The Perception of Pregnant Therapists

by

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Abstract

The present study examined the relationship between pregnancy status, participant gender, and the initial perceptions of therapists. A total of 188 participants were recruited from the Qualtrics Online Sample Service. Participants were presented with a simulated online advertisement of a pregnant or non-pregnant therapist and two therapy transcripts attributed to these therapists. Participants were then asked to complete several measures (Counselor Rating Form, Counselor Reactions Inventory, Willingness to See Counselor Scale) and a brief demographic survey. A series of between subject ANOVAs as well as an independent samples t-test were employed to test the hypotheses that pregnancy status and participant gender influenced perceptions of therapist credibility, perceptions of therapist expertness, and willingness to see the therapist and that pregnancy status influenced study participants immediate reactions to the therapist and perceptions of counseling climate, counselor attraction, counselor competency, and study participant willingness to self-disclose. Study results did not support the hypotheses that pregnancy status and participant gender differentially influence the perception of therapists by study participants. However, quasi-qualitative data revealed that despite 91% of study respondents reporting that they would not have a problem seeing a pregnant therapist, several issues were raised in the areas of breadth of ability, emotionality, concern for the therapist, maternity leave/absence, and interaction with personal history, suggesting that additional research is needed to better understand how pregnant therapists are perceived.

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CHAPTER I: INTRODUCTION

The number of women providing mental health services has increased significantly over the past several years (Carey, 2011; Diamond, 2012; Willyard, 2012). The American Psychological Association, the largest scientific and professional organization representing psychologists in the United States, reported a record number of registered women affiliates, members, and fellows in recent years (American Psychological Association Center for Workforce Development, 2014). Women make up 76% of new psychology doctorates, 74% of early career psychologists and 53% of the psychology workforce (Willyard, 2011). Women earning doctoral degrees in psychology outnumber men three to one and this ratio has remained constant for the past ten years (American Psychological Association, 2016). Women also earn four out of five of all Master's Degrees awarded in psychology, they account for more than 90% of social workers under the age of thirty-four, and their numbers have steadily increased in the ranks of professional counselors and marriage and family therapists (Carey, 2011).

The dominating presence of women in mental health fields demands the exploration of issues salient to this population. One such issue is therapist pregnancy, however, this area remains understudied (McCluskey, 2017; Schmidt et al., 2015). In fact a literature search for the term "pregnant therapist" and relevant variants (therapist pregnancy, pregnant counselor, counselor pregnancy, pregnant social worker, social worker pregnancy, pregnant psychiatrist, psychiatrist pregnancy, mental health professional pregnancy) via various electronic databases (Academic Search Premier, PsycInfo, PsycArticles) yielded a total of 58 articles from academic

journals as well as two books and two book chapters. The vast majority of these writings focused on the topic of therapist pregnancy from a psychodynamic perspective and utilized a case study or anecdotal methodology, with therapists providing retrospective data regarding their experiences with their clients. Fewer than five of these articles were quantitative in nature and the vast majority were written prior to the year 2000.

The limited amount of research in the area of therapist pregnancy belies the richness of the topic. Therapist pregnancy is said to enliven both countertransference and transference in the therapy setting (Barden 1985; Bienen, 1990, Cole, 1980, Diamond, 1992, Penn, 1986, Rosenthal, 1990). Pregnant therapists are said to experience their own guilt, fear, and anxiety, as well as vulnerability and dependency issues (Bueno, 2009; Nadelson, 1974), and their clients are often said to experience feelings of abandonment, exclusion, and loss (Barden, 1985; Hopkins, 2004; McKamy, 1984; Rubin, 1980). Therapist pregnancy has been described as destroying the anonymity of the therapist (Dyson & King, 2008; Penn, 1986), disrupting the therapeutic environment (Underwood & Underwood, 1976), and betraying the stable therapeutic setting (Dufton, 2004). Simultaneously, therapist pregnancy has also been credited with providing an opportunity for more profound therapy (Underwood & Underwood, 1976), allowing for the working through of important issues (Dyson & King, 2008), and the deepening of the therapeutic relationship (Rubin, 1980). This complex interplay between therapist pregnancy and the process and product of therapy raises fundamental questions about how pregnant therapists are initially perceived and how this perception may influence their work with clients.

The pregnant therapist literature largely focuses on the perspective of the pregnant therapist and her observations of client reactions. Very few articles have focused on the clients' perspectives and their initial perceptions of the pregnant therapist (McCluskey, 2017; Schmidt,

2015). Generally speaking, therapist perception is a frequent topic in scholarly literature, specifically as it relates to client judgments of the therapists' outward physical appearance and how this corresponds to treatment outcomes. Scholars have examined therapist characteristics such as gender (Angle & Goodyear, 1984; Banikiotes & Merluzzi, 1981; Kratz & Marshall, 1988), race (Atkinson et al., 1978; Green et al., 1986; Redfern et al., 1993), and disability (Mallinckrodt & Helms, 1986; Miller, 1993; Nosek et al., 1991; Risica & Nevid, 1990; Strohmer, 1983). The area of therapist physical attractiveness has been studied at length with results indicating that clients perceive physically attractive therapists as more competent, trustworthy, genuine, and effective than less attractive therapists (Cash et al., 1975; Cash & Salzbach, 1978; Green et al., 1986; Harris & Busby, 1998; Vargas et al., 1982).

The majority of these studies have utilized social influence theory as a means of understanding how therapist characteristics influence the perception of the therapist. Social influence theory posits that the client's perception of a therapist's attractiveness, expertness, and trustworthiness determines the therapist's ability to influence that client (Strong, 1968). According to Wampold (2015), it is during the initial meeting with a therapist that the client makes determinations regarding trustworthiness and competence. Corrigan et al. (1980) have noted especially as it relates to expertness, "aspects of a counselor that are immediately evident to a client (e.g., sex, race, attire) affect the client's estimation of that counselor's expertness" (p. 399). This not only highlights the importance of studying the initial perceptions of pregnant therapists but also suggests that these initial perceptions may be better understood within the framework of the social influence theory.

By its nature, pregnancy involves a gradually discernable change in physical appearance generally culminating with an enlarged belly and associated weight gain (Slade et al., 2009;

Stuart, 1997). Pregnancy is said to evoke powerful feelings in others, both positive and negative (Gottlieb, 2006). Pregnancy has also been characterized as a form of self-disclosure (Dyson & King, 2008; Fenster, 1983; Waldman, 2013). The pregnant therapist is no longer anonymous (Penn, 1986) as her pregnancy is a manifestation of her sexuality and an indicator of another life dimension (Underwood & Underwood, 1976). The evocative and self-disclosing nature of pregnancy suggests that quick judgments are likely made regarding pregnant women based on their appearance. These quick judgments influence the perception of the therapist and may take the form of stereotypes.

Numerous stereotypes about pregnant women that foster discriminatory behavior have been documented in the literature (Crawley et al., 2008; Halpert, 1993; Hebl, 2007; Morgan, 2013; Pattison, 1997; Shafir, 2006). These stereotypes become most visible when considering the pregnant woman's relationship to work (Budig & England, 2001; Halpert, 1993; Harrington, 2004; Hebl, 2007; Masser et al., 2007; Morgan, 2013; Pattison, 1997; Williams, 2001; Williams & Segal, 2004). Legislation has been developed to protect pregnant women in the workplace from bias and discrimination (Siegel, 1985). Despite this legislation, The United States Equal Employment Opportunity Commission and state-level fair employment practice agencies fielded approximately 31,000 charges of pregnancy discrimination between 2010 and 2015, with women of color being disproportionately represented among complainants (National Partnership for Women and Families, 2016). Similarly, the literature indicates that pregnant women are prone to discriminatory behavior in the workplace based on stereotypes (Hebl, 2007; Morgan, 2013) with men more likely to view pregnant women in the workplace more negatively than women (Halpert, 1993; Pattison, 1997). These findings suggest that initial perceptions regarding

pregnant women influence their work lives and highlights the need for research examining the initial perceptions of pregnant therapists.

Summary of Initial Perceptions of Pregnant Therapists

The literature has reflected a relationship between therapist physical appearance and the manner in which they are perceived (Cash et al., 1975; Cash and Salzbach, 1978; Green et al., 1986; Harris & Busby, 1998; Vargas et al., 1982). This relationship has been only minimally explored in the area of therapist pregnancy. Only one study to date has addressed this relationship, finding that pregnant therapists are often viewed as less expert, and as operating with less depth in counseling sessions than their non-pregnant counterparts (Stockman, 1995). Related research examining the perception of pregnant graduate students and female graduate students with children suggested that students who were not parents often possessed more negative stereotypes about their pregnant peers that those who were parents (Shafir, 2006). There are no recent empirical studies that address the client's initial perceptions of the pregnant therapist and the relationship that this may have on therapy outcomes (e.g., continuation of therapy).

Statement of the Problem and Research Hypotheses

The pregnant therapist literature is dominated by case studies and anecdotes in which the pregnant therapist retrospectively outlines their experiences with clients. Although this information is of great value, these experiences cannot be replicated, do not allow for causal inferences, and are vulnerable to researcher bias (McLeod, 2008). The pregnant therapist literature is driven heavily by psychodynamic theory, with minimal integration of other theoretical perspectives (McCluskey, 2017; Schmidt et al., 2015; Wollheim, 2001). Studies that broaden the theoretical focus (Green-Emrich et al., 1994; Stockman, 1995) are plagued by

narrow stimulus sampling (e.g., utilize only one counselor). The pregnant therapist literature also focuses heavily on the process and outcome of therapy (McCluskey, 2017; Stockman & Green-Emrich, 1994) with little attention given to the initial perceptions that clients may have of pregnant therapists.

Considering these limitations, the following research questions were posed: Does pregnancy status influence the perception of therapists in the areas of expertness, attractiveness, and trustworthiness? Does pregnancy status influence the likelihood that someone will see the therapist for counseling in the future? Does pregnancy status influence initial reactions regarding counseling climate, willingness to self-disclose, and understanding and liking for the therapist? Does gender differentially influence the perception of pregnant therapists?

Operational Definitions

Given that most of the pregnant therapist literature is largely anecdotal, research involving this population often involves actual pregnant therapists as they move through the various stages of pregnancy (Cole, 1980; Dufton, 2004; Genende, 1989; Gibb, 2004; Hopkins, 2004; Korol, 1996; McGourty, 2013; Rivera, 1997; Waldman, 2003). Research in more broad areas such as pregnant women and work, which typically employ more quantitative methodologies, tend to utilize a prosthesis to exhibit the final months of pregnancy (Hebl, 2007; Masser et al., 2007; Morgan, 2013). The current study utilized a prosthesis to represent a pregnant woman during her third trimester. It is during this trimester that the physical changes associated with pregnancy (e.g., enlarged stomach) are most visible (Slade et al., 2009) and least likely to be mistaken for other medical conditions (e.g., bloat or obesity).

Perceptions of the pregnant therapist were examined via the framework of Strong's (1968) social influence theory. Social influence theory rests on the assumption that the client's

perception of certain desirable therapist characteristics determines the therapist's ability to influence that client. These desirable characteristics are identified as attractiveness, expertness, and trustworthiness (Strong, 1968). Within the social influence theory, attractiveness is defined as perceived similarity to a, compatibility with, and liking for the counselor. Expertness is the degree to which a client perceives that their therapist is a source of valid information. Trustworthiness refers to the degree of confidence that the client has in the therapists' interest and motives (Corrigan, 1980; Hovland et al., 1953; Strong, 1968). Participants were asked to rate their perceptions of pregnant therapists utilizing the Counselor Rating Form (CRF; Barak & LaCrosse, 1975), an instrument that consists of 36 bipolar scales (12 each for the measurement of attractiveness, expertness, and trustworthiness). Overall therapist credibility was defined as the average total score on the CRF. Additionally, immediate reactions to the pregnant therapist were captured utilizing the Counseling Reactions Inventory (CRI; Helms, 1979) a nine-item scale designed to measure subject/clients immediate reactions to a therapist or simulated therapist to whom they have been exposed. Average scores on the associated subscales (counselor climate, willingness to self-disclose, counselor competence, counselor attraction) were utilized to determine the nature of immediate reactions (positive versus negative). Finally willingness to see the therapist in the future was measured utilizing a brief questionnaire developed for this study.

Purpose

The purpose of the current study was to add to the body of knowledge concerning pregnant therapists by providing updated information regarding the perception of pregnant therapists. The study empirically examined the initial perception of pregnant therapists via the social influence variables of trustworthiness, attractiveness, and expertness, expanding both the

theoretical and methodological knowledge base on this topic, and opening the door to a greater diversity in research approaches to this topic. This study also examined initial reactions to therapy content and the potentially moderating variable of gender in the perception of pregnant therapists. Additionally, an aim of this study was to provide therapists with information about how they are perceived when pregnant and how this information might inform the manner in which they initiate treatment with clients when visibly pregnant. For example, the therapist may be inclined to address possible negative perceptions during initial contact so as to alleviate any anxiety that a client might have about continued therapy.

