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ABSTRACT

Interpersonal behaviors and factors may facilitate or hinder the ability of one person to exert influence over another. To investigate the impact of counselor smoking behavior and status on potential clients' perceptions of counselor attributes, credibility, and expected helpfulness, 134 female college students viewed one of three vignettes showing a counselor/client interaction during which the counselor smoked a cigarette, a pipe, or did not smoke. Prior to viewing the vignette, the counselor was introduced with either high or low status information. Subjects also completed counselor evaluation measures. An analysis of the results showed that subjects given the high status introductions held more positive help-seeking attitudes; but under the control vignette, subjects who observed the low status counselor ascribed to more positive attitudes toward seeking help. The low status counselor was perceived as more expert, attractive, trustworthy, and more willing to help than the high status counselor. The cigarette-smoking counselor was evaluated lower than the non-smoking counselor on all dimensions, with the pipe-smoking counselor falling in between. The non-smoking counselor was evaluated more favorably than both the cigarette smoker and the pipe smoker on the knowledge of psychology and ability to help concepts. (BL)

THERAPIST PRESTIGE AND SMOKING IN COUNSELING

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Psychotherapists and counselors, as well as theorists, have become increasingly attentive to the role of interpersonal behaviors and factors that facilitate or hinder the ability of one person (therapist) to exert influence over another person (client) (Strong, 1978). Though not ingredients of a specific psychotherapeutic technique, such factors may be considered therapeugenic in that they are likely to increase or decrease the effectiveness of therapy independent of the therapeutic technique (Bloom, Weigel, & Truatt, 1977). A variety of therapeugenic variables (e.g., therapist reputation, professional title, race, sex, attire, office decor) have been related to clients' initial impressions of therapists and to clients' expectancies for therapeutic help. (See reviews by Corrigan, Dell, Lewis, & Schmidt, 1980; Heppner & Dixon, 1981; Strong, 1978.) Interestingly though, research on the impact of counselor smoking has received very little attention.

Poussaint, Bergman, and Lichtenstein (1966) investigated the effects of treating physician's smoking or not smoking in front of patients during treatment to help patients stop smoking. Smoking on the part of the treating physician was unrelated to outcome during the treatment period, drop-out rates, or outcome at follow-up six months after treatment. It should be noted that only during the initial interview did the physician smoke and that the initial interview was the only extensive interview analogous to a therapy session. Lichtenstin, Ransom, and Brown (1981) reported that the credibility of the rationale for treatment programs to stop smoking and the personal attributes of the programs' counselors were enhanced if the counselors were ex-smokers. No

differences emerged between current and never-smoking counselors. The work of Lichtenstein and his colleagues suggests that in some specific counseling situations (i.e., programs to stop smoking) whether the counselor smokes or not has little bearing on the treatment, clients' perceptions of the counselor, or credibility of the treatment program. Possibly these differences simply represent an affirmation of the clinical lore that addicted clients prefer ex-addicts or fellow addicts as counselors because of their shared experiences and consequent ability to emphathize (Lichtenstein et al., 1981).

Whether the impact of a counselor's smoking status on smoking-addicted clients is generalizable to other client populations and treatment of non-smoking problems remains speculative. Evidence bearing directly on this question is lacking, but given the implications of counselor smoking behavior in the context of counseling and interpersonal influence theory it seems reasonable and important to examine the issue empirically. Along related lines, Tamerin and Eisinger (1972) surveyed psychiatrists concerning their cigarette smoking. Their investigation revealed that: (a) a higher percentage of psychiatrists (42%) smoked than did all other physicians (20%) or other medical specialty groups, (b) psychiatrists were the least successful medical specialty group in quitting smoking, and (c) psychiatrists were more likely to smoke in front of their patients than other medical specialists. Thus, the portrayal of the psychiatrist who smoked during psychotherapy interviews with an adolescent male in the award-winning film Ordinary People may have been a realistic representation of some aspects of common practice in therapy.

