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Potential Effects of Political Polarization on Relational Variables in Mental Health Outcomes

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Potential Effects of Political Polarization on Relational Variables in Mental Health Outcomes

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Abstract

Objectives: Growing political polarization and instability in the United States has increasingly influenced reactions to important topics such as health disparities and class inequality. Political biases and divisions influence the health and wellbeing of individuals and institutions. This study was designed to examine the effects of political bias in the social sciences on mental health treatment seeking and outcomes. The experimental design observed potential differences in therapeutic relationship/alliance and treatment seeking based on the perception of political bias in a therapy context. **Methods:** Four groups of participants were formed based on self-identified political ideology and were asked to read a politically biased vignette and answer questions regarding therapeutic relationships and outcomes. This study tested the hypothesis that perceived political bias in a therapy context acts as a barrier to treatment and negatively impacts the therapeutic alliance/relationship. The primary researcher predicted that an interaction effect between perceived bias and participant self-identified political ideology would statistically predict scores on the outcome measures. **Results:** Initial regression models for the full sample of participants did not indicate differences between groups based on political ideology or bias. As such, this study did not find statistically significant results for the primary hypotheses predicting differences in outcomes measures of essential therapeutic factors based on self-identified political ideology or perceived political bias. After a participant correction controlling for rapid responders, a supplemental analysis revealed differences between groups based on politically bias therapy context. Additionally, the population density of the setting a person grew up in accounted for a statistically significant amount of the variance in outcomes, with a small effect size. **Conclusions:** Discussion contains methodological limitations and directions for future research related to implicit bias within the academic social sciences. Key limitations for this

study included the omission of validity check questions, flaws in how the data service defined a "quality completed response," the sample was not drawn from the clinical mental health setting, and the analogue nature of the study may not observe the same psychological effects as lived experience. Future directions could include correcting the limitations described and sampling for regional effects, especially in specific populations thought to be experiencing this phenomenon, like some military and first responders.

Keywords: clinical relationship, therapeutic alliance, treatment seeking, barriers to treatment, treatment outcomes, political polarization, political ideology, implicit bias

Table of Contents

Table of Tables

Table of Figures

Potential Effects of Political Polarization on Relational Variables in Mental Health Outcomes

Chapter 1

Political Polarization

The current state of political affairs in the United States does little to offer peace, hope, or contentment for many people living within its borders (Iyengar & Westwood, 2015). Over the past several decades, polarization and hostility in the social-political arena have steadily increased (Abramowitz & Saunders, 2008). Some reasons for this are suggested in a news article written by well-known social and political psychologists Haidt and Abrams (2015). These include the purification of ideology within major parties, policy changes that decrease cross-party contact, changes in mass media that silo group thinking processes, and the lack of a common purpose or goal in society. Haidt (2016) described how ideological and political polarization has increased negative views of the political other as well as hostility between people with conflicting views. Among the many negative impacts of this process is the impact of censorship of thought and speech from both external sources and self-censorship in academics (Lukianoff & Haidt, 2015). It is thought that this censorship in academic settings is a major concern as these institutions highly influence societal thought processes and cultural development that affect all groups in America, including those being censured.

Although there is an abundance of evidence showing that the United States is becoming increasingly divided politically, there is a lack of social scientific research about how this affects

the quality and accessibility of mental health treatment. Restricted access to quality health care in a perceived safe environment is not a new concern for the health professions (Gee et al., 2020; Miranda et al., 2015). There is a plethora of past research looking at how some aspects of race/ethnicity and socioeconomic status influence clinical relationships, create barriers to treatment, and reduce treatment seeking. This study looks to expand the understanding of how contextual factors influence these important areas. It also looks to help create a more nuanced view of how current mental health treatment options may not be available, wanted, or effective because of patients' beliefs, values, or identity. Central to these concerns and specific to the mental health field is the lack of theoretical and ideological diversity that is rooted in the academic social sciences, the foundation of clinical mental health. It is important for the field to look at how a patient's misalignment with the political paradigm dominant in the social sciences influences the clinical relationship, treatment seeking, and treatment adherence.

In one meta-analysis, Wampold (2015) found that across many studies, the three most significant predictors of treatment outcomes were goal consensus between patient and therapist, empathy, and strength of the therapeutic alliance. Strongly held political affiliations typically do not increase goal consensus, empathy, and alliance between people with perceived ideological differences. Keltner and Robinson (1993) found that perceived ideological differences between people reduced their ability to offer support and think favorably of each other, key elements of empathy and alliance. Areas that are potentially affected by ideological differences include mutual goal construction in therapy, genuine empathy in the therapeutic relationship, respect for the values of the client, and a healthy working alliance rooted in the relationship. The focus of this study was to gather preliminary evidence asking if political bias in a polarized context

impacts clients' perceptions in ways that undermine the working alliance/relationship and creates additional barriers to treatment.

Lukianoff and Haidt (2015) explored polarization and ideological imbalance on college campuses and reported that implicit political bias is as strong as implicit bias between races. Heightened political polarization in the United States and increasing imbalance in the field should raise concerns about how that bias plays out in mental health care. The therapeutic relationship in clinical mental health work is very sensitive to power dynamics. To help in this area, academic thought leaders created the age, disability, religion, ethnicity, sexual orientation, social status, indigenous heritage, nationality, and gender (ADDRESSING) model looking at how therapeutic interactions are influenced. It was created as a way to reduce the harmful effects of bias and prejudice by increasing awareness of inequality in social power among health workers (Hays, 1996). This model for conceptualizing power dynamics based on identity markers is a widely accepted method for mental health professionals to understand how social power dynamics influence a patient's sense of safety, control, or self-efficacy, all essential elements for therapy and mental health treatment. It was designed to encourage those among groups holding what are perceived as more powerful identity markers to monitor their bias regarding patient differences in those areas. One study found that the strength of implicit bias and subsequent discrimination against partisan opposites exceeds that of implicit bias among races, with no social norms preventing the enactment of that discrimination (Iyengar & Westwood, 2015). It is thought that using the ADDRESSING framework within the context of social-political narratives could help reduce the negative influence of implicit bias on power dynamics in therapeutic relationships.

Political Bias in Social Sciences and Clinical Psychology

The field of clinical psychology has long produced professional people widely considered premier experts on people and society, a group deemed to have preeminent knowledge regarding the intricacies of human thought, emotion, and behavior. The field also has an established pattern of attracting, accepting, and supporting a significant majority of people from one side of the social-political spectrum in the United States (Haidt, 2016; Jussim, 2012). Over the past 30 years, several calls have been made to address the political imbalance and bias among the social sciences, including clinical psychology (Tetlock, 1994; Redding, 2001; Haidt, 2016). These calls for bringing the ideological balance in social sciences closer to that of the general population have had little effect in training institutions, as evidenced by an increasingly unbalanced ratio of liberal to conservative professors and practitioners (Gartner et al., 1990; Inbar & Lammers, 2012; Duarte et al., 2014). This imbalance is well known to the academic fields, as are the implications of implicit bias; however, there is very little research regarding this phenomenon as it relates to treatment outcomes, adherence, and culturally appropriate treatments in clinical work.

The significant imbalance in social/political views and resulting implicit bias has received very little attention from researchers regarding its impact on the social, emotional, and mental health of student practitioners (Gross & Simmons, 2007; Graham et al., 2009; Lukianoff & Haidt, 2015). Conservatives within the field of psychology claim it is very difficult for them to speak up with opposing opinions or views, due to potential social and professional consequences (Haidt, 2016). To ignore this fact and assume that it does not affect treatment delivery is problematic. One potential reason for the report that conservative voices are increasingly stifled in the social sciences is the increasing imbalance of liberal to conservative professors. Haidt (2016) reported that this ratio held steady at around four liberals to one conservative from the

1940's, until the presidency of the first George Bush in the early 1990's, where it began a sharp increase to the current ratio of fourteen to one.

Given that the therapy room is traditionally one of the most intimate and emotionally vulnerable settings in the professional world, it is a problem to assume that an implicit bias about strongly held ideological beliefs has no effect. This study attempts to add to the limited research that currently exists about political academic bias by examining the effects on the working alliance/relationship, and participants' willingness to seek out and remain in treatment.

Therapeutic Alliance/Relationship

Four areas extensively examined by researchers regarding therapeutic outcomes include extra-therapeutic factors; expectancy; specific therapeutic techniques; and the therapeutic alliance, which relies on the therapeutic relationship (Norcross & Wampold, 2019). In these reviews, the authors note that the therapeutic alliance accounts for roughly 30% of the variance in therapeutic outcomes. Among the common factors across therapeutic orientations, the therapeutic alliance/relationship has often been found to be the most influential. Focus on this common factor has roots in the highly successful work of Carl Rogers, who laid the conceptual foundation for relationally focused, humanistic therapies (Rogers & Wood, 1974). Although his "facilitative" conditions as stand-alone interventions have mixed results for therapeutic change (Lambert et al., 1978; Greenberg et al., 1994), common factors research continues to show that the working alliance and clinical relationship are a strong predictor of outcomes. Lambert and Barley (2001) noted that patients report success in treatment due to factors like warmth, empathy, and genuineness, which approximate Roger's facilitative conditions of empathy, positive regard for the client, and therapist congruence. As foundational elements for healthy

relationships, empathy, positive regard, and self-awareness play an integral part in therapeutic outcomes.

