
<tr>
<td>Outcome</td>
<td>13 did not return for recommended individual therapy, 4 did return for individual therapy, 1 has not returned but plans to in the fall, and 1 was not recommended services</td>
</tr>
</tbody>
</table>

#### Table 3.2: Summary of Participant Multicultural Diversity

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Similar Dyads</th>
<th>Dissimilar Dyads (client/therapist)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>2 ages within 5 years</td>
<td>6 therapists 11 to 20 years older</td>
</tr>
<tr>
<td></td>
<td>4 ages within 6-10 years</td>
<td>7 therapists more than 20 years older</td>
</tr>
<tr>
<td>Gender</td>
<td>3 both male</td>
<td>2 female/male</td>
</tr>
<tr>
<td></td>
<td>9 both female</td>
<td>5 male/female</td>
</tr>
<tr>
<td>Race/Ethnicity</td>
<td>1 both African descent</td>
<td>1 African descent /European descent</td>
</tr>
<tr>
<td></td>
<td>7 both European descent</td>
<td>1 Asian descent /African descent</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 Biracial descent /African descent</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 Biracial descent /Asian descent</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 European descent/African descent</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 Asian descent /European descent</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 European descent /Asian descent</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 Middle Eastern descent/European descent</td>
</tr>
</tbody>
</table>

#### Table 3.3: Summary of Participant–Therapist Dyad Multicultural Diversity
As is typical for research in psychology, this study was fully approved by the OSU Behavioral and Social Sciences Institutional Review Board (IRB). The research review board at the counseling center where it was conducted also approved this study. Data collection did not proceed until both boards granted approval.

**Participant Interviews**

Each of the 19 individuals consented to participate (see Appendix C for consent form) and completed initial interviews (see Appendix D for interview schedule). Initial interview length varied from 30 minutes to two hours (average = 1.00 hours). These interviews were conducted between February 2003 and August 2003. At the end of each initial interview, participants were queried regarding interest in a possible follow-up interview (all indicated an interest) and given a study debriefing form (see Appendix E).

Five follow-up interviews were conducted in July and August 2003. The length of these interviews varied from 45 minutes to two hours (average = 1.35 hours). While some new information was gleaned during follow-up interviews, their main purpose was to perform member checking. This member check included (a) reviewing and verifying highlights from the initial interview and (b) getting input and reactions to the codes being revealed through a grounded theory analysis of the interview data.

All interviews were conducted in a private room in the psychology building, a location that is rarely frequented by counseling center staff. Each interview began with a reminder that the person would receive $10 for coming and that the person was not required to complete the interview to receive compensation. No participants chose to leave before completing the interview. All interviews were audiotaped and subsequently transcribed by the researcher.

**Other Data Sources**

The therapist-written intake session notes and client-provided intake information were additional sources of data. These sources allowed the researcher to roughly cross-check the accuracy of the interview data as Zaharlick (1992) suggests. Therapist-written intake notes are not an ideal source of data for several reasons: (a) they...
reflect the therapist’s viewpoint about why the client came to the counseling center, which may or may not be accurate, (b) intake note writing at the center is not standardized, which means great variability in the amount of information recorded, (c) due to their sensitive and permanent nature, therapists may be careful about they include in intake notes. Despite these limitations, session notes and client-provided intake information were useful for a rough cross-checking transcribed interviews.

**Data Analysis**

In qualitative research, data analysis begins at the inception of a project and continues throughout the process of gathering the data, analyzing the data, and even writing the results. It begins informally during the conceptualization of the research project, influencing the choice of research questions, sample, and site. Data analysis continues informally during interviews as “the researcher formulates ideas and questions that may be used in the interview itself or saved for the earliest possible opportunity to make notes once the interview is complete” (Morrow, Rakhsha, & Castañeda, 2001, p. 597). Data analysis continues as the researcher immerses herself in the data. “By reading and rereading transcripts, replaying tapes, and re-viewing artifacts, the investigator becomes so familiar with the data that she or he can almost instantaneously find a quote by a participant out of mounds of data and verify or disconfirm an emerging theme” (Morrow et al., 2001, p. 597).

Data analysis formally commences when the researcher begins to try to make sense of the gathered information by searching for small units of meaning or codes in the data. Thoroughly familiar and deeply involved with the emergent data, the researcher uses an inductive (data-up) approach to develop early codes or themes. “It is important that these early codes or themes are very concrete and are expressed, as nearly as possible, in the words of the participants” (Morrow et al., 2001, p. 598). These are the basic building blocks of the analysis. The next step is to further organize the codes or themes into
conceptual families, which are subsequently organized into broader conceptual families and so on until a meaningful hierarchy of codes and conceptual families has been created. This is the process of grounded theory analysis.

Grounded theory analysis (Glaser & Strauss, 1967; Strauss & Corbin, 1990) is a “comprehensive method of data collection, analysis, and summarization in which an emergent theory is constructed from (and therefore grounded in) direct experience with the phenomena under study (in this case, interview data gathered from participants)” (Richie, Fassinger et al., 1997, p. 134). The strategies of grounded theory include overlapping and repeated data collection, analysis, and theory construction. Furthermore, as theory emerges, sampling strategies are typically modified (for example, asking new or modifying existing interview questions) to refine the theory being constructed (Charmaz, 2001).

Formal data analysis began in June 2003 and continued through September 2003. Initially, the analysis involved combing through each transcribed interview in search of early codes and themes. By June 2003, 13 of the 19 initial interviews had been completed and transcribed. In early July, I met with an expert on qualitative research methodology and practice to discuss emergent themes and get guidance on strategies to move the data analysis forward. Early codes and evidentiary warrants were organized in a codebook. In an attempt to further organize codes and encourage higher level theorizing, a graphical representation of the emergent themes was created.

The final six initial interviews were conducted between the middle of July and the beginning of August 2003. After being transcribed and coded, the emergent codes were merged into the growing codebook as it continued to undergo refinements. The five follow-up interviews were conducted in this same period. Whereas the main purpose of initial interviews was to elicit stories tracing the intake experience at the counseling center and positive and negative reactions to that intake experience, follow-up interviews predominantly served as an early member check. Consequently, follow-up interviews were structured quite differently.

7 Evidentiary warrants are participant quotes from interviews that act as evidence for or against a given code.
In general, follow-up interviews began with a review of the main points gleaned from the initial interview. Participants gave feedback on the accuracy of the main points and were encouraged to make additions, deletions, or corrections. Next, questions were asked to elicit specific pieces of information that were missing or needed clarification in the transcript of the initial interview. Finally, participants were asked to give feedback on some segment of the graphical representation of the emergent themes. This second form of member checking served to get participant input on the bigger picture that was emerging through the analytic process.

In September 2003, the formal data analysis was largely complete, however, the inductive analytic process continued on an informal basis until I completed writing the dissertation. While this is consistent with Laurel Richardson’s (2000) assertion that writing is a form of analysis, I was surprised by and sometimes frustrated with the extent of additional analysis I found necessary as I wrote, re-wrote, condensed, and re-represented various parts of the findings chapter. The end result is clearly more powerful and succinct than it would have been if I had not allowed the process of writing to further the analysis. It also made the writing task more formidable than I had imagined.

As I struggled with the challenge of selecting themes worthy of highlighting from this rich data set, I was guided by several goals. First, it was important to highlight the relevance of these findings to current debates and conversations within psychology (e.g., the importance of cultural empathy to multicultural competence). A second important goal was to add to the psychology literature by sharing the experiences of these multiculturally diverse students who completed intake sessions at a university counseling center. The third goal was to augment the counseling process literature with the rich and varied voices of these students. And the final goal was to create a set of practical and realistic recommendations that could help this and other university counseling centers improve their practice.

The selected findings are presented in narrative form and are richly interspersed with quotations from the interviews. The presented findings reflect the story that this rich data set told me. The story is grounded in the 19 initial and 5 follow-up student interviews, but it is decidedly mine. “As a writer, you engage in a sustained act of
construction, which includes selecting a particular ‘story’ to tell from the data you have analyzed, and creating the literary form that you believe best conveys your story” (Glesne, 1999, p. 155). Throughout the analysis and writing, every attempt has been made to accurately reflect participants’ voices and participants were given the opportunity to provide feedback on the way they have been represented.

**Rigor and Trustworthiness**

As discussed in the introduction to qualitative research (see Appendix X), the quality criteria that are appropriate in qualitative research are different from those used in quantitative research. Consequently, this discussion of rigor and trustworthiness does not include traditional quantitative terms like internal and external validity, reliability, and objectivity. Morrow et al. (2001) identify and discuss trustworthiness standards in qualitative research and include a list of quality criteria for qualitative research. Table 3.4 presents several quality criteria along with a description of how each was met by this study.
<table>
<thead>
<tr>
<th>Quality Criterion</th>
<th>How Criterion Met in this Study</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immersion in the field</td>
<td>Researcher has experience with the intake process and individual therapy at the counseling center. Most interviews exceeded 30 minutes and follow-up interviews were conducted with five participants.</td>
</tr>
<tr>
<td>Sufficient data</td>
<td>Data collection continued until the end of the academic year and included interviews with 19 individuals.</td>
</tr>
<tr>
<td>Triangulation</td>
<td>Interview transcripts cross-checked with intake therapist session notes and participant self-report data at the time of intake.</td>
</tr>
<tr>
<td>Immersion in the data</td>
<td>This ongoing process began with the first interview, was enhanced by the researcher acting as interview transcriber, and continued until writing was done.</td>
</tr>
<tr>
<td>Participant checks</td>
<td>Member checks were completed during the five follow-up interviews. Each participant was offered a chance to review and offer input on the written research results.</td>
</tr>
<tr>
<td>Search for disconfirming evidence</td>
<td>As coding proceeded and themes emerged, disconfirming evidence was continually sought. Follow-up interviewees were also asked for disconfirming evidence in the emergent codes.</td>
</tr>
<tr>
<td>Management of researcher subjectivity</td>
<td>A self-reflexive journal to monitor and manage researcher biases, assumptions, and emotions was maintained.</td>
</tr>
<tr>
<td>Thick description</td>
<td>The research context was fully developed through client interviews and the researcher’s firsthand knowledge of the counseling center facilities and intake process.</td>
</tr>
<tr>
<td>An audit trail</td>
<td>An audit trail, a physical record of the raw data used in this study, was kept as part of the reflexive journal.</td>
</tr>
<tr>
<td>Sharing power and privilege</td>
<td>Client voices have been intentionally privileged, partly due to their longstanding under-representation in psychological research. Power shared with clients via collaboration.</td>
</tr>
<tr>
<td>Reciprocity</td>
<td>Participants directly benefited through compensation for each interview. It is also possible that interview participation resulted in a more favorable opinion of counseling and openness to counseling in the future. The counseling center benefited through research-driven feedback presented at a full staff meeting and through a list of suggestions for improvements shared with the counseling center director.</td>
</tr>
</tbody>
</table>

Table 3.4: Quality Criteria Fulfilled by this Research  
(Adapted from Morrow, Rakhsha, and Častañeda (2001))
CHAPTER 4

FINDINGS

Probably the most significant impact this research has had on me is to facilitate an important shift in perspective. At the beginning of this project, I was a therapist/researcher looking at clients. Almost two years later as this project nears its end, my perspective is closer to that of a student/researcher looking at therapists and counseling centers. The nineteen students, who shared their intake experiences with me and who helped me understand their perspectives of the counseling center and counseling process, facilitated this shift.

With this shift has come a fuller and clearer understanding of what it is like to be an intake client at this counseling center. Certainly, trying to understand client perspectives is not a new practice for me. But this research has truly allowed me to appreciate how students experience intake. The result has been a critical alteration in my lens that gives it better focus and more depth. With this enhanced clarity, I am a more effective critic of my intake practice and the intake process at this center. By sharing these findings with other therapists and counseling centers, I hope others can also develop a more thorough appreciation of college student perspectives regarding intake.

That is the common thread that is woven throughout these findings and ultimately binds them together. I believe that the wisdom of student perspectives can guide us in finding effective ways to reduce the poor return rate following intake at university.
Based on and grounded in the findings presented in this chapter, the final chapter offers specific recommendations for improving our practice with a goal of decreasing the rate of non-return following intake.

An important goal for me in the presentation of this research has been to stay as close to students’ voices as possible. The psychology literature has been dominated by the voices of therapists and researchers and has been unduly influenced by research using analog counseling clients rather than actual counseling clients. Because these interviews are with real clients who largely decided to not return following intake, it was important to me to keep their voices highly visible.

In accordance with my constructivist underpinnings, I believe that a researcher’s subjectivities influence what she chooses to study, how she studies it, how she makes sense of what she finds, and how her findings are presented. Thus, I believe that truth is partial, perspectival, and situated and that complete objectivity is an impossibility. Like Hare-Mustin and Marecek, I believe that “ultimately, our ideas about things, which are our theories, reveal our value systems – how we view the world” (1990, p. 3). However, through rigorous inductive analysis of numerous student interviews and through member checks, I believe I have accurately captured the essence of these students’ experiences. I hope my presentation of these findings allows the voices of these college student, counseling intake clients to be fully heard.

The remainder of this chapter is divided into several sections. The second section introduces the students who participated in this research. The next four sections describe major findings that came to light through an inductive analysis of interview transcripts. The final section uses three case studies that illustrate the need for more cultural empathy as therapists negotiate differences in the context of the intake session. Each section begins with a synopsis of the finding, provides evidentiary support and disconfirming evidence, and closes with concluding remarks. The remainder of this opening section provides a brief summary of each major finding and makes a statement about transcription conventions.

Students put off coming to counseling: “I didn’t really want to go”. Two factors that make coming especially difficult are the strong stigma associated with getting
counseling and the inherent awkwardness involved with sharing very personal problems with a total stranger. While quite straightforward, this finding is important to highlight. Thus, this first section reminds us how difficult this process is for students and, perhaps, can motivate us to better appreciate how students experience us at intake. My goal is to heighten awareness of student perspectives.

Troubling Our Assumptions. One of the things I hope comes out of this enhanced appreciation is a deliberate examination and questioning of the assumptions that we as therapists and counseling centers inadvertently make about student familiarity with the intake process. We need to trouble, that is, critically question, our assumptions. This is the focus of the second finding. For us, intake sessions are an everyday event; for students, coming to an intake is an anomaly precipitated by some personal distress. This familiarity leads us to make unwarranted assumptions, which can lead to student misunderstandings and negative intake experiences. This section focuses on misunderstandings based on confusion about the intake process, but easily and naturally extends to other areas of the counseling process.

Intake As A Beginning, Not A Screening: “I just wanted to start” Students put off coming to counseling and already have been in distress for some period of time. Since this center doesn’t offer drop-in appointments, many students wait up to two weeks for an intake appointment. By the time they get here, they are ready to start counseling. Consequently, an intake appointment designed to solely screen students is often inadequate from the students’ point of view. Given my goal of heightening awareness of student perspectives, this is a most important finding. This section focuses on two aspects of the intake session that can help it be a beginning rather than a screening. First, it discusses the tangible things that can happen at intake to help it feel like things are starting, and second it touches on the importance of continuity across the intake and individual counseling sessions.

What Therapist Preferences Do Students Have? The purpose of this section is to illuminate students’ perspectives on client-therapist matching at a very specific and individual level. For a variety of dimensions (age, race/ethnicity, and so on), I invited students to compare themselves to the intake therapist and talk about how they felt about
that similarity or difference. With some students, I also talked about what, if any, preferences they had for an individual therapist using the same dimensions. This section first describes the methodology that I used to discuss preferences and is followed by a presentation of how clear these students were about their preferences and the relative importance of their preferences. The section closes with some cautions about therapist preferences. While being asked for preferences can feel empowering, not honoring preferences can lead to disappointments.

**Negotiating Difference With Cultural Empathy.** The last finding discusses the challenges involved with the successful negotiation of the complicated and multiple dimensions of difference between the student and intake therapist. Three of the nineteen students with whom I spoke had negative experiences that were, in some part, traceable to the unsuccessful negotiation of cultural differences. The first case was based on a racial misunderstanding, the second was religiously based, and the last was based on ethnic difference. Each of these cases is described in detail. I believe that these cases are underscored by one or more failures in cultural empathy, which were not noticed at all or, if noticed, the recovery effort was unsuccessful. Breakdowns in communication are inevitable, given the nature of the very intimate and personal conversation that is part of the intake process. We are bound to make mistakes – even culturally based ones. Yet, it is important that we effectively use cultural empathy to notice our mistakes, so we can try to recover and use them as a means to build rapport rather than creating distance.

Throughout this chapter, evidentiary warrants in the form of quotations from interview transcripts are included. Quotations are identified by student pseudonym and interview date. I asked each of the nineteen students to create a pseudonym to better protect their identities. Underlined words in quotations reflect an emphasis made by the person speaking unless otherwise noted. The symbol “…” represents deleted text in a quotation, and [text in brackets] has been added in some quotations to clarify intended meaning. In order to protect the identities of intake therapists, I have modified references to the therapists in quotations to consistently use feminine pronouns. A second way quotes have been altered to protect identity is based on the replacement of specific time, date, name, and location information with <bracketed text>. 

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**Student Introductions**

A total of 19 individuals were interviewed; follow-up interviews were completed with five individuals. During each initial interview, students were asked to select a pseudonym. Table 4.1 provides pseudonyms and summary information about each student, including age, gender, race/ethnicity, citizenship, level of distress, and return status. Level of distress is defined by two measures: (a) “Urgency” is the intake student’s rating of the urgency of their concerns as measured on a 1 to 7 scale, where 7 is an emergency, and (b) “Severity” is the intake therapist’s rating of the severity of the student’s concerns as measured on a 1 to 4 scale, where 4 requires an emergency hospitalization. The return status indicates if the person returned to the counseling center for more services. More detailed descriptions of each student follow the table.

**April Showers** is a 21-year-old, heterosexual, biracial (African American, European American) woman in her senior year. A variety of concerns and life stressors brought her to counseling, including relationship, academic, self-image and identity, and financial issues. At intake, April self-rated her distress at 5 and her intake therapist rated her distress at 3.

April did return to the center for individual counseling. We met after her first appointment with her assigned therapist who was also her intake therapist. April reported that her experience with the center and her therapist has been very positive. At first, she was quite nervous about the whole process. She shared that if she had felt judged by either the receptionists or her intake therapist, she would not have gone back. It is my sense that April is someone who tentatively came to counseling. Since her initial experience was quite good, she felt comfortable returning and will have the opportunity to benefit from counseling.