The literature on smoking as a rule suggests that smokers would be at a disadvantage in interpersonal situations. Individuals, especially non-smokers,

perceive cigarette smokers as less considerate of others (Bleda & Sandman, 1977), less physically attractive (e.g., Polivy, Hackett, & Bycio, 1979), and more undesirable in terms of personality characteristics (Campbell, 1981; Dermer & Jackson, 1983). Studies of in vivo cigarette smokers have shown that smokers elicit shorter latencies to flight reactions (Bleda & Bleda, 1978) as well as a desire for more personal territory (Kunzendorf & Denny, 1982). However the interpersonal influence literature suggests that clients' perceptions may be modulated by status of counselors (see Corrigan et al., 1980; Heppner & Dixon, 1981). Additionally smoking implements (i.e., cigarette, pipe, cigar) might temper clients reactions to counselors. A survey conducted by Criswell (cited by Beaumier & Camp, 1980), found that 90% of the men and woman participants held socially favorable impressions of pipe smokers. The top 12 adjectives that women used to describe male pipe smokers included: mature, intelligent, capable, attractive, loyal, masculine, sincere, stable, dependable, kind, friendly, and responsible. The women also felt pipe smokers were not flirtatious, conceited, or arrogant. Most research on social reactions to smokers involve cigarette smoking, but Criswell's study suggests the possibility of a differential pattern of responsiveness to pipe smoking.

Given the current anti-smoking zeitgeist and controversies surrounding the health hazards of smoking, therapists who smoke in front of their clients would seem to risk introduction of a negative therapeugenic factor into the soical influence process. On the other hand, the status of the therapist and/or the smoking implement might modify perceptions clients form of counselors who smoke. Because of the potential therapeugenic nfluence of smoking behavior in the counseling situation, this investigation used as analog paradigm to examine impact of counselor smoking behavior and status on potential

clients' perceptions of counselors' personal attributes, credibility and expected helpfulness.

Method

Subjects

One hundred thirty-four undergraduate females enrolled in psychology courses served as subjects. Volunteers received partial course credit for their participation.

Measures

Attitudes Toward Seeking Professional Help (ATSPH). The ATSPH (Fischer & Turner, 1970) consists of 29 Likert-type items presented in a 4-point agree-disagree format. Allowing for reverse keying of negative items, total scores can range from 0 to 87 with higher scores indicating a global prohelp attitude. Internal and retest reliabilities range from .73 to .89. The total score is obtained by summing over four relatively independent subscales: recognition of need, stigma tolerance, interpersonal openness, and confidence.

Counselor Rating Form (CRF). Barak and LaCrosse (1975) devised the CRF to assess perceptions of three counselor atttributes: expertness, attractiveness, and trustworthiness. Twelve 7-point scales with scores ranging from 12 to 84 measure each of the three factors with high scores indicating greater degrees of expertness, attractiveness, and trustworthiness. Barak and LaCrosse (1975) reported split-half reliabilities ranging from .84 to .90 for the three CRF dimensions.

Counselor Evaluation Rating Scale (CERS). The CERS is a semantic differential instrument tapping several concepts related to counselor credibility along the evaluative dimension of meaning (Atkinson & Carskaddon, 1975). Ratings on three 7-point scales (i.e., good-bad, valuable-worthless, meaningful-

meaningless) are summed to obtain an independent score for each of five concepts: counselor's knowledge of psychology, counselor's ability to help the client, counselor's willingness to help the client, counselor's comprehension of the client's problem, and the counselor on the tape as someone I would go to see if I had a problem to discuss. For each concept, scores have a possible range of from three to 21 with high scores indicating a more positive evaluation.

Counseling Expectancies (CE). The CE consists of a list of 14 specific personal problems adapted from Cash, Begley, McCown, and Weise (1975). On 8-point Likert scales, subjects indicate their degree of confidence that the counselor would be helpful with each problem, where 1 = no confidence and 8 = extreme confidence. Four problems were added to Cash et al.'s list: academic problems, choosing a major, losing grip on reality, and religious problems.