Several studies have shown that the therapeutic relationship is an important, if not essential, element of the therapeutic alliance required for positive therapeutic change (Baldwin et al., 2007; Horvath et al., 2011). The therapeutic alliance is related to the clinical relationship because the relationship facilitates the alliance, which also has additional elements. Lambert and Barley (2001) defined the major components of the therapeutic alliance as tasks, goals, and bonds, the relationship falling within the bonds category. Tasks are the behaviors and actions in the therapy room, goals are the agreed-upon objectives, and bonds are defined as the quality of attachment between therapist and client.

The importance of the relationship as a foundation for the therapeutic alliance cannot be overstated. One team of researchers claimed that the therapeutic relationship accounts for approximately 80% of therapeutic change, while other factors, including the specific therapeutic techniques, compose the remaining twenty percent (Duncan et al., 2010). The impact that the clinical relationship has on outcomes should prompt mental health professionals to closely examine how factors such as ideological and political implicit bias work within therapy. Several reasons for this include the current state of polarization, an ever-increasing political and ideological bias in clinical psychology, factors regarding the strength of implicit political bias including a decreased warmth for the political other inherent in today's society. Perceived warmth is a key component in clinical relationships that could influence outcomes related to the therapeutic alliance. The recent increase in values-focused treatments amplify questions about the access and effectiveness of treatments in different contexts.

Values

Understanding values is important for conceptualizing how people make important decisions and why they behave in certain ways (Haidt & Joseph, 2008). A person's values help shape their understanding of the world and form the psychological basis for the decisions they make in various domains, including morality, or choosing if something is right or wrong. Morals form ethical principles or rules that guide a person's or institution's decisions. This can affect many important areas, including policies, career choices, and decisions in relationships. Leaders often make decisions for groups based on their own values, moderated by the amount of control groups have over their leaders.

Recent research with moral foundations theory has illuminated some differences and similarities between conservative and liberal values to understand better how they influence moral decision-making (Haidt & Joseph, 2004; Haidt & Graham, 2007). This theory indicates differences in moral decision-making such that liberals and conservatives tend to rely on similar and different values to guide decision-making. They describe the following categories as foundational values underlying humans' moral decision-making: harm/care, fairness/justice, ingroup/loyalty, authority/respect, and purity/sanctity. They describe these values as cross-cultural and universal to human history. These foundations are clustered into the individualizing foundations of harm/care and fairness/justice and the binding foundations of ingroup/loyalty, authority/respect, and purity/sanctity. Individualizing foundations of harm/care and fairness/justice were found to be primary constructs used by politically liberal people for moral decisions. Political conservatives relied equally on both individualizing and binding foundations (Graham et al., 2009). It is important to understand that these conclusions are presented in

dichotomous form, while values underlying moral choices and political affiliation likely fall more along a dynamic spectrum.

Some issues have come out of the phenomena of values research in the context of increasing political animosity and political bias within academics. One of the most notable is the use of research to pathologize and stigmatize the values of the political other, which is not a new phenomenon in this academic field (Adorno et al., 1950). Although psychologists have a long history of researching moral intuition and values, it has often been done from a critical progressive lens, and often seems to highlight the inherent dysfunction of the political other. This could be amplified by the dramatic increase in the political ratio within higher education, which dramatically increased within the past few decades. This political influence has led to implicit bias in the academic social sciences that emerges in the research as identifying personality traits and values possessed by progressive in-groups that are socially accepted to underly a superior morality. Although this morality is rooted in values shared by conservative people, conservatives tend to rely on additional values as well to guide morality and subsequent actions. Haidt and Graham (2007) found that liberal people tend to make moral decisions based on individualizing values of harm/care and fairness/justice, while these values only account for part of the system used by conservatives, as well as more traditional societies cross-culturally. Additional values of ingroup/loyalty, authority/respect, and purity/sanctity are also important aspects of the conservative worldview and underly their decision-making process.

It is important to consider how the expression of these values in behaviors and policies depends on group and individual perceptions of what constitutes harm/care and fairness/justice. As a basic example, a liberal person could decide that it is “just” for everyone to have food to eat and not take into context the required impacts on community workload. Conversely, a

conservative might decide that it is just to require a minimum contribution to the community workload to receive a portion of food, and not take into account things like intentional oppression, abuse, and the effects of trauma. As this plays out in politics, it is much more complicated than this, given myriad dynamic contributors like technological advances complicating labor needs and responsibilities, unforeseen effects of governmental resource allocation, environmental changes, and social attitudes about many constructs, including perceived success and meaningful community contribution. A reductionist view of complex values systems without balance of the pros and cons, observed and described with an implicit social/political agenda, in a "helping" profession with large influence could be creating more problems than it is solving.

Despite the complexity of values in action, the effects of stigmatizing and pathologizing out-group beliefs and values in therapeutic work, advocacy efforts, and policy-making are extensive. The stigmatization of conservative personality traits and values has become more prevalent in recent research literature. These personality traits and values are complex and integral to many people's worldviews. Yet, they are often reduced and objectified to describe and represent the "immorality" of the political other. An example of this can be seen in heavily cited publications about ingroup bias and submission to authority (Altemeyer, 1981; Altemeyer, 2004).

Starting in the middle of the 20th century, following World War II, studies conducted about authoritarianism and dogmatism set the stage for future research about the political other (Adorno et al., 1950). Ultimately, authors like Altemeyer (1981) created scales that measured "right-wing authoritarianism" (title page) which had emerged in the social/political literature as a common construct. It was explicitly paired with the Nazi political party, and the term now

applies almost exclusively to perceived social/political conservatism in western countries like the U.S. This research has increasingly drawn negative conclusions of conservative values and the people with those values as the source of negative attributes and events—like racism and genocide (Ray & Furnham, 1984; McCann, 2009).

Little research has been done to critically examine the negative effects of the dominant worldview within social science research on mental health clinical services, much less politics and society at large. This can become a problem when there is little done in the field to understand and acknowledge the positive and protective aspects and evolutionary determinants of these values (Haidt & Graham, 2007; Haidt & Joseph, 2008). For example, one study showed that in older adults, conservativism is associated with higher self-esteem, even when controlling for narcissism (Van Hiel & Brebels, 2011). Thus, conservatism could be seen as an important protective factor for our elders as they enter the phase of life where the psychological conflict of integrity versus despair is lived out in the waning years of their lives (Erikson, 1994).

Following the research on implicit bias, the increasingly negative views of conservative values and culture generated by the presentation and application of social scientific research could influence how liberally trained mental health clinicians view, diagnose, and treat those with conservative or more traditional values. It seems entirely possible that this also influences how White, western, academic clinicians treat people from collectivistic cultures in the "out groups." This may happen not just around the world, but also at home, affecting elder populations, military veterans, and low-income people of all races, who often live in more collectivist cultures than those experienced by the typical middle/upper class academic. Many cultures around the world value strong ingroup loyalty and respect for authority. It was found that in cultures with strong collectivistic values of respect for authority and ingroup loyalty, individuals present

differently based on how their personality is constructed (Triandis et al., 1988). Triandis et al. (1990) later concluded that those with personality features out of line with the dominant ingroup structure often look for groups that are more similar to themselves. Ideological homogenization among academics could help explain how psychology is becoming less ideologically diverse in a culture with much ideological diversity. How this growing homogeneity of philosophy and ideology affects important factors known to influence clinical outcomes has been sparsely researched.

People leaving or avoiding specific academic fields because their values are not in line with the dominant narrative, or even may be stigmatized and pathologized, limits the thought diversity and healthy discussion that could help clinicians learn to reach broader audiences with helpful and wanted therapeutic solutions. Pagliaro et al. (2011) concluded from their research that shared group values influence individual identity such that the anticipation of in-group respect is a key factor in subsequent moral decision-making. The inherent assumption that in-group value systems and subsequent morality are superior to others is subjective and debatable and yet underlies much of the rhetoric in social sciences. Purification of in-group identity, ideology, and thought diversity should be considered a problem in a field that lauds diversity and exercises authority in a system that contains much ideological diversity.

Little research has been done to observe the effects on quality and outcomes for therapy in the context of limited access to treatments that are culturally sensitive to conservative, or other traditional/non-dominant values systems and worldviews. Values systems and worldviews are complex topic that academics and clinicians should seek to understand and accept through a diverse lens, starting in their training programs. As of yet, the field tends to construct and purify its own ingroup value systems among small and powerful groups of people, like high-level

academic or government employees. These groups then internally discuss and take actions that influence broader culture with the stated objective of improving the mental health of all people, often with little input from those people. The use of mental health research as a political tool to drive social changes, constructed within small in-groups with a distinct bias, should be concerning especially in the context of the current political instability.