CHAPTER II: LITERATURE REVIEW

The following review summarizes the literature on therapist pregnancy as well as stereotypes about working women. It also highlights why social influence theory is useful as a foundation for understanding the perception of pregnant therapists.

Therapist Pregnancy

Hannett wrote the first paper on therapist pregnancy in 1949. In that paper she described the impact that her miscarriage had on her work as a psychoanalyst (Hannett, 1949). Since that time numerous authors have addressed the pregnancy of the therapist, most drawing from their own personal experiences (Barden, 1985; Bienen, 1990; Breen, 1977; Cole, 1980; Dufton, 2004; Gibb, 2004; Hopkins, 2004; Imber, 1995; Korol, 1996; Maat & Vanderslyde, 1995; Naparstek, 1976; Paluszny & Poznanski, 1971; Rubin, 1980; Waldman, 2003). Therapist pregnancy has been examined in treating both adult (Dyson & King, 2008; McCluskey, 2017; Penn, 1986; Rosenthal, 1990; Underwood & Underwood, 1976) and child populations (Byrnes, 2001; Locker-Forman, 2005), in individual (Al-Mateen, 1991; Atlas-Koch, 2008; Halton, 2004; Napoli, 1999; Silverman, 2001) and group therapy modalities (Anderson, 1994; Breen, 1977), in a variety of treatment settings to include outpatient facilities (Bassen, 1988; Brouwers, 1989; Imber, 1995, Napoli, 1999; Rubin, 1980) long term treatment facilities (Maat & Vanderslyde, 1995) and prisons (Rivera, 1997), and with a variety of presenting therapeutic issues (Bridges & Smith, 1988; Katzman, 1993; McGourty, 2013; Robbins, 1998; Strobeck, 2005). What the

majority of these writings have in common is that they speak from the therapist's perspective and offer some insight into the effect that therapists believe pregnancy has on their work.

In the literature, therapists are said to experience a variety of reactions in response to their pregnancy (Bienen, 1990; Dyson & King, 2008; Gerber, 2005; Imber, 1995; Korol, 1996; Rubin, 1990; Rosenthal, 1990; Turkel, 1993). Dyson and King (2008) state that therapists may be overly preoccupied in their first trimester with physical symptoms and the ambivalence associated with learning of their pregnancy. As the pregnancy proceeds they may move into a period of worry where they begin to consider the demands of their work and how they will balance this with family life. They describe the final stages of pregnancy as fraught with conflict as the therapist is caught between a desire to be fully present for her patients and also for her unborn child. Rosenthal (1990) identifies several challenges that pregnant therapists face to include navigating their evolving identity, integrating roles, maternal identification, and the redefinition of important relationships. Korol (1996) points out that pregnant therapists often experience a conflict between being a competent professional and being a nurturing mother, noting that the integration of mother and therapist roles can be quite difficult. The literature also highlights other common countertransference reactions such as guilt about having to leave the client, fear that conducting therapy will damage the fetus, discomfort with being in the patient role, and anxiety about how clients will handle pregnancy disclosure (Bienen, 1990, Rubin, 1990). Pregnant therapists are encouraged to be aware of their own needs and conflicts so that they can better address the needs of their clients (Turkel, 1993) and to explore the possibility of obtaining supervision (Gerber, 2005; Imber, 1995).

According to the literature, the issue of self-disclosure is central to the subject of therapist pregnancy. Pregnancy is said to be a form of non-verbal communication (Dyson and King,

2008). It is also a manifestation of sexuality and an indicator of another life dimension of the therapist (Underwood & Underwood, 1976), thus violating the anonymity of the therapist (Penn, 1986). In describing the intersection of her work as therapist and her pregnancy, Zucker (2014) illustrates these points, stating,

> "Pregnancy asserts the therapists presence and shatters her privacy in a way that nothing else does. My baby bump represented different things to different patients: an active sex life, a certain relationship status, a desire to raise a family. And as my patients often told me, it stimulated longings that stemmed from their own maternal lines " (p.1)

When pregnancy becomes visible, it reveals more than may be ordinarily shared by therapists. These revelations may lead to feelings of vulnerability and a sense of expanding boundaries (Waldman, 2003). Fenster (1983) interviewed several psychotherapists in their final trimester and asked them to rate the degree to which they self-disclosed to clients pre-and post-pregnancy, with the majority of therapists describing themselves as more self-revealing in therapy sessions post-pregnancy. The literature also highlights how therapists often wrestle with the logistics of sharing their pregnancy status with clients (Chiramonte, 1986; Dyson & King, 2008; Gerber, 2005; Haber, 1992; Naparstek, 1976). The literature is somewhat mixed regarding the timing of pregnancy disclosure, with some arguing the importance of announcing pregnancy as early as possible to minimize client anxiety (Naparstek, 1976) and other's arguing for the therapeutic utility of allowing clients to discover therapist pregnancy on their own (Dyson & King, 2008). Fenster (1983) found that the majority of therapists waited to disclose pregnancy until their clients directly asked or indirectly indicated recognition of the pregnancy. Alternately, Byrnes (2001) found that 72% of child therapists disclosed pregnancy in the second trimester and that only 20% of therapists waited for clients to directly ask before disclosing their pregnancy.

Another common theme in the pregnant therapist literature is the effect that therapist pregnancy has on clients. According to Maat and Vanderslyde (1995), the "pregnancy form" exacerbates transference issues. As clients are faced with their therapist's changing physical appearance they may experience a host of behavioral and emotional reactions and these reactions may be facilitative and/or disruptive (Bassen 1988). Within the literature, behavioral reactions to therapist pregnancy include, but are not limited to, silent sessions, weight loss or gain, cessation/initiation of birth control, becoming pregnant, aborting a fetus, frequent crises, and missed appointments (Barden, 1985; Diamond, 1992; Dufton, 2004; Dyson and King, 2008; Gibb, 2004; Hopkins, 2004; Paluszny & Poznanski, 1971; Rubin, 1980; Stuart, 1997). Napoli (1999) examined missed appointments and fee payments (payment for therapy services) for clients seeing a pregnant therapist by following six female clients who were in therapy for one year or more prior to their therapists' pregnancy. Missed appointments and fee payments prior to learning of the therapists' pregnancy and after learning of the therapists' pregnancy were compared. There were no findings related to fee payment, however clients missed more appointments after learning of their therapists' pregnancy. Similarly, Fenster et al. (1986) found that 77% of the 22 analysts that they interviewed lost at least one of their clients during pregnancy. According to the literature, these behavioral reactions often stem from a spectrum of emotions: envy, jealousy, sadness, anger, avoidance, ambivalence, betrayal, and excitement (Barden, 1985; Cole, 1980; Diamond, 1992; Dufton, 2004; Dyson and King, 2008; Gibb, 2004; Hopkins, 2004; Paluszny & Poznanski, 1971; Rubin, 1980, Stuart, 1996). Cole (1980) described a young male client becoming teary eyed and expressing his wish to have her as a mother when she revealed her pregnancy. Conversely, Rubin (1980) described her work with a young female client who engaged in denial about her pregnancy, avoiding all discussions of pregnancy and

changes in her therapists' physical appearance. The literature indicates that men and women both differentially and similarly experience therapist pregnancy (Rosenthal, 1990) although some research has found that there may be an underestimation of male patient responses to pregnancy (Naparstek, 1976). The literature suggests that clients will respond differently to therapist pregnancy based on their own life histories and experiences (Dyson & King, 2008; Rubin, 1980).

The literature also shows a shift in therapeutic themes during the therapist's pregnancy (Barden, 1985; Breen, 1977; Bridges & Smith, 1988; Diamond, 1992; Dyson & King, 2008; McKamy, 1984; Nadelson, 1974; Naparstek, 1976; Rubin, 1980; Underwood & Underwood, 1976; Waldman, 2003). Perhaps most heavily addressed in the literature are themes of abandonment and loss (Barden, 1985; Bridges & Smith, 1988; Dyson & King, 2008; McKamy, 1984; Naparstek, 1976; Waldman, 2003). This theme of abandonment and loss may result from ignited unresolved childhood issues as well as concrete fears regarding the impending absence of the therapist due to maternity leave (Barden, 1985; Bridges & Smith, 1988; Dyson & King, 2008; McKamy, 1984; Naparstek, 1976; Waldman, 2003). According to the literature, pregnant therapists also note an increase in sexual themes in therapy (Breen, 1977; Diamond, 1992; McKamy, 1984; Nadelson et al., 1974; Underwood & Underwood, 1976). This is often attributed to pregnancy's disclosure of an active sex life (Breen, 1977; Diamond, 1992; Nadelson et al., 1974). According to Diamond (1992), therapist pregnancy intensifies erotic and maternal aspects of transference because it highlights the therapists' sexuality and fertility. Similarly Nadelson et al. (1974) describe the pregnancy of the therapist as evoking internal sexual conflict. Common themes may vary according to treatment modality. Breen (1977), in her case studies comparing individual and group work during her pregnancy, found that her individual work

yielded more themes of deprivation and sharing and her group work evoked more themes of sexuality and identity.

It is commonly understood in the literature that therapist pregnancy has a significant impact on the therapeutic process; however, there is no research regarding treatment outcomes. Within the literature, pregnancy has been described as unsettling the therapeutic environment (Underwood & Underwood, 1976), betraying the stable therapeutic setting (Dufton, 2004), and as a disruption (Dyson & King, 2008). Despite these descriptions it is widely agreed upon in the literature that the pregnancy of the therapist can be a powerful conduit for more profound therapy (Dyson & King, 2008; Dufton, 2004; Paluszny & Poznanski, 1971, Wollheim, 2001). Many therapists have found that their pregnancy allowed clients to address hurts from their past and work through other important issues by helping them to gain increased insight and awareness (Dyson and King, 2008; Dufton, 2004; Paluszny and Poznanski, 1971). Wollheim (2001) examined therapist pregnancy from a phenomenological perspective and utilized demographic questionnaires and open-ended interviews to explore six therapists' experiences in working with clients during pregnancy. The therapists reported that the experience of providing therapy during pregnancy was transformative for themselves, for their patients, and for the client-therapist relationship. They noted an increase in empathy on both their part as well as their clients and overall described their pregnancy as having a positive effect on their therapy.

Although literature on pregnant therapist treatment outcomes is limited, there is some literature that posits that therapists may have tenuous outcomes with certain populations given their presenting issues and course of treatment (Balsam & Balsam, 1974; Bridges & Smith, 1988; Brouwers, 1989; Fenster et al., 1983). Brouwers (1989) asserts that work with a pregnant therapist may be detrimental to an individual diagnosed with an eating disorder (due to the

increasing size of the therapist) and may exacerbate symptoms. Fenster et al. (1983) found a significantly greater incidence of acting out, crises, clinging, rage, emotional withdrawal, and abandonment fears reported by those diagnosed with borderline personality disorder. Balsam and Balsam (1974) have found that pregnant therapists have difficulty providing helpful and neutral guidance in the area of abortion counseling. Bridges and Smith (1988) in their work with "seriously disturbed patients" receiving long term treatment note that these patients are much more affected by therapeutic disruptions and have significant difficulty coping with the feelings of loss and abandonment that pregnancy may engender.

Client Perspectives in the Pregnant Therapist Literature

As previously stated, little research exists that highlights the perspective of the client in the pregnant therapist-client dyad. To date only three empirical studies have attempted to elucidate client reactions to pregnant therapists. Katzman (1993) studied the reactions of 24 clients who were being treated for an eating disorder who remained in treatment during and after her pregnancy. Clients were given checklists before and after sessions, and their punctuality, missed sessions, changes in weight, dress, and appearance were also monitored along with session content. Clients had mixed reactions regarding her pregnancy with responses ranging from happy (73%), jealous (33%), resentful (13%), and competitive (13%) when asked how they felt about the therapists' pregnancy when first discussed. One year follow-up data revealed that the majority of the clients found their experience with the pregnant therapist to be a positive one. McCluskey (2017) interviewed eight clients of formerly pregnant therapists in a qualitative study based in constructivist grounded theory. She found six emerging themes in her interviews with clients: (1) implications of timing of self-disclosure, (2) trust and deepened connections, (3) disruption, abandonment, distancing, and avoidance of defining feelings, (4) maternity leave, (5)

life versus loss and desire versus guilt, (6) and role reversal. Finally, and perhaps most germane to the current study, Stockman (1995) examined the relationship between the social influence variables of trustworthiness, expertness, and attractiveness and therapist pregnancy. She enlisted 60 undergraduate students with identified personal problems to meet with a therapist before and after her pregnancy. She found that pregnancy status influenced both perceptions of expertness and perceptions of depth suggesting that therapist efficacy may be influenced by pregnancy status. This study underscores the utility of social influence theory in understanding the perception of pregnant therapists.