Stimulus Tapes

A script of a brief initial interview adapted from Cash and Salzbach (1978) was enacted by a male doctoral candidate in counseling psychology who served as the interviewer and a female doctoral counseling psychology student who role-played the client. The adaptation omitted two personal and two demographic disclosures from the script. The script portrays a client describing symptoms of anxiety, low self-esteem, sleep difficulties, and a submissive-deferential attitude.

Three vignettes, each using the same script were videotaped. In the first taping, the counselor lit a cigarette and took six additional puffs during the conversation. At identical points in the dialog in the second vignette, the counselor lit and puffed on a pipe. Finally to control for arm movements, in

the third taping, the counselor stroked his lower jaw or chin at the same points during the interview. After rehearsing the parts, all three vignettes were taped in a TV studio against the same background. This procedure allowed for rigorous technical control over the counselor's attire, visual background, camera angle, lighting, counselor gestures, amount of time spent smoking, and intervals in the dialog between counselor inhalations. On the final vignettes, the confederate client sat offscreen and the counselor was visible only from the waist up. The tapes were reviewed by three Ph.D. psychologists who judged them equivalent in technical and performance quality.

Procedure

Subjects were randomly assigned to view one of the three taped vignettes in small groups of two to five subjects. Upon arrival, subjects completed a demographic questionnaire and the ATSPP Pre-viewing information about the counselor varied for each small group such that the counselor was given either a high or low status information (Merluzzi, Banikiotes, & Missbach, 1978). Half the subjects viewing each vignette were read a high or low status biographic sketch of the counselor. The high status counselor was introduced as follows:

> The counselor you are about to see is Paul Larson. He has been a practicing psychologist for a number of years since obtaining his Ph.D. from Columbia University. Besides his private practice, Dr. Larson also teaches graduatel-level seminars on psychotherapy and counseling at Stanford University.

The low status introduction consisted of the following:

> The counselor you are about to see is Paul Larson, who is just beginning to learn about counseling. Paul has had no previous counseling experience

but he is being supervised by a Ph.D. psychologist who tries to guide him if and when he needs it.

All subjects were told the tape was a brief initial interview and were instructed to try to put themselves in the client's place while viewing the session. After observing the vignette, subjects completed the CRF, CERS, and CE measures. The final design included two counselor status introductions completely crossed over the three counselor smoking conditions.

Results

ATSPH total scores were submitted to a 2 x 3 (status x smoking condition) analysis of variance (ANOVA) to examine for consistency of help-seeking attitudes across conditions. Significant differences emerged for the smoking condition as well as for the interaction of status and smoking conditions, respectively, F (2, 128) = 5.29, $p < .006$, and F (2, 128) = 4.53, $p < .013$.

Insert Table 1 about here

Table 1 shows the ATSPH total means and standard deviations. Subjects receiving the high status introductions held more positive help seeking attitudes but under the control vignette, subjects who observed the low status counselor ascribed to more positive attitudes toward seeking help.

As the attitudes toward help-seeking were not consistent over all subjects, ATSPH total scores were used as a covariate in subsequent analyses. A 2 x 3 (status x smoking condition) multivariate analysis of covariance (MANCOVA) was performed on the expertness, attractiveness, and trustworthiness scales of the CRF. The MANCOVA indicated significant differences only for the status factor, F (3, 125) = 4.39, $p < .01$. Table 2 shows that the low status

Insert Table 2 about here

counselor was perceived as more expert, attractive, and trustworthy. Univariate analysis of covariance (ANCOVA) revealed that the females perceived the low status counselor as significantly more attractive and trustworthy, respectively, F (1, 127) = 4.39, $p < .01$, and F (1, 127) = 5.07, $p < .01$.

