

Exploring the impact of Asian stereotype endorsement, multicultural counseling competence,
and motivation to respond without prejudice on White therapists' clinical judgment

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ABSTRACT

Exploring the impact of Asian Stereotype Endorsement,
Multicultural Counseling Competence, and Motivation to Respond Without Prejudice
on White Therapists' Clinical Judgment

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People have the tendency to rely on stereotypes while making judgments due to limitations of cognitive capacity. The shifting standards model suggests that people tend to use stereotypes as a standard when they make subjective judgments about members of stereotyped groups and that they unconsciously shift their standards based on stereotypes they hold for particular groups. Researchers have found that White therapists tend to shift their standards while making clinical judgment of their clients of Color. The majority of the research to date has focused on White therapists and Black clients, while the research on White therapists and Asian clients is scant.

The current study investigated whether White psychology trainees shift standards in making subjective clinical judgment based on race and residency status of a fictitious White, Asian and Asian-American clients described in a vignette. The study also examined the potential relationships among White psychology trainees' level of self-reported Asian stereotype endorsement, multicultural counseling competence, and motivation to respond without prejudice and their impact on White trainees' initial clinical judgment. Participants included 439 (350 females, 89 males) White psychology trainees across the US. It was expected that White trainees would show less concern regarding symptom severity and a more optimistic prognosis for Asian target clients compared to a White target client. Furthermore, it was expected that White trainees

would show less concern for symptom severity and a more optimistic prognosis for an Asian international student target compared to an Asian American target client.

Results of an ANOVA revealed that White trainees did show less concern for symptom severity and more optimistic prognosis for an Asian international target client compared to a White target client. However, the results showed no difference between the ratings of symptom severity and prognosis for an Asian international student versus an Asian American student target client. For ratings of prognosis, regression analyses identified interaction effects between target client race and Asian competence stereotype endorsement, and also between target client race and participants' age. For ratings of symptom severity, no interaction effects were found. However for White trainees who responded to Asian international student target client there was a main effect for multicultural awareness on ratings of symptom severity. Similarly, for White trainees who responded to the Asian American target client vignette, main effects were found for multicultural awareness and Asian competence stereotype endorsement on ratings of symptom severity.

Implications for training, practice, and research are discussed.

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Chapter I

Introduction

Human beings are surrounded by a complex environment, which contains large amounts of information. It would be an unmanageably tedious and overwhelming task to take in all information before forming an impression of every person we encounter or making every decision in our lives. It would also be unrealistic to thoroughly evaluate all information before reaching a decision under certain conditions, such as under time constraints, or when the amount of information is too vast or complex. Fiske and Taylor (1984) coined the term “cognitive miser” to suggest that human beings can only actively perceive a small amount of information while making decisions. Lippmann (1922) pointed out in his classic book *Public Opinion* that:

"For the real environment is altogether too big, too complex, and too fleeting for direct acquaintance. We are not equipped to deal with so much subtlety, so much variety, so many permutations and combinations. And although we have to act in that environment, we have to reconstruct it on a simpler model before we can manage it" (p. 16).

However, the question which remains unanswered is how human beings "reconstruct" the environment to a “simpler model.”

Social psychologists have long been trying to answer this question by investigating human social-cognitive functioning, especially the cognitive shortcuts, such as heuristics, that help simplify process of making judgments (e.g., Epley, Keysarr, Van Boven, & Giovich, 2004; Jacowitz & Kahneman, 1995; Tversky & Kahneman, 1973, 1974). Among the abundant studies of social cognition, stereotypes have been one of the most studied topics (see Operario & Fiske, 2001 for a review). Stereotypes have been frequently characterized as “energy-saving devices” that help simplify perception and judgment in social context (Cloutier, Mason, & Macrae, 2005;

Fiske & Neuberg, 1990; Macrae, Milne, & Bodenhausen, 1994). For instance, people frequently construe others on the basis of the social groups to which they belong, based on easily perceived physical features, such as race (McArthur, 1982; McCann, Ostrom, Tyner, & Mitchell, 1985). The process of categorizing others based on their membership in particular groups activates schematic processing of information.

A schema is a cognitive structure that represents knowledge about a concept, and its attributes and the relations among those attributes, which is built up from past experiences (Fiske & Taylor, 1991). Stereotypes can be seen as a form of role schema which is the cognitive structure that organizes one's knowledge and expectations about sets of behaviors that are expected of people in particular social positions (Snyder, 1981; Fiske & Taylor, 1991; Operario & Fiske, 2001). Although stereotypes can be built up from past experiences as schemas, racial stereotypes mostly come from social conditioning (Fiske & Taylor, 2008; Sue, 2003). In other words, it is inevitable for social beings to acquire prevailing racial stereotypes in the society while having limited direct experiences with individuals from certain racial groups.