A basic understanding and acceptance of the perspective that there are contained within the spectrum of conservative and liberal people similar, and yet distinct values systems, with values assigned different weights before being used to make decisions. Although these values systems are in part separate and distinct, they also have significant overlap, the understanding of which may help curb the political bias in research and practice. This, in turn, could help reduce the social sciences' contribution to political polarization and the negative effects that follow. Among these is the potential for opposing views to rupture relationships, having an effect in both the dyadic therapy context as well as macro levels such as academic training in patient conceptualization, policy making, and advocacy. In practice, this might look like focusing on therapeutic goals that are irrelevant to the values of the client, conceptualizing the client in ways that are not accurate to their own understanding of themselves, increasing social policies that ignore conservative values, and the marginalization or removal of conservative practitioners, thereby reducing patient access to therapists with less implicit bias about their worldviews and values.

These concerns parallel those of ethnic, cultural, sexual, and gender factors heavily researched and discussed in social sciences and mental health. In one seminal publication, Sue (1991) makes the argument that it is important to research how ethnic and cultural differences influence psychological theory and practice through the lens of differing values not “deficits” in

functioning. Yet, social scientific research continues to focus on the deficits of social/political/religious out-groups, a problem that has been shown by the author to reduce cultural awareness. These factors include lack of contact, simplifying perceptions of the other, and ingroup bias (Sue, 1991), which can be readily observed in many mental health settings. A recent trend in social scientific literature has academics and practitioners moving away from the idea of cultural competence toward cultural humility, as a means to build connection between groups (Fisher-Borne et al., 2015). Applying the concept of humility to within-group value differences found within the U.S. could help to reduce some of the harmful effects of political polarization and social conflict. Encouraging humility to help increase social-political diversity in the mental health field will result in better clinical practice, and equitable access to culturally sensitive mental health treatments for more people.

Treatment Attrition

One long-standing concern for mental health clinicians and researchers has been treatment attrition or early termination of treatment. It remains important to consider and assess factors that could be related to high rates of treatment attrition or drop out, that are found within the mental health field (Hiler, 1958; Barrett et al., 2008). One meta-analytic review by Swift and Greenberg (2014) compiled results from 669 studies comparing dropout rates between different theoretical orientations and found no significant differences. They reported that between orientations, dropout rates varied from 15% in CBT to 20% in psychoanalysis. Individual studies show a broader range of variation, from 20% to 60%, which is thought to result from a variety of factors including the setting of services, the disorder being treated, patient population factors, and how the researchers defined dropout (Reneses, et al., 2009).

A plethora of studies exist looking at a wide variety of patient/therapist traits, environmental factors, and aspects of treatment protocols that may increase dropout (Swift & Greenberg, 2014; Sharf et al., 2010). No research could be identified investigating the role of social-political bias within mental health on treatment attrition. One meta-analysis found increased rates of early termination for ethnic minority youth and suggested that this could be reduced by paying attention to the therapist–client ethnic match, and the therapeutic relationship (de Haan et al., 2018). Flaskerud (1986) found that ethnically compatible therapeutic dyads were more likely to complete the course of treatment than those who were not matched. Although currently unresearched, these observations could potentially generalize to other areas of identity that are not often considered in social scientific literature, including social-political factors. This may be especially relevant given the increasing polarization and social unrest in the current American cultural context.

Trust and Drop Out in Trauma Work

There is some evidence showing that dropout rates can be especially high for therapies focused on trauma and trauma-related disorders, including post-traumatic stress disorder (Lewis et al., 2020). They observed dropout rates of 16% in a pool of randomized clinical trials, conducted with highly trained therapists, with specific participant selection, including strict inclusion criteria. One study seeking to understand how these rates differ among disorders found that those with eating disorders, depression, and post-traumatic stress disorder showed elevated rates of early drop out (Swift & Greenberg, 2014). Trauma work is challenging for both client and clinician for many reasons, one of which is that trauma impacts the individual's ability to actively engage in trusting others (Bell et al., 2019). As seen in Davidson (2016), trust is a complex topic that can be conceptualized from a variety of different perspectives. An important

one for health fields includes how trauma reduces the overall trust of others and impacts a patient's desire or ability to begin and complete work with health professionals.

Ommen et al. (2008) examined the importance of trust in a broad range of health settings; they found that a lack of patient trust has significantly negative consequences for the provider-patient relationship and treatment outcomes. After experiencing significant trauma, a basic loss of trust in people is common, a phenomenon that has been discussed and researched in various ways throughout psychological literature (Guasto, 2014; Bell et al., 2019). Although there is a plethora of research about building trust in trauma work, examining whether the political bias in mental health care impacts patients' ability to trust healthcare providers has not been explored. The potential effects of political mistrust on the therapeutic alliance, moderated by trauma could be an important area of discussion. In addition to having a significant relationship with treatment outcomes, the therapeutic alliance has also been shown to have a moderately strong effect on dropout rates. One meta-analysis found a moderately strong effect size ($d = 0.55$) for 11 studies that observed the strength of the relationship between dropout rates and perceived therapeutic alliance (Sharf et al., 2010). Given that opposing political views were shown to erode trust and undermine important elements of relationships, it is worth asking if it is also associated with dropout rates.

Barriers to Treatment Seeking

In addition to asking if political bias influences therapeutic alliance/relationship and trust, it is also worth considering factors that influence initial treatment-seeking behaviors. There is a lot of research on barriers to treatment that are primarily focused on important factors such as patient traits, stigma about mental health treatment, issues of ethnic diversity, and economic problems (Miranda et al., 2015; Gee et al., 2020; Byrow et al., 2020; D'Anna et al., 2018).

Although there has been a lot of research looking at various stigmas held by conservative groups toward mental health treatment (Gonzales, 2022), there has been little to no research looking at stigma held or created by the mental health field about cultural, political, and religious groups outgroups. For example, an article by DeLuca et al. (2018) examined differences in mental health stigma across political attitudes; they concluded that right wing authoritarianism predicts mental health stigma. Consistently applying such results, and labels to specific political or religious groups, serves to reinforce and justify stigma and bias within mental health. The field of social science has identified many biases and stigmas held about its own ingroups but neglected to address ways that its own research focus, presentation of results, and advocacy efforts may influence treatment-seeking and create barriers for non-dominant groups. Assessing the rates at which people from different views or values systems access mental health treatment has been, at best, sparsely researched, and possibly just overlooked.

Purpose of the Study

This study investigated concerns about political and ideological bias in the academic social sciences, including potential influences on various aspects of mental health treatment. This bias could be hindering access to treatment and reducing positive therapeutic outcomes. This experiment was designed to gather preliminary evidence by asking if a person's self-identified political ideology interacts with perceived political bias to predict various outcomes. It is an analog design that used visual and verbal cues to elicit the perception of political bias in mental health treatment, then observed potential effects on factors related to treatment seeking, the strength of clinical alliance/relationship, and drop out.

The following hypotheses were examined:

H1: Self-identified political ideology will interact with perceived political bias to predict outcomes on the Agnew Relationship Measure.

H2: Self-identified political ideology will interact with perceived political bias to predict outcomes on the Modified Barriers to Treatment Scale.

Chapter 2

Methods

This study consisted of an experimental design with self-identified political ideology and perceived political bias as independent variables. Dependent variables included measures of clinical relationship barriers to treatment. Questions pertaining to potential drop out were to be included in the outcome measures but were unintentionally omitted from the survey. Self-identified PI was broken down into four groups ranging on a continuum from very conservative to very liberal. The perception of political bias in a therapeutic context was manipulated by assigning an equal number of participants from each group to one of three clinical vignettes containing politically laden information. The content of the three vignettes contained information indicating either a conservative, neutral, or liberal ideological preference.

After reading the vignette from one of the three conditions, each participant answered questions from existing measures that were modified to fit the analog nature of this study. These questions related to the perceived strength of the therapeutic alliance, treatment seeking behaviors, and treatment adherence. After reading the therapeutic scenario designed to elicit the perception of a political bias, it was hypothesized that participant responses would vary as a function of their self-identified political ideology. In sum, four PI groups from a nationally-based convenience sample of U.S. adults were randomly assigned to one of three therapeutic conditions of political bias. The twelve interactions were evaluated for differences in response patterns to questions in the dependent measures related to factors that affect mental health care treatments.

Participants

A total of 297 participants were selected by Qualtrics, an online data collection service that pays participants a nominal fee to complete various surveys. This number was determined based on a power analysis conducted using G-power statistical software which estimated a sufficient number of participants to achieve a moderate effect size at 85% power. Participants were filtered by Qualtrics into the four dichotomous groups of self-identified political ideology (strongly liberal, liberal, conservative, strongly conservative) until there was an equal number of participants per group. Participants were excluded from the study if they selected a fifth option stating that they did not identify on the conservative/liberal spectrum because self-identified political ideology was an independent variable. Before entry in the study, participants read an informed consent and checked a box confirming their consent to participate. Internal Review Board approval was received through George Fox University.

Materials

The documents and measures used in this study included an informed consent document, a general demographics questionnaire including the PI question, three randomly assigned case vignettes, and several dependent measures looking at elements of the therapeutic relationship and barriers to treatment. Outcome measures consisted of standardized questionnaires designed to assess the therapeutic alliance and treatment seeking, some of which were modified to fit the format of this analog research study. Each vignette described liberal, conservative, or neutral political identifiers about the therapist, context, or process factors designed to indicate the presence or absence of political bias in a therapeutic setting.

