

# THE INFLUENCE OF AN ALASKA NATIVE ACCENT AND REPUTATION ON PERCEIVED THERAPIST CREDIBILITY

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*Abstract: In this study, we examined the influence of an Alaska Native (AN) accent and reputation on perceived therapist credibility after controlling for universal-diverse orientation. Participants listened to and rated therapist audio recordings that differed in AN accent (strong, minimal) and reputational cues (expert, recent graduate, student). While credibility ratings of the accent conditions did not differ in the expert and recent graduate scenarios, the graduate student therapist was seen as less attractive and useful when she spoke with a strong accent.*

In recent years there has been an increased interest in studying the role of the therapist in producing client change (Baldwin & Imel, 2011; Miller, Hubble, Chow, & Seidel, 2013; Okiishi, Lambert, Nielsen, & Ogles, 2003). A number of studies have documented that client outcomes frequently differ from one therapist to the next, even when the therapists use identical treatments (Crits-Christoph & Mintz, 1991; Laska, Smith, Wislocki, Minami, & Wampold, 2013; Wampold & Brown, 2005). Although therapist effects have been well documented in the research, less is known about the exact therapist characteristics that are thought to play a role in client change. One therapist variable hypothesized to play an important role in psychotherapy outcomes is client perception of therapist credibility, which can be defined as the client's opinion about the therapist's expertise, trustworthiness, and attractiveness (friendliness, approachability, and likeability; Hoyt, 1996). In 1968, Strong argued that a therapist's ability to influence change in a client is dependent, at least in part, on how credible the client perceives him or her to be. According to Strong (1968), if a therapist is seen as credible, then he or she will have greater power to persuade the client to become involved in psychotherapy, and any efforts or techniques to implement changes in the client's cognitive framework and/or behavior will be maximized.

Over the past half century, a body of research has found support for Strong's (1968) claim of therapist credibility being associated with treatment outcomes. For example, in one meta-analysis, Hoyt (1996) found that perceived therapist credibility was significantly related to client satisfaction with therapy ( $d = 1.33$ ), and to both attitude ( $d = 0.69$ ) and behavior change ( $d = 0.41$ ). In a more recent study, Goates-Jones and Hill (2008) found that perceptions of therapist credibility explained 58% of the variance in client-rated outcomes, 25% of the variance in therapist-rated outcomes, and 22% of the variance in target problem change after a single session of therapy. In another recent study conducted across 18 different psychotherapy centers, Yuar and Chen (2011) found that client perceptions of therapist credibility significantly predicted the development of a working alliance after two sessions of psychotherapy.

Given the important role that perceptions of therapist credibility play in the development of the therapeutic alliance and overall treatment outcomes, it is important to gain a better understanding of the variables that have been found to predict and influence this type of perception. In one review of the topic, Hoyt (1996) identified five types of cues that predict perceptions of therapist credibility: reputational cues (e.g., prestigious title, introduction as an expert), therapist characteristics (e.g., age, physical attractiveness, attire), verbal cues (e.g., use of psychological terminology, type of interventions used), nonverbal cues (e.g., eye contact, attentiveness), and therapist-client match (e.g., same ethnicity, same gender). Based on data from 136 studies, Hoyt found evidence linking each of these types of cues to perceived therapist credibility, with effect sizes ranging from  $d = .24$  for therapist characteristics to  $d = 1.59$  for combinations of verbal and nonverbal cues.

For the purpose of this study, we were interested in the role of one particular therapist characteristic (accent), reputational cues, and their interaction on perceptions of therapist credibility.

### **Therapist Culture, Accent, and Perceived Credibility**

In addition to the cues that are thought to influence perceptions of therapist credibility, race/ethnicity and culturally relevant therapist variables can also influence client preferences. Research indicates that there is no universally preferred therapist race/ethnicity or culture; rather, clients prefer a racial/ethnic match (Cabral & Smith, 2011). That is, Hispanic/Latino(a) American clients tend to want a Hispanic/Latino(a) therapist, White/European American clients tend to prefer a White/European American therapist, and so on. However, research has also indicated that the strength of this preference is less than the strength of preferences for other important culturally relevant therapist variables (Swift, Callahan, Tompkins, Connor, & Dunn, 2014). Further research is needed to examine the relationship of various culturally relevant therapist variables to client opinions of the therapist.