Social Influence Theory

Strong's (1968) characterization of counseling as a social influence process provides a framework from which to view the perception of pregnant therapists. He hypothesized a two-stage model of counseling in which counselors first attempt to enhance their perceived expertness, attractiveness, and/or trustworthiness as well as enhance their client's involvement in counseling. Secondly, counselors make maximum use of their influence to precipitate opinion change and/or behavior change in clients (Strong, 1968). In other words, the counselor's influence potential is largely based on the degree to which they are perceived to demonstrate trustworthiness, expertness, and attractiveness.

Within the social influence literature, attractiveness is defined as perceived similarity to, compatibility with, and liking for the counselor (Strong, 1968). Attractiveness may be inferred from a person's apparent familiarity, friendliness, likability, and relevant attitudinal or group membership similarity (Corrigan et al., 1980). Attractiveness is also inferred from counselor qualities such as unconditional positive regard, and non-possessive attitudes towards clients (Dorn, 1984). Expertness is defined as the, "extent to which a communicator is perceived to be a

source of valid assertions" (Hovland et al., 1963, p. 21), or the degree to which a client perceives the counselor to be a source of valid assertions (Strong, 1968). Several factors may contribute to the counselor being viewed as an expert by a client. The perception of expertness is likely to occur when the client views the counselor as someone with specialized training, when the counselor is seen as confidently offering knowledgeable arguments that may dispute those of the client and/or when the client becomes cognizant of the counselor's credibility and reputation from sources in the community (Corrigan et al., 1980; Dorn, 1984). Expertness may also be inferred from a person's apparent competence, history of success in solving problems, seniority, status, and prestige (Corrigan et al., 1980). Finally, trustworthiness is defined as "the degree of confidence in the communicator's interest to communicate assertions that he considers most valid" (Hovland et al., 1963, p.21). Trustworthiness is inferred from a counselor's apparent sincerity, fairness, objectivity, honesty, and lack of vested interest in persuasive content (Corrigan et al., 1980). According to Dorn (1984), trustworthiness is also a product of the client realizing that their counselor is not involved in the relationship for personal gain.

Three main cues that serve as the basis for how counselors are perceived along the dimensions of attractiveness, trustworthiness, and expertness have been highlighted in the social influence literature (Corrigan et al., 1980, Heppner & Dixon, 1981) These cues are evidential, reputational, and behavioral. According to Corrigan et al. (1980), evidential cues are characteristics of the counselor such as looks, attire, and office location and décor. Reputational cues involve information made known about the counselor and his or her background. Finally behavioral cues consist of the verbal and non-verbal behavior of the counselor.

Therapist pregnancy can be considered an evidential cue, as it represents an outward characteristic of the therapist. According to Corrigan et al. (1980), "aspects of a counselor that

are immediately evident to a client (e.g., sex, race, attire) affect the client's estimation of that counselor's expertness" (p. 399). Numerous studies have been conducted examining various evidential cues of the therapist such as counselor gender (Angle & Goodyear, 1984; Banikiotes P. G. & Merluzzi, 1981; Kratz and Marshall, 1988), counselor race (Atkinson et al., 1978; Green et al., 1986; Redfern et al, 1993), counseling setting (Nasar & Devlin, 2011; Siegel & Sell, 1978), counselor physical attractiveness (Cash et al., 1975; Lewis & Walsh, 1978; Paradise et al., 1986; Vargas & Borkowski, 1982), and counselor disability (Mallinckrodt & Helms, 1986; Miller, 1993; Nosek et al., 1991; Risica & Nevid 1990; Strohmer, 1983). These studies, especially those related to outward therapist characteristics are particularly salient to the pregnant therapist literature because they highlight the manner in which these characteristics are perceived by clients or potential clients. For example, physical attractiveness research indicates that counselor physical attractiveness may bias observers initial perceptions and expectations (Cash et al., 1975; Lewis & Walsh, 1978) and that physically attractive counselors may be perceived more favorably along dimensions described by social influence variables (Paradise et al., 1986; Vargas & Borkowski, 1982). Similarly research examining therapist disability and perceptions in the areas of trustworthiness, expertness, and attractiveness has found some facilitative effects for counselor disability on expertness and attractiveness (Mallinckrodt & Helms, 1986; Miller, 1993; Nosek et al., 1991; Risica & Nevid, 1990; Strohmer, 1983).

As previously discussed, the only study to date that examines therapist pregnancy utilizing social influence variables was conducted by Stockman in 1995. In her study she examined the relationship between pregnancy, gender, and the social influence variables of attractiveness, expertness, and trustworthiness. She found no main effects for gender or

counselor pregnancy status and willingness to see the counselor. However, she did find main effects for counselor pregnancy status and perceptions of expertness and depth.

Pregnant Women and Stereotypes

The perception of pregnant therapists is presumed to be heavily influenced by stereotypes associated with pregnant women. Surprisingly, the research literature examining pregnant women and stereotypes is very limited. Marvan et al. (2008) studied stereotypes of women in various phases of their reproductive life by surveying over 300 college students from the United States and Mexico. Specific to pregnancy they found that only college students from Mexico described pregnant women as "happy." This suggests that there may be a cultural component that influences how pregnant women are perceived. Shafir (2006) also examined stereotypes among students, specifically psychology graduate students by examining their views of their peers who were pregnant or parents. Her findings indicate that, across gender, students who were not parents possessed more negative stereotypes about their pregnant peers than those who were parents.

Stereotypes associated with cognitive decline, also referred to as "baby brain" have been examined in the literature. Crawley et al. (2008) compared non-pregnant and pregnant women's perception of cognitive change and their performance on several cognitive tasks. Although pregnant women rated their cognitive abilities as worse than pre-pregnancy, non-pregnant women did not and the two groups did not perform significantly different on cognitive tasks. Crawley et al. (2008) also examined how gender impacts beliefs about cognitive decline in pregnant women. They found that beliefs about cognitive decline were largely dependent on the participants' intimate knowledge of pregnancy. Among those participants who had no immediate experience of pregnancy, the cognitive abilities of pregnant women were seen as only

slightly worse than those of non-pregnant women. Those participants who did have an immediate experience of pregnancy viewed the cognitive abilities of pregnant women as significantly worse than those of non-pregnant women. Crawley et al. (2008) conclude that although pregnancy may have mild effects on cognitive abilities such as memory, perceived cognitive deficits may be based on cultural expectations influenced by the "baby brain" myth.

Pregnancy has also been characterized as sickness or disability in the pregnancy and work literature (Pattison, 1997; Taylor-Myers & Grasmick, 1990) and has been discussed with illness and disability within the pregnant therapist literature (Dewald & Schwartz, 1993; Schwartz & Silver, 1990). In her research on perceptions of pregnant workers, Pattison (1997) discusses the stereotype of the pregnant woman as an invalid. Researchers have found that pregnant women are often described in ways that are consistent with Parson's model of the "Sick Role" (Taylor-Myers & Grasmick, 1990). Parsons model suggests that the "sick person" is exempt from normal social roles and should focus on getting well (Parsons, 1951). Along this vein, pregnant women are often excused from certain responsibilities and are encouraged to return to those responsibilities when they "get well" and return to "normal" (Taylor-Myers & Grasmick, 1990).

Women, Work, and Stereotypes

A better understanding of the relationship between work and pregnancy may offer some insight into the perception of pregnant therapists. The literature highlights how pregnant women often battle the pervasive stereotype of the good mother (mother that is always there for her children) contrasted with that of the good worker (employee with no responsibilities outside of work; Harrington, 2004), with an assumption that they cannot excel in both roles simultaneously (Williams, 2001). Such biased attitudes often lead to negative consequences for pregnant

women in the workplace (Budig & England, 2001; Masser et al., 2007; Williams & Segal, 2004). In response to this, legal measures have been enacted to protect pregnant women from discriminatory behavior in the workplace (Siegel, 1985). The Pregnancy Discrimination Act of 1978 amended Title VII of the Civil Rights Act of 1964 to include protections for pregnant women. The Act prohibits sex discrimination on the basis of pregnancy, childbirth or related medical conditions (Siegel, 1985). Despite its protections, nearly 31,000 charges of pregnancy discrimination have been fielded by the Equal Employment Opportunity Commission and state-level fair employment practice agencies between 2010 and 2015, with women of color disproportionately affected (National Partnership for Women, 2016). Recent research appears to support this trend in pregnancy discrimination in the workplace. Morgan et al. (2013) identified several problematic stereotypes about pregnant employees: incompetence (inability to perform to one's expected performance capacity), lack of commitment (lack of effort and/or dedication to performance), inflexibility (unwillingness to compromise or alter work schedule to meet work demands), and need for accommodation (the need for prolonged assistance or accommodation in the workplace) and tested the application of these stereotypes using pregnant and non-pregnant confederates applying for open employment positions at retail stores. The study found that pregnant applicants were treated with more interpersonal hostility (e.g., rudeness) than non-pregnant applicants by hiring managers. However, the researchers also found that when hiring managers were provided with counterstereotypic information regarding flexibility and commitment they displayed less discriminatory behavior. Similarly, Hebl et al. (2007) conducted a naturalistic field study which examined behavior toward pregnant versus non-pregnant women in traditional versus non-traditional roles. Women confederates (both pregnant and non-pregnant) posed as job applicants in a retail store. The pregnant applicants received

more hostile (e.g., rude) behavior when they were job applicants, and they received more benevolent (e.g., touching, overfriendliness) behaviors when posing as customers.

There is also some indication that perceived nontraditional work roles and responsibilities may also fuel stereotypes against pregnant women. Corse (1990) conducted an experiment that asked participants to observe a simulated conflict of an employee with a woman manager in which the woman manager was either pregnant or not pregnant and exhibited an authoritative style. She found that participants had more negative impressions of and lower satisfaction with the pregnant manager than the non-pregnant manager. Participants indicated that they expected the pregnant manager to be passive, nice, giving, and not as authoritative. Hebl et al. (2007) also examined traditional versus non-traditional occupations for women and their relationship to negative stereotypes about pregnancy in the workplace. They enlisted participants to read an application portfolio of a pregnant or non-pregnant woman applying for a "feminine" job (e.g., family lawyer, maid, kindergarten teacher) or a "masculine" job (e.g., corporate lawyer, janitor, high school math teacher). They found that pregnant women were more likely to encounter hostility when applying for masculine versus feminine jobs.

Research on pregnant women in the workplace also suggests that perceptions of them and its effect in the workplace is quite complex. Masser et al (2007) utilized the stereotype content model to examine the perception of pregnant women in the workplace. The stereotype content model theorizes that all group stereotypes and interpersonal impressions form along two dimensions (1) warmth and (2) competence (Fiske et al., 2002). They found that despite pregnant job candidates being rated as both warmer and more competent than non-pregnant job candidates, they were still discriminated against in that they were less likely to be hired by study participants for an employment position.

Finally, pregnant workers and their own views of the interface between work and pregnancy shed some light onto the manner in which they believe they will be perceived. Turner and Norwood (2014) interviewed eleven women that applied for jobs during the most outwardly visible stages of pregnancy. They found that the women perceived themselves to be less than ideal job candidates and described their identities as mother and employee as being at odds. Some believed that even searching for a position during pregnancy was futile, but simultaneously felt a need to overcompensate (to be more professional) to overcome pregnancy status. Many feared that men would evaluate them more harshly and that generally speaking their pregnancy would put them at risk for covert discrimination.

Pregnant Women, Stereotypes, and Gender

There is some research that indicates that gender influences the manner in which pregnant women are perceived in the workplace. Pattison et al. (1997) surveyed over 150 working people regarding their beliefs about pregnancy and employment. They found that women were more positive about pregnancy and work than men. They also found that those ages 26-45 were more positive about pregnancy and work than other age groups and that university workers tended to be more positive about pregnancy and work than those in the manufacturing industry. This study also found that direct experience with pregnancy was a factor in how pregnancy was perceived along with having a positive experience with a pregnant co-worker. The authors conclude that many negative views surrounding pregnancy and employment are related to the stereotype of pregnant women as invalids. Halpert et al. (1993) examined stereotypes about women and how these stereotypes affect performance evaluations. Results showed substantial negative stereotyping on the part of men. Additionally, when both men and women were asked to watch a pregnant and non-pregnant worker engage in the same

task, the pregnant worker was consistently rated more poorly, although there were no differences in how they performed the task. This was especially true for men, who often rated the pregnant worker much more negatively than their fellow women observers.