**Beth** is a 21-year-old, heterosexual, European American woman in her senior year of college who struggles with chronic depression and anxiety. These issues were exacerbated by a recent breakup with her boyfriend of two years and occasional excessive use of alcohol. Beth self-rated her distress at 5 and her intake therapist rated her distress at 3.
<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Age</th>
<th>Gender</th>
<th>Race/Ethnicity</th>
<th>Citizen</th>
<th>Urgency / Severity</th>
<th>Return?</th>
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<td>US</td>
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<td>US</td>
<td>5 / 3</td>
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<td>Female</td>
<td>European American</td>
<td>US</td>
<td>4 / 2</td>
<td>No</td>
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<tr>
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<td>Male</td>
<td>European American</td>
<td>US</td>
<td>3 / 2</td>
<td>No</td>
</tr>
<tr>
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<td>Male</td>
<td>Asian</td>
<td>Taiwan</td>
<td>4 / 1</td>
<td>No(^a)</td>
</tr>
<tr>
<td>Inuyasha</td>
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<td>Female</td>
<td>African American</td>
<td>US</td>
<td>4 / 2</td>
<td>No</td>
</tr>
<tr>
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<td>US</td>
<td>5 / 1</td>
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<td>US</td>
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<tr>
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<td>US</td>
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<tr>
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<td>European American</td>
<td>US</td>
<td>4 / 2</td>
<td>Yes</td>
</tr>
<tr>
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<td>Iran</td>
<td>5 / 3</td>
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<tr>
<td>Radhika</td>
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<td>India</td>
<td>4 / 1</td>
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</tr>
<tr>
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<td>No</td>
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<tr>
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<td>US</td>
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<tr>
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<tr>
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<td>African American</td>
<td>US</td>
<td>4 / 3</td>
<td>No(^b)</td>
</tr>
</tbody>
</table>

Table notes. “Urgency” is the intake student’s rating of the urgency of their concerns as measured on a 1 to 7 scale, where 7 is an emergency, and “Severity” is the intake therapist’s rating of the severity of the student’s concerns as measured on a 1 to 4 scale, where 4 requires an emergency hospitalization. With the exception of Sue who identifies as heterobisexual, all of the students identify as heterosexual. \(^a\)Ichiro was not offered further services. \(^b\)X-CAL reported that he does plan to return. \(^\text{wl}\)Students who were not assigned to therapists but remained on the waitlist and were offered appointments by the front desk. Follow-up interviews were conducted with Maryam, Sarah, Tina, Vicky, and X-CAL.

**Table 4.1: Introduction to the Students**

Beth did not return to the center. She said she would try counseling there again in the future but is concerned she would be perceived as irresponsible and wouldn’t be taken seriously. Beth reported she did not get a follow-up call but admits that her answering machine was broken during that period. She got a follow-up letter from the center six to
eight weeks after her intake session but felt the tone of the letter was insulting. Beth’s counseling needs have not been explicitly met elsewhere. However, she shared that just getting away during Christmas break was helpful and, while she was at home, she learned some useful coping tools from her mom who has been in therapy.

**Cat** is an 18-year-old, heterosexual, European American woman in her first year of college who had experienced a number of recent life stressors, including her parents filing for divorce, trying to get adjusted to college, and breaking up with her boyfriend. At the time of our interview, drinking moderate to excessive amounts of alcohol multiple times during the week was one of her coping mechanisms. Cat self-rated her distress at 4 and her intake therapist rated her distress at 2.

Cat did not return to the center. She said she would try counseling there again in the future. Cat reported that she did not get a follow-up call from the center and that she got her counseling needs met by meeting with a therapist at home over the Christmas break.

**Colin MacMillan** is a 20-year-old, heterosexual, European American man in his junior year at college. He sought counseling because he was having problems with his relationship with his partner and wanted to get advice from an “objective” source. Colin self-rated his distress at 3 and his intake therapist rated his distress at 2.

Colin did not return to the center. When he left his intake, it was his impression that he would be on the waitlist for 6-8 weeks. Having already waited three weeks for his intake and not wanting to wait further led him to pursue other counseling options using the referral list given to him at intake. Colin ended up seeing a therapist at the Marriage and Family Therapy Clinic. He reported that the center never contacted him after the intake session but he also reported that this lack of follow-up did not bother him.

**Ichiro** is a 23-year-old, heterosexual, Asian man who is an International student from Taiwan. He has just completed his undergraduate degree and will be beginning a graduate program in the fall. Ichiro lived in Taiwan until middle school when he moved with his parents to the Middle East (Kuwait). He attended his first three years of high school at an American school in Kuwait and his senior year at a private school in the United States. He reported that concerns about his academic performance in graduate
school and curiosity about counseling brought him to the center. At intake, Ichiro self-rated his distress at 4 and his intake therapist rated his distress at 1.

Ichiro was not referred for individual counseling because he was not an enrolled student and he was not referred to another counseling source because his concerns were about future academic performance. During the intake, his therapist presented some possible study strategies to him. He found these tips helpful and plans to use them when he begins graduate school in the autumn. At that time, if he experiences difficulties, Ichiro reports that he will seek counseling at his new school.

Inuyasha is a 19-year-old, heterosexual, African American woman in her first year at college. In the intake paperwork, Inuyasha reported circling a variety of concerns and, during the intake interview, she reported crying a lot even though she wasn’t feeling sad. She shared that career concerns were the main issue that brought her to counseling but that she also had concerns regarding her weight and body image. Inuyasha self-rated her distress at 4 and her intake therapist rated her distress at 2.

Inuyasha did not return to the center. She reported that she did not get a follow-up call from the center for either individual or group counseling. Her needs were not met elsewhere and she said she has given up on getting help from university agencies. Instead, she has decided she has to rely on herself and her religion for support. During her intake session, Inuyasha expressed an interest in joining a depression group but felt like her intake therapist kept pushing her to join an African American women’s group. This resulted in what I call a “failure in cultural empathy”. Inuyasha reported feeling like her therapist was trying to make race an issue when she felt her concerns weren’t racially based at all. The concept of negotiating difference with cultural empathy is a finding presented below.

Jean is a 32-year-old, heterosexual, European American woman with a master’s degree. She works full-time in a mental health profession and is a part-time doctoral student. The main concerns she shared during her intake related to career questions, some dissatisfaction with her current job, and relationship problems. Jean self-rated her distress at 5 and her intake therapist rated her distress at 1.
Jean did not return to the center. She said that her busy schedule made it hard to find a good appointment time. She felt the center tried very hard to accommodate her needs. Her intake experience was generally quite positive, however, she reported some disappointment that her intake therapist wasn’t either older or more experienced. Jean’s case is a little unusual since she is a practicing mental health professional. Jean got her counseling needs met by a private practitioner; however, she felt her choice to see a private therapist was unrelated to her experience at the center.

Jeff is a 20-year-old, heterosexual, European American man who identifies as a non-practicing Catholic and who is in his sophomore year of college. He presented at the center complaining of frustration about the distribution of college scholarships, a loss of interest in school, difficult relationships with his parents, and a family history of depression. During our interview, he admitted he may have minimized his distress at the intake. Jeff self-rated his distress at 4 and his intake therapist rated his distress at 1.

Jeff did not return to the center. He got his counseling needs met at home during the Christmas break through working with a psychiatrist and a psychologist. Jeff believes that being put on an antidepressant was an important intervention. He reported disappointment that his intake therapist did not make a psychiatric referral. Jeff was also unhappy about the anticipated long wait for services and had the misconception that he would only be able to see a therapist for 30-minute sessions about every four weeks.

John is a 26-year-old, heterosexual, European American man in his second year at college who reported being involved with mental health professionals since age eleven. The intake paperwork indicates that John had several concerns, including depressive symptoms, concerns about his anger, and dissatisfaction with his relationships. During our interview, he revealed other factors that complicate his situation like a history of brain surgery and a seizure disorder that is managed through medication. John self-rated his distress at 6 and his intake therapist rated his distress at 3.

John did not return to the center. He was quite dissatisfied with his experience at the center. He reported frustration with the intake process, disappointment about not getting a direct referral to a specific therapist, and a lack of faith that the center could offer him anything new that hadn’t been offered in previous counseling. Part of his
frustration with the intake process was based on having to tell his story more than once. John was further frustrated by what he perceived as a lack of experience in his intake therapist. He felt like his therapist had limited experience with people his age, depressed people, and people who regularly use marijuana to calm themselves. John has not gotten his counseling needs met elsewhere.

Mark Hatt is a 20-year-old, heterosexual, European American man in his junior year at college. He sought counseling in order to explore his difficulties with romantic relationships. Mark self-rated his distress at 4 and his intake therapist rated his distress at 2.

Mark did return to the center for individual counseling. We met after his second individual session. During our interview, Mark expressed some curiosity about the process by which he was matched to a therapist and what information was exchanged between his intake and assigned therapist. Mark was also anxious to get started and left the intake session confused about how long he would have to wait. He called the center after one week and learned that he could expect to wait about two weeks before being assigned a therapist. In total, he waited about four weeks between his original call and seeing his assigned therapist. Mark expressed some concern about this length of wait, especially if his problem had been “pressing”.

Maryam is a 27-year-old, heterosexual, Middle Eastern woman from Iran who describes herself as culturally Muslim. She is an international student and has been in the United States less than three years. She has just completed her master’s degree and is about to begin a doctoral program. Over the past two years, Maryam has had multiple involvements with the center. She has had two intakes, twelve sessions of individual counseling, and some group experience.

Maryam’s first intake occurred about two years ago. At this intake, Maryam self-rated her distress at 6 and her intake therapist rated her distress at 3. She was referred to individual counseling and met with a therapist for twelve sessions and then she was referred to a group. (She reports attending several group sessions; her record indicates no
group attendance.) This year, Maryam came in for a second intake at which she self-rated her distress at 5 and her intake therapist rated her distress at 3. She was assigned to her previous therapist.

Maryam did not return to the center following her second intake. She reported that two factors contributed to her decision. The first was the 4-week delay between her second intake session and being offered an individual therapy appointment. The second factor was that she wanted to work with a different therapist and was dismayed when she was reassigned to her previous therapist.

Radhika is a 27-year-old, heterosexual, Asian woman who is an International student from India. She grew up in the Middle East (United Arab Emirates) but completed her first undergraduate degree in India. She is currently enrolled in a graduate program that she will finish next year. She reported that anxiety, the stress of being a graduate student, and stress-related relationship problems with her husband led her to seek counseling. At intake, she self-rated her distress at 4 and her intake therapist rated her distress at 1.

Radhika did not return to the center for individual counseling. Immediately following her intake, she attended the first session of a 3-session psychoeducational series offered by the center that is designed to teach mental skills to help people function more effectively. Radhika described herself as “skeptical but curious” about counseling. Her experience at the center appears to have reinforced her skepticism and reduced her curiosity. Radhika reported her intake therapist (a) was not objective enough, (b) focused too much on Radhika’s feelings, and (c) tended to treat her like a small child. She also expressed skepticism about the mental skills session she attended. She felt like the material presented didn’t give her any new information (“It’s like reading a self-help book.”) and didn’t feel helpful to her (“I just found that [self-coach concept] so extremely cheesy”).

Ravi is a 22-year-old, heterosexual, Asian man who is an International student from India in his senior year of college. He was born in India and almost immediately moved to the Middle East (Bahrain) where he lived until he 12. At that point, he returned to India, stayed there until he graduated from high school, and then moved to the United
States. Ravi reported that academic concerns and curiosity about counseling brought him to the center. His intake therapist reported that depression and academic concerns brought him to the center. At his intake, he self-rated his distress at 4 and his intake therapist rated his distress at 3.

At the time of our interview, almost two months after his intake, Ravi had not returned to the center. His assigned therapist had left him two phone messages but he hadn’t responded. Nonetheless, Ravi said he intended to return for counseling. A month after our interview, Ravi began meeting with his assigned therapist.

Sarah is a 26-year-old, heterosexual, European American woman who was enrolled in a doctoral program at the time of her intake. She reported a resurfacing of anxiety and depression since she had finished her master’s at another college and began her doctoral work at this university. She has benefited from counseling in the past. Sarah self-rated her distress at 3 and her intake therapist rated her distress at 3.

Sarah did not return to the center. Her stated reason for not returning was her withdrawal from the doctoral program. However, she kept her student health insurance, so technically she was still eligible for counseling services, and she understood that she was still eligible. During our second interview, Sarah shared a different perspective with me: withdrawing from the program changed the character of her distress. Before her withdrawal, she felt comfortable discussing her distress with a therapist. After her withdrawal her distress shifted from feelings about being in the program to feelings about having withdrawn from the program. She wasn’t ready to explore these new feelings in therapy, so she didn’t return for counseling despite the fact that she was still in distress. Sarah has not sought counseling elsewhere.

Sue is a 49-year-old, heterobisexual, European American woman who recently completed her bachelor’s degree and is now a graduate student. During her intake, she reported feeling overwhelmed by a number of issues in her life, including depression, anxiety, career indecision, relationship difficulties, alcohol abuse, and a history of sexual abuse. Her intake lasted an hour instead of the usual 30 minutes. Sue self-rated her distress at 4 and her intake therapist rated her distress at 3.
Sue did return to the center for individual counseling. We met immediately following her first session with her assigned therapist. During our interview, she expressed disappointment that her assigned therapist was so young, especially since Sue had indicated a preference to work with someone closer to her age. Sue brought this up with her assigned therapist and was given the option to get reassigned, but she decided to keep her assigned therapist because she didn’t want to have to start all over again. Sue’s discomfort with her therapist’s age was based on a previous negative counseling experience with a younger therapist and her concern that a young person wouldn’t have enough life experience to understand her. Secondarily and less importantly, Sue also expressed confusion about the lack of continuity between her two sessions. The intake therapist gave her some homework; the assigned therapist did not follow up on that homework.

Tina Pumpernickel is a 20-year-old, heterosexual, biracial (African American, European American) woman in her junior year of college who identifies as a Christian. She has benefited from Christian counseling in the past and sought similar counseling at the center. She reported that a variety of issues brought her to the center, including chronic and reactive anxiety, difficulty sleeping, and a history of sexual abuse. Tina self-rated her distress at 5 and her intake therapist rated her distress at 3.

Tina did not return to the center. She has not gotten her counseling needs met elsewhere. During her intake, Tina expressed an interest in working with a counselor who identified as Christian. It was her impression that it would be difficult for the center to meet her needs because of her request for a Christian counselor and because her busy schedule made her only available in the evenings. Her intake session was an hour long instead of the usual 30 minutes. During it, her therapist tried to enhance their connection by sharing her own Christian beliefs. Unfortunately (and likely unbeknownst to her therapist), this highlighted differences rather than similarities and left Tina feeling less rather than more connected. Tina also heard the message that she could be matched with a therapist who would “tolerate” her religion. This result was an instance of in what I call a “failure in cultural empathy”. The concept of negotiating difference with cultural empathy is a finding presented below.
Trooper is a 26-year-old, heterosexual man in his sophomore year of college who didn’t want to be identified by his ethnicity. When asked to select a pseudonym, he deliberately chose one that didn’t reflect his ethnic background. We discussed this. Trooper believes he frequently has been prejudged based on his name, and he believes this happened during his intake session.

I want to honor Trooper’s resistance to being labeled by highlighting it here. However, I think it is important to reveal that Trooper is a domestic student from Iran who has been in the United States for six years. I think this is an especially difficult time for students who come from the Middle East. Trooper’s experience is another manifestation of a failure in cultural empathy (a finding presented below) that is based on ethnicity rather than race or religion. I believe that this “failure in cultural empathy” contributed to his choice to not return.

In the last year and a half, Trooper attended two intake sessions. In both cases, anger management was his main presenting concern. His girlfriend convinced him to come the first time. At that intake, he self-rated his distress at 4 and his intake therapist rated his distress at 2. The second time he was self-referred; he self-rated his distress at 6 and his intake therapist rated his distress at 2.

Trooper did not return to the center following either intake. After his first intake, he was interested in the anger management support group for athletes, but never followed-up on that opportunity. More recently, after his second intake, Trooper chose not to return for a variety of reasons that include (a) the time delay between his intake appointment and when he was offered an appointment with his assigned therapist, (b) his disappointment with the services offered, and (c) his sense of feeling misunderstood by his intake therapist.

Vicky is a 23-year-old, heterosexual, biracial (¾ European American, ¼ Native American) woman who identifies as a Jehovah’s Witness and is in her junior year at college. She came to counseling because she was having difficulty dealing with feelings of depression and anxiety, which were provoked by a recent, traumatic situation in which she was involved. Vicky self-rated her distress at 4 and her intake therapist rated her distress at 3.
Vicky did not return to the center. Vicky reported that the main reason was due to being so busy. Other reasons we discussed, in order of importance, were that she got some of her needs met through support from her family and church, she experienced some symptom reduction by moving closer to campus and taking later classes, and she was concerned that ten sessions wouldn’t be enough for her to deal with her issues. While Vicky believes that counseling will be necessary at some point to help her deal with some of her concerns, she didn’t want to pursue counseling at the present time.

X-CAL is a 19-year-old, heterosexual, African American man in his sophomore year at college who was referred to a specific therapist by a person at the Office of Minority Affairs. X-CAL’s case is a little unusual because prior to his intake session, he reported having a single session with the referred therapist to whom he was assigned. The issues that brought X-CAL to counseling include academic and relationship concerns. X-CAL self-rated his distress at 4 and his intake therapist rated his distress at 3.

X-CAL had not returned to the center but indicated that he plans to return in the fall. He and his assigned therapist did schedule a second meeting that X-CAL had to cancel. They continue to stay in touch through email. X-CAL was very satisfied with his meetings with his intake and assigned therapist. In both cases, he was somewhat anxious about talking to someone he didn’t know; however, both therapists effectively used chitchat and self-disclosure to help put X-CAL at ease.

Students Put Off Coming To Counseling: “I didn’t really want to go”

This finding is straightforward yet important because it was relevant for so many students and because it is something that intake therapists may not always keep in mind. Interviews revealed that initially coming to get counseling was a challenge for almost every student. For the counseling center, intake sessions are ordinary and commonplace. For students, an intake session is an unusual event that is precipitated by some personal distress. It is often difficult for students to admit they need help coping with an issue, take the initiative to call for an appointment, and come in to talk to a therapist about their concerns. As a result, many students put off coming to counseling until they feel they have exhausted other resources.
Data analysis revealed three important contributing factors that make initial contact so difficult. All three are related to the social stigma associated with getting counseling. They include negative counseling expectations, privacy issues, and the awkwardness of talking to a stranger about personal issues. These are especially potent because they were true across the wide multicultural diversity of students I interviewed, including across the dimensions of race/ethnicity, country of origin, and gender. Each is elaborated below then some disconfirming evidence is offered. The section ends with concluding remarks.

The Stigma Associated With Counseling Is Still Strong

“When you first come up there, you think you’re going into a loony bin.”
(X-CAL, 5/9/03)

Very few people actually used the word “stigma” when talking about the prospect of getting counseling. Very few people admitted sharing X-CAL’s strong concerns. However, almost every student expressed some level of apprehension due to negative expectations about counseling, fears that others would find out they had come to counseling, or a reluctance to share personal issues and problems with a stranger.