Demographics Questionnaire

The demographic questionnaire assessed age, ethnicity/race, gender identity, education level, social class, religiosity, region of the country where they were raised, the political climate of their state, and history of military service. Participants were asked to answer a qualitative question about which occupation best describes their usual means of financial gain. An additional question was used to identify political ideology using a 4-point Likert scale, which served as one independent variable.

Independent Measures

Client Vignettes. Three similar case vignettes were created to illustrate liberal, conservative, or neutral political identifiers about the therapist, context, and process factors in the therapeutic setting. The vignettes were standardized to include similar conceptual categories of political factors across the three conditions. This was done in an attempt to standardize the vignettes and activate a similarly strong perception of an ideological or political leaning across the conditions. For example, each vignette described several observations made in the parking lot and upon entry into the therapy office, including the types of cars and bumper stickers on cars in the parking lot. The vignettes can be found in Appendix B along with a table illustrating the conceptual categories and elements for each vignette in Appendix C. The following is a sample of the conservative case vignette (to view all three vignettes please refer to Appendix B):

> You have just arrived for your first therapy appointment at a well-known mental health clinic in a small town in West Texas. You circle the parking lot once or twice before you find an open parking space between a red Ford F-250 and an orange Dodge muscle car. As you walk toward the building you notice several bumper stickers, one supporting Trump 2020, a pro-2nd Amendment sticker, and

a Harley Davison sticker. As you enter the office building the receptionist greets you with a smile and after a quick introduction, you take your seat to wait for your appointment. As you relax in the lobby, you notice a large painting of an elephant on the wall. After a short wait, your therapist arrives, greets you with a gracious smile, and takes you back into their office. While you're taking your seat, you notice that there are several college degrees on the wall, one from the University of Texas and the other from the University of Florida. Your therapist starts by looking you in the eye, giving you a strong handshake accompanied by a robust "howdy!" After asking your name they begin with; "well, what do you want to talk about today?

Dependent Measures

Agnew Relationship Measure (ARM). The Agnew Relationship Measure-12 Item Short Form (ARM-12) is a standard series of questions used to assess elements of the therapeutic relationship, including the working alliance (Cahill et al., 2012). The ARM-12 is a shortened version of the full measure and was developed by a team of researchers using conceptual and empirical strategies. They evaluated previous measures and composed a set of questions for each conceptually distinct subscale identified in the research. These scales were empirically tested in individual psychotherapy sessions and refined by retaining appropriate items, rewording others, and conducting a psychometric factor analysis (Agnew-Davies et al., 1998). The ARM has good convergent validity with the Working Alliance Inventory, a widely used and well-established empirical measure of working alliance (Stiles et al., 2002). The ARM-12 uses four of the original five conceptual categories, including Bond, Partnership, Confidence, and Openness, and has acceptable internal consistency and good convergent validity with the full measure (Cahill et al.,

2012). Calculation of Cronbach's alpha showed that reliability was high for the ARM in this sample (12 items; α=.84).

Modified Barriers to Treatment Scale. Drawing on previous research investigating perceived barriers to treatment, this researcher selected ten questions from an existing measure to fit the analog study. The resulting brief measure was designed to assess some well-established factors affecting treatment-seeking within the framework of this experiment. It was hypothesized that cognitive and emotional elements are central to perceiving political bias as a barrier to treatment. As such, specific questions were used from an existing validated measure to fit both the hypothetical nature of the vignettes and the emotional nature of avoidance. Lingley-Pottie and McGrath (2011) created the Treatment Barrier Index comparing differences in barriers for in-person psychotherapy versus virtual psychotherapy. The Treatment Barrier Index questions, based on five conceptual categories, were modified to fit this study's experimental design, and termed the Modified Barriers to Treatment Scale (MBTS). The MBTS asks 10 questions, with answers falling on a 5-point Likert continuum from 1 (*strongly disagree*), 2 (*disagree*), 3 (*neither agree or disagree*), 4 (*agree*), 5 (*strongly agree*) and can be found in Appendix E. Calculation of Cronbach's alpha showed that reliability was high for the MBTS in this sample (10 items; α=.82).

Drop-Out Questions. Two questions regarding participants' inclination to drop out of therapy were supposed to be included to determine if differences in political ideology are related to potential dropout rates for clients engaged in mental health treatment. The first question was supposed to be a single item following the ARM assessing the likelihood that they would remain in treatment given the context described in each vignette. Participants would have answered on a 7-point Likert scale ranging from 1 (*not at all likely*) to 7 (*extremely likely*). Participants were

asked if they had ever had a mental health disorder, if they sought treatment for that disorder, and if they completed treatment or dropped out early. If they had a mental health condition in the past but never sought treatment or dropped out early, they would- be given a qualitative space to explain their decision.

Duke Religion Index. The Duke Religion Index (DUREL) is a standardized five item measure about participants' practice of faith/spirituality and religious behaviors. The scale has three subscales: Organizational Religious Activity, Non-Organizational Religious Activity, and Intrinsic Religious Motivation. Organizational Religious Activity includes religious behaviors such as attending group meetings and participation in religious social events. Non-Organizational Religious Activity includes private religions engagement such as private prayer. Organizational Religious Activity and Non-Organizational Religious Activity are measured with single items with responses on a 6-point Likert continuum, while intrinsic religious orientation is measured using three items, each rated on a 5-point Likert scale. Alpha for the DUREL in the present sample was .872.'

Procedure

To ensure that groups of equal numbers were created, the participants were selected and filtered using the Qualtrics service based on their initial answer to the question about self-identified political ideology. The participants consisted of a convenience sample selected from an online pool of paid participants in the United States. The surveys were administered individually in a remote online setting. The researcher requested that Qualtrics filter participant entry until equal groups of $n = 72$ participants were reached; the final numbers ranged between $n = 73$ and $n = 75$ per group. The plan and justification for the study were scrutinized by the Institutional Review Board at George Fox University, IRB approval # 2203009.

Participants were grouped into four PI categories by using a self-reported 4-point Likert scale—1 (*conservative*), 2 (*slightly conservative*), 3 (*slightly liberal*), and 4 (*liberal*). A fifth response alternative, 5 (*none of these describe me*), was used as a disqualification category. After selection, participants were provided with an informed consent form and were then provided monetary compensation for their efforts. They were asked to affirm consent by clicking "I consent" before entering the study.

Four equally-sized groups were created based on PI categories. Next, groups read one of three randomly assigned case vignettes and then responded to items from the measures mentioned above. These included the ARM-12 to gauge therapeutic alliance and the MBTS to gauge perceived barriers to treatment. Next, participants were asked to indicate if they believed a political bias exists in the mental health field using a 7-point Likert scale ranging from 1 (*strongly disagree*) to 7 (*strongly agree*). Participants were also asked about their opinion about the political direction of the reported bias by using a 7-point Likert scale ranging from 1 (*strongly liberal*), 2 (*liberal*), 3 (*slightly liberal*), 4 (*there is no specific bias*), 5 (*slightly conservative*), 6 (*conservative*), to 7 (*strongly conservative*). Participants were next asked to identify their perception of the dominant political party in their state of residence ranging from 1-right, 2-left, or 3-swing state. Finally, participants were asked if they had ever experienced a mental health problem and whether or not they sought out professional mental health treatment. If participants indicated that they had been in therapy, they were asked if they completed treatment or if they stopped treatment early. A voluntary qualitative question was provided to explain why they had not sought out mental health treatment, or why they stopped treatment early. At the conclusion of the survey participants were asked to complete the demographics questionnaire which can be found in Appendix A.

Chapter 3

Results

Participants

Two-hundred and ninety-seven participants were selected using Qualtrics online data collection service. One participant was dropped due to identified invalid responses, leaving a final count of $N = 296$ participants. These participants created four almost equal sized groups based on PI. The breakdown of group size is as follows: strongly liberal $n = 74$, liberal $n = 75$, conservative $n = 73$, and strongly conservative $n = 74$. Participants had a mean age of 45.71 years ($SD = 17.53$) with a median age of 40 years. Roughly half the sample was above the age of 40 years and roughly half below it. Of the $N = 296$ participants $n = 148$ were female, $n = 146$ were male, $n = 1$ identified as trans-male, and $n = 2$ participants declined to answer. Breakdown of the ethnicities of participants included White or European American, $n = 219$, 73.7% of the sample, Black or African American $n = 43$, 14.5%, Hispanic or Latino $n = 16$, 5.4%, Asian or Asian American $n = 12$, 4%, Native Hawaiian or other Pacific Islander $n = 3$, 1%, American Indian or Alaskan Native $n = 4$, 1.3%. For an in-depth breakdown of demographics, see Table 1.