Summary

Based primarily on case studies and theoretical speculation, the pregnancy of the therapist has been seen as evoking powerful reactions both inside and outside the therapy room. However, much of the literature is dated, and does not reflect the increased frequency of pregnant women in the field of mental health or in the world of work. Much of the literature also characterizes the experience of the therapeutic dyad in psychoanalytic terms and misses the voice of the client, specifically as it relates to their initial perceptions of the pregnant therapist. The social influence theory offers a useful way to conceptualize the initial reactions of clients to the pregnant therapist utilizing the variables of expertness, trustworthiness, and attractiveness. Literature related to the stereotyping of pregnant women in general and as it relates to work offers some insight into how pregnant women may be initially perceived along these variables, suggesting that pregnant workers may experience more negative reactions, especially from men. Therefore, the next step is to examine the perception of pregnant therapists utilizing the social influence variables of attractiveness, expertness, and trustworthiness.

CHAPTER III: HYPOTHESES

The study addressed the following hypotheses:

(1a) Pregnant therapists will be viewed as less credible than their non-pregnant counterparts. Therapist credibility was measured by the total score of the Counselor Rating Form.

(1b) Pregnant therapists will be viewed as less expert than their non-pregnant counterparts. Therapist expertness was measured by the total score of the expertness subscale of the Counselor Rating Form.

(2a) Men will view pregnant therapists as less credible than will women.

(2b) Men will view pregnant therapists as less expert than will women study participants

(3a) Study participants will be less likely to say that they would see the pregnant therapist than they would the non-pregnant therapist for counseling in the future. Willingness to see the counselor was measured by the total score on the Willingness to See the Counselor Scale.

(3b) Women will be more likely than will men to say that they would see the pregnant therapist for counseling in the future.

(4a) Immediate reactions to the pregnant therapist will be more negative than immediate reactions to the non-pregnant therapist. Immediate reactions were measured utilizing the total score on the Counselor Reactions Inventory.

(4b) Study participants will view the counseling climate more favorably when seeing a non-pregnant therapist versus a pregnant therapist. Counseling climate was measured by utilizing the counseling climate subscale on the Counseling Reactions Inventory.

(4c) Study participants will indicate that they would be more willing to self-disclose when seeing a non-pregnant therapist versus a pregnant therapist. Willingness to self-disclose was measured by utilizing the willingness to self-disclose subscale of the Counseling Reactions Inventory.

(4d) Study participants will view the non-pregnant therapist as more competent than they view the pregnant therapist. Competency was measured by utilizing the competency subscale of the Counseling Reactions Inventory.

(4e) Study participants will view the non-pregnant therapist as more attractive than they will the pregnant therapist. Attractiveness was measured by utilizing the counselor attraction subscale of the Counseling Reactions Inventory.

CHAPTER IV: METHOD

Participants

Participants were recruited via the Qualtrics Online Sample Service. Qualtrics is a commercial web-based survey company that offers a national sampling platform for conducting online surveys in academic research. Qualtrics recruits potential study participants via a variety of sources to include website intercept recruitment, member referrals, targeted e-mail lists, gaming sites, customer loyalty web portals, permission based networks, and social media. Inclusion criteria consisted of age and country of residence. Study participants were required to be at least 18 years of age, representing the age of consent. Participants were also required to be residents of the United States. Finally, equal numbers of men and women were recruited for this study based on previous research indicating that men may be more likely than women to harbor negative perceptions of pregnant therapists and pregnant women in general (Halpert, 1983; Pattison et al., 1997).

Based on the work of Cohen (1992), it was determined that the sample had to consist of at least 180 participants in order to achieve 80% power for finding a medium effect size (0.5) when using an alpha level of .05. The initial sample consisted of 231 participants; however data was excluded for 43 participants because they did not successfully navigate the attention check. The attention check consisted of a question at the end of the survey in which participants were asked if the therapist in the advertisement that they viewed was pregnant. Those that did not respond correctly were excluded from the study. Thus the total number of study participants was one hundred and eighty-eight (n =188). The mean age of study participants was thirty-six, with

52% (n = 97) of participants being women and 48% (n = 91) being men. Table 1 summarizes the ethnic background, highest level of education and employment status of study participants. Table 2 summarizes the relationship status and identity of study participants.

Table 1

Descriptive Statistics: Ethnic Background, Education, and Employment Status (N = 188)

Variables	*Frequency*	*Percentage*
Ethnic Background		
White	128	68.09
Hispanic/Latino	20	10.64
Black/African American	19	10.11
Asian/Asian American	5	2.66
American Indian or Alaska Native	4	2.13
Native Hawaiian or Pacific Islander	1	0.53
Multicultural	10	5.32
Other (Italian)	1	0.53
Highest Level of Education		
Less than high school	8	4.26
High school/GED	83	44.15
Associates Degree	44	23.40
Bachelors Degree	38	20.21
Masters Degree	12	6.38
Doctoral Degree	3	1.60
Employment Status		
Employed for wages	79	42.02
Student	28	14.89
Out of work and looking	25	13.30
Homemaker	19	10.11
Unable to work	16	8.51
Retired	15	7.98
Self-employed	13	6.91
Out of work and not looking	4	2.13
Military	1	0.53

Note: For employment status participants were able to choose more than one answer.

Table 2

Descriptive Statistics: Demographic Variables of Relationship Status and Identity

Variables	*Frequency*	*Percentage*
Relationship Status		
Married	63	33.51
Divorced	15	7.98
Widowed	3	1.60
Separated	6	3.19
Never been married	79	42.02
A member of a committed couple	32	17.02
Identity		
Heterosexual (Straight)	167	88.83
Gay or Lesbian	6	3.19
Bisexual	12	6.38
Don't know/unsure	2	1.06
Other (pansexual)	1	0.53

Note: For marital status participants were able to choose more than one answer.

Demographic data was also collected regarding children and pregnancy. A little over half of study participants had children (51%; n = 96), with the number of children ranging from one to six with a mean of two children. Thirty-one percent of study participants (n = 59) indicated that they had been pregnant at some point in their lives. Five percent (n = 10) indicated that they (or their partner) were trying to become pregnant and were having difficulty doing so.

Finally, study participants were asked about their eating disorder history and about their willingness to see a pregnant therapist. Six percent of study participants (n = 12) endorsed having an eating disorder. Four percent of participants (n = 7) stated that they were unsure if they had an eating disorder or not. The vast majority of study participants (91%; n = 172) indicated that they would not have any concerns about seeing a pregnant therapist.

Measures (in order administered)

Counselor Rating Form.. In order to assess therapist credibility, participants were asked to complete the Counselor Rating Form (CRF, Barak and La Crosse, 1975). The CRF measures expertness, attractiveness, and trustworthiness as dimensions of counselor influence with the client. It consists of 36 pairs of bipolar adjectives with 12 pairs for each of the three dimensions. Each item uses a 7-point Likert scale, producing a subscale score range of 12-84 for each of the three dimensions. Higher scores indicate perception of a higher degree of expertness, attractiveness and trustworthiness. Sample items include bipolar pairs such as "agreeable and disagreeable," "inexperienced and experienced," and "sincere and insincere."

The Counselor Rating Form is one of the most frequently utilized and widely researched counselor rating measures (Heppner et al., 1999). The reliability and validity of the CRF is also well documented (Barak & Dell, 1997; LaCrosse, 1980). Internal consistency reliability of the expertness, attractiveness, and trustworthiness scales using split half is .87, .85, and .91 respectively (LaCrosse & Barak, 1976). Research has also shown the CRF to differentiate between relative amounts of expertness, attractiveness, and trustworthiness (Barak & Dell, 1977; Barak & LaCrosse, 1975; LaCrosse & Barak, 1976) and higher levels of these traits are associated with counseling outcomes in several studies (Barak & LaCrosse, 1975; LaCrosse, 1979). Construct validity has been supported through factor analysis (Barak & LaCrosse, 1975). Higher CRF scores have been found to be predictive of positive post-counseling outcomes (LaCrosse, 1980), as well as with willingness to self-refer in various problem areas (Barak & Dell, 1977).

The Counseling Reactions Inventory. In order to assess immediate reactions to the therapist the Counseling Reactions Inventory (CRI) was utilized. The CRI is a nine-item scale

designed to measure subject/clients immediate reactions to a counselor or simulated counselor to whom they have been exposed (Helms, 1976). Participants are asked to respond to the items using five-point Likert scales with possible answers ranging from strongly agree to strongly disagree. The inventory measures four dimensions: (1) counseling climate (the extent to which respondents would feel comfortable with the counselor); (2) willingness to self-disclose (the extent to which respondents feel free to disclose to the counselor); (3) counselor competence (perceptions of the counselors perceived understanding and concern); and (4) counselor attraction (respondents liking for the counselor). Total scores are obtained by adding responses to the nine items and range from 9 to 45. Subscale scores are computed by adding together the relevant item numbers (counseling climate = item 1 + item 2 + item 3; willingness to self-disclose = item 4 + item 5; counselor competence = item 6 + item 7; counselor attraction = item 8 + item 9). Sample items include statements such as, "I would feel comfortable in my first session" and "I would feel I could discuss anything I wished in my session."

In terms of reliability, coefficient alpha for the standardized scale was .78 and standardized alpha was .79 suggesting moderate reliability. Factor analysis was utilized to investigate the construct validity of the scale. Five factors were identified as accounting for 79% of the variance: factor 1 which measures interview comfort (items 1 and 2), factor 2 which measures a lack of verbal restriction (items 5 and 7); factor 3 which measures friendly feelings towards the counselor (items 6 and 9); factor 4 which measures attraction to the counselor in his/her role as counselor (items 4 and 8), and factor 5 which measures anticipated anxiety (item3). Convergent validity was established with the Counselor Evaluation Inventory. The correlation between the total scores on both instruments was .65 suggesting that the two scales measure similar but not synonymous constructs (Helms, 1976). Discriminant validity was

established with the Client Perception Scale (r = .16) (Helms, 1976, 1979). Comparisons to the Counselor Evaluation Inventory and the Counselor Rating Form suggest that the Counselor Reactions Inventory emphasizes personal reactions to the counselor in contrast to the latter two scales which place greater emphasis on the perception of certain counselor characteristics (Helms, 1976).

Willingness to See Counselor (Appendix A). The Willingness to See the Counselor Scale was developed for this study and assessed willingness to see the counselor by asking participants to respond to the following stems: "I would be willing to see this person for counseling in the future" and "I would be willing to recommend this counselor to a close friend or family member." Each item contained a 5-point Likert scale ranging from strongly agree to strongly disagree. The total score was utilized to measure willingness to see the counselor with higher scores representing a greater willingness to see the counselor.

Demographic Questionnaire (Appendix B). A 15-item demographic questionnaire consisting of both multiple choice and open-ended questions was utilized to collect information regarding age, gender, education, employment status, relationship status, eating disorder history, and pregnancy history.

Procedure

After gaining approval from the Auburn University Institutional Review Board, participants were recruited via the Qualtrics Online Sample Service. As previously outlined, Qualtrics is a commercial web-based survey company that offers a national sampling platform for conducting online surveys in academic research. Potential participants meeting the inclusion criteria for the study were invited to complete the study via an email sent by Qualtrics. The email included a hyperlink to the study along with a description of compensation. Participants

were incentivized in a variety of ways (e.g., airline miles, cash, gift cards) and received one dollar or equivalent compensation based on their agreement with Qualtrics.

Once participants clicked the hyperlink to the study, they were directed to an information letter (see Appendix C) describing the study. This information letter informed them that they would view a therapist's online advertisement along with two therapy transcripts and complete a series of questionnaires. Additionally the letter outlined eligibility (e.g., age 18 or over and United States resident), expected study completion time, incentives, anticipated risks, the voluntary nature of the study, ability to withdraw without penalty and the anonymity of participant responses. Participants indicating that they were in agreement with the information letter were permitted to proceed with the study while those indicating that they were not in agreement were directed to the end of the study.

In the information letter participants were told that the study was about the perception of therapists' online advertisements, when in fact it was about the perception of pregnant therapists. Deception was utilized to avoid response bias. Rather than explicitly drawing attention to the pregnancy of the therapist and possibly altering participant responses, the study was presented as an examination of the perception of therapists' online advertisements.

After providing consent, participants were randomly assigned to one of four conditions (pregnant therapist 1, pregnant therapist 2, non-pregnant therapist 1, non-pregnant therapist 2) and asked to view a simulated online advertisement for therapy services. The advertisements were identical except for photographs which depicted the therapist as pregnant or not pregnant and text within the advertisement which indicated pregnancy status. After viewing the simulated online advertisements, participants were asked to read two simulated therapy transcripts. They were then asked to complete a set of online questionnaires. The questionnaires were

administered in the following order: Counselor Rating Form, Willingness to See Counselor Scale, Counseling Reactions Inventory, Demographic Questionnaire. Following completion of all measurement instruments, participants were provided with a debriefing form (see Appendix D) and thanked for their participation in the study.