Negative Counseling Expectations

Negative expectations about counseling were expressed in a variety of ways. X-CAL made one of the strongest statements:

“It’s something you don’t want to do because … you see the movies and people laying on that little couch and spilling their guts and crying or screaming and going crazy or whatever. So, you kind of figure, ‘I’m never going to do that.’” (X-CAL, 5/9/03)

Students’ counseling expectations are based on their pre-existing conceptualizations of what happens in counseling, what counselors are like, what kind of people seek counseling, what kind of problems merit counseling, and so on. Some students base their notions about counseling on firsthand, personal experience or stories shared by friends or family members. Other students like X-CAL base their expectations on the media and popular culture, which often negatively portray people who are in psychotherapy.

While negative media images fueled X-CAL’s expectations, a fear of the unknown seemed to fuel Maryam’s negative expectations. At the time of her first intake session,
she had been in the United States for less than a year. This is what she shared about that experience:

“I was so hesitant about coming to such a service. And I was just kind of — I didn’t know what’s going to go on, what they’re going to ask me, what they’re going to [do].” (Maryam, 7/10/03)

In Iran, where Maryam grew up, the negative stigma associated with counseling is quite strong. According to Maryam, some universities do offer counseling and some young people do use the service, but most people don’t talk about it. For example, Maryam’s sister is getting counseling at a university in Iran and has told their mother. However, their mother, who is well-educated with a Ph.D. in pharmacy, continues to oppose it for her sister: “My mom always said ‘hey, these things, they don’t work, you’re good, you’re not having any disorder or something.’” (Maryam, 7/10/03)

Radhika expressed an interesting negative expectation. She felt like psychologists tend to treat clients like children:

“I feel sometimes that psychology people – students or anybody – and I don’t mean it for you – but I feel sometimes there’s a tendency perhaps – for all the people I’ve interacted with – to sort of talk to you like you’re a three-year-old.” (Radhika, 8/1/03)

Several other students also reported negative counseling expectations:

“I was very nervous the first time I went up there. … Anything that’s scary, you’re not going to want to do.” (April, 7/25/03)

“You’re nervous because you’re going by yourself and you’re going to see a psychologist and everything that you think goes with that.” (Beth, 2/13/03)

“From the beginning, I thought that the process of finding a counselor would be intimidating.” (Tina, 2/20/03)

“I thought it would be kids in training. … I didn’t know it was so professional.” (Mark, 5/19/03)

Thus, many students had negative expectations of counseling based on their preconceived notions about therapy and university counseling centers. This pessimism seemed to stem from a variety of reasons, including how counseling is portrayed in the media and popular culture, fear and nervousness about venturing into unknown territory,
concern that counselors treat clients like children, worry that trying to find a counselor will be intimidating, and concern that the university counseling center would not offer professional counseling services.

Privacy Issues

Concern regarding privacy issues was a second manifestation of the stigma associated with counseling. Several students expressed apprehension that “others” would find out that they had come to counseling. The “other” ranged from people in general to specific persons like friends or family members. There seemed to be two bases to this fear. The first focused on not wanting the “other” to know they were getting counseling, while the second focused on not wanting the “other” to know they had problems that merited counseling. These two types are clearly discernable as Mark and Vicky talked about their parents. Mark just didn’t want his parents to know he was in counseling:

“I’ve been thinking about seeing a psychologist for a long time, but I didn’t want to really tell my parents necessarily.” (Mark, 5/19/03)

Vicky, on the other hand, didn’t want her parents and other family members to know she was having such difficult problems:

“I didn’t want to let my parents know - like my family and everything - because they have enough problems.” (Vicky, 5/28/03)

In other cases, the type of fear wasn’t clear but its presence was evident. For example, April talked about “being afraid that somebody would find out and take it the wrong way” (April, 7/25/03). John put it this way: “I don’t tell anybody, you know, what I go through. … I can’t … because of the stigma attached to it.” (John, 2/27/03)

During my interviews, I did not further explore the nuances of these students’ fears. My hunch is that they are difficult to tease apart and that it may be hard for students to articulate the underlying contributors to their fears that others will find out they are in counseling. Nonetheless, it would be a worthwhile future project. The more completely we understand their fears, the better equipped we are to take steps to begin to address them. Fear and negative expectations create barriers that make it more difficult for students in distress to seek counseling.
Opening Up To A Stranger Is Difficult

The final contributing factor that made initial contact with the counseling center so challenging for students was the prospect of having to share personal problems with an unfamiliar person. Some students had not discussed their issues with anyone in the past. Even if they had, having to share such private matters with a stranger was a significant obstacle. The way students expressed their discomfort is informative. This was Radhika’s first counseling experience, and she felt required to “expose” herself.

“I guess I was just not comfortable with exposing myself so much to somebody I don’t really know.” (Radhika, 8/1/03)

Ravi (another first-timer) was also reluctant to talk to a stranger.

“Talking about your personal matters with a total stranger can be nerve-wracking a little.” (Ravi, 7/14/03)

For Cat, who had been in counseling before, the discomfort was expressed more indirectly. And, for her, the added dimension of knowing she was unlikely to see the intake therapist again seemed salient.

“I think a lot of people aren’t that comfortable. And seeing someone – dishing all that out – to someone that they’ve never seen before and that they might not see again might be a problem for them.” (Cat, 2/12/03)

For Jeff, the difficulty of talking to a stranger was exacerbated because the issues that brought him to counseling were ones he hadn’t previously expressed.

“You walk in there and sit down in front of somebody and they start asking questions. You almost kind of lie a little bit because you don’t want to tell them the truth because you don’t express those things very much.” (Jeff, 2/19/03)

As a researcher, these conversations were challenging because I was distinctly aware of my “stranger” status as the interviewer. I wondered how that influenced what students voiced and didn’t voice. It’s true that the focus of our interviews was on their experience at the intake session and not on the issues that had brought them to counseling, which probably reduced the discomfort. But our interviews were quite personal. Were students less likely to share their negative experiences? I can’t know. I had the impression that they shared honestly. Students with negative experiences
appeared to appreciate having the opportunity to express dissatisfaction and many seemed hopeful that what they shared could make a positive difference. Nonetheless, this is a potential limitation of this research.

Being asked to confide in a stranger is unavoidable in the intake session. By definition, an intake session requires a student to meet and talk to a therapist who is unknown, and the intake therapist needs to ask the student some very personal questions (e.g., to assess self-harmful behavior). In addition, many people are uncomfortable talking about personal distress in any setting, and that discomfort may be exacerbated when the setting requires talking to a stranger.

As therapists, the intake session is well within our comfort range. Often this is not the case for students, especially those coming to counseling for the first time. The difference in perspective is easy to forget, and overlooking it can lead us to make inaccurate assumptions about students (e.g., how it feels to be sharing with a stranger). It’s critical that intake therapists remain cognizant of students’ points-of-view because for many students the intake session is a unique, possibly strange and uncomfortable, social situation that they have never experienced in the past.

The First Time Was Easy For A Few

Most students had difficulty making initial contact. Of the few who didn’t appear to have trouble, only two students specifically indicated it was an easy process. Ichiro reported that he stopped by the center when he had some free time.

“It’s something that concerns me, but I was busy with other stuff and it just did not come to my mind. And one day I had a chance to go there and I just went upstairs.” (Ichiro, 7/28/03)

Part of the reason it was easy for Ichiro may have been the nature of the problems that brought him to counseling. He was concerned about his future academic performance in a graduate program he would start in the fall. Nonetheless, he seemed very comfortable initiating contact. Trooper also reported that it was an easy process.

“That wasn’t that hard. That wasn’t like I feel like this is something embarrassing or something odd, abnormal to do. Because this center – you
have bad tooth, you going to go to a dentist – that’s the same thing. I know some people they are very conservative about this kind of stuff. But I don’t think that way.” (Trooper, 7/11/03)

It’s not surprising that a few students found it easy to begin the counseling process. In fact, this disconfirming evidence nicely buttresses the assertion that it is difficult for students to come in for the first time. However, it is somewhat surprising that these are two students whom we might have predicted would have difficulty initiating contact. Both Ichiro and Trooper grew up in cultures that tend to more strongly stigmatize counseling. Ichiro grew up in Taiwan and Trooper grew up in Iran. This is an excellent example of how individual differences can be more salient than culturally-based expectations. Thus, it underscores the importance for therapists to be guided but not governed by expectations based on multicultural training and life experiences.

Concluding Remarks

To reiterate, it is often difficult for students to initiate the counseling process. These findings indicate that this stems from the stigmatization of mental health counseling in our culture, which is fueled in part by students’ negative expectations of counseling, in part by students’ fears that others will find out they are in counseling, and in part by the prospect of sharing one’s distress with an unknown person. These are significant barriers that cannot be completely dismantled. However, it is important for therapists and counseling centers to proactively work toward reducing the stigmatization and to bear in mind the barriers that make it difficult for students to come in for counseling.

Troubling Our Assumptions

Another important finding that emerged from the analysis of these interviews is that implicit, unspoken assumptions made by therapists and counseling centers can contribute to negative outcomes. While that, in and of itself, isn’t surprising, I question how aware and mindful we are of the numerous assumptions we make, especially with students we see on intake. This questioning or “troubling” of our presumptions is the focus of this section. More specifically, it troubles what we assume about students’ understandings of the counseling process and the center’s procedure for intake and client assignment.
Assuming students understand the process more fully than they do leads to procedural confusion. And, procedural confusion can contribute to a student’s negative experience and subsequent decision to not return to the center for recommended services.

This section enumerates the ways in which some students were confused about the process and the influence that confusion had on their intake experiences. A secondary goal of this section is to increase awareness of the important role our assumptions (as intake therapists and receptionists at counseling centers) can play in creating misunderstandings. I encourage us to adopt a more critical eye that deliberately examines and questions students’ understandings of the counseling process. This is especially important given the increasing multicultural diversity of students in college settings.

Naturally, this need to trouble our assumptions extends beyond this specific area and could be applied to each of the major findings in this chapter. Given the nature of the intake session, it is inevitable that students and therapists will be strongly guided by preconceived notions, since that is the largest contributor to first impressions. As therapists, it’s important for us to remember this. Troubling all of our assumptions about students who come in on intake will lead us to more accurate understandings of students, which will increase our ability to be effective.

However, this section focuses specifically on the assumptions we make about students’ understandings of the counseling process and the center’s procedure for intake and client assignment. Students who have been in counseling before have some familiarity with the counseling process. Students who have been to the center before have some familiarity with the center’s procedures. Few students fall into both categories; many don’t fall into either category. Furthermore, the knowledge and preconceived notions (even those based on previous experiences) may be inaccurate and can lead students to make false assumptions about the process. All students are susceptible to procedural confusion at some level.

**Procedural Confusion: An Underlying Cause And Three Points Of Mix-Up**

Procedural confusion was a principal contributing factor to negative aspects of intake experiences for several students. There are likely several sources of the confusion,
but an important one is that students don’t carefully read the paperwork they get at intake. This is a significant problem, especially if the intake paperwork is designed to educate students about the counseling process and procedures used at the center. Thus, it is a mistake to assume that students understand the process and procedures based on having signed a form indicating they have “read and understood the above information.”

This section begins by offering supporting evidence for the assertion that intake paperwork is not carefully read. Next, the section discusses three specific aspects of the process that students were confused about and the negative ways in which some students experienced each. The implication is not that all students experienced these three aspects negatively. Instead, the assertion is that for some students these points of mix-up added unnecessary negativity to their overall experience. The three aspects that are covered are based on (a) the flow of the intake appointment, (b) the process and timing of intake follow-up, and (c) the process of individual counseling once a therapist was assigned.

**Intake Paperwork Is Skimmed, Not Carefully Read**

When a student arrives for an intake appointment, she is presented with a folder of papers to read, complete, and sign. This folder includes four pages of questions regarding personal information to be completed and five pages of informed consent and notice of privacy practices to read. The student is asked to sign the informed consent form and an acknowledgement form that the notice of privacy practices has been reviewed. The informed consent form has a wealth of useful information regarding the center’s therapy services and office practices. Unfortunately, many students either don’t read or don’t absorb the information provided by this form.

These days it’s standard practice for people seeking any kind of health care to be given long forms to read and sign. While some of the forms may contain valuable information, others are pretty standard across health care professionals and don’t appear to contain immediately practical or pertinent information. Many people (myself included) don’t bother to read these forms before signing them.

During interviews, I generally asked what happened when the student arrived for the intake appointment. Many students spontaneously shared that filling out the

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8 The Methods chapter describes the precise contents of the folder in *The Intake Process* section.
paperwork was part of the process. For students who didn’t, I asked if they filled out paperwork. If the answer was a simple “yes”, then I asked a follow-up question (e.g., “How did you find the paperwork?” or “What was that like?”). I asked about the paperwork because I was curious if filling it out had any positive or negative influence on their intake experience. Retrospectively, it’s fortuitous that I didn’t specifically ask if students had read the paperwork. Had I done that, I would feel the need to question how much social desirability influenced student responses. What I learned was that many students don’t carefully read the paperwork.

Mark skimmed the paperwork because it was lengthy and it didn’t seem important.

“They have standard forms they give everybody. It was kind of a lot but I didn’t mind. … Well, there’s a lot to read through and sign. I skimmed most of it. I figured it wasn’t that big a deal.” (Mark, 5/19/03)

Trooper perceived the paperwork as a formality that served no purpose for him or the center.

“I think it [the paperwork] just some official thing. It not really mean anything. Not to me and not to them. I don’t think they even look at those paperwork.” (Trooper, 7/11/03)

While not every student seemed to find the paperwork as meaningless as these two, no student reported carefully reading the paperwork. Some students did report being influenced by the paperwork, but that was due to thoughts provoked by completing the personal information forms, not reading other forms.

My interpretation of the data is that generally the paperwork isn’t read very thoroughly. An alternative explanation is that students do read it but aren’t able to retain the procedural information. For example, it is possible that being in distress makes it difficult to absorb the information conveyed by the paperwork. Whether it’s only skimmed or cannot be retained, the outcomes are identical. Not taking in the content of the intake paperwork can lead to misunderstandings about the center’s therapy services and office practices and can result in procedural confusion.

Flow Of The Intake Appointment

One source of confusion that surprised me was based on student expectations of how soon they would meet with an intake therapist once they had given the receptionist
the completed paperwork. At the center, intake appointments are scheduled for hour-long blocks. During the first 30 minutes, students complete the paperwork. During the second 30 minutes, students meet with an intake therapist. From the student’s perspective, the intake appointment begins with their arrival at the center. From the therapist’s perspective, the intake appointment doesn’t begin until 30 minutes later. Most students complete the paperwork within 10 to 15 minutes. Thus, a student who arrives on time might finish the paperwork 15 to 20 minutes before the intake therapist is scheduled to meet with her or him. This can lead to misunderstanding, frustration, and confusion.

Three students clearly misunderstood the delay between when they completed the paperwork and when they met with the therapist. Each of these students reported waiting approximately 20 minutes. And, for each student, that wait was negatively experienced. Ravi felt it was a waste of time.

“I didn’t really know why I had to wait for 20 minutes. … It’s kind of a waste of time.” (Ravi, 7/14/03)

Ichiro wanted to understand why he was waiting. And, the wait made him question the professionalism of his intake therapist.

"I was sitting on the couch for about 20 minutes and no one told me what was going on. So that part was kind of lousy, but the session was good. But I was just hoping she was professional about it – on time. If not, then tell me what’s going on. I was just sitting there wondering, ‘Well hey, I was here on time. What’s going on?’” (Ichiro, 7/28/03)

Trooper also didn’t understand why he was waiting. Because the waiting room was empty and because therapists were not obviously working with other clients, his wait generated questions about the professionalism of all the therapists at the center.

“It’s busy but I don’t see any students. They come talk to each other – stuff like that. I mean, I was the only one there in the waiting room. It took like 20 minutes until somebody come and talk to me. … It didn’t feel good because I see the people walking around, talking, chatting.” (Trooper, 7/11/03)

It is unquestionable that these are not the first impressions that a counseling center would want to give students. Furthermore, these first (mis)impressions stem from students’ lack of familiarity with the intake process. This type of confusion is
unnecessary. If we do a better job of informing students about the flow of the intake appointment, this kind of negative experience based on misunderstanding is less likely to occur.

Another important consideration is that each of these students did not grow up in the United States. Ravi is an international student who grew up in India and the Middle East, Ichiro is an international student who grew up in Taiwan and the Middle East, and Trooper is a domestic student who grew up in the Middle East. Perhaps these students view waiting differently than students raised in the United States. Perhaps they have a lower comfort level with coming to counseling at all, which makes sitting in the waiting room more difficult. Whatever the source, all three experienced the wait negatively.

This is an important problem to tackle. I don’t believe that we intentionally hide our processes and procedures from students. I would guess that most centers make some sort of effort to inform students about the intake process. For example, this center includes a short description of the intake process in the paperwork students are given:

“Shortly you will meet for a brief consultation (called an intake) with a clinician who will collect some preliminary information in order to make a recommendation to assist you in addressing your concerns. Quite possibly, your future contacts will be with a clinician other than the one you speak with today or perhaps with a clinician outside this agency if indicated.”

Unfortunately, that description does not explicitly discuss the delay that might occur between paperwork completion and meeting with a therapist. And, for these three students, the information provided was insufficient. If the paperwork were more detailed, perhaps they would have understood why they were waiting and perhaps their reactions would have differed.

While it is only one event in the intake process, this highlights the need to question the extent to which each step of the intake process is detailed to students. I hope centers adopt a more critical eye to examine how they describe the intake process to students. Furthermore, I want therapists to recognize that students may have negative reactions to parts of the intake process that are misunderstood. While none of these students indicated

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9 This is an excerpt from the Informed Consent for Therapy Services and Office Practices form used by the counseling center.
that the unexplained wait made them decide to not want counseling services, to some extent it did undermine their initial impressions of the agency and its therapists. And, it was a point of procedural confusion for some.

**Intake Follow-Up**

Another source of students’ dissatisfaction with their intake experience revolved around the center’s follow-up to the intake session. As a reminder, most of these students were not immediately assigned to individual therapists. Instead, their names were added to the center’s waitlist, and, at some later time, they were contacted by the center and offered an appointment. Data analysis revealed two components of the follow-up contact that was problematic for students. The first component was based on the follow-up timeframe. For many students, the length of wait before being offered an appointment was longer than expected. The second component was disconcerting: four students reported that they did not receive any form of follow-up contact from the center. Procedural confusion may have contributed to both problems.