Table 1

Demographic Characteristics of Participants

Demographic variables	Qualtrics sample	
	N	%
Gender		
Female	147	49.7
Male	147	49.7
Trans male	1	0.3
Prefer not to say	1	0.3
Age		
18-25 years	32	27.1
26-35 years	73	24.7
36-50 years	77	26.0
51-65 years	50	16.9
> 65 years	64	21.6
Ethnicity		
American Indian or Alaska Native	4	1.4
Asian or Asian American	11	3.7
Black or African American	43	14.5
Hispanic or Latino	16	5.4
Native Hawaiian or other Pacific Islander	3	1.0
White or Caucasian	219	74.0
Income class		
Upper class	13	4.4
Upper middle	44	14.9
Middle	98	33.1
Lower middle	82	27.7
Living in or close to poverty	52	17.6
Prefer not to say	7	2.4

Demographic variables	Qualtrics sample	
	N	%
Military service		
Yes	45	15.2
No	251	84.8
Regional location		
Northeast	67	22.6
Southeast	80	27.0
Northern Midwest	46	15.5
Southern Midwest	23	7.8
Southwest	49	16.6
Northwest	24	8.1
Alaska or Hawaii	2	0.7
Outside of the US	3	1.0
PI of current state of residence		
Conservative lean	132	44.6
Swing state	68	23.0
Liberal lean	96	32.4
Population density		
Urban (city)	107	36.1
Rural (country)	76	25.7
Suburban (in-between)	113	38.2

Note PI = political ideology

Data Analysis

Upon completion of data gathering using the Qualtrics platform, the statistical software SPSS 29.01 was used to organize and conduct the analysis. As part of data screening, a descriptive analysis was performed to identify outliers in ARM and MBTS distributions. Extreme outliers, greater than 2 standard deviations, were removed. Missing data was addressed by not including participants with significant amounts of missing data in statistical analysis. Results for the ARM indicated a mean score of $M = 59.45$, $SD = 11.30$, Skew = .139, SE Skew = .142, Kurtosis = -.366, *SE* Kurtosis =.282. The MBTS $M = 36.20$, $SD = 7.24$, Skew = -.177, *SE* Skew = .142, Kurtosis = .075, *SE* Kurtosis =.282. An analysis of internal consistency was conducted, yielding alpha coefficients showing high reliability for the ARM (12 items; $\alpha = .837$) and the MBTS (10 items; $\alpha = .820$). An overview of the descriptive data can be found in Table 2.

Table 2

Descriptive Results for Dependent Measures

Measures	*N* Items	*M*	*SD*	Cronbach's α
Agnew Relationship Measure	12	59.45	11.31	.837
Modified Barriers to Tx. Scale	10	36.19	7.236	.820
Duke Religion Index	5	39.08	6.269	.872

Note. Tx = treatment.

Correlations of the outcome measures and participant demographics were calculated to test the assumption that there was an absence of multicollinearity. The variables included in the correlation matrix were the outcome measures, age, gender, ethnicity, and income. As seen in Table 3, participant scores on the ARM were not significantly correlated with age, gender, ethnicity, income, or political ideology. A significant correlation was found between ARM scores and residential population density (r = -.144 p = .013). This was measured by asking what population density setting the participant grew up in or spent most of their life. These findings suggest an absence of multicollinearity. Results for ARM correlations can be found in Table 3.

Table 3

Pearson Correlations of the Agnew Relationship Measure with other Variables

Measures	Agnew Relationship Measure	
	N	Pearson correlation
Age	296	-.034
Gender	296	.055
Ethnicity	296	-.002
Income	296	-.015
Political ideology	296	-.042
Population density	296	-.144*
MBTS	296	.778**
DUREL OR	296	.117
DUREL NOR	296	.109
DUREL INTRINSIC	296	.057

Note. MTBS = Modified Barriers to Treatment Scale; DUREL OR = Duke Religion Index, Organized Religious Activities; DUREL NOR = Duke Religion Index, Non-Organized Religious Activities; DUREL INTRINSIC = Duke Religion Index, Intrinsic Religious Beliefs

Calculations looking at MBTS scores also indicated that the participants' total scores on the measure were not significantly correlated with age, gender, ethnicity, income, or political ideology. This also suggests an absence of multicollinearity. As with the ARM, there was a significant correlation between MBTS scores and population density (r = -.146 p = .012), results for MBTS correlations can be found in Table 4. The strong correlation between scores on the ARM and MBTS indicate that they could potentially be measuring the same thing, relational variables that predict treatment outcomes and potentially act as barriers to treatment.

Table 4

Pearson Correlations of the Modified Barriers to Treatment Scale with other Variables

Measures	Modified Barriers to Treatment Scale	
	N	Pearson correlation
Age	296	.084
Gender	296	-.012
Ethnicity	296	.045
Income	296	.004
Political ideology	296	-.034
Population density	296	-.146*
Agnew Relationship Measure	296	.778**
DUREL OR	296	.039
DUREL NOR	296	.043
DUREL INTRINSIC	296	.007

Note. DUREL OR = Duke Religion Index, Organized Religious Activities; DUREL NOR = Duke Religion Index, Non-Organized Religious Activities; DUREL INTRINSIC = Duke Religion Index, Intrinsic Religious Beliefs

Hierarchical Regressions

Assumptions regarding normality, linearity, and homoscedasticity were conducted using bar graphs, predicted probability plots, and scatter plots. Hypothesis one and two asked how much incremental variance in ARM and MBTS scores is accounted for by self-identified political ideology, perceived political bias, or an interaction of the two. The statistical outcomes failed to reject these null hypotheses, indicating that this study did not find an effect on either clinical relationships or barriers to treatment due to self-identified political ideology or perceived political bias in a therapy context. Regression models predicting ARM and MBTS outcomes after controlling for demographic variables of age, gender, ethnicity, income, education, PI, and political bias/vignette were non-significant at (R^2 = .016, F(7, 289) = .676, p = .693), and (R^2 = .014, F(7, 289) = .565, p = .784) respectively.

Supplementary Analyses

Based on the information gathered from correlations and cluster analysis, several supplementary areas of interest emerged. To better understand the characteristics of groups of participants who answered questions in similar ways, three further sets of analyses were conducted. First, demographics were used to cluster participants to see if there were significant demographic differences. Second, upon noting correlations between geographical proximity to urban areas or population density and outcome scores, supplementary regression analyses were conducted to clarify this factor as a predictor. Third, after noting some of the limitations of the data collection process, additional selection criteria were applied to participants and a supplementary analysis was conducted to determine if invalid responses played a part in the non-significant results for the primary analyses.

Demographics and Political Ideology

K-cluster analysis of demographic variables was used to determine that the optimal number of clusters was five. A K-means classification with analysis of variance was conducted for five groups to determine if demographics could create groups with similar and distinct political ideologies. It was determined that age ($F_{4,291}$ = 1292.024, p = < .001), ethnicity ($F_{4,291}$ = 7.659, p = < .001), gender ($F_{4,291}$ = 3.555, p = .008), and income ($F_{4,291}$ = 3.586, p = .007), were statistically significant predictors of political ideology. This means that demographic clusters of participants tended to group best for political ideology around age, ethnicity, gender, and income (see Table 5 for more information).

Table 5

Cluster Analysis and Analysis of Variance (ANOVA) of Demographic Variables Comparing Cluster Membership for Political Ideology

Number of clusters	Iterations	Demographic variables	*F*	Significance
5	4	Age	1292.024	< .001
		Gender	3.586	.007
		Education	1.260	.286
		Ethnicity	7.659	< .001
		Income	3.555	.008

Note: *DF* = 4, 291 for all analyses.

Population Density Regression

Geographical proximity to urban areas, or the homelife setting in which a person spent most of their life, whether rural, suburban, or urban, was found to correlate with outcomes on the ARM and MBTS. Given the study was intended to look at factors that affect clinical relationships and attitudes that act as barriers to treatment, a regression analysis with these factors was conducted. The results show a statistically significant regression model predicting ARM scores from case vignette/political bias, as well as population density (R^2 = .034, F(2, 294) = 5.164, p = .006). Population density was the only statistically significant factor at (p = .009), with political bias/vignette close at (p = .052). The model for predicting MBTS outcomes with vignette/political bias, and population density was significant at (R^2 = .026, F(2, 294) = 3.778, p = .024) with population density being the only significant factor (p = .010). Although these factors predicted statistical differences in outcome measures, the overall effect sizes were small.

Hierarchical Regression W/O Rapid Responders

Supplementary analyses were also conducted to address one area of concern regarding data collection, namely that the minimum time requirement for participants to complete the survey was set quite low by the data collection service. This raised questions about the effort put into the survey by the participants at the lower end of response times. The primary researcher timed how long it took to click through the study, skim read the questions, and select a response and it was observed to take about 5 min to rapidly finish the survey. Survey responses that were completed any faster meant that the participant likely did not read and answer the questions in a meaningful way. After removing participants who completed the survey in under 5 min from this analysis, Cronbach's alpha showed increased reliability for both the ARM (12 items; α = .85) and

the MBTS (10 items; α = .83). A correlation matrix to identify potential covariates and reliability analysis of the outcome measures was performed, finding that the only demographic variable associated with the outcome measures was age at r = -.136 (p = .043).

Supplementary regression analysis using the model of PI, vignette, and age as predictors produced a statistically significant result for the ARM at (R^2 = .047, F(3, 240) = 3.911, p = .009) with both political bias/vignette (p = .013) and age (p = .047) as statistically significant contributors. The same model for the MBTS did not yield significant results (R^2 = .022, F(3, 240) = 1.758, p = .156).