A therapist's accent is one cultural variable that may influence client perceptions of therapist credibility. Broadly speaking, the influence of accent on perceptions and evaluations of an individual's credibility/competence has been studied in a number of contexts. In most of these studies, participants listened to an audio recording or observed a video in which the individual being evaluated either speaks with a standard (that which is heard in the speech of the majority of individuals in the area) or a nonstandard (that which is heard in the speech of the minority of individuals in the region) accent. (It should be noted that the definition of standard and nonstandard accent depends on the context—although an individual may be considered as having a standard accent in one region of the country or world, that individual may be considered as speaking with a nonstandard accent in another area of the country or world.) A recent meta-analysis (Fuertes, Gottdiener, Martin, Gilbert, & Giles, 2012) that included data from 20 studies found that, across contexts, speakers with standard accents were rated overall more positively than speakers with nonstandard accents ( $d = 0.82$ ). Specifically, standard accent speakers were rated higher in terms of status ( $d = 0.99$ ), including perceptions of the speaker's intelligence, competence, and education; solidarity ( $d = 0.52$ ), including evaluations of the speaker's similarity to the listener, attractiveness, and trustworthiness; and dynamism ( $d = 0.86$ ), including perceptions of the speaker's energy, activity level, and liveliness.

The results of this meta-analysis suggest that a therapist with a nonstandard accent would be rated as less credible when compared with a therapist with a standard accent. However, to our knowledge, only one empirical study has been published testing whether accent actually does influence perceptions of therapist credibility. Fuertes and Gelso (2000) had 212 university students from the Northeast U.S. watch a 2-minute non-audio video recording of a therapist-client interaction while listening to an audio recording of the therapist describing himself and his approach to treatment. Half of the participants heard the message from a therapist with a strong Spanish accent while the other half heard the same message, but with a standard accent. They then asked the participants to rate the therapist's credibility and their willingness to seek treatment from the therapist. Although credibility ratings did not differ depending on accent, participants did indicate a stronger willingness to seek therapy from the therapist with the standard accent. But these results represent only one setting and one type of accent (Spanish). Additionally, other variables, such as reputational cues, may interact with the influence accent has on perceived therapist credibility.

### **Therapist Reputation and Perceived Credibility**

In contrast to the little research that has been conducted examining therapist accent, the influence of reputational cues on perceived therapist credibility has been studied extensively in the literature. Reputational cues refer to indications of a therapist's status, such as awards, degrees, or being introduced as an authority/expert. Studies examining reputational cues are often similar

to studies of accent—typically, participants are asked to read, listen to, or watch two identical therapists who differ only in the level of reputation with which they are described. For example, in one of the earliest studies of the topic, Greenberg (1969) randomized 112 undergraduate students to listen to an audio recording of a therapist who was described as being either very experienced or a student. Greenberg found that the experienced therapist was seen as significantly more attractive and receptive than the inexperienced one. Although not all of the more recent studies have found an association between reputational cues and perceived therapist credibility, the majority have found significant results indicating that experienced therapists are perceived as being more credible than less experienced ones (Conoley & Bonner, 1991; Littrell, Caffrey, & Hopper, 1987; Miller, 1993). Pooling together both the positive and negative results from this body of research, in the previously mentioned meta-analysis, Hoyt (1996) found a significant relationship between these two variables with a medium-sized effect in favor of experienced therapists ( $d = 0.51$ ).