**Delay of Follow-Up Contact**

Several students expressed dissatisfaction with the lag of time between the intake session and any follow-up contact from the center. For some, procedural confusion was part of the problem. There is some inherent negativity in having to wait for counseling; so, it’s unlikely procedural confusion was the only contributor. But at least some of the disappointment with the wait can be traced to misunderstandings, which stemmed from students’ mistaken expectations regarding how long it would be before they were offered an appointment.

At this center when a student is put on the waitlist, the goal is to assign a therapist to the student within two weeks. Once a therapist has been assigned, it may be another two weeks before the therapist has an opening that matches the student’s available times. Thus, when the waitlist is in effect, a student might realistically wait four weeks before getting the next appointment. In a perfect world, each student would leave the intake appointment with a clear understanding of the follow-up contact timeframe. Many students were confused about this point, including Trooper and Maryam, who both expected a wait of about two weeks.
“The only problem for [the center], they not really follow you. They say that they going to call you back in a week or two weeks for next appointment and something take three weeks. So you completely lose your interest about going back.” (Trooper, 7/11/03)

“They were supposed to call me back in two weeks but these two weeks extended to one month. And then they called me in one month. This was about timing, you know, that happened. … One month was too long.” (Maryam, 7/10/03)

Mark had a different experience because he didn’t leave the intake session with any understanding of how long it would be until he was contacted.

“I kind of wish – I understand with availability it would have taken a good two weeks or so – they didn’t really explain that to me though. … I called [the center] a week later and they said, ‘oh, it usually takes two weeks.’” (Mark, 5/19/03)

Mark did take the initiative to phone the center to find out how long he could expect to wait, but, unfortunately, he was given inaccurate information. Since it is likely he spoke to a receptionist on the phone, it appears that both therapists and receptionists conveyed inaccurate two-week estimates for the expected wait. Colin had yet another experience. His understanding of the expected wait was somewhat exaggerated.

“I expected to be on the list for a couple months or probably 6 to 8 weeks type of deal.” (Colin, 5/29/03)

Retrospectively it is difficult to know if students were actually given inaccurate information or if they misheard/misunderstood what they were told. Conversations with the clinical director and experience as an intake therapist at the center lead me to believe that students generally were being told they would be on the waitlist for two weeks, which was true. The important piece of information omitted was that it might take another two weeks to be offered an appointment. Thus, there was a disconnect between the center’s point of view (students stay on the waitlist for two weeks) and the student’s point of view (it may be four weeks before an appointment is offered). Thus, procedural confusion results. Furthermore, students care about how long it will be until they can see a therapist again. Whether the delay is due to being on the waitlist or the therapist’s inability to schedule an appointment is meaningless to students.
Lack of Follow-Up Contact

Four of the nineteen students I interviewed reported that they received no follow-up contact from the center. This was one of the most challenging things I negotiated as a researcher. I was keenly aware of the conflict it generated between my loyalty to the center and my loyalty to the students. I wanted very much to find a way to account for these stories without tarnishing my high respect for either the counseling center’s practices or the students’ experiences. These conflicting loyalties contributed to my meaning-making process. First, however, let me present the evidence provided by these four students.

Inuyasha, the first student, admitted to being confused about the process and concluded that she wasn’t contacted because she wasn’t in enough distress.

“During the appointment she was telling me that they were really booked and it was real hard to get in. I don’t know about the process. She wasn’t telling me that. I kind of assumed because I didn’t get a call that if you weren’t in dire need of services, you weren’t going to get them.” (Inuyasha, 2/26/03)

Inuyasha’s client folder at the counseling center has this notation: “Client was offered an appointment for <date> and she did not call to confirm her availability for that date.”

The second student was Cat who tried to justify the lack of any follow-up contact by remembering that her voicemail wasn’t set up at the time. As this excerpt illustrates, she seems conflicted about who was at fault.

“But I never got a call back. But then again I don’t have my voicemail set up in my dorm room. So, they might have tried to call but I didn’t get any messages from my roommates or anything. So, I mean, I’m sure they tried to call me but I might have missed their call. But I think they would keep trying to call to get a hold of me.” (Cat, 2/12/03)

There is no mention of attempted follow-up contact or a failure to respond to offered appointments in Cat’s client folder at the counseling center.

Colin, who got his needs met at another clinic on campus, reported that the lack of follow-up contact didn’t matter to him.

“I’ve never heard anything back from CCS. … I hadn’t thought about how it made me feel they didn’t return my phone call. It meant nothing to me.” (Colin, 5/29/03)
According to Colin’s client folder, he was offered three appointments past the intake session.

And, finally, Vicky’s situation was a bit different. When she left the intake appointment, her understanding was that she needed to give the center her class schedule for the upcoming academic term, which she didn’t do. Even though Vicky reported that she wasn’t surprised that they didn’t contact her, it was my impression that there was some disappointment about the lack of follow-up contact.

“Nobody ever called back to say, ‘Did you get your schedule? Do you want to come back in?’” (Vicky, 5/28/03)

The notation in Vicky’s client folder is “Terminated due failure to respond.”

In making sense of this contradictory data, I was forced to examine two important dilemmas. First, what happened? Were these students contacted or not? If only one student had reported no follow-up contact, I would wonder about some oversight or anomaly that led to a special case. But, four of nineteen students reported this lack of follow-up contact. That’s a pattern. And, it’s a pattern that conflicts with my worldview of the center. I resolved this dilemma by choosing to believe the center does regularly make follow-up contact.

The second dilemma regards the reliability of these four students’ stories. Doubting their stories conflicts with my experience during our interviews and challenges my values as a constructivist, feminist researcher. I resolved this dilemma by choosing to assume these students’ accounts were truthful. Thus, two key assumptions underlie my interpretation of this contradictory data (the center is doing its job as it defines it, students are telling the truth).

Given this, the interpretation that evolved is that some students are unaware of the follow-up contact that they get from the center. At first blush, this may seem groundless. But when it’s more closely examined, it is conceivable. The follow-up contact that waitlisted students often receive is in the form of a very vague and innocuous phone message. For example, “Hi, this is Clay Bean. I’m calling from <university> to offer you an appointment on X day at Y time. Please call <phone number> to let us know if you

10 Again, I want to highlight my underlying loyalty to the center and belief in the professionalism of their practices.
will be able to attend this appointment or not.” The phone message does not explicitly mention the counseling center or that the appointment is for counseling because it is important to protect the student’s privacy as much as possible.

What if these students did receive that phone message but did not connect it with counseling? We know the delay can be as long as four weeks after the intake appointment, so perhaps students are left a message, ignore it as being irrelevant, and then mistakenly conclude that the center did not follow-up. If this does happen, part of the problem could be due to students having a poor understanding of the type of phone message that will be received from the center. This is another important point of procedural confusion.

**Individual Counseling Following Intake**

There is some evidence that procedural confusion extended to the individual counseling that would follow the intake session. Unfortunately, I didn’t systematically ask students about their expectations regarding individual therapist assignment or limitations to individual counseling. Based on the anecdotal evidence I have, it seems that there was some confusion about this area of the process as well.

Two students (Mark and Ravi) reported that when the intake session started, they were unaware that the intake therapist would not be the individual therapist. For both, it wasn’t until sometime in the intake session that the intake therapist clarified that point of confusion. One student (Sue) explicitly said she understood that the intake session was simply a screening process.

Two other students (Jean and Jeff) expressed confusion regarding individual session limits. Jean was unsure if the 10-session-limit rule applied to each academic session or the academic year. Jeff mistakenly believed that he would have to repeatedly wait for individual sessions and that each individual session would only be 30 minutes long.

As I said, this is not a strong finding, however it does suggest that there may be confusion about this part of the intake process as well. The intake paperwork at the center does explicitly discuss the *Limitations of Service* and *Therapist Assignments*. And the *Intake* section does say, “Quite possibly, your future contacts with be with a clinician
other than the one you speak with today or perhaps with a clinician outside this agency if indicated. Nonetheless, this could be another important point of procedural confusion.

Concluding Remarks

Fully explaining the intake process to students is an important form of empowerment. Information is not consciously withheld, but our over-familiarity with the intake process makes it easy for us to forget how novel the entire experience is for students. Deliberately making the effort to inform students about the intake process and troubling the implicit assumptions that lead us to not expose that process more fully are critical steps in the movement to overcome procedural confusion. And, as I mentioned earlier, I believe the need to critically question our assumptions extends beyond this specific area and could be applied to each of the major findings in this chapter. Troubling all of our assumptions about students who come in on intake will lead us to more accurate understandings of students, which will increase our ability to be effective.

Intake As A Beginning, Not A Screening: “I just wanted to start”

The counseling center tends to view the intake as an initial screening of students to assess severity, lethality, and level of service that would be most helpful. The center’s informed consent form describes the intake as a “brief consultation” during which “preliminary information” will be collected. The intake therapist has 30 minutes allotted to meeting with the student and writing the intake assessment, and the center’s intake training recommends the therapist spend 20 to 25 minutes discussing the student’s concerns. Thus, from the center’s perspective, the intake is fundamentally a screening process. But, students have a different perspective. They want more than that:

“I didn’t feel like I was actually beginning. I was real proud of myself for calling and making the appointment when I did, but then when I went there I felt like it was just halted. I didn’t feel like I was making any more progress in getting better.” (Beth, 2/13/03)

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11 This is an excerpt from the Informed Consent for Therapy Services and Office Practices form used by the counseling center.

12 Note this model doesn’t hold for students with urgent needs.
While the screening function is important, students don’t tend to view the intake as a means to enter the system but rather as a means to start counseling. Instead of perceiving the intake as a screening process, many students tend to view it as a beginning. As discussed earlier, most students have difficulty initiating contact with the center and many have been in distress for some period of time before seeking services. That factor is coupled with the delay in services due to being put on the waitlist. It’s hard to know the relative importance of each of the factors, but the result is that most students want to feel some shift in their knowledge or beliefs as a result of the intake session. And, for the two students who did return for individual counseling (Mark and Sue), a sense of continuity between the intake and first session seemed important. These two findings will be discussed and then some concluding remarks will be made.

Wanting A Shift In Knowledge Or Beliefs

Interviews suggested that students wanted to experience some small change as a result of attending intake. As Tina described it, she wanted “just a little something, so you could walk out with something that day” (Tina, 2/20/03). She wasn’t alone in that sentiment. Data analysis revealed that what students wanted to experience was some sort of a shift in what they knew, felt, or believed. I deliberately use the word “shift” instead of “change” because it’s smaller and subtler. While most students would be thrilled to solve all of their problems at intake, that’s not what they expected to happen. They did seem to expect something to happen – some shift – as a result of the intake. I don’t know what influence, if any, being put on the waitlist had on their expectations. And, there was some variation in what students wanted to happen. The inductive analysis allowed me to identify two core areas of desirable shifts (in knowledge and in beliefs). Each of these is described below.

In Knowledge

An increase in factual information is the first form of tangible outcome that some students expressed wanting. Students talked about three types of shifts in knowledge:

13 All but three students (April, Ichiro, X-CAL) had their names added to the waitlist and were told there would be some delay before they could be assigned to a therapist.
(a) helpful tips or advice, (b) normalization of their experiences, and (c) enhanced understanding of their issues and how counseling might help. The first of these was expressed as a desire to be given helpful ideas, advice, or things they could try on their own. Trooper appreciated the advice he got during his first intake and found it very helpful.

“She gave me some advice, some general advice. Maybe I knew it beforehand but that was helpful to refresh what things to do, what things not to do. And, I think it helped a lot – that one session. I think because I was already ready.” (Trooper, 7/11/03)

Tina thought it would be helpful to have the therapist help her learn how to cope more effectively with her anxiety.

“It would be nice if that person who was doing the intake session, regardless of beliefs, regardless of anything – they could say, ‘okay, I know exercises you can do in the midst of having an anxiety attack.’” (Tina, 2/20/03)

Finally, Sue seemed to appreciate being given things to do while she was waiting to get matched with a therapist for individual sessions.

“She made a list of three things I needed to do, like get help with doing mock interviews at <career services>. Tangible things. … I thought those were some tangible steps for me to take. I liked that.” (Sue, 4/8/03)

Thus, many students appreciate being given helpful ideas, advice, or things to try during their intake session. However, not all students want this. For example, X-CAL felt like he already was getting too much advice.

“They just listened all the way through until I stopped at my sentence. And then they continued. That was a lot better because usually, when you with your family or you’re with friends or somebody, they tend to tell you what to do or tend to give you advice all the time when really you don’t need that because you already have too much going on.” (X-CAL, 5/9/03)

And, Colin didn’t think the therapist knew enough about him to be able to offer helpful advice.

“I get the feeling that you don’t want to – in one 15 minute conversation – you want to snap judge somebody’s problems and give advice to them when you don’t know what underlying issues may also be there.” (Colin, 5/29/03)
The second form of knowledge that some students appreciated gaining was to have some normalization of their experiences. This was a less common request, but it seemed important for those who talked about it. Normalization helps people feel more normal and less ill, sick, weird, or whatever negative stigma they associate with people who go to counseling. This was true for April.

“This is a normative thing and everybody goes through it – or a majority of people probably go through it.” (April, 7/25/03)

It was also strikingly true for Tina, who described herself as feeling like a “freak” when she left her intake session. This is how Tina described what she wanted during our follow-up interview:

“I thought, ‘I am such a freak. I have all these issues.’ That thought, ‘I’m a freak’” spouted in a billion different directions, like, no one’s going to ever want to be around you or with you - stuff like that. If there were some way that at the end of the session, after I’ve revealed all these things, that that person could be like you know, ‘you’re not the only one to have been abused in such and such an area. In fact, X amount of people in the United States have been abused in some way or shape or form.’ Just even factual statistics kind of things.” (Tina, 2/20/03)

During our follow-up interview, Tina made this wonderful observation about having her situation normalized:

“So you don’t have to feel like you’re alone. I mean, those are – they’re simple words to say but they leave just such a great impact on you.” (Tina, 8/4/03)

In most cases, students didn’t directly express a desire to have their problems normalized. However, the way that many students framed how normal it was to come to counseling leads me to believe that it is generally important to remind students that they aren’t ill, sick, weird, or whatever for seeking help through counseling. For example, this is what Ichiro shared:

“Seeking counseling – a normal person might need a counseling because life is – life it’s very – you face a lot of things – you see a lot of people. I’m sure if you’re doing things, you’re going to need probably to seek help in some way.” (Ichiro, 7/28/03)

The third and final form of knowledge that students want from the intake session is to develop a clearer understanding of the issues they want to work on or to hear some of
the ways that counseling can help them feel better. This was the least frequently mentioned of the three types but it seemed an important one to include. Beth described it this way:

“Maybe if she had given me some of her thoughts. It was just an intake session, but if she had given me some thoughts on how I could approach the problem or how a counselor would approach the problem with me.”

(Beth, 2/13/03)

The first half of what Beth wanted is closely aligned with getting helpful advice. But the second half is asking for information about how counseling can help. While not many students identified that as something that they wanted to happen, several students listed it among the things that they appreciated during their intake session. It is my sense that discussing the ways that counseling helps can foster a sense of continuity between the intake and future individual counseling, and I believe that one of the important things that doesn’t get well articulated is a desire to have continuity across the intake and individual counseling sessions.

It is difficult to know how being given some new information is helpful. It could be directly helpful because it empowers the student (offering new things to try or new ways to think about something) or its benefit could be more indirect (giving the student a sense of relief that things can get better). These things do seem helpful. Tips and advice give students things to try or do differently and this can generate a sense of enhanced control over the situation. Normalization of experiences helps students feel less isolated and alone. Enhanced self-understanding and ideas about how counseling can help also can generate a sense of relief.

**In Beliefs**

The other basic type of tangible shift that some students wanted to experience during the intake session was based in a change in beliefs rather than an increase of knowledge. In this case, there is a clear connection between desired belief changes and a consequent sense of relief from distress. The types of belief shifts that students talked about included a belief that help is possible and a sense that things can get better. Both of these were often linked with hopefulness. To illustrate, a few examples are offered.
Ichiro and Vicky left with beliefs that help was possible. Ichiro expressed a high level of confidence that the intake session had been helpful, yet he honestly didn’t have a sense of how helpful it would be until he could put it into practice.

“That’s why I go there. I wanted help and I know it’s going to help. It’s going to help me one way or another. No matter if it’s going to help me a lot or just a little bit. I know it’s going to help.” (Ichiro, 7/28/03)

Vicky directly mentioned how hopeful she felt as a result of the intake session.

“It was very helpful. … It looked as though there was going to be something that could really help. And I was really hopeful.” (Vicky, 5/28/03)

Radhika was disappointed because she didn’t leave with a feeling that counseling could help. She came in with a “skeptical but curious” attitude. During her intake, she and her therapist seemed to have the conflicting goals and Radhika’s skepticism about counseling was unchanged. In the end, she was disappointed that she didn’t feel any different.

“It didn’t really change anything. I was still really skeptical about it.” (Radhika, 8/1/03)

To summarize, interviews revealed that students had an expectation that they would experience some shift or small change as a result of the intake. Two types of desirable shifts were identified by the inductive analysis. The first was a shift in knowledge in the form of helpful tips or advice, normalization of their experiences, and an enhanced understanding of their issues and how counseling might help. The second was a shift in beliefs that would give them a sense of hopefulness that help is possible and things can get better.

**Wanting Intake-to-First-Session Continuity**

An expressed desire for continuity between the intake session and individual counseling was the second strong indicator that led me to conclude that students want the intake to be more than a simple screening. Several students expressed a desire to continue working with the same therapist. For example, Ravi shared this with me.

“Since I talked to her the first time, I would have liked to have talked to her in the future also.” (Ravi, 7/14/03)
For most students, this wasn’t an option. The two students (April and X-CAL) who knew and had met with their assigned therapist liked that. April appreciated being given the choice.

“She asked me if I wanted to meet with her again or if I wanted to meet with someone else. And I told her that I would prefer to just keep going with her since we had already started.” (April, 7/25/03)

The two students (Mark and Sue), who returned for counseling but were assigned to new therapists, both expressed concerns about continuity. Mark was curious about how he would be matched with a therapist and what information was exchanged.

“I was wondering about the exchange. What was said between her and the person I was assigned to. I was kind of curious what she was writing down and what she was filling out and how that would affect how I’d be placed and how I’d be thought of before I even came in.” (Mark 5/19/03)

Sue experienced two disconnecting points between her intake and her first session. The first was that she had expressed a desire to work with an older female therapist but got matched with a younger female instead. This is described in some detail in the following section, which discusses students’ preferences for therapists. The second disconnection was related to a lack of follow-up by the assigned therapist regarding the things Sue’s intake therapist had asked her to do. As noted above, Sue really appreciated being given things to do, steps to follow to help her move forward, while she was waiting for services. But it was confusing that there was no follow-up, especially on the list of thoughts that her intake therapist had asked her to generate.