The MANCOVA performed on the five CERS dimensions resulted in significant Fs for smoking conditions, F (10, 238) = 2.07, $p < .03$, for status, F (5, 119) = 16.87, $p < .001$. Examination of the means in Table 3 shows that the cigarette smoking counselor was evaluated lower than the non-smoking

Insert Table 3 about here

counselor on all dimensions with the pipe-smoking counselor falling in between. The only exception to this pattern occurred on the dimension of comprehension of the problem. Univariate ANCOVAs of the smoking conditions revealed differences on three concepts: knowledge of psychology F (2, 123) = 3.33, $p < .04$; ability to help, F (2,123) = 3.97, $p < .03$; and someone I would see, F (2, 123) = 3.11, $p < .05$. Differences in smoking conditions were examined using the Duncan multiple range test. The non-smoking counselor was evaluated more favorably ($p < .05$) than both the cigarette smoking and the pipe smoking therapist on the knowledge of psychology and ability to help concepts. With respect to the concept someone I would see, the non-smoking counselor was evaluated more positively than the cigarette smoking counselor.

For the status factor, only the ANCOVA for the willingness to help dimension attained significance, F (5, 119) = 5.78, $p < .001$. On this concept

the low status counselor (adjusted mean = 17.02) was evaluated more favorably than the high status therapist (adjusted mean = 14.48).

The 18 problems listed on the CE were also subjected to MANCOVA. Both the smoking conditions and status effects were significant, respectively, F (36, 218) = 2.00, $p < .001$, and F (18, 109) = 1.91, $p < .03$. Table 4 presents the adjusted means for smoking conditions. With the exception of four CEs

Insert Table 4 about here

(major, employment worries, shyness, dating), subjects expressed least confidence in obtaining help from the pipe smoker counselor and most confidence in the non-smoking therapist. ANCOVAs for smoking conditions revealed significant differences in subjects' expectancies for obtaining help for three problem areas: study problems, F (2, 126) = 4.42, $p < .02$; performing poorly academically, F (2, 126) = 5.38, $p < .006$; and drug problems, F (2, 126) = 3.23, $p < .05$. Examination of these differences with Duncan's multiple range test showed that pipe smoking counselors elicited less confidence ($p < .01$) in helping with study problems than both cigarette smoking and non-smoking therapists. For helping with academic performance, pipe smokers also elicited less confidence ($p < .01$) than the other two therapists. Finally subjects expressed less confidence ($p < .05$) in the pipe smoking therapist than in the non-smoker for helping with drug problems.

Discussion

Potential female clients' reactions to counselors who smoked or did not smoke were investigated while statistically controlling for the subjects' differential propensities to avail themselves of mental health services. For theoretical reasons, it was thought that the status of the counselor and the

smoking implement used could exert an interactive influence on clients' impressions of counselors. However, no evidence emerged to support such a contention.

With regard to counselor smoking behavior differences did emerge on the CERS and CE, although differences on the CE might be considered modest in light of current social trends to curtail smoking. Analysis of the CERS concepts suggested that clients evaluate the helpfulness of therapists most favorably when therapists are not smoking. With respect to clients' confidence about obtaining help for specific problems (i.e., academic performance, study problems, drug problems), pipe smoking counselors were viewed less favorably than non-smoking counselors. This unfavorable impression of pipe smoking counselors is interesting when juxtaposed to the positive impressions females tend to have of pipe smokers which Criswell reported (cited by Beaumier & Camp, 1980). Respondents to Criswell's survey may have varied in that they were more focused on their reactions to pipe-smokers per se where as subjects in the present study presumably attempted to put themselves in the client's place. To the extent subjects' in the present study identified with communicating personal distress to another (the therapist), pipe smoking may have exerted a negative therapeugenic effect.