### **Role of Universal-Diverse Orientation**

Universal-diverse orientation refers to an individual's ability to both recognize and accept similarities and differences in people who are different from oneself (Miville et al., 1999). An individual with a higher level of universal-diverse orientation is interested in other cultures and seeks opportunities to engage in culturally diverse activities. Applied to the current study, it could be hypothesized that, regardless of reputational cues, individuals who are high in universal-diverse orientation would be more accepting of therapists who belong to a different cultural group or who speak with a nonstandard accent. In fact, Fuentes and Gelso (2000) did find that, while participants with low universal-diverse orientation rated therapists with a nonstandard accent as less credible than therapists with a standard accent, individuals with high universal-diverse orientation rated therapists with a nonstandard accent as slightly more credible than those with a standard accent.

### **Aims of the Current Study**

In summary, the small amount of existing research suggests that therapists who speak with a nonstandard accent may be viewed as being less credible than therapists who speak with a standard accent. However, research has yet to be conducted examining the interaction of accent and reputational cues on perception of therapist credibility. It is possible that accent plays a significant role in perception of credibility when a therapist has little to no reputation, but when a therapist is an expert or has a prestigious degree, accent is less important. Also, in testing for a possible interaction between accent and reputational cues and its effect on perception of therapist credibility, it is important to recognize the potential role of the rater's universal-diverse orientation.

In this study, we were interested in examining whether participants, after controlling for their level of universal-diverse orientation, would rate an Alaska Native (AN) therapist's credibility differently depending on whether she spoke with a strong AN accent. AN is a term that is used to describe the indigenous peoples that have lived and thrived in present state of Alaska (Roderick, 2009). Within this region, there are many distinct AN cultures (e.g., Athabascan, Haida, Tsimpshian) with unique languages, arts, and spirituality (Roderick, 2009). According to the U.S. Census Bureau (Norris, Vines, & Hoeffel, 2014), American Indians and ANs make up 1.2% of the national population, but 14.7% of the population of Alaska. Although many in the Alaska region today hold an attitude of respect for AN cultures, ANs historically have experienced oppression in the region, and some subtle and not-so-subtle forms of marginalization and discrimination can still be seen today (Alaska Advisory Committee to the U.S. Commission on Civil Rights, 2002; Deacon, 2011).

For this study we hypothesized that participants would rate the therapist and her treatment approach lower in credibility when a strong AN accent was used. This hypothesis matches research indicating that individuals who speak with a non-standard accent are frequently viewed less favorably than speakers with standard accents (Fuertes et al., 2012) ANs sometimes still experience marginalization and discrimination in our current society (Alaska Advisory Committee to the U.S. Commission on Civil Rights, 2002; Deacon, 2011). However, we hypothesized that the influence of accent, after controlling for universal-diverse orientation, would be moderated by reputational cues, such that credibility ratings would not differ between strong- and minimal-accent conditions when the therapist was described as being very experienced and well known, but would be significantly different when the therapist was described as having little experience. The results of this study could have important clinical implications, particularly for therapists who speak with a nonstandard accent.

## METHOD

### Participants

Participants in this study were 120 students currently enrolled in a large Northwestern university. Participants were on average 23.86 years old,  $SD = 7.20$ , ranging from 18 to 56 years. They were primarily female (78.3%), single (78.3%), and Caucasian (70.8%). Other ethnicities/cultural groups included in this sample were Asian or Asian American (8.33%), American Indian or AN (5.8%), African American (5%), Hispanic (5%), and bi-/multiracial (5%). Participants were primarily undergraduate students (30% first-year undergraduates, 22.5% sophomores, 20% juniors, 22.5% seniors), with an additional 5% being graduate students. While only 12.5% of the sample was receiving psychotherapy services at the time of study participation, 39.2% had previous therapy experience.