After survey closure, all raw data was downloaded from Qualtrics to the Statistical Package for the Social Sciences (SPSS). Partial responses, those who started the survey and did not finish, and those who failed survey screeners or quality checks were not included in the final sample.

Stimulus Photograph Confederates. Stimulus photographs (see Appendices E and F) were taken of two confederates who posed as both the non-pregnant and pregnant therapists (through the use of a prosthesis) as part of the simulated online advertisement. Confederates were recruited via word of mouth at a local nursery school. The confederates were similar in physical appearance in that they represented an age range of 30-39, and had similar body shapes (height within 2-3 inches and weight within 15-20 pounds). The confederates chosen were also both Euro-American women. This is reflective of current American Psychological Association demographics. Recent census data has shown that 83.6% of active psychologists are Euro-American and that the age distribution of active psychologist women peaked at ages 31 to 35 (American Psychological Association, 2016). Finally, confederates were made to appear 8-9 months pregnant via the use of a pregnancy prostheses purchased from an online retailer (Amazon.com; Imposta Pregnant Body Suit; Product Code BOOBLOEROE). A simulated pregnancy of 8-9 months was chosen because it represents the third trimester, when a woman is most visibly pregnant (Slade et al., 2009).

Confederates appeared similar in all photographs aside from their pregnancy status. They had similar expressions on their faces in pictures (natural smiles) and had a similar stance (turned toward the camera). All confederates were photographed wearing a casual pair of black slacks and a gray shirt. The pictures were adjusted utilizing photography software to ensure that the background and lighting were identical across pictures. Confederates gave both verbal and written permission to have their photographs posted online as part of this study.

Manipulation Check. Prior to conducting the main study a group of different participants was recruited via the Qualtrics Online Sample Service in order to perform a manipulation check to ensure that therapist pregnancy was salient in the stimulus photographs. After providing consent, participants were randomly assigned to view one of the four confederate photographs utilized in the study. After viewing the photograph they were asked to write down ten words describing the most prominent characteristics of the confederate in the photograph. They then provided basic demographic information (age and gender). It was predetermined that in order for the photographs to be utilized 80% of participants had to indicate pregnancy/pregnant (or some variation) as one of their 10 descriptors after viewing the picture in which the confederate was represented as being pregnant.

The manipulation check included thirty-three participants (n = 33). Fifty-two percent of participants (n = 17) were women and 48% (n=16) were men. The youngest participant was eighteen and the oldest was seventy-six, with a mean participant age of forty-one. All participants (n = 16) who viewed a picture depicting pregnancy used word choice indicating that the confederate whom they viewed was pregnant. Fifteen used the word “pregnant”, while one used the word “embarazada”, which means pregnant in Spanish. Several participants coupled their use of the word “pregnant” with other adjectives describing pregnancy such as “expecting”

(n = 3) and "almost due" (n = 1). None of the participants who viewed the picture depicting the non-pregnant confederate used word choice indicating that they thought she was pregnant. Based on these results it was determined that the manipulation was successful and that pregnant confederates were indeed viewed as being pregnant.

Stimulus Website Information (Appendices E and F). The stimulus website information was taken from the work of Keating and Fretz (1990) and Pecnik and Epperson (1985). The organizational structure and formatting of the website information was based on a popular website which advertises therapists and their services (GoodTherapy.org). The web advertisements on this site typically offer a photograph of the therapist along with a description of their services beneath the photograph. The stimulus website had a Flesch-Kincaid grade level of 9.2.

Stimulus Therapy Transcripts (Appendix G). The stimulus therapy transcripts were developed after viewing several training videos outlining best practices in psychotherapy. Additionally, the researcher consulted with her doctoral advisor and Counseling Psychology Ph.D. students and graduates for believability and readability. The topics addressed in the transcripts (depression and low self-esteem) were chosen because they represent commonly treated disorders within the population (Center for Behavioral Health Statistics and Quality, 2015). The stimulus therapy transcripts had a Flesch-Kincaid grade level of 5.5.

Research Design and Data Analytic Strategy

This study utilized a 2X2 between subjects design. The two between group variables were gender of participant and pregnancy status of the therapist. The between group variable gender had two levels (male and female). The between group variable of pregnancy status had two levels (pregnant and not pregnant).

This study had eight dependent variables: counselor credibility (as measured by the full scale Counselor Rating Form), counselor expertness (as measured by the expertness scale of the Counselor Rating Form), counseling reactions (as measured by the full scale of the Counseling Reactions Inventory), willingness to self-disclose (as measured by the self-disclosure scale of the Counseling Reactions Inventory), counselor attraction (as measured by the attraction scale of the Counseling Reactions Inventory), counselor competency (as measured by the competency scale of the Counselor Reactions Inventory), counseling climate (as measured by the climate scale of the Counselor Reactions Inventory, and the Willingness to See the Counselor Scale score (as measured by the Willingness to See the Counselor Scale).

In terms of data analysis, reliability coefficients (Cronbach's Alpha) were computed for the CRF, CRI, WSC and their subscales. Secondly, the data was assessed for linearity, homogeneity, and normality to ensure appropriate choices for statistical testing. Hypotheses were tested utilizing between subjects Analysis of Variance (ANOVA) and an independent samples t-test.

Summary

This investigation was designed to explore the relationship between therapist pregnancy status, participant gender, and perceptions of therapist credibility. An experimental design was employed with therapist pregnancy status and gender as between subjects variables and CRF, CRI, and Willingness to See the Counselor full scale and subscale scores as dependent variables. Data was analyzed via a series of between subjects ANOVAs and an independent samples t-test. The results are detailed in the following chapter.

CHAPTER V: RESULTS

All analyses were conducted using the Statistical Package for Social Sciences version 25.0 (SPSS 25.0). This chapter is divided into sections. The first section describes the development of study scales, preliminary analyses regarding the testing of assumptions for ANOVA and independent samples *t*-test, and scale inter-item reliability. The subsequent section provides an overview of dependent variable descriptive statistics. The most comprehensive section is a presentation and discussion of results in relation to the study research questions and hypotheses. Qualitative findings are discussed in the final section of the chapter.

Preliminary Analyses

Computation of Study Scales

Descriptive statistics (i.e., mean, standard deviation, minimum and maximum scores) were conducted on the three study dependent variables, namely the Counselor Rating Form (CRF) full scale and subscales, the Counseling Reactions Inventory (CRI) full scale and subscales, and the Willingness to See Counselor (WtsC) scale which was created specifically for this study. Descriptive statistics are presented in Table 3.

The CRF measures counselor attractiveness, expertness, and trustworthiness as dimensions of counselor influence with the client (Barak & LaCrosse, 1975). As seen in Table 3, the mean score for the CRF full scale was 195.09 (*SD*=34.91).

The CRI is a nine-item scale that measures clients' immediate reactions to a counselor or simulated counselor to whom they have been exposed (Helms, 1976). Item 5 of the CRI ("I would feel I could ask any questions I wished in my session") was inadvertently omitted on the participant survey. This omission required that an eight-item CRI total scale and a one-item CRI willingness to self-disclose scale be used in the study. The CRI full scale had a mean of 28.51 (*SD*=5.84).

The Willingness to See the Counselor (WtsC) Scale, developed for this study, is a 2-item measure which examines study participants' desire to engage in therapy in the future with the simulated counselor. The two-item WtsC full scale had a mean of 7.34 (*SD*=1.93).

Table 3

Descriptive Statistics: Dependent Variables

	N of Items	*M*	*SD*	*Min*	*Max*
Counselor Rating Form	36	195.09	34.91	84.00	252.00
CRF Attractiveness Subscale	12	62.53	10.90	31.00	84.00
CRF Expertness Subscale	12	65.69	12.42	31.00	84.00
CRF Trustworthiness Subscale	12	66.88	13.20	22.00	84.00
Counselor Reactions Inventory	8	28.51	5.69	8.00	40.00
CRI Counseling Climate Subscale	3	10.35	2.04	3.00	15.00
CRI Counselor Competence Subscale	2	7.32	1.87	2.00	10.00
CRI Counselor Attraction Subscale	2	7.31	1.81	2.00	10.00
CRI Willingness to Self Disclose Subscale	1	3.53	1.01	1.00	5.00
Willingness to See Counselor	2	7.33	1.93	2.00	10.00

*Not*e The Counselor Reactions Inventory is actually a 9-item scale; however as noted earlier, only 8 items were utilized to determine mean scores. The properties of the three-item Counseling Climate Scale are reported here; however the two-item scale was utilized in hypothesis testing due to better internal consistency.

Assumptions

Independent sample *t*-tests and ANOVAs share assumptions: (a) independence of observations - the data between groups is not paired with or dependent on one another; (b) normality in the dependent variable distribution of scores; and (c) homogeneity of variance - the

dependent variable variances are similar across independent variable groups (Mertler & Reinhart, 2016). Each of the underlying assumptions were examined to determine if any violations occurred. The assumption of independence of observations was met, as data were collected from individual participants at one point in time.

Statistical tests of normality revealed that the Counselor Rating Form (CRF) and CRF subscale scores had slightly left-skewed distributions (towards a higher scale or subscale score), resulting from multivariate outliers. However, the Counselor Reactions Inventory (CRI) total scale, the CRI subscales, and the Willingness to see Counselor (WtsC) scale were normally distributed. There remains a debate in the statistical literature whether outlier cases should be removed from the data set, especially when the removal of outliers results in less representative sample data (Aguinis, Gottfredson, & Joo, 2013; Barnett & Lewis, 1994; Osborne, 2004) and when between-group statistics are robust to deviations from normality (Mertler & Reinhart, 2016; Maxwell & Delaney, 2004). Monte Carlo simulation studies testing the effects of violations of the normality assumption on between-group statistical findings have furthermore shown that violations do not unduly increase the Type 1 error rate (Aguinis et al., 2013; Schmider et al., 2010).

Levene's tests for equality of variances were conducted to address the homogeneity of variances assumption. The Levene's test determines if the dependent variable variances significantly differ across the independent variable categories of pregnant/not pregnant counselor condition and participant gender. None of the Levene's tests were significant, indicating that dependent variable variances were similar for both conditions and gender groups. The homogeneity of variances assumption was met.

Reliability Statistics

Cronbach's alphas were computed to determine the inter-item reliability for the dependent variable scales and subscales. A Cronbach's alpha from .70 to .79 is considered *good*, from .80 to .89 is considered *very good*, and a Cronbach's alpha that is .90 or higher is considered *excellent* (Tavakol & Dennick, 2011). Table 4 presents the Cronbach's alphas (αs) for all study scales and subscales, and shows the Cronbach's αs of the measures as reported in the literature (when available). As seen in Table 4, study scales and subscales had good to excellent internal consistency. In the current study, the inter-item reliability of the 36-item full-scale CRF was excellent ($\alpha = .97$). The CRF subscales – all of which had 12 items – had very good to excellent inter-item reliabilities (CRF attractiveness subscale $\alpha = .87$, CRF expertness subscale $\alpha = .91$, and CRF trustworthiness subscale $\alpha = .94$). The Cronbach's alphas for the CRF scale and subscales were actually higher than those previously reported in the literature (Atkinson & Wampold, 1982; Ponterotto, 1985).

The eight-item full-scale CRI also had very good inter-item reliability, with a Cronbach's α of .86, substantially higher than the Cronbach's a of .78 reported by Helms (1976). The 2-item CRI competency and the 2-item counselor attraction subscales also demonstrated good or very good internal consistency, αs $= .76$ and $.81$, respectively. The 3-item CRI counseling climate subscale had poor internal consistency, $\alpha = .44$. However, the removal of the third item of the scale (i.e., "I would feel anxious talking to the counselor") resulted in a very good Cronbach's $\alpha = .80$. Low Cronbach's αs are a result of low or even negative correlations between scale/subscale items (Tavakol & Dennick, 2011). The improved α resulting from the removal of the third item that measured anxiety regarding the counselor suggested that anxiety level may be independent of other reactions to counseling (Helms, 1976). The WtsC scale, developed

specifically for this study, had very good inter-item reliability (i.e., Cronbach's $\alpha = .82$). As the Willingness for Self-Disclosure (WfSD) scale was comprised of a single item, Cronbach's α could not be computed for this scale.