“It made sense for her [the intake therapist] to tell me to do that, but I wasn’t going to see her the next time. Now I’m wondering what am I supposed to do with the list? Okay? That was, I thought, a good idea but what am I supposed to do with it now that I’ve made it – or started it anyway.” (Sue, 4/8/03)

Although many students would enjoy being assigned to their intake therapist, it is not logistically feasible for several reasons. One is that some therapists, most notably trainees with an insufficient amount of experience and training, can’t conduct intake sessions. Equally legitimate and related concerns can be raised regarding the difficulty and complexity of students’ presenting concerns, special expertise and training therapists may have (e.g., drug and alcohol specialty), and irresolvable schedule conflicts...
(especially for part-time therapists). There are centers that use a model that directly assigns all students seen on intake to the intake therapist. I am aware of at least two that operate under that model. Nonetheless, given the reasons stated above, I don’t consider it to be an attractive alternative.

Therefore, it isn’t feasible for therapists to pick up every student they see on intake. At least some and perhaps many students will see a different therapist for individual counseling. Given that reality, our challenge is to do a better job at providing the continuity students would like to feel between their intake session and individual counseling. In Sue’s particular case, it would have been helpful if the intake therapist had noted the tasks she asked Sue to start working on in the intake report. More generally, I hope to heighten our awareness of how important that is to students and challenge us to come up with ways to facilitate that process.

**Concluding Remarks**

Students want the intake session to serve more of a purpose than a simple screening. This may or may not be true when there is no waitlist in effect. But when there is a waitlist, students appear to want more to happen at the intake. In particular, they want to feel like there has been some tangible shift in knowledge or beliefs. Furthermore, students want to feel like there is a tangible connection between the intake session and individual counseling. This is something that we, as therapists and counseling centers, can and should address more effectively.

**What Therapist Preferences Do Students Have?**

At this center, the intake process sometimes includes asking students if they have any preferences regarding the type of therapist they want to work with in individual counseling. Not all of these students I interviewed remembered being queried for preferences. When they were queried, the most common question was related to gender preference.

The waitlist form completed by the intake therapist has space reserved for therapist preferences. The intake report form has an explicit item about gender preference (female,
male, none) and room for listing other preferences. Identified preferences can refer to a specific therapist, to a therapist with a given specialty, or to a therapist with one or more characteristics (e.g., lesbian or Christian).

The discussion in this section begins with a brief introduction and description of a measure I developed to query students about therapist preferences. Next is a presentation of the results of an inductive analysis of the ways students talk about their preferences. In a nutshell, students do know their preferences, they seem relatively comfortable discussing those preferences, and they are able to differentiate among strong and weak preferences. Following that presentation, some of challenges associated with asking for preferences are discussed.

**Written Assessment Of Preferences**

Over the course of this research, I became increasingly interested in students’ therapist preferences. During early interviews, we discussed preferences if that seemed salient to the student. After several interviews, I decided to deliberately pursue discussions about therapist preferences. To facilitate that, I created a form that students completed near the end of interviews that helped generate such discussions. The survey (see Appendix F for the *Initial Preferences Questionnaire*) was developed in March 2003. It queries students about their similarities and differences as compared to their intake therapist across multiple dimensions of difference. For each dimension (age, race/ethnicity, gender, sexual orientation, religious beliefs/spirituality, and ablebodiedness), the questionnaire asks students:

(a) To compare themselves to their intake therapist (Similar, Different, Not Sure),

(b) To rate the importance of that comparison using a 5-point Likert scale that ranged from “NOT Important” to “EXTREMELY Important”,

(c) To briefly explain why that dimension was or was not important, and

(d) To self-identify on that particular dimension.

Two of my committee members previewed the questionnaire to assess its appropriateness and offer suggestions.
In April 2003, I began asking students to complete this form at the end of interviews. Over the next four months, ten students completed the questionnaire, and we had rich discussions about therapist preferences. Based on student input and responses, I decided to create a modified version that could potentially be used to allow students seen on intake to specify their preferences for an individual counselor. Two students (Ichiro and Tina) completed this new version (Preferences for Individual Counselor). The questionnaire was intended to inquire about strong preferences, but it was immediately apparent that “strong” wasn’t obvious enough, so I introduced a few minor changes\(^\text{14}\) and finalized it as the Strong Preferences for Individual Counselor questionnaire (see Appendix G). One student (Radhika) completed this version.

The findings presented in the remainder of this section are predominantly based on interviews that occurred after I started using the form described above. Thus, I deliberately discussed therapist preferences with thirteen students. However, a few contributions were gleaned from earlier interviews. For example, in my very first interview, Cat volunteered, “She was a young woman, a pretty young woman, so I felt really comfortable with her. I don’t know what my experience would have been if it was a guy or an older person.” (Cat, 2/12/03).

**Students Know Their Preferences**

Students do know what therapist characteristics are and aren’t relevant to them. And, there was a great deal of variation in the preferences that were expressed. Some students had none. Others did have specific preferences, which they were easily able to identify. Students who had multiple preferences didn’t appear to have any difficulty prioritizing those preferences. Finally, it seemed relatively straightforward for students to categorize their preferences as “weak” or “strong”. In short, students know if they have preferences and, if they do, they are able to articulate those preferences.

In terms of frequency, a gender preference was most common. This was followed by age/generation, and race/ethnicity/cultural background ranked third. I was surprised

\(^{14}\) First, the word “Strong” was added to the title and the text “PRIORITIZE your PREFERENCES” was changed to “PRIORITIZE your STRONG PREFERENCES”. Second, other instances of the words “strong” and “strongly” had their fonts italicized and bolded to make them stand out more clearly.
that a preference for racial matching wasn’t more strongly endorsed. For example, of the four students who identify as African American or Biracial American (half African American), only X-CAL expressed a preference for racial matching. While his preference wasn’t strong, he did indicate that it was easier to connect with someone of the same race.

“That wasn’t really a big issue but it helped a little bit easier. Automatically with society today, you feel that someone of the opposite race doesn’t connect with you as easy.” (X-CAL, 5/9/03)

This finding is difficult to interpret because I don’t know how my race influenced our conversations. It’s possible that these students didn’t feel comfortable sharing a preference to work with a racially similar therapist with me. My whiteness is bound to have shaped the ways we co-constructed and negotiated our conversations. I did attempt to create a space in which students would be able to openly share without being judged and without worrying about other negative consequences. And, I did wait until the end of interviews to explore therapist preferences in hopes that our rapport would be stronger by then. Nonetheless, I wonder what a non-white interviewer would have learned about preferences for racial matching.

In terms of the strength of preference, gender clearly stood out as being strong for many students. Other strong preferences were expressed, but not with the same consistency as gender. It was informative to witness students go through the process of identifying, rank ordering, and rating their preferences. These students had clarity and a certainty about therapist preferences that I found quite striking and impressive.

Rationales For Preferences

The relative frequency and strength of gender preferences made it a good candidate for further analysis. Of the nine students who cited a gender preference, seven preferred the same gender and two preferred a female therapist. For seven of the nine students this

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15 For example, a few times I suspected a student might be worried about protecting the intake therapist or a receptionist by underreporting their dissatisfaction with a portion of their intake experience. In these cases, I reminded students that my goal was to improve the process and not punish any given therapist or receptionist, and I reminded them that protection of confidentiality prevented me from directly giving feedback to any single therapist.
was a strong preference; two students (X-CAL and Vicky) rated it as moderately
important. As we discussed preferences, I asked students to explain the rationale behind
their preferences. Several underlying themes emerged.

For some, presenting concerns made gender more salient. This was true for Sue.

“Gender is important because I have a lot of issues about – for instance, I
was raped when I was younger and I would just feel more comfortable
talking with a woman about that.” (Sue, 4/8/03)

For others, a similarity in background and life experience seemed more important. For
example, Mark thought a male therapist would be better at understanding his relationship
problems with his girlfriend.

“Because I was talking about girl issues, I think it was nice to talk to a man
because he has my same perspective and therefore he can relate a lot better
to me because he has probably gone through the same things.” (Mark,
5/19/03)

X-CAL felt talking to another man made it somewhat easier to connect.

“In an uncertain, unstable environment, you kind of want to talk to a male
or whoever because you feel like you’ve got that little bit of connection
because you are male and male.” (X-CAL, 5/9/03)

Finally, a few preferred working with a female therapist based on past experiences of
positive interactions with women. This was true for the two men who preferred working
with a female therapist (Ravi and Ichiro). It was true for Vicky as well.

“With the girl, it was more like I was talking to one of my sisters. With a
guy, I think I would have been more formal. … I’d be more comfortable
with a girl simply because we can do it informally. And it made me –
every tension I had in the beginning was reduced by the counselor through
her manner.” (Vicky, 5/28/03)

Thus, a variety of rationales contributed to students’ expressed therapist
preferences, including presenting concerns, similarity in background and/or life
experience, and past interpersonal relationships.

Weak Versus Strong Preferences

Another area that I explored with these students was to ask them to rank order and
rate the strength of their preferences. Students didn’t appear to have any difficulty with
either task. Once they had rated the strength of preferences, it was quite natural to talk
about the tradeoff between matching preferences and time spent on the waitlist. In the context of that discussion, students were able to further differentiate between desirable preferences and those that felt necessary.

Ten students completed the first questionnaire described above (see *Written Assessment Of Preferences*), which asked students to rate the importance of various dimensions of difference. Students’ responses to that item are listed in Table 4.2. Because all students indicated that “Special Ability/Disability” was of low importance, it has been omitted.

<table>
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<th></th>
<th>Age</th>
<th>Race / Ethnicity</th>
<th>Gender</th>
<th>Sexual Orientation</th>
<th>Religious Beliefs / Spirituality</th>
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</table>

Table note. Ratings are on a 5-point Likert scale (1 = NOT Important, 5 = EXTREMELY Important) to indicate the relative importance of each given dimension (age, race/ethnicity, gender, sexual orientation, religious beliefs/spirituality).

**Table 4.2: Ten Students Preference Rankings For Five Dimensions Of Difference**

As can be seen from the table, some students (like Trooper and April) had very little preference. Other students, like Maryam and Mark, had some fairly strong preferences. No student expressed strong preferences across all of the dimensions. The other thing that is clear from the table is the high frequency of a relatively strong gender preference. The previous subsection focused on gender preferences, so more won’t be said here.

However, it’s important to take a brief look at each of the remaining preferences having a relatively high importance (i.e., rated as 4’s and 5’s in the table). Sue, who is 49,
wanted to work with someone of a similar age because “I think a person of the same
generation would understand me better” (Sue, 4/8/03). X-CAL tied his age preference to
a desire to work with someone with a similar background.

“I didn’t want anybody exactly like me or my age that had been telling me
the same thing I already knew. I want to see somebody … a little bit older
that’s worked through some of the same things that I’ve worked through
with a similar background.” (X-CAL, 5/9/03)

Maryam felt very strongly about wanting someone who would understand her
background and her culture so that she wouldn’t have to spend so much time explaining
herself.

“I want somebody that knows this backgrounds. I cannot just all the time
explain about this backgrounds. Because my main problem, actually I told
her, my main problem is I feel I don’t belong. I feel people they don’t
understand me.” (Maryam, 7/10/03)

Finally, Mark rated sexual orientation and gender as both being important. He came to
counseling with concerns about “girl problems” and felt that a heterosexual male
therapist would be more helpful.

“It would probably have been important because of the relationship issue,
specifically since I went in for girl problems. If he was homosexual, I don’t
think he’d be able to relate as much. He could have as a trained
psychologist but it would have made a lot more sense to me talking to
another straight male.” (Mark, 5/19/04)

Tina completed the *Preferences for Individual Counseling* form instead and
indicated a strong preference for a Christian, female therapist. And, for her, religion was
the most salient: “if they didn’t have a Christian female, I would go towards the Christian
male before I went towards the non-Christian male or female.” (Tina, 8/4/03).

**Not All Students Have Preferences**

Similar to students with preferences, those who have none had no difficulty
identifying and articulating that. From the table, it is clear that neither Trooper nor April
had any strong preferences. Radhika, the only student who completed the *Strong
Preferences for Individual Counselor* questionnaire, also didn’t report any preferences.
Lastly, there was Ichiro, one of the two students who completed the *Preferences for
Individual Counseling* form. Initially he indicated that he strongly preferred a
heterosexual, female therapist but, after discussing this with him, it seems he misunderstood the intent of the form and had overlooked the word “strongly”. In our subsequent discussion, he clarified as follows:

“I don’t know about strongly though. That word – strongly is absolute. I don’t have to have this female. And I don’t have to have a female counselor. All I’m saying is I don’t want to limit myself.” (Ichiro, 7/28/03)

Thus, by the end of our interview, Ichiro had changed his mind and didn’t want to specify any preferences because he felt that would limit his options. In total, four out of thirteen students specified they had no preferences.

Some Cautions Regarding Preferences

Based on the previous discussion, it is clear that students know their preferences. Talking to students about the kind of therapist they would prefer to work with can be empowering. It can give students a sense of control over the process, and a collaborative conversation about preferences can offer students the facts they need in order to make an informed decision about the relative immediacy of their concerns as weighed against having certain preferences met. There is a tradeoff that is inherent to specifying therapist preferences: the more specific the request, the longer it takes to find a matching therapist.

I am happy to say that such collaborative conversations do appear to happen sometimes at this counseling center. For example, in the six months I served on the waitlist disposition committee, I occasionally saw requests of the form “<Name of therapist> unless wait is longer than 4 weeks.” I don’t know how often they do occur. I wish they happened at every intake because I think it’s important that we help students who we see on intake to become informed and empowered mental health consumers.

However, there are at least two difficulties associated with talking to students about preferences. The first is based on misunderstandings that can occur when students do have specific preferences that they have shared during the intake. The second potential problem is how intake therapists respond when students make requests that appear to be politically incorrect or in some way viewed as unpalatable or offensive.
Misunderstandings About Matching Preferences

While discussing preferences can be empowering, it is vital that students have a clear understanding about the waiting-time price associated with preferences so they can make the most informed decision regarding preferences they would like to have specified. During my interviews, I encountered two students who had misunderstandings regarding preferences. Tina was one. She requested a Christian therapist but left believing that the center couldn’t meet her needs. Her situation is detailed in the next and final section of this chapter.

Sue was the other student. She was one of only three students I interviewed who chose to return for subsequent counseling. Quite coincidentally, our interview was scheduled immediately following her first session with her assigned therapist. As usual, I reminded her that the research was focused on her earlier intake session – not the session she had just finished. However, a few minutes into our interview we had the following exchange:

Sue: “So I’m not supposed to say anything about today?”
Clay: “You can say a little bit about today, if you want to.”
Sue: “Well – I had a good session today, I think, with somebody. But I requested somebody that was more my age and she’s not. She’s – so I feel like somebody didn’t read my papers.” (Sue, 4/8/03)

As we talked about it more, it was clear that Sue felt she had requested an older therapist and was quite disappointed that she had been assigned a relatively young therapist.

“I did my part. I filled out my papers and I put in my request. But maybe I was being unreasonable by thinking that they would match me up with somebody that was over 40. Because I am over 40 and I kind of wanted to talk to somebody in my own generation. And they gave me somebody who’s probably early 20s.” (Sue, 4/8/03)

And, in fact, Sue’s intake paperwork does specify “only female older than 40 y.o.” in the space allotted for identifying therapist preferences. There is no mention in the file why the “older than 40” portion seems to have been ignored in the therapist assignment process.

I asked Sue if she and her assigned therapist had discussed the age difference in the first session that she had completed just prior to our interview. She said they had, which I
was delighted to hear. However, I was dismayed to learn that Sue was the one who initiated the age difference conversation. Given that she had specifically requested an older therapist and given that her request is clearly mentioned in the intake paperwork, I am disappointed that her 20-something therapist didn’t initiate that important conversation. In my perfect world, a mismatched therapist assignment should be one of the first things a therapist would address with a new client.

Fortunately, Sue’s disappointment didn’t interfere with her interest in getting counseling. She decided to continue working with the younger therapist – partly because she had enjoyed the first session and partly because “I feel like if I don’t get started that it’s going to take another month or something to line me up with somebody. I don’t really have that amount of time. I just want to get it started.” (Sue, 4/8/03)

One of the problems associated with discussing therapist preferences is that, like Sue, students may have unrealistic expectations about their therapist requests being met. Sue did recall being told her request might not be granted (although this was not documented in the intake paperwork). Yet, she was pretty unhappy to be assigned to a therapist in her 20s. Nevertheless, she chose to come back for more counseling. Other students might not be willing to persist in the face of that disappointment.

In general, I think it’s important to ask students about their therapist preferences. While there are some dangers associated with asking students about their preferences (e.g. misunderstandings, students making difficult requests), I believe the benefits of asking for preferences outweigh possible problems. Asking is empowering. It gives students some control over the process and communicates the message that the center is committed to meeting their special needs. Asking must be accompanied by discussion of the feasibility of having requests met. It’s very important for students to understand what criteria will be used to match them with a therapist.

And, the tradeoff inherent in making specific requests also needs to be discussed so that students are able to make the most informed decision about what therapist requests (if any) they want to specify. The truth is that the more specific a student’s requests are, the longer it will take to match the student with a therapist. I believe that all of this needs to be openly discussed with students who are limited in terms of therapist preferences or
times available to attend counseling. Students who are not directly assigned to a therapist on intake need to leave the center with an accurate sense of how long they will wait and the likelihood of their preferences being met.

**Politically Incorrect Preferences**

The second potential problem with asking for students’ therapist preferences is associated with how we field preferences that are perceived as politically incorrect or in some way offensive to the intake therapist. Discussing preferences invites students to expose their biases and prejudices, and therapists may have judgments about the relative appropriateness of some expressed preferences. Fellow trainees at the center have shared stories about students making requests that I would judge as inappropriate, for example, a request to work with a “native English speaker” or “someone who isn’t gay”.

I have not personally experienced this type of request at the university counseling center. However, in a different position at another agency last year, I did interact with students who expressed therapist preferences in writing. On a few occasions, I was aware of having a negative reaction to a student’s request. For example, one individual identified a preference to work with a “pretty, white female” and another wrote “not an Asian”. In that situation, these were not students who sought counseling services, but university students who were being screened as potential counseling clients.

Certainly, it could be said that all requests are prejudicial because they are based on preconceived judgments that may or may not have a reasonable basis. But, some requests will have a stronger negative stimulus value than others. Some requests feel more appropriate (politically correct, understandable, reasonable and so on) than others. For me, it is easier to be sympathetic with and want to grant requests made by members of historically oppressed groups to work with similar others (e.g., an African American client who wants to work with an African American therapist). It’s the ones that I react negatively to that challenge me the most.