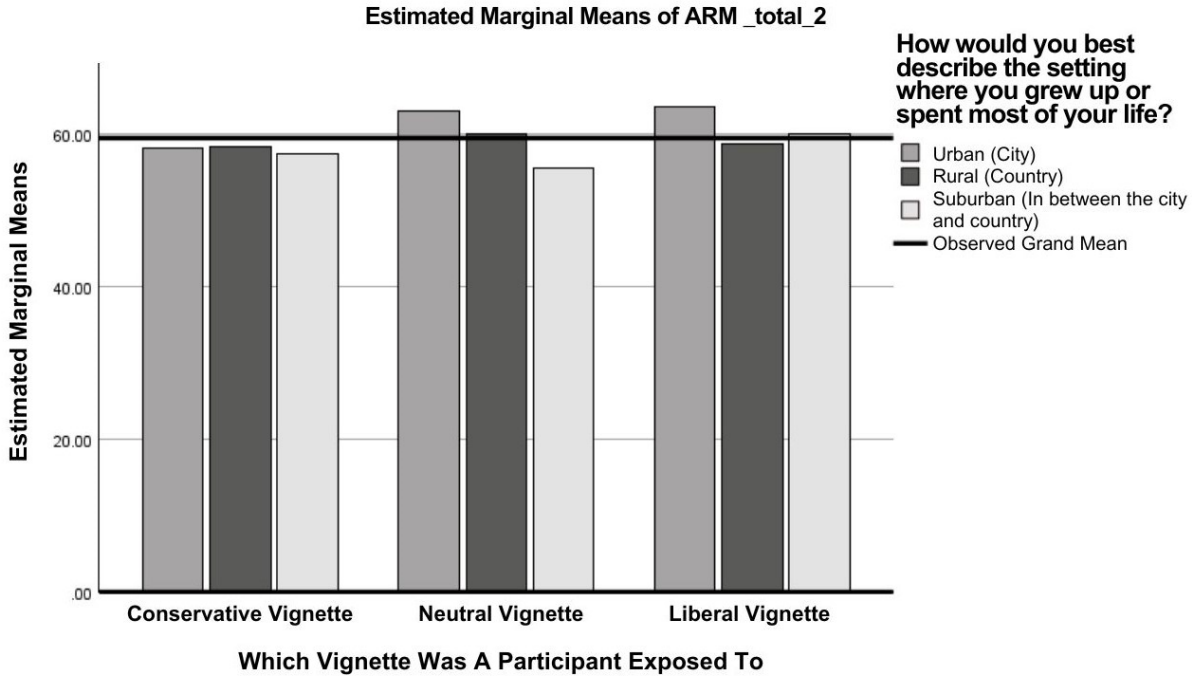
Adding population density to the regression model increased the amount of variance explained for the ARM (R^2 = .075, F(4, 239) = 4.832, p = <.001) with significant contribution from political bias/vignette (p = .011), and population density (p = .007), while age approximated statistical significance at (p = .052). The MBTS regression model with PI, political bias/vignette, age, and population density was also significant at (R^2 = .046, F(4, 239) = 2.892, p = .023) with contributions from political bias/vignette (p = .045), and population density (p = .014). Although these factors account for some of the variance in the outcome measures the small effect sizes indicate that unknown factors in this sample had more statistical influence.

A two-way analysis of variance was conducted to determine the effects of political bias and population density on ARM scores while controlling for age as a covariate. The analysis resulted in a significant main effect for political bias ($F_{2,234}$ = 3.190; p = .043; η^2 = .027) and for population density ($F_{2,234}$ = 3.642; p = .028; η^2 = .030). Age as a covariate was also significant at ($F_{1,234}$ = 4.645; p = .032; η^2 = .019). There was not a statistically significant interaction effect between population density and political bias ($F_{4,234}$ = 2.039; p = .090; η^2 = .034). Post hoc testing using the Bonferroni correction for multiple comparisons showed that ARM scores were

significantly higher among urban participants in the liberal bias condition compared to the conservative bias condition ($p = .041$). ARM outcomes for urban participants assigned to the neutral condition were not significantly different than the conservative ($p = .071$) or liberal ($p = 1.00$) conditions. ARM scores were significantly lower for suburban participants in the neutral condition compared to the liberal condition ($p = .039$), but not the conservative condition ($p = .405$). There were no statistical differences in ARM scores for suburban participants between the conservative or liberal conditions ($p = .923$). The results revealed no statistically significant differences in ARM scores for rural participants in any of the three bias conditions conservative, neutral, or liberal ($p = 1.00$; $p = 1.00$; $p = 1.00$; see Figure 1).

Figure 1

ARM Scores, Vignette and Population Density



Chapter 4

Discussion

This study was developed to observe the potential effects of political polarization on various factors related to mental health treatment. Political polarization continues to worsen in the United States and has had a major effect on institutions and the individuals within them. The presence of bias about conservative values in the social sciences has existed since the 1950s, and continues in today's institutions (Adorno et al., 1950; Silander et al., 2020). As Haidt (2016) described, the purification of political ideology, and the underlying values systems among academic institutions has separated people to the extremes. This is evidenced by political ratios in academic programs, the effects of which can be seen in subsequent areas of the workforce supplied by these training institutions, both government and private.

There is a plethora of research on the broad-reaching effects of implicit bias, primarily related to important areas such as race, ethnicity, and gender (Greenwald et al., 2009). The various ways that political bias impacts factors directly related to mental health treatment, such as clinical relationships, have been sparsely researched. This analog study of political bias in a mental health context was designed to look for the potential effects of these issues on treatment seeking, clinical relationships, and adherence to treatment. It was thought that the perception of political bias in a mental health context would interact with participants' self-identified political ideology to predict outcomes on measures of clinical relationships, barriers to treatment, and dropout rates.

Overall, for the initial participant pool, the study found no differences between people when grouped together based on political affiliation or perceived political bias. These results

suggested that the primary hypotheses of an interaction effect between political bias in mental health and relational outcomes in therapy were unsubstantiated in this sample. Planned analyses for his study failed to demonstrate any statistically significant effects of the political bias in social sciences and mental health on barriers to treatment or clinical relationships.

However, supplementary analyses revealed several areas of interest related to the data collection and the overall topic. Correlational analysis indicated population density had some relationship with the outcomes. When entered into a regression analysis with PI, political bias/vignette, and population density, a statistically significant model of the variance in ARM and the MBTS outcomes emerged. Although the effect size of this model was small, it is worth noting that some evidence of political bias exists in this data set, and future research should be considered, given some of the limitations discussed below.

Additional supplementary analyses were conducted after a participant correction removed those who completed the survey in under 5 min, a subjective benchmark of the minimum necessary time to read and answer the questions adequately. Regression analyses showed that three factors in this revised data set could predict affiliation (ARM) and barriers (MBTS) outcomes. The presence of political bias, age of the participant, and the population density of the area where participants spent most of their lives significantly predicted perception of affiliation and perceived barriers in the vignettes.

A two-way analysis of variance controlling for age showed significant differences between mean perceived affiliation (ARM) scores based on perceived political biases in the vignettes and population density setting where the person spent most of their life. Post hoc comparisons revealed that rural participants had similar outcomes on perceiving affiliation (ARM) regardless of their political bias. However, urban participants tended to report

statistically higher perceived affiliation (ARM) outcomes, favoring more liberal bias conditions in the vignettes when compared to neutral or conservative conditions. Suburban participants reported lower affiliation (ARM) scores for the neutral bias condition with no significant differences between the conservative and liberal bias conditions.

Limitations

The reader should consider the following limitations to the methods and execution of the proposed study. Several mistakes were made in the construction of the survey, which included the author's omission of questions in the outcome measures asking if patients would drop out of treatment with this therapist, which made related analysis impossible.

Additionally, the validated barriers to treatment measures used to construct the MBTS for this project should have been changed to the conditional tense to match the analogue nature of the study. As this was not done, it likely added some confusion for the participants as to what was being asked of them. The researcher also intended to modify and use additional questions from the Perceived Barriers to Treatment index (Mohr et al. 2006) to help create a more robust measure of barriers to treatment scale that would be relevant to the study question. Ultimately, only half the questions from the Treatment Barrier Index scale were modified, half were left in their original form, and none of the questions intended to be used from the additional measure made it into the MTBS scale. Although internal consistency for both measures was decent, it can be hypothesized that the confusing and limited conceptual categories within the measure influenced outcomes about barriers to treatment.

After data collection, some questions were raised about the validity of the data regarding what constituted a "quality completed response" as defined by the data collection service. Of the $N = 297$ people that were paid to participate only $n = 243$ took longer than 5 min to complete the

survey. Anecdotal evidence suggested that a minimum of 5 min was necessary to read and navigate the survey rapidly. After controlling for this potential problem, statistically significant results began to emerge. The problem of rapid thoughtless responding could have been mitigated with a series of validity check questions that were not included in this study. Given the statically significant results that started to emerge when controlling for time spent on the survey it is possible that the overall data were polluted by invalid responses.

Other areas of concern arose in regard to the analog nature of the study, conducted with a national sample of the general population. The study was conceptualized based on observations of the potential effect of political bias in the social sciences, yet the study was conducted using a national sample. Using a sample of $N = 296$ participants from around the U.S. did not leave room to observe any regional effects of political polarization. It is entirely possible that political polarization is affecting different regions of the U.S. in different ways.