Table 4

Cronbach's Alphas of Study Scales and Subscales with Comparisons to Cronbach's Alphas in the Empirical Literature (N=188)

	Cronbach's α Sample Data	*Cronbach's α In Established Literature*
Counselor Rating Form	.97	.96
CRF Attractiveness Subscale	.87	.85
CRF Expertness Subscale	.91	.87
CRF Trustworthiness Subscale	.94	.91
Counselor Reactions Inventory	.86	.78
CRI Counseling Climate (items: 1,2,3) Subscale	.44	*
CRI Counseling Climate (items: 1,2) Subscale	.80	*
CRI Counselor Attraction Subscale	.81	*
CRI Counselor Competence Subscale	.76	*
Willingness to See Counselor Scale	.82	*

Note.Information on the Cronbach's alphas for the CRS total scale and subscales derived from Atkinson & Wampold (1982) and Ponterotto (1985). Information on the Cronbach's alpha for the CRI obtained from Helms (1976). An asterisk denotes that established Cronbach's alpha reliability data are unavailable.

Hypotheses Testing

This research study addressed the following hypotheses:

(1a) Pregnant therapists will be viewed as less credible than their non-pregnant counterparts.

(1b) Pregnant therapists will be viewed as less expert than their non-pregnant counterparts.

(2a) Men will view pregnant therapists as less credible than will women.

(2b) Men will view pregnant therapists as less expert than will women study participants

(3a) Study participants will be less likely to say that they would see the pregnant therapist than they would the non-pregnant therapist for counseling in the future

(3b) Women will be more likely than will men to say that they would see the pregnant therapist for counseling in the future.

(4a) Immediate reactions to the pregnant therapist will be more negative than immediate reactions to the non-pregnant therapist.

(4b) Study participants will view the counseling climate more favorably when seeing a non-pregnant therapist versus a pregnant therapist.

(4c) Study participants will indicate that they would be more willing to self-disclose when seeing a non-pregnant therapist versus a pregnant therapist

(4d) Study participants will view the non-pregnant therapist as more competent than they view the pregnant therapist

(4e) Study participants will view the non-pregnant therapist as more attractive than they will the pregnant therapist.

Hypotheses 1(a) and 2(a)

A 2 X 2 ANOVA was conducted to examine the effects of gender and pregnancy status on perceptions of counselor credibility, as measured by the CRF full scale. There was not a statistically significant interaction between gender and pregnancy status on CRF full-scale scores, $F(1,187) = 1.08$, p = .300, partial $\eta^2 = .006$. There were also no significant main effects of pregnancy status or gender on perceptions of counselor credibility, $F(1,187) = 0.25$, $p = .621$, partial $\eta^2 = .001$, and $F(1,187) = 0.347$, $p = .556$, partial $\eta^2 = .002$, respectively. Hypothesis 1(a) and 2(a) were rejected due to lack of significance findings.

Hypotheses 1(b) and 2(b).

A 2 X 2 ANOVA was conducted to examine the effects of gender and pregnancy status on perceived counselor expertness, measured using the CRF expertness subscale. There was not a statistically significant interaction between gender and pregnancy status on expertness scale scores, $F(1,187) = 0.39$, p = .796, partial $\eta^2 = .00$. There also were no significant main effects for pregnancy status $F(1,187) = 0.65$, $p = .208$, partial $\eta^2 = .00$ or gender, $F(1,187) = 0.70$, $p = .164$, partial $\eta^2 = .00$. Hypothesis 1(b) and 2(b) were rejected due to lack of significance findings.

Hypotheses 3(a) and 3(b)

A 2 X 2 ANOVA was conducted to examine the effects of gender and pregnancy status on Willingness to See Counselor scale scores. There was not a statistically significant interaction between gender and pregnancy on Willingness to See Counselor scale scores, $F(1,187) = .06$, p = .812, partial $\eta^2 = .00$. An analyses of the main effects for pregnancy status $F(1,187) = 2.65$, $p = .105$, partial $\eta^2 = .01$ and gender $F(1,187) = 0.66$, $p = .418$, partial $\eta^2 = .00$ did not yield significant results, therefore hypothesis 3(a) and 3(b) were rejected.

Hypotheses 4(a), 4(b), 4(c), 4(d), and 4(e)

An independent samples *t*-test was run to determine if there were differences in CRI total and subscale scores between pregnant and non-pregnant confederates. There were no statistically significant differences in CRI total scores, $t(186) = -0.47$, $p = .642$. There were also no significant differences in CRI competency scale scores, $t(186) = -0.32$, $p = .753$, CRI counselor attraction scale scores, $t(186) = 0.48$, $p = .634$, CRI counseling climate scale scores, $t(186) = -1.58$, $p = .115$, or CRI willingness to self-disclose measures, $t(186) = -0.06$, $p = .956$. Therefore hypotheses 4(a), 4(b), 4(c), 4(d), and 4(e) were rejected due to lack of significance findings.

Quasi-Qualitative Analysis

As part of this study, participants were asked several demographic questions. The following question was posed, "If you were interested in seeking therapy would you have any concerns about seeing a pregnant therapist?" along with a request for participants to explain their answer to this question. As discussed in chapter IV, the majority (n=172; 91%) of study respondents said that they would not have any concerns about seeing a pregnant therapist. An analysis of the open-ended responses of study participants offered additional clarity regarding therapist perception. Several participants openly expressed their belief that pregnancy has no impact on the therapists' ability to provide counseling services, responses included: *"I don't think pregnancy is a factor in what makes someone capable of helping me with my mental state," "Pregnancy is not a factor in determining my decisions," "pregnancy shouldn't affect their ability to provide therapy," "…because that [pregnancy] would have nothing to do with my therapy," "I do not feel that pregnancy affects her wisdom or judgment," "I don't feel that being pregnant has anything to do with her ability to diagnose a patient."* A number of study

participants expressed the importance of factors such as competence, understanding, caring, and trust in making judgments about a therapist: *"No as long as that person understands me and I feel they care," "I would not be concerned if they were competent," "I don't care who I'm talking to as long as they are qualified," "[No]...because I would trust them," "if they are qualified and come highly recommended, gender or condition would not matter."* Many study participants cited the personhood of the therapist as a reason for not being concerned about her pregnancy stating, *"I just wouldn't, that's her personal life and has no bearing on her being my therapist," "They are still a person…," "She has a life too," "it's her life."* Along that same vein many study participants highlighted the fact that pregnancy is a part of life *("it's life")* and that it is "natural." Several study participant's expressed positive views of therapist pregnancy, even indicating that it might be an asset: "*it could be helpful," "I would think she is more suited because she is surrounded by family," "she's amazing."* Some study participant responses captured the multiple roles/identities inherent in being a pregnant therapist: *"She should be able to put her role as therapist before her role as soon to be mother," "I would assume that an expectant mother would still be able to remain professional."*

Despite the majority of respondents indicating that they would have no concerns about seeing a pregnant therapist, there were a host of concerns offered when study participants were given the freedom of open-ended responses. Some study participants expressed concerns about the breadth of the pregnant therapists abilities stating: *"they may only specialize in pregnancy problems," "no concern, but she may not be able to relate to a man problem*." Study participants also discussed the emotionality of the pregnant therapist*: "too emotional," "pregnant women can be more emotional…," "A little bit, this is because some ladies hormones can affect their sense of judgment."* A few study participants expressed worry for the pregnant

therapist in her role: *"No I would not have concerns, I just wouldn't want the baby to pop out midsession," "No concerns, just that she doesn't stress over herself," "I don't feel like that would matter, unless said therapist is stressed about the clients, because that wouldn't be good for the child."* Perhaps the most prominent concern for study participants surrounded maternity leave and the absence of the pregnant therapist: *"When would the therapist be leaving for maternity leave and how would this affect the progress of the sessions," "If I were to seek a therapist, I would want one that is available and not going to potentially be unavailable for a month or more at a time," "I would have some concerns that as a pregnant mom about to have a baby, the counselor would at some point be absent for a set amount of time (maternity leave). However, these concerns are not enough for me not to see someone. Everyone has a life and deserves time away to be involved with and in their lives," "Not about the pregnancy, but if she was to continue her work or decide to be a stay at home mommy," "Only her availability afterwards. I would understand her wanting to spend time with her child and becoming distant, but it could cause personal issues with me. I could lose my counselor."* One participant expressed a desire to be informed of the pregnancy, *"I would like to know."*

Finally, several participants offered information regarding their own personal history in response to the question: *"...had a hysterectomy," "I've been pregnant, no big deal," "...been pregnant twice."* One respondent indicated that they preferred a therapist that was not pregnant: "*I would also prefer them not to have kids so they could better understand where I'm coming from as I never want kids."* Another reflected on the manner in which her own experiences might complicate therapy, *"I lost my second child at 32 weeks gestation and might be guarded on the subject with a pregnant therapist."* This information is summarized in Table 5.

Table 5

Study Participant Concerns Regarding Seeing a Pregnant Therapist

Theme	*Comments*
Breadth of Abilities	*"they may only specialize in pregnancy problems"* *"no concern, but she may not be able to relate to a man problem*"
Emotionality	*"too emotional"* *"pregnant women can be more emotional…"* *"A little bit, this is because some ladies hormones can affect their sense of judgment"*
Concern for Therapist	*"No I would not have concerns, I just wouldn't want the baby to pop out midsession"* *"No concerns, just that she doesn't stress over herself",* *"I don't feel like that would matter, unless said therapist is stressed about the clients, because that wouldn't be good for the child"*
Maternity Leave/Absence	*When would the therapist be leaving for maternity leave and how would this affect the progress of the sessions"* *"If I were to seek a therapist, I would want one that is available and not going to potentially be unavailable for a month or more at a time"* *"I would have some concerns that as a pregnant mom about to have a baby, the counselor would at some point be absent for a set amount of time (maternity leave). However, these concerns are not enough for me not to see someone. Everyone has a life and deserves time away to be involved with and in their lives",* *"Not about the pregnancy, but if she was to continue her work or decide to be a stay at home mommy",* *"Only her availability afterwards. I would understand her wanting to spend time with her child and becoming distant, but it could cause personal issues with me. I could lose my counselor"*
Interaction with Personal History	*"…had a hysterectomy"* *"I've been pregnant, no big deal",* *"…been pregnant twice"* "*I would also prefer them not to have kids so they could better understand where I'm coming from as I never want kids"* *"I lost my second child at 32 weeks gestation and might be guarded on the subject with a pregnant therapist"*

CHAPTER VI: DISCUSSION

Meaning and Interpretation of Findings

The aim of the present study was to examine the initial perceptions of pregnant therapists. More specifically this study examined the relationship between gender and pregnancy status on ratings of counselor credibility and expertness. Additionally, this study examined the relationship between pregnancy status and ratings of counseling climate, counselor competence, willingness to self-disclose, and counselor attraction. Despite previous research that found that pregnant therapists were perceived as less expert and as operating with less depth (Stockman, 1995), no significant relationship between pregnancy status and expertness was discovered in this study. Previous studies have also indicated that pregnant women are often discriminated against in the workplace, very often by their male peers (Halpert et al., 1993; Hebl et al., 2007; Masser et al., 2007; Morgan, 2013; Pattison et al., 1997). However the current study found no relationship between pregnancy status, gender, and willingness to see the counselor or pregnancy status and ratings of counseling climate, counselor competence, willingness to self-disclose, and counselor attraction. In summary, pregnancy status and gender had no influence on ratings of counselor credibility and expertness, and willingness to see the counselor and pregnancy status did not influence ratings of counseling climate, counselor competence, willingness to self-disclose, and counselor attraction.

These unexpected results can be interpreted in several ways. It may be that there truly is no link between pregnancy status, gender and ratings of counselor credibility and expertness. In

fact the vast majority of study participants indicated that they would have no concerns about seeing a pregnant therapist. Census data indicates that more women are working during pregnancy, and working longer during their pregnancy and perhaps this has normalized the presence of pregnant women in the workplace (U.S. Census Bureau, 2011). Similarly, the high percentage of women in the fields of counseling and social work may also play a factor in normalizing the pregnant therapist (Carey, 2011; Diamond, 2012; Willyard, 2012).

Alternately, it may be that there is an association between the variables but the study's design was not sensitive enough to identify the association. This may be a result of a variety of potential factors. First, a lack of association may have been the result of sample problems. The participants in this study were not seeking therapy and were not having an interaction with a live therapist. Also, the study did not require participants to disclose information about their previous/current participation in therapy, which means that some may not have been able to relate to the prospect of initiating therapy with a pregnant therapist. Secondly, the measures utilized were prone to the "good person" response bias, which suggests that study participants may respond to survey items in a socially desirable manner to appear "good" (Bergin, 1971). Perhaps social norms against openly expressing negative attitudes towards pregnant women in the workplace have grown stronger. Certainly the literature regarding therapist pregnancy has taken a decided trend to a more positive description of the pregnant therapist in the past several decades (Dyson & King, 2008). Participants may harbor negative views of pregnant therapists, but may not be willing to endorse those views in a research study. Finally, perhaps the research questions did not go far enough in their examination of therapist pregnancy. Research studies such as those conducted by Masser et al. (2007) and Hebl et al. (2007) have shown that the perception of pregnant workers is very nuanced. As it relates to therapist pregnancy, perhaps

studies of pregnancy status and occupational setting/job duties or pregnancy status and treatment population would offer more information about how pregnant therapists are perceived in these particular populations. Relatedly, there is research that has found that women are assessed as being more suited to occupations that are deemed to be more "feminine." The occupation of therapist may indeed be considered a more "feminine" profession. This might make study participants less likely to find major differences between the pregnant and non-pregnant confederates in the study.