## Procedures

This study was advertised on the psychology department's online subject portal. From the subject portal, participants could click on the study link, and go directly to the online study, which they could complete on their own time from their personal computers. The informed consent page explained that participants would be asked to listen to an audio recording of a therapist and then provide their opinions of that therapist. Those who agreed to participate were first asked to complete a set of demographic questions. Participants were asked to imagine that they were experiencing a significant amount of psychological distress and were considering seeking help from a mental/behavioral health professional. Then they were instructed to listen to an audio recording of a therapist describing herself and her approach to therapy. After listening to the audio recording, participants were asked to complete measures assessing opinions of the credibility of the therapist. Last, to avoid social desirability bias related to questions about multicultural beliefs, participants completed a measure of their personal universal-diverse orientation. In total, the survey took about 30 minutes to complete. As compensation, participants could receive credit in participating psychology department courses; the amount of credit was determined by individual course instructors. This study was approved by and conducted in compliance with the University of Alaska Anchorage Institutional Review Board.

### **Audio Recordings/Experimental Conditions**

In this factorial design, each participant was randomly assigned to one of six conditions. Each condition was presented with a brief text describing the therapist as a 35-year-old AN and a 5-minute audio recording of the therapist describing herself and her approach to therapy. All aspects of the conditions were held constant (therapist demographics and treatment approach) except for the description of the therapist's reputation (low, medium, and high) and the level of AN accent (strong or minimal) that she used in the audio recording. In the low-reputation condition, the therapist was described as a first-year student in a doctoral program. In the medium-reputation condition, the therapist was described as a recent graduate from a doctoral program who is excited to get her private practice up and running. In the high-reputation condition, the therapist was described as a practitioner in the field for the past 7 years since graduating from a doctoral program. She also was described as being well known in the community for her clinical work, having a very successful private practice, and having recently received a national award. A Tanaina Athabascan and Aleut woman raised in a rural village in Southwest Alaska and currently living in an urban area was the voice for all of the audio recordings, reading the script with minimal to no AN accent three times (one for each reputation scenario) and with a strong AN accent three times. As a manipulation check, two independent coders listened to each audio recording and rated the level of accent as either "no

to minimal accent” or “strong accent.” There was complete agreement between the coders ( $\kappa = 1.00$ ,  $p < .05$ ), matching the respective conditions. Rather than describe AN accents and risk perpetuating stereotypes, we have made available general audio recordings of speakers with AN accents, which can be found in the International Dialects of English Archive ([www.dialectsarchive.com](http://www.dialectsarchive.com)). Examples of the specific audio recordings used in this study can be found at [www.psychotherapyresearchlab.com](http://www.psychotherapyresearchlab.com).

## Measures

### **Counselor Effectiveness Rating Scale (CERS)**

The CERS was developed by Atkinson and Carskaddon (1975) as a measure of perceived therapist credibility. It includes three subscales (expertness, trustworthiness, and attractiveness) and one item measuring utility (“This therapist is someone I would see for psychotherapy”). Each subscale includes three items rated on a 7-point scale ranging from 1 (*bad*) to 7 (*good*); thus, total scores on each subscale range from 3 to 21. Items from the expertness subscale include ratings of the therapist’s perceived expertness, competence, and skill. Items from the trustworthiness subscale include ratings of the therapist’s perceived sincerity, reliability, and trustworthiness. Last, items from the attractiveness subscale include ratings of the therapist’s friendliness, approachability, and likeability. The utility item is also rated on a 7-point scale ranging from 1 (*no*) to 7 (*yes*). Adequate psychometric properties for the CERS have been reported. According to Atkinson and Wampold (1982), internal consistencies for the subscales range from .76 (trustworthiness) to .88 (expertness). With our sample of participants, we found an internal consistency of .95 for the expertness subscale, .87 for the trustworthiness subscale, and .95 for the attractiveness subscale. Although the CERS was developed almost four decades ago, it is still commonly used to measure perceptions of therapist credibility.