Should the intake therapist adopt the role of social change agent and challenge or try to educate the student? Or, is it more prudent for the intake therapist to defer passing judgment on unpalatable requests and engage in the usual discussion of the tradeoff between matching preferences and having to wait for services? I lean toward the latter for
a couple of reasons. First, based on the short duration of the intake, the therapist may not have enough information to fairly evaluate requests. Second, the intake therapist’s job is to engage the student in the counseling process, not to challenge the student’s belief system.

I suggest we trouble any evaluations we might have of student preferences and instead focus our energy on empowering students to make well-informed decisions about what preferences they want to specify. More generally, I question our right to act on our evaluations. Which therapist preferences shall we deem “acceptable” and worthy of accommodation? Which ones shall we marginalize and devalue? What makes us qualified to differentiate between the two types? And is my differentiation more correct than yours? Certainly I would benefit from troubling my tendency to assign place positive or negative valences to therapist preferences that students specify. I wonder if other therapists need to do the same.

**Negotiating Differences With Multicultural Empathy: Three Cases**

The last finding discusses the challenges involved with the successful negotiation of the complicated and multiple dimensions of difference between the student and intake therapist. Three of the nineteen students had negative experiences that were, in some part, traceable to the unsuccessful negotiation of multicultural differences. For Inuyasha, the misunderstanding was racially based; for Tina, it had a religious basis; and for Trooper, ethnic difference was the underlying cause. This section describes each of these cases in detail.

I believe each student’s negative experience was a result of a breakdown in cultural empathy, which is defined by Ridley and Udipi (2002) as follows:

> “Cultural empathy is a special case of empathy. Ridley and Lingle (1996) define the construct as the learned ability of counselors to understand accurately the self-experiences of clients from other cultures. The counselors’ understanding is informed by their interpretation of cultural data. Cultural empathy also includes the ability of counselors to communicate their accurate understanding effectively with an attitude of concern.” (Ridley & Udipi, 2002, p. 318)
Thus it has two important components: understanding and responsiveness. Each of these cases is underscored by some failure in cultural empathy, which was not noticed at all or, if noticed, the recovery effort was unsuccessful. Breakdowns in communication are inevitable, given the nature of the very intimate and personal conversation that is part of the intake process. We are bound to make mistakes – even culturally based ones. Yet, it is important that we effectively use cultural empathy to notice our mistakes, so we can try to recover and use mistakes as a means to build rapport rather than creating distance.

There are two things I hope you keep in mind as you read about these three students’ experiences. The first is to draw your own conclusions about the role that cultural empathy – both understanding and responsiveness – may have played in each of these cases. And the second is to bear in mind how critical the negotiation of differences and the meaning-making process are in that short, one-shot, one-sided, intimate conversation that we call intake. As Hare-Mustin and Marecek (1990) remind us, “meanings are multiple, changing, and always being renegotiated and regenerated by communication and action” (p. 2). How might these three therapists more successfully have negotiated these misunderstandings?

Initial Observations

It is important to protect the therapists’ identities, so, I have been careful about how I describe them. Yet there are two things about them that I need to share. First, none of them are trainees (average years of counseling is greater than 10) and, second, at least some of them are members of one or more groups that historically have been marginalized and oppressed. Another significant consideration is that this counseling center has a very strong commitment to multicultural sensitivity, awareness, and training. Consequently, it is difficult to attribute these cases to a lack of multicultural training, experience, or knowledge.

I am also protecting students’ identities. Thus, I was unable to discuss these specific cases with the respective therapists. Nonetheless, it’s my sense that each therapist was to

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16 This assertion is based on the multicultural diversity of trainees and full staff members, my experiences as a trainee, my conversations with staff members, and my participation in multicultural trainings at the center.
some degree unaware of the effect of her/his behavior on the student. I also believe that
each therapist was trying to convey a different message than the message the student
heard. Finally, I don’t believe that any of these therapists intended to be multiculturally
insensitive.

These cases are told from each student’s point-of-view. That’s a limitation because
we can never know what the therapist did say, intended to say, or meant to say. Likewise,
we can’t guess if the therapist perceived the disconnection and attempted to repair it.
These are completely one-sided stories. But this one-sidedness is also a strength. Each
story reflects the student’s remembered experience of that intake session and, more
importantly, reflects how the student continues to think about the counseling center.

Another poignant observation is that these three students are members of groups
that tend to underutilize university counseling services and tend to “terminate
prematurely” (i.e., decide not to return despite more services being recommended). Given
the qualitative nature of this study, one must be careful not to overgeneralize findings.
However, it is worth noting that no students of European-American descent reported
similar experiences.

“This Has Nothing To Do With Me Being African American”

The important multicultural dimension in this first case was race. Inuyasha is a
19-year-old, African American woman in her first year of college. Inuyasha reported
circling a variety of concerns in the intake paperwork and crying a lot during the intake
interview even though she wasn’t feeling sad. Career concerns were the main issue that
brought her to counseling but that she also had concerns regarding her weight and body
image. Although individual counseling was recommended to Inuyasha, she did not return
to the center.

During our interview, Inuyasha shared that she went to the counseling center after
having disappointing experiences at three other university services: academic advising,
career services, and the academic learning center. She felt like none of these services
offered helpful advice or guidance. In her words, “It was stuff that I already knew.
Nothing – nobody was telling me nothing new.” (Inuyasha, 2/26/03)
Her experience at the counseling center was disappointing as well. Although she described her intake therapist as “very nice”, she felt like the intake session was too focused on reviewing what she had indicated on the intake paperwork. Inuyasha did not describe herself as being annoyed and feeling talked down to, but her words gave me that sense:

“But [the intake session] was just over what I signed on the paper. It was nothing more - nothing more about my issues. Strictly word-for-word we went over the paper. Why? Pretty much redundant. Word-for-word going through the paper. … [We] talked about the paperwork for half an hour - not saying why I wanted it but ‘did I circle this?’ ‘is this correct?’ So, I was like, ‘I’m a college student. I know what I circled.’” (Inuyasha, 2/26/03)

Near the end of the intake session, they spent some time discussing the counseling center’s therapy groups. I think it is likely that Inuyasha’s reaction to the intake session influenced her experience of this discussion. This was the part of the intake session in which racial insensitivity was clearly evident.

Part of the intake paperwork that Inuyasha had completed was a single sheet listing the available therapy groups that asks people to indicate which groups, if any, they would be interested in joining. Inuyasha had indicated an interest in joining a depression group but felt like her intake therapist repeatedly tried to interest her in the African American women’s group. As Inuyasha shared with me:

“During the appointment she was telling me that they were really booked and it was real hard to kind of get in. … She just said, ‘We’re booked. Would you like to do some of our group meetings?’ I circled down on the paper that I would. I circled which group I would on paper. But she asked me again to make sure. And I said, ‘yeah’. Then she asked me about a group that I didn’t circle. And I told her – well she wanted to know why I didn’t circle my ethnic group. And I’m like, ‘Well, because I didn’t want to’. And she was like, ‘Well why don’t you want to be with the African American women about African American issues?’ ‘Well, it’s because this has nothing to do with me being African American. It has something to do with my major and my physicality. Not with me being black.’ And she was like, ‘But they’re available.’ And I’m like, ‘But I circled a different group – a group for being depressed. Not a group for being African American.’ And she was like, ‘Yeah but they meet more.’ And I’m like ‘But I want to be in the depressed group because I think that there’s something wrong with me.’ She just kept referring back to them. And I’m like, ‘No’. So – I don’t know why she did that now that I think about it.” (Inuyasha, 2/26/03)
Later in our interview, as she was completing the Cross-Cultural Counseling Inventory-Revised (an observer rating scale of a therapist’s multicultural competence (LaFromboise, Coleman, & Hernandez, 1991)), Inuyasha spontaneously offered the following clarification:

“She was aware of cultural differences, but she kind of made that present and I didn’t really think that was an issue about the culture. It was like –

maybe I should address that – and I wasn’t addressing my culture at all. But she kind of made an issue of it and it wasn’t an issue of it.” (Inuyasha, 2/26/03)

Inuyasha did not return for counseling. She reported that she did not get follow-up calls for either individual or group counseling. Her needs were not met elsewhere and she has given up on trying to get help from university agencies. “I’m not going to seek out for help any more because I’m going to have to solve it on my own. And that’s what I’m going to do from now on.” (Inuyasha, 2/26/03). Although she didn’t directly talk about religion as a source of support, Inuyasha did say that she would refer a friend who was in distress to her church: “I’d tell her to find a church or something. I would refer her to a church – a church that I know.” (Inuyasha, 2/26/03)

“I Don’t Want Somebody Who’s Going To Tolerate Me”

In this second case, religion was the salient multicultural dimension. Tina is a 20-year-old, heterosexual, biracial (African American, European American) woman in her junior year of college who identifies as Christian. She has benefited from Christian counseling in the past and sought similar counseling at the center. In her intake paperwork, she indicated that a variety of issues brought her to the center, including chronic and reactive anxiety, difficulty sleeping, and a history of sexual abuse.

Tina did not return for counseling. The main reason that she gave for not returning was that she wanted to work with a Christian counselor but had the impression it would be difficult to match that request. “Honestly that is the reason why I didn’t go back. Because I felt it was too much of a hassle” (Tina, 2/20/03).

Tina felt that her intake therapist was “very kind” and “asked a lot of good questions to kind of dig deeper below the surface” (Tina, 2/20/03). However, the overall
intake experience turned out to be relatively negative for three reasons. First, in her words, “I didn’t feel like my needs were going to be met the way I wanted them to be” (Tina, 2/20/03). Second, Tina felt like she opened up to share some painful material with her intake therapist but wasn’t given any help to re-contain or put away the painful feelings. In her words: “I walked away feeling like I was a open book - like there wasn’t any closure” (Tina, 2/20/03). Lastly, Tina left the session feeling like she was isolated and alone in her experiences and that there weren’t others who struggled with similar issues – “When I left, I felt – I thought, ‘I am such a freak’” (Tina, 2/20/03).

Misunderstandings and miscommunications based on religious differences were apparent in a few ways. First, the therapist tried to enhance their connection by self-identifying as Christian. Unfortunately, Tina’s Christian beliefs were more fundamental than her therapist’s. Instead of capitalizing on similarities, the therapist’s self-disclosure served to highlight their differences.

“When I said that I believe in God – I’m a Christian, she said, ‘Well, well, that’s nice because I’m a [Christian-based religion].’ And she expressed the churches she goes to, which I know of – I don’t go to – but they consider themselves [XYZ], which to me is not the same thing. … So, I could picture, like if she were to be my counselor, you know, we would disagree on things that are, that make who I am who I am.” (Tina, 2/20/03)

Later in our interview, Tina specifically mentioned not feeling connected with her therapist:

“I wouldn’t want to see her again after that session because I knew we didn’t connect. She didn’t understand when I would talk about God or talk about how involved he was in my life and all these other things. So I knew afterwards that I probably wouldn’t want to see her again. That’s why I asked towards the end how possible is it that you can connect me with a counselor who is where I’m at in terms of my religious beliefs.”

The second manifestation of a religiously based communication breakdown occurred when they talked about Tina’s request to be matched with a Christian therapist. The center does have therapists who identify as Christian, and a client can request to be matched with someone who identifies as Christian. When there is a waitlist (as there was at this time), more specific therapist requests take longer to be met, so there’s a tradeoff between time spent waiting and matching specific requests. In this case, Tina’s distress
was high, her available times were limited, and she wanted to work with a Christian therapist. I think her therapist tried to explain the dilemma, but that is not what Tina heard. This is her description of that conversation:

“It was a lot of ‘well, you know, even if we can’t find somebody who can give you some scripture verses – although we know there are counselors here who could do that,’ she stressed that ‘even if we can’t get you them, we can find you somebody who’s very tolerant.’ And that just – it just didn’t sit well with me. I don’t want somebody who’s going to tolerate me. I want somebody who’s going to understand and they’re going to believe the same thing I believe. And that – so that – honestly, that is the reason why I didn’t go back. Because I felt it was too much of a hassle although she did tell me there were people there that could – who could probably – help me out the way I wanted to be helped.” (Tina, 2/20/03)

And, finally, Tina wasn’t given a referral to a Christian counseling center. Her therapist seems to have misunderstood how central religion is to Tina’s identity. She also may have underestimated the importance of religiously-based interventions (e.g., praying and being directed to specific passages in the Bible) to Tina as a counseling client. Finally, it also appears that Tina’s therapist wasn’t aware of how alienated Tina felt by the end of her intake.

Tina did not return for counseling. She reported that she did receive phone and email messages from the counseling center. She appreciated the follow-up contact, but she didn’t feel her needs would be met at the counseling center. Tina also reported that she would consider going back and trying again in the future.

“That’s Why I Didn’t Get Anything Out Of The Counseling: Because Of My Name”

Ethnicity was the important multicultural dimension in the final case. Trooper is a 26-year-old, heterosexual man who is a fourth year college student. Over the past year and a half, he has attended two intake sessions at the counseling center but has received no other services. At both intakes, Trooper’s presenting concern was anger management. Our interview focused on his most recent experience, about which he was “really disappointed” (Trooper, 7/11/03).

Trooper did not return for counseling for a variety of reasons, including the time delay before he was offered an appointment, his disappointment with the services offered,
and feeling misunderstood by his intake therapist. Trooper believes that his ethnic background contributed to being misunderstood. There is some evidence that his intake therapist misunderstood his distress based on the discrepancy between Trooper’s self-rating (6 on a 7-point scale) and the therapist’s rating (2 on a 4-point scale). He reported having a sense that his distress was underestimated and attributed that misunderstanding to his ethnicity.

Clay: Do you think she had an accurate understanding of your level of distress?
Trooper: No.
Clay: Over? Underestimate?
Trooper: Underestimated it.
Clay: And I want you to explain. Say why.
Trooper: I think one reason because like as soon as she find out I from Middle East – I’m not saying she was prejudiced or anything – but I feel like it give her some wrong idea. (Trooper, 7/11/03)

Later, Trooper had more to say about the “wrong idea” his therapist got about him:

The way that she look at me, then it’s like you come from a background – like men’s obviously they have – it’s still I felt it, you know – like there’s more angry men. It’s like that’s why I have the anger problem. That’s exactly my point: this. If maybe she didn’t know what country I’m from, she wouldn’t have the mold – so, like put her in the position like she look at the way is not even true. It’s not the way – like put her in the wrong road. That’s exactly my point. (Trooper, 7/11/03)

This was not the first time that Trooper has felt judged by others based on his ethnic background. He talked about how uncomfortable he is in classes where he’s asked to talk about himself because he doesn’t want to get labeled as Persian. He believes, “it’s just enough one person say something about him or herself and you see everybody pretty much like close to that thing” (Trooper, 7/11/03). In addition, while Trooper was raised in Persia, he’s lived in the United States for six years and describes himself as being quite different. He feels that being identified as Persian denies the numerous ways he has changed over time. Finally, Trooper talked about being multi-faceted and strongly resisted the notion of being defined by a single dimension like ethnicity.

Part of the reason that Trooper felt misunderstood during his intake session was because he believed his therapist attributed his anger management issues to his culture, which is very different from how Trooper views it:
“Because my issue is not about culture. It is not about race. It is not about anything. It is not about because I am Persian or because I’m Muslim. This is not about what do you believe. This is something I cannot control it. So it’s not about my beliefs.” (Trooper, 7/11/03)

Feeling pigeonholed because of his country of origin, feeling like his distress was underestimated, and feeling like the cause of his anger was misattributed to his culture were only some of the reasons Trooper was disappointed by his intake session. He also was dissatisfied because (a) the advice offered was not helpful or new information, (b) he felt his therapist confused him with an 18-year-old freshman instead of seeing him as a 26-year-old man, and (c) the center didn’t contact him within the specified time frame.

Near the end of our interview when I asked Trooper to describe himself (the same question I have asked in every interview), his response was:

I usually don’t answer the question like what I think about myself – how I define myself – because I’m not like some formula in a mathematic book. I can’t define myself on like million things. So, I have no answer for that. Sorry. (Trooper, 7/11/03)

When I asked him to select a pseudonym, he first wanted to go by his given name. However, I was uncomfortable about that since his name is rather unusual and might compromise his confidentiality. His second choice was “Trooper”. My initial response was to encourage Trooper to pick a different name, but he helped me understand why “Trooper” was a perfect choice for him:

Clay: I would like it better if it was a Persian name – but if you want it to be Trooper, I’ll make it Trooper because this is your name. It’s not my name. You know what I mean? It’s supposed to be what you want it to be. Now, personally I would like it if it were reflective of your culture: a Persian name.
Trooper: But that comes back to that point.
Clay: Definitely. Yes. I know. And so, you want Trooper?
Trooper: Yeah. Let’s go that way.
Clay: Trooper’s your name then. Because this is really your name.
Trooper: That’s why I didn’t get anything out of the counseling because of my name. The first thing she asked me, ‘where are you from’ when she saw my name. (Trooper, 7/11/03)

Trooper did not return for counseling. The center left him a phone message to offer him an appointment but he chose to not respond. He says he would be willing to give the
counseling center one more chance in the future. If he does go back, he plans to be more
direct with his intake therapist about his expectations to find out if the center can meet his
needs.

**Important Lessons**

There are valuable things we can learn from each of these students’ experiences. The first is that race/ethnicity (and all of the many facets of multiculturalism) is not necessarily a dimension that clients view as salient to the counseling situation. Identity is not a simple, fixed, and consistent entity. Rather, identities are complex, multi-layered, often contradictory, and context dependent (Holland, Lachicotte, Skinner, & Cain, 1998). Inuyasha was quite clear she didn’t consider her race to be salient to her concerns. Since she repeatedly tried to steer Inuyasha to the group for African American women, it seems that the therapist assumed that race was salient and was markedly attached to that assumption. This is a culturally empathic failure in understanding. And, it’s another example of a place in our work where it would be helpful to trouble our assumptions. It’s a mistake for counselors to assume that any given dimension of multicultural identity is immediately salient for any given student. Thus, racial identity may not be salient to clients of color, GLBT issues may not be salient to GLBT clients, disability may not be salient to a client with a disability, and so on.

The second important lesson is about the powerful, negative influence that racial bias can have on our work with clients. “Counselor’s unintentional racial biases lead to perceptual ‘blind spots’ and misattributions that limit their multicultural counseling effectiveness” (Jackson, 1998, p. 3, as cited by Pedersen, 1999, p. 153). I would extend Jackson’s comment to encompass all other forms of biases, for example, gender and heterosexual biases. A racial bias led Inuyasha’s therapist to conclude that the African American women’s group was the best one for her, and an ethnic bias led Trooper’s therapist to somehow convey that she believed that anger and Middle Eastern males go hand-in-hand.