The qualitative analysis of an open-ended question (If you were interested in seeking therapy would you have any concerns about seeing a pregnant therapist? Explain.) revealed data consistent with the pregnant therapist literature. Many study respondents expressed the thought that pregnancy was a normal part of the life cycle and would have no bearing on the therapists' ability to do her work. As in the literature, others highlighted the role conflict that may occur (Dyson & King, 2008; Korol, 1996; Nadelson et al., 1974; Rosenthal, 1990), and at times role reversal with the study participants' caretaking the therapist (Rubin, 1980). Similar to the literature, this analysis is also evidence of the evocative nature of pregnancy, as many study participants, mostly women, highlighted their own experiences with pregnancy and other reproductive issues (Gottlieb, 2006; Maat & Vanderslyde, 1995). Study participants' responses also aligned with the literature that posits that certain populations may not be suited for work with a pregnant therapist, with one study participant in particular highlighting how a negative birth experience would likely hamper her work with a pregnant therapist (Balsam & Balsam, 1974). Perhaps most prevalent in study participant responses were concerns about maternity leave. Although these concerns were not addressed in a negative manner, they did reflect some worry about the absence of the therapist. Concerns along these lines are well documented in the

pregnant therapist literature (Chiramonte, 1986; Gerber, 2005; Haber, 1992; McKamy, 1984). Perhaps a new stereotype that was elucidated in the analysis of this question was that of the overly emotional pregnant woman, with a few study participants citing this as a potential area of concern.

Limitations

Although this study has the potential to inform researchers about how therapist pregnancy is perceived and aspects of therapist pregnancy that are important for future consideration, there are a few limitations, which must be considered.

Sampling Bias

Study participants were recruited via Qualtrics. Research indicates that Qualtrics provides samples with specific demographic attributes that are often only within a 10% range of corresponding values in the United States population (Heen et al., 2014). However, Qualtrics does not differ significantly from other survey platforms in this regard (e.g., Mechanical Turk, Survey Monkey), and the facility with which these platforms collect data make them much more effective than traditional survey methods (e.g., telephone, mail; Heen et al., 2014). It is also unknown if people who take surveys for incentives differ from the general population. Although there is an advantage to using an internet-based survey, this tends to exclude individuals who do not have access to the internet, or who lack basic computer skills (Pew Research Center, 2015). Research indicates that about 13% of Americans do not use the internet and many of these individuals are lower income and possess less than a high school education (Anderson & Perrin, 2016). Additionally, considering that the Flesch-Kinkaid grade level for the stimulus website

information was 9.2, those with low reading levels would likely find this survey protocol challenging.

Lack of Research Studies

As has been previously outlined, therapist pregnancy is an understudied area with very little empirical research (McCluskey, 2017; Schmidt, 2015). Although this allows for greater exploration within the topic area of therapist pregnancy, it also makes it much more difficult to define and operationalize key constructs. Pregnancy alone is a difficult topic of study, because it does not represent a distinct event, but a gradual change that occurs over a specified period of time. This study focused only on late-term pregnancy (i.e., when pregnancy was clearly observable). So, for example, this study did not attempt to illuminate the possible client reactions to the specific moment when they discover (conclude or are told) of the therapist's pregnancy.

Relevance to Clinical Sample

This study is beset by many of the criticisms associated with analogue research. The participants in the study were potential clients, but not actual clients and were assessing a potential therapist, but not one from whom they might actually receive services. The study did not gather information about the study participants and their experiences with counseling or attitude towards counseling. So it is likely that the participants in this study differ from those individuals who are actively seeking a therapist. Thus, generalizability to a clinical population is in question.

Pregnant Confederates

The pregnant confederates utilized in the study were not pregnant, and instead wore a prosthesis. Although the manipulation check indicated that the confederates did appear pregnant, there may be something about actual pregnancy that affects how pregnant women are perceived. The confederates' photographs also appeared in a simulated online advertisement. In order to make the pregnancy salient full torso photographs were taken of confederates and placed in the simulated online advertisement. This differs from most online advertisements which often only show a "head shot".

Cross Cultural Relevance

The two "simulated" therapists utilized in this study were each Euro-American. In future research, it would be beneficial to have a more diverse representation of therapists.

Measures

There are several study limitations associated with the psychometrics of the measures utilized. The Willingness to See a Counselor scale was developed by this researcher and as such there is not literature outlining validity and reliability. However, it was determined to be the only method of capturing willingness to return to therapy with a pregnant counselor. The Counselor Reactions Inventory has very limited use in research. However, it has moderate reliability and has demonstrated convergent and divergent validity (Helms, 1976). Additionally, it places a greater emphasis on personal reactions to the counselor than other counselor rating measures (Helms, 1976). Finally, the Counselor Rating Form has been criticized for having client responses that are heavily influenced by the "good person" or "cooperative subject" response bias (Bergin, 1971). Furthermore, there is some question as to whether the three scales of the CRF (expertness, trustworthiness, attractiveness) are unidimensional or if they represent

three meaningful dimensions as predicted by social influence theory. Despite these critiques, the CRF is one of the most frequently utilized counselor rating instruments (Ponterotto, 1985). It has been utilized in numerous studies examining therapist physical characteristics and in a study of pregnant therapists in which separate analysis of the scales proved meaningful (Stockman, 1994).

Statistical Testing

Participant data did not meet the assumption of normality. Testing was carried out despite this violation based on research indicating that ANOVA's and t-tests are considered robust to deviations in normality (Maxwell & Delaney, 2004). Research regarding Type I error has shown that the false positive rate is not affected significantly by this violation (Aguinis et al., 2013; Schmider et al., 2010).

Implications

Although the results of this study were not statistically significant, the quasi-qualitative component of this analysis does offer some implications regarding how therapists may want to proceed with new clients if they are in the final stages of pregnancy. For example, maternity leave seems to be an important topic for those possibly seeking therapy with a pregnant therapist. It will be important for the pregnant therapist to address this issue along with the apprehension it might produce at the outset of therapy. Generally speaking, a potential client may not openly discuss their response to a visibly pregnant therapist and may require more open-ended inquiry, as in this study, to determine their reactions and the influence that they might have on the therapeutic process. Pregnant therapists also need to be attentive to the manner in which their pregnancy highlights the reproductive history of potential clients and attentive to the possibility

that it could conjure stereotypes which may influence therapy. Finally, the quantitative results of this study may be viewed in a positive manner, as pregnant therapists and their non-pregnant counterparts were perceived similarly within the context of this study.

Future Research

Generally speaking, more empirical research is needed in the area of therapist pregnancy. Specifically, research that speaks to direct client reactions would add to the literature in a substantial way. Prospective studies, which examine client perceptions over time, would likely prove particularly enlightening, as pregnancy is a process rather than a distinct event. Studies that examine therapy events distinct to pregnancy, such as maternity leave and pregnancy disclosure, would be beneficial. Additionally studies, which involve actual therapy clients and actual pregnant therapists, may more fully capture the influence of pregnancy on the therapist/client relationship.

Additional theoretical approaches would also add to the pregnant therapist literature in a substantial way. The current literature is based in psychoanalytic/psychodynamic theories, where the analyst/therapist is much more anonymous and client reactions are labeled as transference. However this is not true of all therapy traditions, which differ in their view of the client therapist relationship (e.g., Adlerian theory) as well as the level of importance that the client-therapist relationship plays in the therapy (e.g., solution focused therapy; Hartwell-Walker, 2016). Future research could include a focus on how other theoretical traditions conceptualize therapist pregnancy and how these conceptualizations influence clients' perceptions and treatment outcomes.

Another area lacking attention in the pregnant therapist literature are the perspectives of colleagues and supervisors. Although the literature suggests that colleague responses may be

similar to client responses, there is no research addressing this assertion (Dyson & King, 2008). Relatedly, the supervisor's response to the pregnant therapist is largely missing in the literature although supervision is frequently encouraged to address issues of countertransference (Gerber, 2005; Imber, 1995). Future research could address therapist pregnancy from these perspectives as they offer a glimpse into the working environment of the pregnant therapist.

Perhaps the most glaring omission in the pregnant therapist literature is its lack of diversity. Race and/or ethnic background are rarely, if ever discussed in the literature. There is also an implicit assumption that the therapists discussed in the literature are heterosexual and having children via "traditional" means. Future research needs to address the diversity of pregnant therapists, and the diverse ways in which they may become a parent.

Therapist pregnancy may also be influenced by stereotypes about pregnant women. Although some literature does exist in the area of pregnancy stereotypes, research is limited. Perhaps an understanding of which stereotypes are most salient in our current culture will help in understanding how pregnant therapists are perceived. Future research embracing both the therapist pregnancy literature and the pregnant worker literature may shed some light on underlying mechanisms that influence the perception of pregnant therapists.

Finally, how pregnant therapists are perceived may be largely based on the settings in which they work, their duties, and the type of clients that they treat. Research indicates that more "masculine" work settings (Hebl, 2007; Morgan, 2013) as well as more "masculine" work behaviors (Corse, 1990) may influence the manner in which pregnant workers are perceived. Additionally, research indicates that individuals diagnosed with certain mental health disorders may find it more challenging to work with a pregnant therapist (Balsam & Balsam, 1974;

Brouwers, 1989; Fenster et al., 1986). Future research needs to address the role that setting, job responsibilities, and mental health diagnoses play in the perception of pregnant therapists.

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Appendix A

Willingness to See the Counselor Scale

Please read the following statements and mark the answer that best shows how you feel about Dr. Jones.

1. I would be willing to see Dr. Jones for therapy in the future.

◯ Strongly Disagree

◯ Disagree

◯ Undecided

◯ Agree

◯ Strongly Agree

2. I would be willing to recommend Dr. Jones to a close friend or family member.

◯ Strongly Disagree

◯ Disagree

◯ Undecided

◯ Agree

◯ Strongly Agree

Appendix B

Demographic Questionnaire

Please answer the following questions

1.What is your age?

2. How do you describe yourself?

- ◯ American Indian or Alaskan Native
- ◯ Asian or Asian American
- ◯ Black or African American
- ◯ Hispanic or Latino
- ◯ Native Hawaiian or Pacific Islander
- ◯ White
- ◯ Multicultural:
- ◯ Other:

3.What is your gender?

- ◯ Male
- ◯ Female
- ◯ I do not identify with a specific gender

4. What is your highest level of education completed?

- ◯ Less than high school
- ◯ High school diploma (GED)
- ◯ Associates Degree
- ◯ Bachelor's Degree
- ◯ Master's Degree

◯ Doctoral Degree

5. What is your current employment status?

◯ Employed for wages

◯ Self-employed

◯ Out of work and looking

◯ Out of work and not looking

◯ Homemaker

◯ Student

◯ Military

◯ Retired

◯ Other:

6. Which of the following best describes your current relationship status? (you may select more than one answer)

◯ Married

◯ Divorced

◯ Widowed

◯ Separated

◯ Never been married

◯ A member of a committed couple

7. How many children do you have?

◯ None

◯ One

◯ Two

◯ Three

◯ Four

◯ Five or more

8. Which of the following best describes you?

◯ Heterosexual (Straight)

◯ Gay or Lesbian

◯ Bisexual

◯ Don’t know/unsure

◯ Other (please explain):

9. If female, have you ever been pregnant?

◯ Yes

◯ No

◯ Unsure

10. Do you have an eating disorder?

◯ Yes

◯ No

◯ Unsure

11. Are you and /or you and your partner trying to become pregnant and having difficulty doing so?

◯ Yes

◯ No

◯ Unsure

12. If you were interested in seeking therapy would you have any concerns about seeing a pregnant therapist?

◯ Yes

◯ No

◯ Explain:

13. Did the images of Dr. Jones download for you to see them clearly?

◯ Yes

◯ No

14. Was Dr. Jones pregnant?

◯ Yes

◯ No

Appendix C

Information Letter

INFORMATION LETTER (MAIN STUDY)

Information Letter

Special Education, Rehabilitation and Counseling, 2084 Haley Center, Auburn, AL 36849, (334) 844-7676 phone, (334) 844-7677 fax, serc@auburn.edu

(NOTE: DO NOT AGREE TO PARTICIPATE UNLESS IRB APPROVAL INFORMATION WITH CURRENT DATES HAS BEEN ADDED TO THIS DOCUMENT)

INFORMATION LETTER
for a Research Study entitled
"The Perception of Therapists' On-line Advertisements"

You are invited to participate in a research study focusing on perceptions of information provided by therapists in their on-line advertisements. The study is being conducted by Eddrina R. Miller, MSW under the direction of Randolph B. Pipes, Ph.D. in the Auburn University Department of Special Education, Rehabilitation, and Counseling. You were selected as a possible participant because you live in the United States and are age 18 or older.