The current sample had two issues with testing this assumption. First, the sample size was not large enough to observe an interaction between self-identified PI and political bias from a minimum of six different regions of the U.S. Second, the regions that were used in the survey had no conceptual basis for differences in PI. Third, more diligent steps to detect robotic and "mindless" responses from online participants were not employed. Effects are more likely to be observed for people in regions where the minority political group is out of line with the social science's dominant political narrative. Clarifying these factors seems more likely to demonstrate the hypothesized interaction effect.

Were the study to be conducted again, several things could be done differently to help conceptualize the negative effects of political bias on mental health care. First, attention to detail regarding methods and execution is paramount. This would include scale development,

conducting a small pilot study, incorporating validity checks, and requiring more sensitive parameters for participant inclusion to ensure quality responses. In addition, sampling a local or regional population with a more focused research question could yield more significant findings. Such a study regarding mental health outcomes related to political bias in the social sciences would have more clinical utility if conducted in vivo with a clinical sample, as this would be more relevant to the research question about any existing bias.

Conclusions and Future Directions

Although primary analysis from this study did not initially yield significant findings. Within the initial sample prior to participant correction, the clinical relationship and barriers to treatment measures were not significantly influenced by self-identified political ideology, political bias in an analog therapy condition, or an interaction of the two.

However, after controlling for potential errors in data quality by removing rapid responders, there were statistically significant effects for PI and population density. Supplemental analyses revealed that the population density setting where participants lived most of their lives had a statistically significant effect on their perceptions of a hypothetical clinical relationship in the presence of perceived political bias in the therapy office.

After controlling for low quality responses by removing participants whose survey completion times indicated thoughtless, rapid responding, statistically significant results emerged. These analyses showed an effect of political bias and population density such that, relational outcomes are higher for the liberal bias condition among urban participants and lower for the neutral condition among suburban participants, with no differences in a rural population. Overall, the rural participants reported lower scores on the outcome measures of alliance and barriers than urban participants.

While weak, these analogue data show evidence that political biases could affect therapy relationships and become barriers to treatment. It is suggested that a future study look at the potential effects of political polarization in mental health outcomes for specific populations. Future research on implicit bias in mental health treatments could be conducted after correcting the previously mentioned limitations, focusing on values in addition to political affiliation, or the overlap and expression of the two.

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Appendix A

Demographics Questionnaire

1) On average how liberal (left-wing) or conservative (right-wing) are you?
    a. Strongly Liberal
    b. Liberal
    c. Conservative
    d. Strongly Conservative
    e. None of these describe me

2) What is your gender?
    a. Male
    b. Female
    c. Trans-Male
    d. Trans-Female
    e. Non-Binary
    f. Rather Not Say
    g. Other- Please Specify _____

3) What is your age in years?
    a. Age in years box _____

4) Ethnicity Origin (Or Race): Please Specify Ethic Heritage.
    a. Asia/Pacific Islander
    b. Black or African American
    c. Hispanic or Latino
    d. Middle Eastern
    e. Native American or American Indian
    f. White
    g. Mixed race
    h. Other: please specify _____

5) What region of the country did you grow up in?
    a. Northeast
    b. Southeast
    c. Midwest
    d. Southwest
    e. West
    f. Northwest

6) Did you grow up in a rural or urban area?
    a. Rural

   b. Suburban
   c. Urban

7) How Important is Religion to You?
   a. A great deal
   b. A lot
   c. Moderately
   d. A little
   e. Not at all

8) Which of the following options best describes the state you live in:
   a. My state usually votes for conservative presidential candidates.
   b. My state is usually a swing state in presidential elections and does not tend to vote in one direction or the other.
   c. My state usually votes for Liberal presidential candidates.

9) In terms of income would you say that you are:
   a. Upper Class
   b. Upper Middle Class
   c. Middle Class
   d. Lower Middle Class
   e. Working Class
   f. Prefer Not to Say

10) How much education have you completed?
   a. Some High School
   b. High School Graduate
   c. Some College
   d. 4 Year College Degree
   e. Graduate Degree

11) Which of the following categories best describes your usual occupation?
   a. Architecture and Engineering
   b. Arts, Design, Entertainment, and Media
   c. Buildings and Grounds Cleaning and Maintenance
   d. Business and Financial Operations
   e. Community and Social Service
   f. Computer and Mathematical
   g. Construction and Extraction
   h. Disabled
   i. Educational Instruction and Library
   j. Farming, Fishing, and Forestry

k. Food Preparation and Serving Related
l. Healthcare Practitioners and Technical
m. Healthcare Support
n. Installation, Maintenance, and Repair
o. Legal
p. Life, Physical, and Social Science
q. Management
r. Military Specific
s. Office and Administrative Support
t. Personal Care and Service
u. Production
v. Protective Service
w. Sales and Related
x. Stay at Home Parent
y. Transportation and Materials Moving
z. Unemployed

12) Have you ever served in the U.S. Military?
    a. Yes
    b. No

Treatment Seeking Questions

13) Have you ever had a mental health concern?
    a. Yes
    b. No

14) If yes to the previous question, did you seek professional help for mental health?
    a. Yes
    b. No

15) If yes to the previous question, did you complete the recommended treatment or leave treatment early?
    a. I completed the recommended treatment.
    b. I left treatment early.

16) If you have experienced a mental health problem and did not seek profession help, please use the space below to explain your decision.
    a. Qualitative Question

17) If you have experienced a mental health problem, sought professional help for the concern and discontinued treatment early please use the space below to explain your decision.
    a. Qualitative question.

18) Please indicate which of the following best generally describes the political leaning of the mental health field?
    a. Strongly Liberal
    b. Liberal
    c. Moderate Liberal
    d. There is no bias
    e. Moderate Conservative
    f. Conservative
    g. Strongly Conservative

Appendix B

Politics and Therapy Vignettes

You are going to read a scenario related to mental health therapy after which you will be asked to answer several questions based on what you have read. Please read the scenario carefully and answer the questions honestly to the best of your ability.

Liberal Bias

Vignette #1:

You arrive for your first therapy appointment at a well-known mental health clinic in Portland, Oregon. You circle the parking lot once or twice before you find an open parking space between a blue Toyota Prius and a green Subaru Forrester. As you walk toward the building you notice several bumper stickers, one supporting Biden 2020, a COEXIST sticker, and a Dutch Bros sticker. As you enter the office building, the receptionist greets you with a smile and after a quick introduction, you take your seat to wait for your appointment. As you relax in the lobby you look around and notice a large painting of a donkey on the wall. Shortly after, your therapist arrives and greets you with a gracious smile and takes you back into their office. While you're taking your seat, you notice that there are several college degrees on the wall, one from Seattle Pacific University and the other from the University of California at Berkley. Your therapist starts by asking your name, your preferred pronouns, and what you want to talk about today.

Neutral Bias

Vignette #2

You arrive for your first therapy appointment at a well-known mental health clinic in Chicago, Illinois. You circle the parking lot once or twice before you find an open parking space between a grey Chevy Malibu and a black Honda Accord. As you walk toward the building you notice several bumper stickers, one showing a stick figure family, one an honor roll sticker from an elementary school, and one advertising for a local sandwich shop. As you enter the office building the receptionist greets you with a smile and after a quick introduction, you take your seat to wait for your appointment. As you relax in the lobby you look around and notice a large painting of a deer on the wall. Shortly after, your therapist arrives and greets you with a gracious smile and takes you back into their office. While you're taking your seat, you notice that there are several college degrees on the wall, one from Connecticut State University and the other from the University of Ohio. Your therapist starts by asking your name, how was your drive over, and what you want to talk about today.

Conservative Bias

Vignette #3

You have just arrived for your first therapy appointment at a well-known mental health clinic in a small town in West Texas. You circle the parking lot once or twice before you find an open parking space between a red Ford F-250 and an orange Dodge muscle car. As you walk toward the building you notice several bumper stickers, one supporting Trump 2020, a pro-2nd Amendment sticker, and a Harley Davison sticker. As you enter the office building the receptionist greets you with a smile and after a quick introduction, you take your seat to wait for your appointment. As you relax in the lobby, you notice a large painting of an elephant on the wall. After a short wait, your therapist arrives, greets you with a gracious smile, and takes you back into their office. While you're taking your seat, you notice that there are several college degrees on the wall, one from the University of Texas and the other from the University of Florida. Your therapist starts by looking you in the eye, giving you a strong handshake accompanied by a robust "howdy!" After asking your name they begin with; "well, what do you want to talk about today?"

Appendix C

Political Ideology Vignettes Table

Biasing Element	Conservative Bias	Neutral Bias	Liberal Bias
Location of Therapy Office	A small town in West Texas	Chicago, Illinois	Portland Oregon
Two Vehicles in Parking Lot	Red Ford Truck & Orange Dodge Charger	A Grey Chevy & Malibu A Black Honda Accord	A Blue Toyota Prius & A Green Subaru Forrester
Bumper Stickers in Parking Lot	A 2nd Amendment Sticker, A Trump Sticker & Harley Davidson Sticker	A stick figure family sticker, an honor roll sticker, & Christian Cross Sticker	A COEXIST sticker, Biden Sticker, & a Dutch Bros Sticker
Paintings in Office	Painting of an Elephant	Painting of a Deer	Painting of a Donkey
Location of Degrees on the Wall	University of Texas and University of Florida	Ohio State University & American University in Washington DC	Seattle Pacific University & University of California at Berkeley
Greeting of Therapist	Asks your name	Asks your name how was your commute over?	Asks your name and pronouns.