Tina’s experience teaches us a worthwhile lesson about how self-disclosures can backfire and increase distance rather than enhance rapport. The notion of finding
common ground in Christianity was a good strategy. In fact, Pedersen (1999) identifies self-disclosure as one of the microskills that can be helpful for a counselor in a culturally ambiguous situation. So, it was a good idea. Unfortunately, the self-disclosure didn’t have the desired effect. One of the problems is that the self-disclosure wasn’t culturally appropriate. While I cannot be certain, I think the therapist over-disclosed in this case. If she had offered less explicit information about her Christian beliefs, the self-disclosure might have had the desired effect. The second (and more glaring) problem with the self-disclosure is that it doesn’t appear that the therapist even realized her mistake. Nothing that Tina reported led me to believe that the therapist attempted to recover.

And, still grounded in Tina’s experience, we might want to consider whether or not there are some dangerous words that don’t belong in the context of differences. I don’t know if Tina’s therapist used the word “tolerate” or “tolerant”. I can’t know that. I do know that that’s the word Tina remembered and that makes me suspect that it popped up in their conversation at least once. I don’t think her therapist intended to imply all of the emotional and historical baggage that accompanies “tolerate” and “tolerant”. I do wonder if therapists give religious differences the same level of respect as other dimensions of difference.

I think there are two important lessons to be learned from Trooper. The first is about just how hard it is to be a male from the Middle East in this decade. I imagine that Trooper has been targeted by prejudice and discrimination in numerous situations. I feel how hard it is for him to be judged by culture/country of origin rather than culture/country of six-year residence. Three years ago, I accidentally insulted a man from the Middle East by asking about his country of origin. In my mind, I was trying to make friendly conversation while checking out at his grocery store. He became very angry because he heard me accusing him of not being an American. That simple question – “So, where are you from?” – can build barriers or increase connection, depending on the context. This is important information, since many therapists begin an intake session with simple questions designed to put the student at ease. Trooper’s experience gives us good reason to be more thoughtful about which questions to use in different situations.
The other valuable lesson from Trooper’s experience is the importance of accepting and acknowledging how complex and multi-layered identities are. Trooper resists putting himself into any kind of formula (i.e., a formula based on age, race/ethnicity, sexual orientation and so forth) simply because it is impossible to say who he is without listing a million things and because who he is today is different than who he was yesterday and who he will be tomorrow. He’s the quintessential post-post-modern man.

Concluding Remarks

Each of these three students had a culturally based negative experience during their intake sessions. None of them explicitly listed that incident as the reason they chose to not return for recommended counseling. However, I believe their decision to not return was indirectly influenced by the negative experience. Inuyasha felt pushed to join a group of African American women, Tina felt that her request to work with a Christian counselor would be too difficult to satisfy, and Trooper felt misunderstood by his intake therapist. We can’t know if they would have returned, if their experiences had been different.

Cultural empathy is an important component of all counseling interactions, but it is especially critical at the initial intake session. Intake therapists are the gatekeepers to the counseling center. In addition, they are the first point of therapeutic contact. A student’s intake experience is bound to influence the choice to return for therapy. This is true for all students, but it is especially true for students who are ambivalent or skeptical about the counseling process or who doubt the center can meet their needs. Furthermore, by its very nature, the intake session (time-limited, one-shot) offers the therapist less opportunity to notice, address, and recover from therapeutic blunders, including those that are multiculturally insensitive. The student and therapist don’t have an existing relationship to help buffer errors, and there is limited time for any sort of trusting relationship to develop.
CHAPTER 5

RECOMMENDATIONS AND CONCLUSIONS

This research has developed a richer and deeper understanding of college student perspectives about counseling and initial “intake” experiences with counseling. The findings, grounded in the data and developed through inductive analysis, strongly guided me in the creation of informed recommendations. Specific student experiences also played a vital role. Changes that can help us be more sensitive and responsive to particular student needs would likely be beneficial for other students as well. The common goal underlying each recommendation is a desire to help us find ways to enhance our practice so that all students’ initial experiences at counseling centers might be a little bit better. Quite possibly, such changes could reduce the poor return rate following intake at university counseling centers.

The majority of this chapter is dedicated to enumerating recommendations that are suggested by the findings of this study. These proposals are specifically targeted, in order of presentation, to individual therapists, counseling centers, and counselor training. The remainder of the chapter identifies research limitations and future directions. Brief concluding remarks are made at the end.

Informed Recommendations

This section offers concrete suggestions about ways to improve our practice. These recommendations are grounded in the experiences of the nineteen multiculturally diverse
students who I interviewed for this research. The findings, based on an inductive analysis of student interviews, guided the generation of these recommendations. To review, the major findings covered in the previous chapter are:

(a) Students put off coming to counseling: “I didn’t really want to go”.
(b) Troubling our assumptions.
(c) Intake as a beginning, not a screening: “I just wanted to start”.
(d) What therapist preferences do students have?
(e) Negotiating difference with cultural empathy: three cases.

Three classes of recommendations are offered. The first type is directed to therapists, the second to counseling centers, and the final one to training in multicultural competency.

For Therapists

I have five recommendations for therapists. The first four begin with the word “try.” That’s deliberate. Conducting intake sessions is one of the trickiest things we do as therapists. The time constraint, the limits of the relationship, the difficulty and uncertainty of presenting issues, and sometimes the hard message that a student will have to wait for services – all of these things make intake sessions particularly challenging. So my first four suggestions begin with “try” because there’s already so much that we have to do as part of an intake. They are:

- Try to more fully and accurately understand the student’s perspective.
- Try to do more than screen at intake.
- Try to expose the process more thoroughly.
- Try to discuss therapist preferences with students.

The final recommendation – Remember that we are the gatekeepers – is worded differently. That too is deliberate. As intake therapists, we are the gatekeepers and this really isn’t something I want us to “try” to remember. I think it’s something we must remember. Each of these recommendations is discussed below.

Try to more fully and accurately understand the student’s perspective. My primary recommendation for intake therapists is to take on the challenge of keeping the student’s perspective in mind during each intake session. First, initial contact is difficult for students. It is hard to come to counseling and most students put it off. Some students feel they have exhausted other resources by the time they arrive. All students bring
preconceived notions about the counseling process and many of their preconceptions reflect the stigmatization of counseling. It’s important to remember how hard this is for students and that they are struggling with some personal distress.

Second, for students, intake is a novel and unique experience. It’s not a routine event. Part of adopting the student’s perspective is to deliberately and critically question the numerous assumptions we inadvertently make as a result of our over-familiarity with the intake process. Our unspoken assumptions can lead to negative experiences such as procedural confusion. For intake therapists, the habitual nature of the process makes it a challenge to keep sight of how students experience this initial visit to the counseling center.

So, what can we do to stay closer to students’ perspectives? One thing we can do is to ask students about their immediate experience. For example, “Was it hard to come in today?” or “What’s it like to be sharing this with me?” or “How does it feel to be here today?” Questions like this are also helpful because they invite students to acknowledge the difficulty associated with getting counseling and the challenge of having to talk to a stranger. Another useful vein of questions are ones that explore how the intake session might be beneficial to the student. For example, “What can we do right now that might help?” or “Let’s see if we can figure out something that could bring you some relief right now.” In addition to helping us stay closer to the student’s experience, these kinds of questions can give us important information regarding their expectations for the intake session. These questions can guide our decision about what small shift in knowledge, beliefs or feelings might be the most helpful or meaningful for each particular student.

It’s important to acknowledge that the method a given therapist uses to facilitate getting a better understanding of the student’s perspective will depend on the therapist’s theoretical orientation. Thus, the questions I have suggested may or may not be helpful for other therapists. Regardless of theoretical orientation, the goal of understanding student perspectives more fully is an important one to pursue.

*Try to do more than screen at intake.* Many students want more than a simple screening at intake. As intake therapists, it’s important to try to help students get a sense of starting. We can do that by striving to give students something tangible to walk away
with that day. This may be especially important when students have to wait to get an intake appointment and have to wait to get a therapist for individual counseling. This finding has led me to question my practice more closely. I do try to give students something tangible at intake, but I don’t always do a good job of documenting that in my intake report. This is something I need to change. Furthermore, when I see a new client for individual counseling, I try to be mindful of the importance of some sense of continuity of care for that person. In addition to scanning the paperwork for any details about homework assignments or whatever, I consciously make an effort to connect our first session to the intake session. I hope I can continue learning how to incorporate both of these more fully into my practice.

Try to expose the process more thoroughly. Since most students don’t read the paperwork thoroughly, it can be useful to talk specifically about the intake process and how therapists are assigned. By doing so, we can avoid making inaccurate assumptions regarding a student’s understanding. This extra explanation also gives us an opportunity to make sure that students are clear about what will happen next. For example, some of the students with whom I spoke would have benefited from a more in-depth account of the vague phone message offering an appointment they would receive and a more accurate description of the actual wait time before an appointment would be offered. One of the important roles of the intake therapist is to educate the student about the processes and procedures at the counseling center. As an intake therapist, I sprinkle process educational comments throughout the session.17

For students who will have to wait for assignment, it’s important for them to have an accurate understanding of the likely length of that wait. Therapists and receptionists are obliged to present this as accurately as possible. But it’s important to get the student involved and invested in the process as well. For example, I encourage students to call the center to find out their waitlist status. I also give students my card and encourage

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17 I usually begin an intake with something like, “This is what is called an ‘intake’ session. Over the course of the next 20 to 25 minutes, I need to learn as much as I can about what brings you here today and we need to figure out what will be the most helpful for you.” For students who are being referred to individual counseling and whose names I am adding to the waitlist, I explicitly describe what will happen next and how long the wait is likely to be. I usually end an intake with something like, “Do you have any questions about what will happen next?”
them to contact me if they have any questions or concerns about their waitlist status. This has the important side effect of giving students some control over their mental health care and gives them the opportunity to play a proactive rather than reactive role in the process.

*Try to discuss therapist preferences with students.* In terms of therapist preferences, students know what they prefer, don’t appear to have any difficulty articulating that, and know the strength of their preferences. Asking for preferences in conjunction with discussing the wait time tradeoff associated with more specific requests gives students all they need to make a well-informed decision about which preferences, if any, they would like to specify. This is another means of giving some control back to students and encouraging students to take some responsibility for their health care. And, students generally appreciate being asked about preferences. It gives them a sense that the center is willing to tailor services to students’ special needs. One note of caution though, asking for and subsequently not honoring preferences can lead to negative outcomes.

*Remember that we are the gatekeepers.* Last but not least, I encourage us to maintain a heightened awareness of our role as gatekeepers. Based on an intake interview, we control a student’s access to the center and where, how, and when a student will get help. More globally, the intake interaction influences a student’s future openness to counseling as a helpful resource. The intake session – that initial contact a student has with the center – leaves important impressions. And those impressions are strongly influenced by the therapist’s cultural empathy. It is inevitable intake therapists will make mistakes and that some of those mistakes will be multiculturally based. Given that there’s no continuity (past or future) to the student-therapist intake relationship, it is especially important to notice and appropriately address ways we may be misunderstanding or ineffectively responding to students. This is especially true at intake.

Our ability to practice culturally empathic understanding and responsiveness can be hindered by the prejudices that we carry into the intake session. Initial impressions are strongly influenced by preconceived notions. This is true for students and it’s true for intake therapists. In the findings chapter, I described three cases where a failure in cultural empathy led to negative experiences and outcomes. I believe therapists’ preconceptions and misconceptions contributed to each of those failures. For some
reason, Inuyasha’s therapist thought the African American women’s group would be a better fit for Inuyasha. Tina’s therapist thought she was enhancing their connection by self-disclosing her own religious beliefs. Trooper sensed that his therapist attributed his anger to his ethnic background and culture. Students want to be heard and feel understood during intake; they don’t want to feel judged. All three of these students felt judged at some level. And, although the therapists certainly didn’t intend to shut the counseling gate on these three students, that was indeed the outcome in each case.

For Counseling Centers

Based on the findings, I have three recommendations for counseling centers. The first is to actively work to reduce the stigma of counseling on college campuses. The next is to review and revise the information provided to students from the perspective of a “naïve” student. And finally, I encourage centers to consider expanding their trainings related to conducting intake and practicing multicultural competency. Each of these recommendations is discussed below.

Proactively pursue stigma reduction. It’s important for university counseling centers to continue trying to find ways to minimize the stigmatization of counseling for all students. My interviews were with students who sought counseling despite their fears and negative expectations. We can’t know how many students in distress never seek counseling because of the stigma. But we can make efforts to reach out more effectively to de-stigmatize counseling in the university environment. This counseling center is addressing this problem in several ways. First, the center has created online and printed materials that are targeted to specific groups (e.g., a “Why Counseling” brochure that is targeted for different groups like African American students and student athletes). Second, the center has an ongoing stigma reduction committee that meets to discuss and implement corrective strategies. Third, therapists often use outreach as a means of increasing our visibility and normalizing the existence of our agency. And, finally, in the past, some intake hours have been conducted at different locations on campus like the multicultural center in an effort to bring our services to the students.
instead of requiring the students to come to the center. I encourage other centers to take similar measures and creatively construct other means of reducing stigmatization within the campus community.

**Review and revise the information provided to students.** This second recommendation is grounded in the finding that several students encountered procedural confusion due to an incomplete understanding of the processes and procedures at the center. For some students, procedural confusion led to negative experiences and outcomes. It is difficult to know if students at other counseling centers experience similarly based situations. Consequently, this discussion does not focus on recommendations targeted for this center\(^\text{18}\) since it is unlikely that they generalize well. However, most counseling centers would probably benefit from a critical examination of the information they give students.

Thus, this recommendation is for counseling centers to scrutinize their materials from the perspective of a “naïve” student. Then, with an eye to that perspective, centers can revise materials as needed in an effort to clarify the center’s processes and services using language that is accessible and inviting to students. ‘Information that students receive’ includes the content of paperwork students get at intake, brochures published by the center, the center’s internet web pages, and form letters the center may send students (e.g., termination of counseling letters).

While possibly difficult to implement, I believe the best way to find deficiencies in the information that students receive is to enlist students to aid in the review/revision process. In a perfect world, a few “authentic and articulate”\(^\text{19}\) multiculturally diverse students from the college community would be recruited for this purpose. These would be students who had not previously been to the center. (Alternatively, the center can recruit one or more staff members to critically review the paperwork. Some attempt should be made to enlist naïve reviewers, for example, recently hired staff members like trainees or

\(^{18}\) Suggestions targeted for this center were shared directly in a research presentation in early April 2004. As a member of the clinical services committee, I was able to suggest specific paperwork changes, which are currently under consideration. And, through working on a special project, I was able to update and revise their internet web pages to make them more informative and helpful for students.

\(^{19}\) During a multicultural competency training at the center in April 2004, Dr. Paul B. Pedersen used the words “authentic and articulate” to describe the most helpful type of community members to recruit to act as pro-counselors and anti-counselors in his Triad Training Model (Pedersen, 1999).
work study students.) Getting multiple perspectives is helpful. These “naïve” reviewers would read through the information provided to students and then describe what they expected would happen if they came to use the services at the center. This type of input could be used to identify content deficiencies.

In addition to content deficiencies, it can be helpful for a center to also consider the presentation. Some of the information may inherently be less accessible (e.g., the “medical-ese” of HIPAA privacy practices notice). However, the material describing services doesn’t have to be difficult to read and understand. Explanations of the center’s processes and procedures need to be written using a clear, direct, concise style. With the increasing multicultural diversity of students across college campuses and in an effort to make our services more accessible to students for whom English is a second language, this is imperative.

Of course, this recommendation is couched within an awareness that many students report skimming the paperwork and not reviewing it carefully. Changes such as these may not actually reduce the procedural confusion that some students experience. It’s difficult to know if student misunderstandings result solely from not reading the paperwork, or if imprecision and a lack of clarity in the paperwork leads students to abandon trying to read that paperwork. It also may be important to emphasize the relative usefulness of the different pieces of paperwork students receive. Perhaps this is something that receptionists might do when they give the paperwork to students to fill out and sign.

Make intake and multicultural competency trainings more comprehensive. For centers that are active training sites, my final recommendation is to encourage them to consider ways in which their trainings might be improved. These findings suggest there might be benefit from enhancements in both intake and multicultural competency trainings. In terms of intake training, it’s important to educate trainees about the special nature of intake and the ways in which intake goals differ from individual counseling goals. While it’s beyond the scope of this dissertation to propose such a training program, this research’s findings would be a helpful guide in that process. In terms of
multicultural competency training, it seems very important to ensure that cultural empathy is a large component of that training. Specific suggestions for training programs are provided in the next section.

For Training In Multicultural Competency

My last recommendations address the issue of multicultural competency training. The three students who had negative experiences due to culturally empathic errors highlight a need to continue improving multicultural competency training. As a counseling psychology graduate student and as a graduate associate at the university counseling center, I have participated in numerous trainings on multicultural competency. But in those trainings, little attention has been given to cultural empathy or to recovery from culturally empathic blunders. Another topic that has received little attention is the role of multicultural competency within the context of an intake interview.

Recently at the center, Dr. Paul B. Pedersen presented a multicultural competency training. For a portion of the day, we focused on using his Triad Training Model (Pedersen, 1999) as a means to gain access to the internal dialogue of multiculturally different clients. While I won’t describe his model in detail, the underlying premise of the model is that when a therapist and client interact, three simultaneous conversations are occurring. The first is the obvious one: the external dialogue between the therapist and the client. The second and third conversations are the unspoken, internal dialogues within each participant that analyze what is and isn’t being said and make meaning of the external dialogue. The therapist knows the content of the external and her own internal dialogue; however, she can only guess about the client’s internal dialogue. The purpose of the Triad Training Model is to help therapists develop awareness, knowledge, and skills in better understanding the hidden, internal dialogue of clients.

I believe that multicultural competency trainings using Pedersen’s Triad Training Model (1999) can help intake therapists deal more effectively with situations like the ones described in the last section of the findings chapter. Each of the three students had negative experiences that are traceable to some lapse in cultural empathy. In each of those cases, an increased sensitivity to, awareness of, and reactivity to the student’s internal dialogue could have led to a different outcome. And, interestingly enough,
developing a better understanding of a student’s internal dialogue is really just another way of learning to better understand student perspectives. Furthermore, trainings tailored to enhance our awareness of and responsiveness to student perspectives will increase our facility with the understanding and responsiveness facets of cultural empathy.