What will be involved if you participate? Your participation is completely voluntary. If you decide to participate in this research study, you will review a web advertisement for a psychotherapist, read two short therapy transcripts, and answer questions regarding what you have read. Your total time commitment will be approximately 20 to 25 minutes.

Are there any risks or discomforts? The risks associated with participating in this study are minimal and likely restricted to any possible emotional discomfort, which arises when exposed to vignettes involving a therapist and her patient. The therapy which is depicted does not involve clients with serious emotional problems. We do not anticipate that you will experience significant distress; however, should you feel significant distress, it is recommended that you seek out a local mental health center, private mental health provider, or university counseling center where appropriate.

Are there any benefits to yourself or others? You will not receive any direct benefits for participation.

Will you receive compensation for participating? To thank you for your time, you will be offered compensation based on your agreement with the survey company which recruited you for this study (Qualtrics).

If you change your mind about participating, you can withdraw at any time by closing your browser window. Once you've closed your browser window, your data will not be submitted and any answers you have provided to that point will be automatically deleted. Because we are not asking for information which would identify you, your data is anonymous and once you have submitted anonymous data it cannot be withdrawn since it will be unidentifiable. Your decision about whether or not to participate or to stop participating will not jeopardize your future relations with Auburn University, the Department of Special Education, Rehabilitation and Counseling, Randolph Pipes, Ph.D., or Eddrina R. Miller, MSW.

Any data obtained in connection with this study will remain anonymous. We will protect your privacy by collecting no identifiable information. Information collected through your participation may be used to fulfill an educational requirement, published in a professional journal, and/or presented at a professional meeting, etc.

If you have questions about this study, please contact Eddrina R. Miller, MSW at erm0006@auburn.edu or Randolph Pipes, Ph.D. at pipesrb@auburn.edu.

If you have questions about your rights as a research participant, you may contact the Auburn University Office of Human Subjects Research or the Institutional Review Board by phone (334) 844-5966 or e-mail at hsubjec@auburn.edu or IRBChair@auburn.edu.

HAVING READ THE INFORMATION ABOVE, YOU MUST DECIDE IF YOU WANT TO PARTICIPATE IN THIS RESEARCH PROJECT. IF YOU DECIDE TO PARTICIPATE, PLEASE PROCEED.

Eddrina R. Miller, MSW TBA

November 20, 2017

The Auburn University Institutional Review Board has approved this document for use from TBA to TBA. Protocol # 17-428-EX1711.

By entering the survey, you acknowledge that you have read this information and agree to participate with the knowledge that you are free to withdraw your participation at any time without penalty.

- o I agree
- o I do not agree

Appendix D

Debriefing Statement

Thank you for participating in this study. We know that you are busy and appreciate the time that you devoted to participating in the study.

There was some information about the study that we were not able to discuss with you prior to the study, because doing so probably would have impacted your actions and thus potentially invalidated the study results. I would like to explain these things to you now:

You were told that we were studying the perception of therapists' online advertisements; however, in reality, the purpose was to study the perception of pregnant therapists. Some participants were shown a picture of a therapist who appeared to be pregnant and other participants were shown a picture of a therapist who did not appear to be pregnant. We used a prosthesis to make the woman appear to be pregnant, even though she was not. The therapy transcripts were provided to make the study seem more real. In fact, the transcripts were fictitious even though we hoped that participants would think of them as real. These various pieces of information were withheld during the study so as not to directly influence your ratings of the therapist featured in the study. Based on prior research we expect to find that non-pregnant therapists are viewed more favorably in certain areas (e.g.,, expertness) than their pregnant counterparts. We hope this clarifies the purpose of the research and the reason why information was withheld.

It is very important that you do not discuss this study with anyone else until the study is complete. Our efforts will be greatly compromised if participants come into this study knowing what it is about and how the ideas are being tested. If you have any questions or concerns you may contact Eddrina R. Miller. MSW at erm0006@auburn.edu or Randolph Pipes, PhD, at pipesrb@auburn.edu. Thank you again for your participation!

Appendix E

Stimulus Photographs and Stimulus Online Advertisement Pregnant

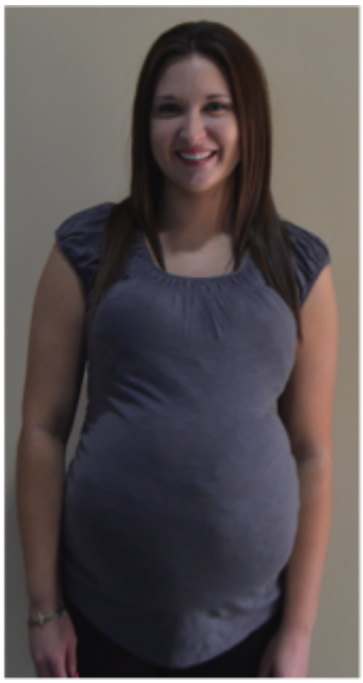
A Few Things About Me and My Approach to Helping

My name is Dr. Jones and I am a licensed psychologist with a PhD in psychology. I am 38 years old, and have been counseling for the past 10 years. I enjoy gardening, hiking, and spending time with my family. I am currently pregnant with my first child.

I have experience in both individual as well as group therapy, and my approach to counseling is client-centered—that is, I let the client guide the session. Basically, that means I trust the client to present and discuss his or her concerns and allow the client to decide what he or she feels is most important to talk about

More Information About My Practice

During the first session I like to gather relevant demographic information (e.g.,, psychological and treatment history, presenting concerns, etc.). I let the client know about my approach to counseling. I also encourage the client to let me know who he or she is, what he or she feels is important, and I seek to address any questions/concerns he or she may have.



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Appendix F

Stimulus Photographs and Stimulus Online Advertisement Not Pregnant

A Few Things About Me and My Approach to Helping

My name is Dr. Jones and I am a licensed psychologist with a PhD in psychology. I am 38 years old, and have been counseling for the past 10 years. I enjoy gardening, hiking, and spending time with my family.

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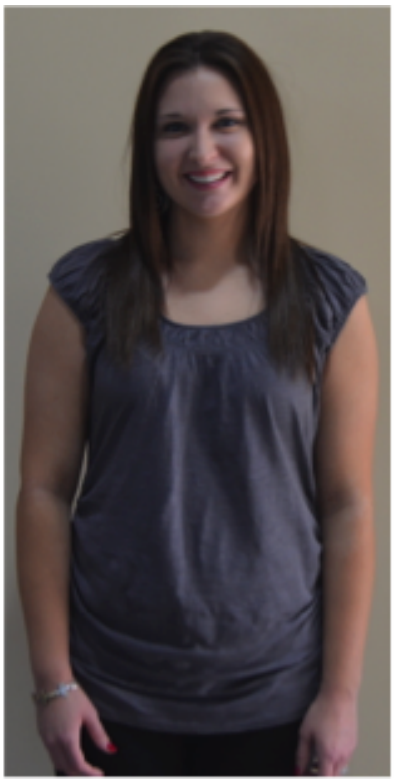

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Appendix G

Stimulus Therapy Transcripts

Stimulus Therapy Transcript 1

To give you a better idea of Dr. Jones' work, she has provided two brief therapy transcripts which represent her therapeutic style. Please read the following therapy transcripts carefully. The clients have given permission for the use of their therapy session transcripts and there is no identifying information so confidentiality has been assured.

Client 1: Mr. Q* is a 36-year-old man seeking treatment for depression and alcoholism.

This is his 6th session with Dr. Jones

Dr. Jones: Where would you like to start today?

Mr. Q : I really have been struggling. I have been sober for almost two years and I feel like I have dealt with my addiction. I know I will always have to deal with it…but today I've been dealing with a lot of depression.

Dr. Jones: What does that look like in your life…the depression?

Mr. Q: It takes me almost an hour to get out of bed and I just feel so tired. I have no motivation…I am supposed to be looking for a job but I can't even do that…

Dr. Jones: It sounds like you have been having a really hard time lately…where do you think the depression is coming from?

Mr. Q: It's always been there to some degree, but it's gotten worse since I lost my job a few months ago. I hated that job, but at least it was something…at least I had a reason to get up.

Dr. Jones: What comes to my mind immediately is the word purpose.

Mr. Q: Right…I have no purpose…I have nothing going on right now…(puts head down)….

Dr. Jones: What would you like your life to look like right now?

Mr. Q: I want to work…I want to contribute….I want money in my bank…I want to do the things I love….

Dr. Jones: What are those things you love?

Mr. Q: Working with my hands…building, carpentry, painting…I love all that stuff…I used to teach a carpentry class at the local community college (smiles)…my students thought I was great.

Dr. Jones: You really lit up when you mentioned your work at the community college.

Mr. Q: It was the best time in my life and the worse…I was on top of the world…then my mom got sick and I started drinking…and I just couldn't hold it together…the college asked me to leave…I was so embarrassed...(tears up)….

Dr. Jones: Tell me what is going on inside you right now.

Mr. Q: (Silent tears) I am so scared…scared to mess up….

Dr. Jones: (softly) because what will happen if you mess up?

Mr. Q: I'll start drinking again and embarrassing myself and I just can't handle that.

Dr. Jones: Whoa…that sounds like a lot of pressure and like you are selling yourself short…

Mr. Q: There is so much pressure….

Dr. Jones: What is the cost of not allowing yourself to be human?

Mr. Q: What do you mean?

Dr. Jones: You can't mess up. You said it yourself. You can't mess up because you can't deal with the outcome. So what's the cost?

Mr. Q: I keep to myself so I don't have the opportunity to mess up…

Dr. Jones: So it seems to me that by trying to avoid messing up you've created a situation where it's very likely that you will mess up.

***Name changed to ensure confidentiality**

Stimulus Therapy Transcript 2

To give you a better idea of Dr. Jones' work, she has provided two brief therapy transcripts which represent her therapeutic style. Please read the following therapy transcripts carefully. The clients have given permission for the use of their therapy session transcripts and there is no identifying information so confidentiality has been assured.

Client 2: Mrs. K * is a 30-year-old woman seeking treatment for depression and low self-esteem. This is her 8th session with Dr. Jones.

Dr. Jones: Let's start with our usual breathing exercise today. A way to get quiet inside so that we can begin our work together. (Dr. Jones and Mrs. Smith sit quietly and practice deep breathing)

Dr. Jones: How was that today?

Mrs. K: It was weird?

Dr. Jones: What was weird about it today?

Mrs. K: I guess I mean hard…It's like someone once asked me "what do you do during your free time?" (Dr. Jones: Mhm) and I am thinking what free time? There never is any quiet.

Dr. Jones: Inside it's fairly noisy

Mrs. K: Yes exactly…It's like I can't turn myself off…I have so many things on my mind

Dr. Jones: Is there a common theme among these things you have on your mind

Mrs. K: (laughs) Yeah…survival

Dr. Jones: Survival…say more about that…

Mrs. K: Survival is being productive in the world…and not just getting by…not failing…being successful I guess

Dr. Jones: Those sound like instructions…be productive…don't fail…be successful

Mrs. K: Yeah they are…but nobody said I had to be that way…I remember back even as a kid wanting to win at everything…always wanting my parents to be proud…but nobody said I had to be the best at everything

Dr. Jones: Except inside…you feel that?

Mrs. K: Yes…I guess I have been thinking about it more lately…I took my son to the dentist and he had a cavity and I was so upset…felt like a failure…I am supposed to make sure that things like that don't happen…I am his mother….all of this because of a cavity…had a million when I was a kid…

Dr. Jones: So you blame yourself?

Mrs. K: Yes…I am supposed to stay on him about those things…

Dr. Jones: And do you?

Mrs. K: Yes I do all the time…I make him brush at least three times a day…(laughs) he says that I harass him

Dr. Jones: What strikes me is how ready you are to find fault with yourself…to blame yourself.

Mrs. K: Yeah I do that

Dr. Jones: Is this a pattern in your life?

Mrs. K: I guess…I try to focus on the good things about me too…but I guess I just like to point out the bad one's before anybody else can…So I can get ready…

Dr. Jones: What are you preparing yourself for?

Mrs. K: I know it's stupid….

Dr. Jones: Even now you find fault with yourself and label yourself "stupid".

Mrs. K: Yeah, yeah I did do that…

***Name changed to ensure confidentiality**