Potential Elements to be Included

Treatment Goal	Standard treatment goal	Standard treatment goal	Standard treatment goal
Apparel worn in Waiting Room	A NASCAR Hat & a "hunting is conservation t-shirt."	A Fed Ex hat, & a Rolling Stones T-Shirt	A Black Lives Matter Bracelet? Tie-Dye and Peace Shirts?
Available Reading Material in Waiting Room	The Epoch Times and Bow Hunter Magazine: Field and Stream	Time Magazine	The New York Times

Appendix D

Agnew Relationship Measure (ARM)- 12 Item (Client Form)

(Bond items)

2. I feel friendly towards my therapist/My client is friendly towards me

19. My therapist is supportive/I feel supportive

22. My therapist seems bored or impatient with me/ I feel bored or impatient with my client (R)

(Partnership items)

20. My therapist follows his/her own plans, ignoring my views of how to proceed/I follow my own plans, ignoring the client's view of how to proceed (R)

26. My therapist and I agree about how to work together/My client and I agree about how to work together

27. My therapist and I have difficulty working jointly as a partnership/My client and I have difficulty working jointly as a partnership (R)

(Confidence items)

6. I have confidence in my therapist and his/her techniques/My client has confidence in me and my techniques

12. My therapist's professional skills are impressive/My professional skills are impressive to my client

21. My therapist is confident in him/herself and his/her techniques/I feel confident in myself and my techniques

(Openness items)

3. I am worried about embarrassing myself with my therapist/My client is worried about embarrassing her/himself with me (R)

5. I keep some important things to myself, not sharing them with my therapist/My client keeps some important things to her/himself not sharing them with me (R)

8. I feel I can openly express my thoughts and feelings to my therapist/My client feels she/he can openly express her/his thoughts feelings to me

*These are the original items used in the ARM (see Agnew-Davies et al., 1998) and reported in Cahill et al. (2012). These items were presented in this order because this is the ARM-12 measure as used by Cahill et al. (2012)

Appendix E

Adapted Barriers to Tx Scale (ABTS)

The domains were taken from Lingley-Pottie & McGrath, 2011. The Original questions appear before my adapted versions done to fit the hypothetical nature of the vignettes. All items were scored on a 5-point Likert scale.

Domain= Personal Comfort Safety

1) Retained the Original Item: I felt uncomfortable when asked personal questions.

2) Adapted Item: I would feel uncomfortable when asked personal questions.
   a. Original Item: I felt uncomfortable when asked personal questions.

Domain= Privacy Anonymity

3) Adapted Item: The privacy I would feel in the treatment setting would help me admit my problems openly. (R)
   a. Original Item: The privacy I felt in the treatment room helped me admit my problems openly.

4) Retained Original Item: The privacy I felt in the treatment setting would help me open up about things I would usually keep to myself. (R)

5) Adapted Item: I would be concerned that people would talk about me when my session was over.
   a. Original Item: I was concerned that people talked about me when my sessions were over.

Domain= Judgement by Others

6) Adapted Item: I feel that I will be accepted for who I am. (R)
   a. Original Item: I felt that I was accepted for who I am.

Client's Judgment of Therapist

7) Adapted Item: I would be annoyed by my therapist during my sessions.
   a. Original Item: My therapist annoyed me during my sessions.

8) Retained Original Item: I formed a negative opinion of my therapist (context, appearance, voice, or what he/she was doing.)

9) Retained Original Item: I got the help I needed from my therapist. (R)

Domain= Accessibility/Convenience

10) Adapted= How easy would it be for you to commit to making it to your sessions with this therapist? (R)
    a. Original Item: It was easy to commit to making my sessions.[1]

[1] Adapted from "Development and Initial Validation of the Treatment Barrier Index Scale: A Content Validity Study." by P. Lingley-Pottie and P. J. McGrath, 2011, *Advances in Nursing Science, 34*(2), 151–162. (https://doi.org/10.1097/ANS.0b013e3182186cc0). Copyright 2011 by Wolters Kluwer Health | Lippincott Williams & Wilkins.

Appendix F

Treatment Barrier Index Scale

Table 1. Revised Items

Revised Item	Original Item (Original I-CVI)	Revised I-CVI	Retained Y = Yes/ N = No
Theme 1: Personal comfort/safety			
I found it hard to focus during my sessions	Distracted by other things going on around me (0.78); It was easy to think and focus on what I needed to (0.73)	0.81	N
I felt uncomfortable when people made notes about what I said	Self-conscious or uncomfortable when others write things about me (0.86)	1.0	Y
I felt relaxed enough in this setting to dress any way I wanted to	Like I could dress any way I wanted to and no one would know (0.65)	0.95	Y
I felt as though I was being analyzed	Like my every move was being watched or analyzed (0.78)	0.87	Y
I felt uncomfortable when asked personal questions	New item suggested to be added under theme	0.96	Y
Theme 2: Privacy/anonymity			
I worried that someone would find out that I was getting counseling	As if no knows I am getting help (0.83)	1.0	Y
The privacy I felt in the treatment setting helped me to admit my problems openly	Easy to admit that you have a problem because no one knows you (0.91)	0.96	N
I felt that what I talked about was confidential	Like my discussions or what I say is private (0.96)	1.0	Y
I felt that what I did during my treatment sessions was private	That how I act or what I do is secret (0.68)	1.0	Y
I felt that my identity was protected	I felt sort of anonymous (0.61)	0.96	Y
The privacy I felt in the treatment setting helped me open-up about things I would usually keep to myself	That I could open-up about things I would usually keep to myself because it was private (0.91)	0.96	Y
The treatment setting provided me with enough privacy	As if my problem is private (0.95)	0.96	Y
I was concerned that people talked about me when my sessions were over	Self-conscious because my therapist and others may talk about me when I am not there (0.90)	1.0	Y
Theme 3: Judgment by others Stigma			
I felt that I was accepted for who I am	Accepted by my therapist (0.91)	1.0	Y
I felt as though no one cared how I looked	Like I could dress any way or have my hair anyway I wanted to and no one would judge me for the way I looked (0.87)	0.91	Y
I felt that people looked down on me for needing counseling	Nervous that other people would judge me because I was getting help (0.91)	0.96	Y

Table 1. Revised Items (*Continued*)

Revised Item	Original Item (Original I-CVI)	Revised I-CVI	Retained Y = Yes/ N = No
Theme 4: Client's judgment of therapist			
My therapist annoyed me during my sessions	Like my therapist does things that annoy me (0.82)	0.96	Y
I formed a negative opinion of my therapist (eg appearance, voice, or what he/she did)	Like I judged my therapist for how he/she looked or behaved (0.91)	1.0	Y
I felt that my therapist knew what he/she was doing	New item suggested to be added under theme	1.0	Y
I got the help I needed from my therapist	New item suggested to be added under theme	1.0	Y
Theme 5: Accessibility/convenience			
There were costs to me to have counseling sessions (eg financial, time or psychological)	As though there was a financial burden to have the sessions (1.0)	1.0	Y
It was easy to commit to making my sessions.	New item suggested to be added under theme	0.96	Y
I would be worried about missing a session if something came up (bad weather, childcare issues, illness, work)	New item suggested to be added under theme	0.87	Y
The wait to get counseling was too long	New item suggested to be added under theme	1.0	Y
My sessions kept me from getting important things done	New item suggested to be added under theme	0.86	Y
The treatment location was convenient for me	Like sessions were easy to get to (0.91)	0.96	Y
There was a lot to organize to make the sessions	New item suggested to be added under theme	0.91	Y

Abbreviation: I-CVI, item Content Validity Index.

Note. From "Development and Initial Validation of the Treatment Barrier Index Scale: A Content Validity Study." by P. Lingley-Pottie and P. J. McGrath, 2011, *Advances in Nursing Science, 34*(2), 151–162. (https://doi.org/10.1097/ANS.0b013e3182186cc0). Copyright 2011 by Wolters Kluwer Health | Lippincott Williams & Wilkins.

Appendix G

Informed Consent

Thank you for choosing to enter this research study; your participation is completely voluntary, and you have the right to withdraw at any time. Your feedback is important, and you will be given monetary compensation for your effort. Please answer the questions honestly.

The purpose of this study is to determine how political ideology interacts with other factors to influence mental health outcomes. This study will be asking you questions about your demographics, political orientation, religiosity, military service, and cognitive and emotional responses to a series of short stories. To protect your identity and keep your responses confidential, please do not provide your name or any other personally identifying information. All responses will be aggregated, and only aggregated data will be reported.

The experiment should take 15-20 minutes to complete and that there will be no inherent risks or adverse effects for your involvement. You may feel some discomfort while reading the stories. There are no inherent benefits to participation in this study other than helping the researchers better understand how certain factors interact with mental health treatment.

If you have any further questions or concerns you may contact the researchers through email: Bhanks18@georgefox.edu or phone: 503-302-3162.