Literature shows that people tend to assume individuals of a particular group all possess similar traits and they use these category-based expectations to guide their interactions with the individuals of particular social groups (Allport, 1954; Brewer, 1998; Fiske & Neuberg, 1990; Macrae & Bodenhausen, 2000). Although stereotypes serve the function of simplifying decision making, relying on stereotypes has consequences. This kind of approach to simplifying perceptions of human groups often leads to overgeneralizations and unexamined assumptions about individuals from particular groups, which clouds people's judgment (Bargh, 1997; Fiske & Neuberg, 1990; Operario & Fiske, 2001). In other words, stereotypes may lead to prejudice.

Although none of us are immune from this much needed human tendency which helps to free up limited cognitive resources for us to engage in multiple tasks at the same time, relying on stereotypes can be more prominent under certain circumstances, such as having more power, being higher in the social hierarchy, lack of motivation, and lack of awareness of one's own values and biases (Depret & Fiske, 1993; Fiske, 1993; Macrae, Hewstone, & Griffiths, 1993; van Knippenberg, Dijksterhuis, & Vermeulen, 1999; Macrae et al., 1994; Plant & Devine, 1998; Sinclair & Kunda, 1999).

One of the specific areas in which researchers are interested is understanding the role of social cognition in clinical settings. Therapists' information processing and clinical judgments can have an impact on their client impressions, prognostic decisions, and treatment plan formulations (Owne, 2008). Despite their well-meaning intentions and efforts, therapists in general are not exempt from this human tendency, particularly given the often complex and ambiguous nature of clients' problems (Pfeiffer, Whelan, & Martin, 2000). As previously mentioned, stereotyping is more prominent under certain circumstances. One of the conditions is that individuals who have power or are near the top of the social hierarchy are more likely to rely on stereotypes to make judgments of those who have less power (Depret & Fiske, 1993; Fiske, 1993). In the United States, White individuals still dominate most of the major institutions and have control over social policies. For instance, 80 % of the House Representatives and 84% of U.S. Senate are White (Sue, 2003). One can find the same pattern in education and mental health fields, such as that 90% of APA members are White (American Psychological Association, 2008). In other words, they have the power to define norms in this society whether it is intentional or unintentional. As a result, White individuals might pay less attention while making judgments of members of racial minority because their fates or outcomes do not depend on them.

The same phenomenon exists in the clinical setting. Literature shows that White therapists were found to be more susceptible to the influence of stereotypes when processing information about ethnic minorities (e.g., Wampold, Casas, & Atkinson, 1981).

As previously mentioned, people frequently construe others on the basis of their membership in racial groups, and this tendency in a clinical setting can be damaging to clients of Color. Researchers have demonstrated that when people use stereotypes to interpret events, they will have different interpretations when the stereotyped character in the event changes from one category to another (Kunda & Sherman-Williams, 1993; Plant, Kling, & Smith, 2004). For instance, in Plant, Kling, and Smith's (2004) study, they changed the gender of an ambiguous angry-sad face by changing the hair or clothing. They found that people interpreted the facial expression as angry if male and sad if female which is in line with gender stereotypes about emotions. This tendency represents a danger especially to clients of Color. The reasons are as following: first of all, therapists' clinical judgments are usually based on quickly-formed clinical impressions (Owen, 2008), and they are influenced by stereotypes due to the nature of cognitive processes. Secondly, research shows that therapists use more confirmatory strategies than disconfirmatory assessment approaches to formulate clinical impressions (Haverkamp, 1993, 1994; Pfeiffer et al., 2000; Strohmer, Shivy, & Chiodo, 1990). This phenomenon is known as confirmatory bias. White individuals are more vulnerable to use stereotypes, as previously mentioned. One may suspect that when therapists hold the stereotype that particular racial minority groups have a higher prevalence of certain disorders or symptoms (e.g., Asians are socially withdrawn), they may tend to elicit and interpret information from their clients of Color to support their existing beliefs.

Relying on stereotypes in a clinical setting can lead to bias. Bias usually implies a prejudgment or prejudice. Although the existing literature shows that clients of Color, especially Black clients, suffer from being overpathologized (e.g., Strakowski, McElroy, Keck, & West, 1996; Trierweiler et al., 2000), biased evaluations do not only occur in one direction. Biased evaluations not only occur in the direction of greater disturbance, they also occur in the opposite direction, toward the perception of lesser disturbance (Lopez, 1989). There are two types of bias of clinical judgments: overestimating and underestimating symptom severity (Lopez, 1989). Although it is important to study the phenomenon of overpathologizing clients of Color, it is equally important to study the other type of biased clinical judgment, which is underestimating symptom severity of clients of Color. Research has found that in high emergency situations, White individuals offered more help at a faster rate to White victims than to comparable Black victims (Kunstman & Plant, 2008). This tendency was associated with White individuals' interpretation of the emergency as less severe and themselves as less responsible to help Black victims rather than White victims. In other words, the interpretation of Black victims' less severe conditions justified their lack of help. If White therapists evaluate clients' of Color symptoms as less severe than they actually are, it would mean less help and treatment for clients of Color.