I suggest that psychology programs and counseling centers consider using Pedersen’s Triad Training Model (1999) for multicultural competency trainings. Additionally, Ridley and Udipi (2002) offer a wonderful list of specific guidelines for using cultural empathy, which are based on the work of numerous researchers (listed in Ridley & Udipi, 2002, p.323). These guidelines are summarized in Table 5.1.

| Respond empathically throughout counseling. |
| Respond to core themes. |
| Recover from misunderstandings. |
| Do not pretend to understand. |
| Use time in ways that reflect empathy. |
| Check yourself for possible cultural biases and hidden prejudices. |
| Do not stereotype. |
| Explore cultural and racial issues early in counseling. |
| Incorporate cultural and racial data into counseling. |
| Use cultural schemas. |

**Table 5.1: Guidelines for Using Cultural Empathy**  
(From Ridley and Udipi (2002))

Another important multicultural competency training topic that has received little attention is the process of recovering from errors. It is inevitable therapists will make mistakes and that some of those mistakes will be the result of a culturally empathic blunder. I agree with Pedersen’s assertion that the function of training “is perhaps not to teach counselors how to avoid making mistakes but, rather, to help counselors who make mistakes recover effectively” (1999, p. 98). He also asserts that recovery skills are often disregarded as “a teachable or learnable skill area” (1999, p. 98). Pedersen explicitly lists
ten microskills that might aid in recovery in multicultural counseling interviews. While generally quite helpful within the context of a developing or ongoing counseling dyad, the usefulness of some of these microskills in an intake situation is questionable (e.g., changing the topic, arbitration, and termination). The intake dyad is sufficiently different from the counseling dyad to merit specialized training in numerous areas, including recovery skills. Finally, the role of multicultural competency within the context of an intake is at least somewhat distinct from its role in individual counseling. Even though our knowledge in these areas is limited, it seems that Pedersen’s Triad Training Model could be expanded to encompass the important topics of recovery and multicultural competency in the unique context of the intake.

**Research Limitations**

Restricted generalizability is a limitation inherent to any qualitative research. Nonetheless, “qualitative inquirers look to the specific, both to understand it in particular and to understand something of the world in general” (Glesne, 1999, p. 153). I believe these results offer important understandings about the experiences of college students who visit a university counseling center for an intake session. Generalizing these results to other counseling settings (e.g., community mental health) may be unwarranted. Other university counseling centers can assess the generalizability of these results to their particular settings using the descriptions of the research context and participants and researcher positioning that have been extensively documented in this dissertation. Increased similarities across settings and practices enhance the trustworthiness of generalization.

Other limitations include the following. First, student disclosures were probably influenced by the characteristics of the interviewer. Different interviewers with different subjectivities and characteristics (e.g. age, gender, race/ethnicity, and so forth) may have asked questions differently and certainly would have had different stimulus value for the students. This would likely produce at least slightly different stories. Second, the pool of potential participants was self-selected and thus limited to students who were willing to talk about their experiences in a paid research interview. Third, triangulation was limited within individual stories. While triangulation between stories was strong, within stories it
was weak. Interview was basically the sole means of assessing student experiences. This limitation was inevitable given my decisions to (a) protect student identities from intake therapists and (b) minimize interfering with the intake process. Personally, I view this as more of a strength than a limitation. It allowed me to meticulously and authentically focus on students’ perspectives and experiences, which adds their voices to the literature in an important way. Finally, the fourth limitation is that despite my efforts to minimize intrusiveness, I was unable to eliminate my research presence. Thus, the students and therapists involved in these intake sessions were well aware that the practices of the counseling center were under scrutiny. This awareness may have resulted in behavior changes.

Future Research Directions

This research has barely scratched the surface of an exciting and important area of study. An abundance of interesting and beneficial future research opportunities are evident. We still know relatively little about how clients experience intake and what can be done to more effectively engage them in the counseling process. In addition to highlighting the importance of understanding and maintaining an accurate awareness of client perspectives, these research findings suggest several potential projects.

Replication and extension are obvious future directions. For example, parallel studies could be conducted (a) at similar and dissimilar university counseling centers, (b) in a completely different setting like a community mental health center, (c) using a researcher with different characteristics and biases, and (d) using a multiculturally diverse research team instead of a single researcher. This type of research is an important addition to the counseling process and multicultural competency literature because it uses qualitative methods to gain access to the experiences and perspectives of real clients in real counseling situations.

In addition to learning more about intake clients’ perspectives and experiences, it would be helpful to pursue research to develop a better understanding of the specialized interaction that is an intake. What is the role multicultural competency in an intake? Does it have the same meaning in that context? How are the aims and goals of the intake similar to and different from other counseling interactions? What specific skills are the
most/least helpful at intake? How different are those skills from those that are most/least useful in other counseling interventions? What recovery skills are the most helpful for intake therapists? What skills help a therapist develop a good-enough culturally empathic rapport in the context of an intake session?

Finally, this research highlights a need to improve trainings in psychology programs and at counseling centers. Specifically it points to a need to enhance our trainings related to intake, recovery, and cultural empathy. Thus, another future direction is in program development. Using the current state of the literature as a starting point, specific training programs could be created, implemented, and tested. Publishing such efforts would add to our knowledge, and, more importantly, would offer practical and concrete training methods that others could use.

Concluding Remarks

This has been an extremely rewarding research project. In addition to meeting the dissertation requirements for this degree, this project has fulfilled many of my personal goals as a feminist researcher. I learned numerous and valuable lessons from these nineteen students, while polishing and sharpening my qualitative research data collection and inductive analysis skills. In addition, the work allowed me to collaborate with students and the counseling center. Students helped brainstorm about possible improvements for the center. The counseling center was open to learning from my research findings and making adjustments that could improve their process. I believe I am witnessing change at an individual and agency level. All of my suggestions for process improvements have been considered and some are being implemented. My presentation of the center’s strengths and challenges was well received by the entire staff and may encourage change in individual therapist practices.
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APPENDIX A

Initial Client Recruitment

Paid Research Opportunity

<CounselingCenter> Intake Research Study

<CounselingCenter> is interested in trying to improve our client services by learning more about how people experience us. Would you be interested in sharing some of your thoughts about <CounselingCenter> in a 30-minute interview? The identities of all participants will be protected, and all information will be strictly confidential. Your involvement will not affect your relationship with <CounselingCenter> in any way.

Please circle one:

YES, I am interested.  NO, I am not interested.

Interested people will be asked to answer a short, five-minute questionnaire at the end of their intake session. A selected sample of interested individuals will be contacted and interviewed. Interview participants will be paid at a rate of $10 per 30-minute interview. Some participants will be given the opportunity to participate in multiple interviews. The Principal Investigator for this research is Dr. Nancy Betz, a professor in the OSU Psychology department.

If you circled YES, I am interested above, please provide the following information about yourself.

Name (printed) ____________________________

SSN ____________________________

Date ____________________________
Final Client Recruitment Script

Clients were contacted by phone and recruited orally by the researcher using the following recruitment script:

(Do you have a few minutes? Did I say your name right?)

**Introduction**
Hi, my name is Clay Bean. I am calling you from the <CounselingCenter>. When you came in X months ago, you indicated an interest in sharing some of your thoughts about <CounselingCenter> in a 30-minute interview. As a reminder, people who choose to participate will be paid $10 for each 30-minute interview. The identities of all participants will be protected and all information will be strictly confidential. Your involvement will not affect your relationship with <CounselingCenter> in any way.

We want to improve our client services by learning more about how people experience us. Are you still interested in sharing your thoughts about <CounselingCenter>?

(If no, thanks for your time and end the phone call.)

**Overview of Interview**
Great! Let me give you some details about what this includes. I would like to do at least one 30-minute interview with you. During that interview, I would ask you to tell me about your experience at <CounselingCenter> when you came in for your initial session. I am interested in all aspects of your experience, including arriving at <CounselingCenter>, making yourself known to the receptionist, waiting for your session, being in your session, and leaving <CounselingCenter>. The problem that brought you to <CounselingCenter> will not be a focus of the interview. Although why you chose to not return to <CounselingCenter> is something you will be asked. As I said earlier, people who participate in interviews will be paid at a rate of $10 for each 30-minute interview.

Do you have any questions at this point? Would you like to hear more?
Audiotaping Interviews

So that I can keep my focus on hearing what you have to share, I will audiotape interviews. However, if at any time you become uncomfortable, you can request that the recording be temporarily stopped. Audiotapes will be anonymously stored and kept for five years following this project. Some of the audiotaped material will be transcribed and included in a paper written about this project. Your name and other identifying information will not be included in transcripts or written material.

Are you willing to give me permission to audiotape our interviews?

Confidentiality

Now, let me say a little more about confidentiality. Your identity will be protected and all information will be strictly confidential. What that means is that only the two of us will specifically know what you share with me. When I write up the results, no one will be able to figure out exactly what you have shared with me. Although <CounselingCenter> does endorse this project, it will not know the particulars of who ends up participating. Furthermore, I am interviewing multiple people, so multiple voices will be included in my written report.

How about now … any questions?

About Me and My Role

I want to say something about myself as well. I am a fourth year graduate student in Counseling Psychology. I am doing this project as part of my dissertation research, and I am a psychologist-in-training. The principal investigator for this research is my advisor, Dr. Nancy Betz, but most of your interactions as part of this research will be with me. During our interviews, I will act only as an interviewer. I will not be in a counseling role and I will not offer any counseling advice. I am interested in gaining an understanding of your experience at <CounselingCenter>. I don’t anticipate that the interviews will be upsetting, but if they make you feel bad in any way, I will encourage you to deal with those feelings in counseling at other agencies.

Research Benefits

Finally, you might be curious how this research might specifically benefit you. One obvious benefit is that I will pay you $10 for each interview. Although I don’t yet know what your experience at <CounselingCenter> was like, I do know that you chose to not return for counseling. If you still are in need of counseling services, I can give you a list of other places you can go for counseling. Plus, there may be some benefit just from knowing that <CounselingCenter> wants to be able to do a better job at having clients come back for counseling.

Okay. That’s all of the information that I wanted to share with you right now. Are you interested in participating? Can we schedule a time/place to meet?

Place and Time to Meet

I have an office in Townshend Hall, the psychology building, that we could meet in, if
that is convenient for you. Townshend Hall is right behind the Main Library at the top of the oval at 1885 Neil Avenue. My office is in a series of rooms that you can reach through room 141. If this would work for you, let’s pick a time to meet. I want the meeting time to be as convenient for you as possible. I am willing to meet in the evenings and on weekends, if that would be better for you. Can you suggest some possible meeting times?

Contact Information
Let me give you some information about how to get in touch with me, just in case you find you need to reschedule our appointment. Again, my name is Clay Bean (spell it). You can reach me at 263-3483 or through my email account, which is bean.54@osu.edu. I am really looking forward to meeting with you and I greatly appreciate your willingness to be interviewed. When we meet for the interview, I will give you the $10 payment in cash. Thanks!
APPENDIX C

Consent Form

CONSENT FOR PARTICIPATION IN SOCIAL AND BEHAVIORAL RESEARCH

Protocol title: A Qualitative Study of the Counseling Client’s Intake Experience

Protocol number: 02B0179

Principal Investigator: Nancy E. Betz, Ph.D.

I consent to my participation in research being conducted by Nancy Betz and Mary Clay Bean of The Ohio State University and his/her assistants and associates.

The investigator has explained the purpose of the study, the procedures that will be followed, and the amount of time it will take. I understand the possible benefits, if any, of my participation.

I know that I can choose not to participate without penalty to me. If I agree to participate, I can withdraw from the study at any time, and there will be no penalty.

- I consent to the use of audiotapes. I understand how the tapes will be used for this study.

I have had a chance to ask questions and to obtain answers to my questions. I can contact the investigators at (614) 263-3483. If I have questions about my rights as a research participant, I can call the Office of Research Risks Protection at (614) 688-4792.

I have read this form or I have had it read to me. I sign it freely and voluntarily. A copy has been given to me.

Print the name of the participant: ____________________________________________

Date: _________________________________

Signed:  ___________________________________  (Participant)

Signed:  ______________________________________________  (Principal Investigator or his/her authorized representative)
APPENDIX D

Interview Schedule

The purpose of initial interviews was to encourage clients to tell their story about their experience at <CounselingCenter> starting from their initial contact to set up an intake appointment and continuing through to their decision to return or not return for individual therapy. I was interested in eliciting information about all of their experiences, including initial phone contact, coming to and entering the Younkin Success Center, filling out paperwork and waiting in the reception area, meeting with their therapist, ending the intake session, and leaving the Younkin Success Center. I was also interested in anything that happened after they left <CounselingCenter> that influenced their decision to not return. Finally, if time permitted, I explored ideas about how the <CounselingCenter> intake process might be adjusted so as to improve the experiences that intake clients have at the center.

Second interviews were used to continue the process started in the initial interview and to allow an early member check with a subset of participants.
APPENDIX E

Debriefing Form

Thanks tremendously for participating in this study.

Your input is greatly appreciated.

<CounselingCenter> is interested in improving their client services, especially for new clients who are coming in for the first time. The purpose of these interviews was to learn more about initial client experiences and to generate ideas for ways to improve the experience of new clients at <CounselingCenter>.

We hope that the study results can be used to aid in understanding how clients experience <CounselingCenter> and to develop changes in the process in order to increase the accessibility of <CounselingCenter> to its clients. In addition to improving the client services offered at <CounselingCenter>, it is also hoped that these results will be extensible to other University counseling centers.

If participating in this research has raised questions or thoughts and feelings that you want to explore further, you may wish to seek counseling. Several local resources for counseling are listed below:

- OSU Psychological Services Center at Townshend Hall located at 1885 Neil Avenue. Contact Dr. Pamela Highlen at 292-0533.
- OSU Counseling and Consultation Services (292-5766), located on the 4th floor of the Younkin Success Center at 1640 Neil Avenue, is open M-F 8 hours a day for appointments and, if needed, on an emergency basis.
- Columbus Area Mental Health Center (252-0711) located at 1515 East Broad Street.
- Southeast Incorporated (225-0990) located at 16 West Long Street.
- North Central Mental Health Center (299-6600) located at 1301 North High Street.
APPENDIX F

Initial Preferences Questionnaire

We would like you to compare yourself to your counselor. The following questions ask you to compare yourself with your counselor in several different areas. For each area, choose one of the three choices:

- Similar – my counselor and I were alike in <this area> (for example, age).
- Different – my counselor and I were different in <this area> (for example, age).
- Not Sure – I am not sure if we were different or alike in <this area> (for example, age).

For each area, also indicate how important that similarity/difference/not knowing of that area was to your ability to interact and share with your counselor. After selecting one of the three choices, please provide a brief explanation about the importance of this area in terms of your conversation with your counselor.

Your answers are completely confidential, so please answer as honestly as you can.

**AGE**

<table>
<thead>
<tr>
<th>Similar</th>
<th>Different</th>
<th>Not Sure</th>
<th>(circle one)</th>
</tr>
</thead>
</table>

How important was this similarity/difference/uncertainty to you?

NOT Important 2 3 4 EXTREMELY Important (circle one)

Briefly explain why age was or was not an important concern in your conversation with your counselor.

__________________________________________________________________________________

If you are comfortable doing so, please identify your age: _______.

**RACE/ETHNICITY**

<table>
<thead>
<tr>
<th>Similar</th>
<th>Different</th>
<th>Not Sure</th>
<th>(circle one)</th>
</tr>
</thead>
</table>

How important was this similarity/difference/uncertainty to you?

NOT Important 2 3 4 EXTREMELY Important (circle one)

Briefly explain why race/ethnicity was or was not an important concern in your conversation with your counselor.

__________________________________________________________________________________

If you are comfortable doing so, please identify your race/ethnicity: ___________________________

**GENDER**

<table>
<thead>
<tr>
<th>Similar</th>
<th>Different</th>
<th>Not Sure</th>
<th>(circle one)</th>
</tr>
</thead>
</table>
How important was this similarity/difference/uncertainty to you?

NOT Important  2  3  4  EXTREMELY Important  (circle one)

Briefly explain why gender was or was not an important concern in your conversation with your counselor.

__________________________________________________________________________________

If you are comfortable doing so, please identify your gender: ________________________________

SEXUAL ORIENTATION

Similar            Different            Not Sure            (circle one)

How important was this similarity/difference/uncertainty to you?

NOT Important  2  3  4  EXTREMELY Important  (circle one)

Briefly explain why sexual orientation was or was not an important concern in your conversation with your counselor.

__________________________________________________________________________________

If you are comfortable doing so, please identify your sexual orientation:

__________________________________________________________________________________

RELIGIOUS BELIEFS/ SPIRITUALITY

Similar            Different            Not Sure            (circle one)

How important was this similarity/difference/uncertainty to you?

NOT Important  2  3  4  EXTREMELY Important  (circle one)

Briefly explain why religious beliefs/spirituality was or was not an important concern in your conversation with your counselor.

__________________________________________________________________________________

If you are comfortable doing so, please briefly describe your special ability/disability:

__________________________________________________________________________________

SPECIAL ABILITY/ DISABILITY

Similar            Different            Not Sure            (circle one)

How important was this similarity/difference/uncertainty to you?

NOT Important  2  3  4  EXTREMELY Important  (circle one)

Briefly explain why special ability/disability was or was not an important concern in your conversation with your counselor.

__________________________________________________________________________________

If you are comfortable doing so, please briefly describe your special ability/disability:

__________________________________________________________________________________

OTHER?

Please list any other areas of similarity/difference/not knowing that are important to you.

__________________________________________________________________________________

__________________________________________________________________________________

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APPENDIX G

Strong Preferences for Individual Counselor

Some people strongly preferences about the type of counselor they would like to see individually. Other people don’t have strong preferences. The purpose of this form is to give you a chance to list and prioritize any strong preferences you have regarding the counselor that you will see individually.

Your answers are completely confidential, so please answer as honestly as you can.

GENDER (check one)
- Strongly prefer a female counselor
- Strongly prefer a male counselor
- No preference

RACE/ETHNICITY (check one)
- Strongly prefer a counselor who identifies as ________________________________________
- No preference (Fill in the desired ethnic background)

SEXUAL ORIENTATION (check one)
- Strongly prefer a counselor who identifies as ________________________________________
- No preference (Fill in the desired sexual orientation, for example, “gay” or “lesbian”)

AGE (check one)
- Strongly prefer an older counselor
- Strongly prefer a younger counselor
- No preference

RELIGIOUS BELIEFS/SPRITUALITY (check one)
- Strongly prefer a therapist who religiously/spiritually identifies as ____________________________
- No preference (Fill in the desired religious/spiritual belief)

EDUCATION / EXPERIENCE (check one)
- Strongly prefer a counselor with a Masters
- Strongly prefer a counselor with a PhD
- No preference

OTHER PREFERENCE
List any other strong preferences you have ___________________________________________________

PRIORITIZE your STRONG PREFERENCES

Rank the importance of each of the strong preferences you noted above (#1 is the most important, #2 is the second most important, and so on). Skip this if you have no strong preferences.

#1 _______________________  #2 _______________________  #3 _______________________

ARE YOU WILLING TO WAIT to start individual counseling until your preferences can be matched?

(circle one)  Yes  No