### **Miville-Guzman Universality-Diversity Scale Short Form (M-GUDS-S)**

The M-GUDS-S was developed by Fuertes, Miville, Mohr, Sedlacek, and Gretchen (2000) as a brief self-report measure of an individual’s universal-diverse orientation. Based on results from an exploratory factor analysis of the full-length Miville-Guzman Universality-Diversity Scale (Miville et al., 1999), Fuertes et al. (2000) created the M-GUDS-S by selecting five items from each of three domains (Diversity of Contact, Relativistic Appreciation, and Comfort with Differences) that had the highest structure coefficients. Diversity of Contact represents interest and participation in activities from multiple cultures. Relativistic Appreciation represents a recognition of the learning and growth that can come from engaging with persons who are different from oneself. Comfort with Differences represents the ease at which an individual finds himself or herself when spending time with someone from a different cultural background. Each of the items on the M-GUDS-S are

rated on a 6-point Likert-type scale ranging from 1 (*strongly disagree*) to 6 (*strongly agree*), and the summed total score ranges from 15 to 90, with higher scores representing a higher level of universal-diverse orientation. Adequate psychometric properties for the M-GUDS-S also have been reported. For example, Fuertes et al. (2000) found an internal consistency of .82 for Diversity of Contact, .59 for Relativistic Appreciation, .92 for Comfort with Differences, and .77 for the total score. With our sample, we found internal consistencies of .75 for Diversity of Contact, .72 for Relativistic Appreciation, .81 for Comfort with Differences, and .74 for the total score.

### RESULTS

In this study, we sought to test the influence of therapist’ accent (strong vs. slight), reputation (high, medium, low), and their interaction on participants’ perceptions of a therapist’s credibility after controlling for participants’ level of universal-diverse orientation. Adjusted (based on M-GUDS-S as a covariate) group means and standard errors of the expertness, trustworthiness, attractiveness, and utility subscales of the CERS can be found in Table 1. The adjusted group means were compared through four 2 x 3 ANCOVAs—one for each of the CERS subscales. First, we had hypothesized that, when the therapist spoke with a strong accent, she would be rated as less credible across reputational conditions. Contrary to this hypothesis, the accent main effect was not significant for any of the CERS subscales: expertness,  $F(1, 112) = 0.01, p > .05, \eta^2_{\text{partial}} = .00$ , trustworthiness,  $F(1, 112) = 0.42, p > .05, \eta^2_{\text{partial}} = .00$ , attractiveness,  $F(1, 112) = 0.07, p > .05, \eta^2_{\text{partial}} = .00$ , nor utility,  $F(1, 112) = 1.90, p > .05, \eta^2_{\text{partial}} = .02$ . These results indicate that, across scenarios, our participants found the AN therapist to be similarly credible regardless of whether she spoke with a strong or minimal accent.

**Table 1**  
**Adjusted Group Means, Standard Errors<sup>a</sup>, and Sample Sizes for the Four Subscales of the Counselor Effectiveness Rating Scale (CERS) for the Reputation and Accent Conditions**

	Graduate Student	Recent Graduate	Expert	Total
<b>Expertness</b>				
Strong accent	14.48 (0.89); <i>n</i> = 18	15.36 (0.86); <i>n</i> = 19	16.58 (0.92); <i>n</i> = 17	15.47 (0.51); <i>n</i> = 54
Minimal accent	15.70 (0.89); <i>n</i> = 18	14.25 (0.82); <i>n</i> = 21	16.64 (0.74); <i>n</i> = 26	15.53 (0.47); <i>n</i> = 65
Total	15.09 (0.63); <i>n</i> = 36	14.81 (0.60); <i>n</i> = 40	16.61 (0.59); <i>n</i> = 43	
<b>Trustworthiness</b>				
Strong accent	15.81 (0.85); <i>n</i> = 18	17.05 (0.88); <i>n</i> = 19	17.14 (0.88); <i>n</i> = 17	16.67 (0.49); <i>n</i> = 54
Minimal accent	17.38 (0.85); <i>n</i> = 18	14.97 (0.79); <i>n</i> = 21	16.34 (0.71); <i>n</i> = 26	16.23 (0.45); <i>n</i> = 65
Total	16.59 (0.60); <i>n</i> = 36	16.01 (0.57); <i>n</i> = 40	16.74 (0.56); <i>n</i> = 43	

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**Table 1, Continued**  
**Adjusted Group Means, Standard Errors\*, and Sample Sizes for the Four Subscales of the Counselor Effectiveness Rating Scale (CERS) for the Reputation and Accent Conditions**