Interestingly manipulation of counselor status had no impact on clients' confidence with respect to CE. However low status counselors were perceived more positively on the CERS willingness to help and CRF attractiveness and trustworthiness scales. This is contrary to the general empirical evidence suggesting that professional reputational cues enhance social influence potential (Corrigan et al., 1980). Perhaps students simply felt more at home with someone who was portrayed as closer to them in status and therapy experience.

Generally non-smoking therapists appeared to have some advantage over smoking therapists in this analog study. However many questions remain. If therapists who smoke during therapy undermine their own efforts to establish social influence, just what aspect of smoking serves as the essential cue--the odor, distractibility of smoking movements, or client attitudinal variables?

Investigations of malodors suggest that cigarette smoke can stimulate instigations to a host of responses, such as, hostility, flight, distancing, and so forth (e.g., Zillman, Baron, & Tamborini, 1981). Cigarette smoking involves increased bodily movements. Nonverbal behavior has been found to have complex effects on clients' perceptions of counselors (e.g., Smith-Hanen, 1977) and to account for more variance in ratings of counselors' empathy as compated to counselors' verbal messages (e.g., Haase & Tepper, 1972). Additionally, attitudinal differences might bias clients' perceptions of smoking counselors. For example, is the client's own experience a key factor? In the present study, less than 9% of the subjects were smokers. Thus, participants may have had some bias against smokers.

The study overall suggests that counselors would be wise to refrain from smoking during the initial interview in order to increase their social influence power. Whether counselor smoking exerts a therapeugenic effect after a therapeutic alliance is formed remains unknown. This issue, as well as questions concerning which variables cue clients reactions to smoking counselors, require further study to find clearer answers.

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Table 1

Means and Standard Deviations for ATSPH Total Score

		Conditions			
		Cigarette	Pipe	Non-smoking	Total
Counselor Status					
	M	53.18	59.00	55.36	55.73
	High SD	9.71	10.45	11.23	10.62
	N	22.00	20.00	25.00	76.00
	M	49.08	52.00	60.96	54.03
	Low SD	9.43	11.94	9.64	11.40
	N	24.00	20.00	23.00	67.00
	M	51.04	55.50	58.04	54.88
	Total SD	9.68	11.63	10.76	11.01
	N	46.00	40.00	48.00	134.00

Table 2

Adjusted Means for the CRF Scales for Status Conditions

	Scales		
Status	E	A	T
High	55.12	53.50	58.22
Low	57.81	58.51	64.02

Note. E = expertness, A = attractiveness, T = trustworthiness.

Table 3

Adjusted Means for the CERS Concepts by Smoking Conditions

	Smoking Conditions		
Concept	Cigarette	Pipe	Non-smoking
Knowledge of Psychology	14.30	14.64	16.28
Ability to Help	13.21	13.50	15.76
Willingness to Help	15.12	15.30	16.83
Comprehension of Problem	15.37	16.32	15.74
Someone I Would See	10.64	11.91	13.35

Table 4

Adjusted Means for 18 CEs by Smoking Conditions

	Smoking Conditions		
CE	Cigarette	Pipe	Non-Smoking
Study Problem	5.16	4.40	5.52
Poor Academic Performance	5.11	4.31	5.46
Choosing a Major	4.65	4.65	4.95
Speech Anxiety	4.48	4.40	4.85
Employment Worries	4.97	4.50	4.84
Insomnia	4.64	4.54	5.29
Drug Problems	4.76	4.04	5.13
Alcoholism	4.51	4.10	4.91
General Anxiety	5.23	5.00	5.53
Shyness	5.02	4.74	5.01
Depression	5.20	4.79	5.04
Dating Problems	4.95	4.63	4.47
Sexual Concerns	4.56	4.08	4.78
Parental Conflicts	5.39	5.10	5.61
Inferiority Feelings	5.28	5.25	5.53
Lack of Friends	5.36	4.65	5.52
Losing Grip on Reality	4.90	4.65	5.30
Religious Conflicts	4.12	3.60	4.48