	Graduate Student	Recent Graduate	Expert	Total
<b>Attractiveness</b>				
Strong accent	14.51 (0.96); <i>n</i> = 18	16.51 (0.93); <i>n</i> = 19	16.73 (0.99); <i>n</i> = 17	15.92 (0.51); <i>n</i> = 54
Minimal accent	17.58 (0.96); <i>n</i> = 18	14.17 (0.89); <i>n</i> = 21	15.40 (0.80); <i>n</i> = 26	15.72 (0.51); <i>n</i> = 65
Total	16.05 (0.68); <i>n</i> = 36	15.34 (0.64); <i>n</i> = 40	16.07 (0.64); <i>n</i> = 43	
<b>Utility</b>				
Strong accent	3.97 (0.40); <i>n</i> = 18	4.53 (0.39); <i>n</i> = 19	4.14 (0.41); <i>n</i> = 17	4.21 (0.23); <i>n</i> = 54
Minimal accent	5.43 (0.40); <i>n</i> = 18	3.98 (0.37); <i>n</i> = 21	4.53 (0.33); <i>n</i> = 26	4.65 (0.21); <i>n</i> = 65
Total	4.70 (0.28); <i>n</i> = 36	4.25 (0.27); <i>n</i> = 40	4.34 (0.27); <i>n</i> = 43	

<sup>a</sup> Standard errors are in parentheses

Second, we had hypothesized that a significant accent by reputation interaction would exist, such that accent would influence credibility ratings to a greater degree when the therapist was a graduate student compared to a recent graduate or an expert in the field. Partial support for this hypothesis was found. Although the interaction between accent and reputation was not significant for ratings of expertness,  $F(1, 112) = 0.91, p > .05, \eta^2_{\text{partial}} = .02$ , or trustworthiness,  $F(1, 112) = 2.48, p > .05, \eta^2_{\text{partial}} = .04$ , it was significant for ratings of attractiveness,  $F(1, 112) = 4.69, p < .05, \eta^2_{\text{partial}} = .08$ , and utility,  $F(1, 112) = 3.35, p < .05, \eta^2_{\text{partial}} = .06$ . As hypothesized, simple effects for attractiveness indicated that, while the level of accent did not result in significant differences when the therapist was described as an expert,  $t(41) = 0.56, p = .58$ , or as a recent graduate,  $t(38) = 1.73, p = .09$ , it did when the therapist was described as a graduate student,  $t(34) = 2.70, p = .01, d = 0.90$ . Specifically, when the therapist was a graduate student she was rated as being less attractive when she had a strong accent. Similarly, simple effects for utility also indicated that, while the level of accent did not result in significant differences when the therapist was described as an expert,  $t(41) = 1.10, p = .28$ , or as a recent graduate,  $t(38) = 0.92, p = .36$ , it did when the therapist was described as a graduate student,  $t(34) = 3.00, p < .01, d = 1.00$ . Again, when the therapist was a graduate student, participants reported that they would be less likely to seek services from her when she had a strong accent.

To control for differences in universal-diverse orientation, scores on the M-GUDS-S were entered as a covariate for all tests. This covariate was not significantly associated with ratings of expertness,  $F(1, 112) = 3.16, p > .05, \eta^2_{\text{partial}} = .03$ , or trustworthiness,  $F(1, 112) = 2.73, p > .05, \eta^2_{\text{partial}} = .02$ ; however, it was significantly related to ratings of attractiveness,  $F(1, 112) = 10.14, p < .01, \eta^2_{\text{partial}} = .08$ , and utility,  $F(1, 112) = 12.07, p < .01, \eta^2_{\text{partial}} = .10$ . Specifically, higher levels of universal-diverse orientation were associated with greater perceived therapist attractiveness ( $r = .28, p < .01$ ) and utility ( $r = .32, p < .001$ ).

It is possible that racial/ethnic groups vary in their perception of a therapist who speaks with an AN accent. Given the small sample size for each of the racial/ethnic minority groups (i.e., the means for some groups were based on scores from one or two participants), we could not conduct analyses for individual minority groups. However, we collapsed scores across the minority groups in order to examine whether differences in response to the AN accent exist, depending on whether the participant belonged to the majority or to a minority racial/ethnic group. Four 2 x 2 ANOVAs were conducted testing for an interaction between racial/ethnic minority status (majority, minority) and accent (strong, minimal). There were no significant interactions for ratings of expertness,  $F(1, 115) = 0.68, p > .05, \eta^2_{\text{partial}} = .01$ , trustworthiness,  $F(1, 115) = 2.45, p > .05, \eta^2_{\text{partial}} = .02$ , or attractiveness,  $F(1, 115) = 2.48, p > .05, \eta^2_{\text{partial}} = .02$ . These results indicate that the racial/ethnic majority and minority participants did not differ in their evaluation of therapist expertness, trustworthiness, and attractiveness based on whether the therapist spoke with a strong or minimal AN accent. However, a small but significant interaction for therapist utility was found,  $F(1, 115) = 4.05, p = .05, \eta^2_{\text{partial}} = .03$ . Specifically, while Caucasian participants indicated that they were equally likely to meet with an AN therapist with a slight ( $M = 4.47, SD = 1.80$ ) or thick ( $M = 4.37, SD = 1.83$ ) accent, racial/ethnic minority participants indicated that they were more willing to meet with an AN therapist with a minimal accent ( $M = 5.05, SD = 1.59$ ) than an AN therapist with a strong accent ( $M = 3.46, SD = 1.94$ ).

## DISCUSSION

The purpose of this study was to examine the influence of AN accent, reputation, and their interaction on perceptions of therapist credibility after controlling for differences in universal-diverse orientation. After listening to an audio recording of an AN woman describing her therapeutic approach, participants rated her credibility as a therapist. We found that ratings of therapist credibility, as measured by the four subscales of the CERS (expertness, trustworthiness, attractiveness, and utility), were not influenced by either accent or reputation when examined alone. However, significant interactions between accent and reputation were found, indicating that the influence of accent on perceived therapist attractiveness and utility depends on the therapist's level of expertise. Specifically, for the graduate student scenario, the therapist was rated as more attractive when she spoke with a minimal AN accent. Additionally, participants indicated a greater willingness to seek treatment from the graduate student therapist when she spoke with a minimal accent. In contrast, there were no statistical differences in credibility ratings between the strong and minimal AN accent conditions when the therapist was described as a recent graduate or as an experienced and well-known professional in the field. In fact, although not statistically significant, an examination of the

means (Table 1) indicates that, for the recent graduate and well-known therapists, a strong accent generally was seen as preferable to a minimal one. It may be that participants found a graduate student therapist with a strong accent less attractive and potentially less useful because they worried about their ability to communicate and connect with the therapist. In contrast, participants may have felt that a therapist who has completed graduate school or who is well known in the community already has established his or her ability to communicate and connect with clients. In such situations, a thick accent may actually signify to clients the potential for a diverse perspective or nontraditional approach to solving problems, both of which could be seen as beneficial.

In this study, we controlled for participants' level of universal-diverse orientation by including it as a covariate in our analyses. Whether an individual perceives a strong accent in a therapist to be positive or negative depends not only on therapist reputation, but also on the individual's interest in diverse cultures and in engaging with people who are different from him- or herself (Fuertes & Gelso, 2000). While some clients may specifically seek out therapists who differ from themselves, other clients may refuse to work with a therapist from a differing racial/ethnic background, regardless of the strength of the accent with which he or she speaks. Fuertes and Gelso (2000) did find that, while low universal-diverse orientation participants rated therapists with a nonstandard accent as less credible than therapists with a standard accent, high universal-diverse orientation participants rated therapists with a nonstandard accent as slightly more credible than therapists with a standard accent. It is thus important to consider not only the characteristics of the therapist (accent and reputation), but also the characteristics of potential clients (universal-diverse orientation) when thinking about client perceptions of therapist credibility. As a covariate, universal-diverse orientation was found to predict ratings of the AN therapist's attractiveness and utility significantly.

### **Limitations**

Several limitations are present in this study. First and foremost are limitations with generalizability. This study was an analogue study conducted with college students. Thus, the perceptions of therapist credibility expressed by these students may not generalize to actual clinical settings. However, the study does provide a test of how accent and reputation may influence perceptions of therapist credibility for a general college student population. This information is important, given that a growing percentage of college students are reported to experience severe psychological problems and would benefit from psychotherapy services on campus (Gallagher, 2012). Perceptions of therapist credibility may be one variable in determining whether these college students seek out and stay in services. Along these same lines, participants were primarily Caucasian, female, and single. Perceptions of a therapist with an AN accent may differ among various demographic groups. In addition, we only examined the influence of one accent (AN) on perceptions

of credibility—a minority accent that is commonly encountered in the location in which the study was conducted. Further research is needed to test whether the findings would replicate with other nonstandard accents and in other areas of the country. Additionally, participants' perceptions of the therapist may have been influenced by characteristics of the therapist other than accent (e.g., age, gender, race/ethnicity); however, since these other variables were held constant across all scenarios, this limitation is an issue with the external rather than the internal validity of the study.

Second, in both accent conditions in our study, the therapist was described as AN. We designed the study in this manner to control for credibility differences that may be due to ethnic group membership rather than accent. However, in real-life situations, potential clients not only have the option of choosing from AN therapists with heavy to no AN accents, they often can choose to work with Caucasian therapists with standard accents, Caucasian therapists with nonstandard accents, therapists from other ethnic minority groups with standard accents, and therapists from other ethnic minority groups with nonstandard accents. Given the many possible accent and ethnicity scenarios that exist, more research is needed to examine the influence of these variables on ratings of therapist credibility.

Along these same lines, in this study we did not examine the interaction of accent with ethnic match on perceptions of therapist credibility specifically for ANs. Research has found that clients prefer a therapist whose ethnicity matches their own (Cabral & Smith, 2011), and that ethnic similarity results in higher ratings of therapist credibility (Hoyt, 1996). It is possible that ANs would prefer an AN therapist to speak with a strong AN accent, while Caucasians would prefer an AN therapist to speak with a standard accent. Given the small number of AN participants ( $n = 7$ ), we could not test these hypotheses due to a lack of power to find significant interactions if they were present. However, comparisons between the racial/ethnic majority and minority participants indicated that, for the most part, the two groups did not evaluate the AN accent differently. Future research, specifically with a larger AN sample, would be useful.

### **Clinical Implications and Conclusions**

Based on the results of this study, a number of implications exist. The results indicate that, at the graduate student level, even when therapists are equally qualified, those who speak with an AN accent may be viewed less favorably by clients (particularly those with low in universal-diverse orientation). Although therapists should never have to excuse aspects of their culture (such as their accent), the results of this study do indicate that speaking with a nonstandard accent may not be seen by clients as a barrier when the provider has more experience, greater credentials, or an established reputation. Prior research has indicated that therapists may increase client perceptions

of their credibility by using reputational cues (Hoyt, 1996). These efforts would be particularly important for graduate student-level providers --both those who speak with a standard accent and those who speak with a nonstandard one.

Unfortunately, the bias against graduate student-level providers who speak with an AN accent is one of many that clients may hold when working with therapists who are different from them. Thus, it is important that helping professionals seek to assist clients, potential clients, and the general public in gaining insight into and challenging their implicit biases and assumptions. Although we only studied an AN accent, across the U. S. many providers may be described as speaking with a nonstandard accent (e.g., AN, Southern, East Coast, or non-U.S.). Advocacy and awareness efforts to address biases against providers based on characteristics such as accent, race/ethnicity and gender may aid in increasing mental health service utilization and decreasing stigma associated with mental health help-seeking behaviors.

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