Biernat and her colleagues proposed the shifting standards model to further illustrate the tendency to rely on stereotypes to make judgments and the mechanisms behind them (Biernat, 2003; Biernat, Collins, Katzarska-Miller & Thompson, 2009; Biernat & Kobrynowicz, 1997; Biernat & Manis, 1994; Biernat, Manis, & Nelson, 1991). The shifting standards model suggests that when people make subjective judgments about members of stereotyped groups, they tend to use racial/cultural stereotypes or schemas as a standard and they unconsciously shift their standards. In other words, people compare individuals with other members of a stereotyped

group, but not to everyone in general (Biernat & Kobrynowicz, 1997; Biernat et al., 2009). For instance, when a woman is judged to be tall, the standard of comparison might be different from judging a male who is expected to be taller than a woman. Thus, a man of the same height might not be considered tall when compared to other men.

Research shows that therapists also have the tendency to shift standards while making clinical judgments (Gushue, 2004; Gushue, Constantine, & Sciarra, 2008). For instance, clients of Color, such as Latino or Black individuals, tend to be judged by White therapists as healthier compared to White individuals. It may seem counter-intuitive that clients of Color are judged to be healthier because stereotypes associated with Black or Latino individuals tend to be negative. However, based on the shifting standards model, individuals of lower-status social groups would be judged healthier by White therapists because of the lower standards they have toward those racial groups. Those lower standards reflect the societal stereotypes which people inevitably acquire through socialization (Brigham, 1971; Enrich, 1973; Sue, 2003). The consequence is that clients of Color may not receive the proper treatment for their presenting problems. As previously mentioned, White individuals are more likely to use stereotypes due to power status; thus, White therapists are considered to be more likely to shift their standards while making clinical judgments of their racial minority clients. When clients of Color perceive their White therapists to be prejudiced, it could influence their perceptions of their White therapists' ability to work effectively with them which in turn may lead to premature termination of services (Constantine, 2007). Literature shows that members of minority groups tend to underutilize traditional mental health services, or when treatment is sought, they prematurely terminate at a much higher rate than do clients who are not members of racial minority groups (Leong & Lau, 2001; U.S. Department of Health and Human Services, 2001; Yang & WonPat-Borja, 2007).

Due to people's tendencies to rely on stereotypes and to shift standards while making judgments, it is important to investigate White therapists' stereotypes associated with racial minority groups, and the mechanisms of their shifting standards/stereotypes while making clinical judgments for different racial minority groups. There are different sets of stereotypes associated with different racial groups, but the majority of existing literature focuses on White therapists' stereotypes of Black clients and their effects on clinical judgment (e.g., Abreu, 1999; Trierweiler et al., 2000; Sohler & Bromet, 2003; Rosenthal, 2004). Although examining the impact of stereotypes for each racial minority group is ideal, it exceeds the scope of current study. The focus of current study will be on Asian individuals, not only because this type of research on Asian clients is scant, but also because stereotyping of Asian individuals represents a complex phenomenon. People's attitudes toward this particular group are often ambivalent (Ho & Jackson, 2001; Lin, Kwan, Cheung, & Fiske, 2005). For instance, people may respect Asian individuals for their perceived intelligence, but resent them at the same time for their perceived success.

According to the Stereotype Content Model (SCM), stereotypes are captured in two dimensions, warmth and competence (Fiske, Cuddy, Glick, & Xu, 2002; Fiske, Xu, & Cuddy, 1999). Whether a group is stereotyped as competent or warm depends on the structural relationships between groups (i.e., status and competition) (Cuddy, Fiske, & Glick, 2007; Lin et al., 2005). The SCM claims that ambivalence of most social stereotypes reflects the structural relationship between groups which is determined by groups' relative status and the nature of interdependence between groups (i.e. whether the outgroup is viewed as being in a competitive or cooperative relation with one's own, Fiske et al., 1999; Operario & Fiske, 2001). Relative status predicts whether the target group is perceived as competent or incompetent, and interdependence predicts whether the target group is perceived as warm or not (Fiske et al, 1999).

Perceived high status of the outgroup leads to stereotypes of perceived competence. Viewing the outgroup as being in a competitive relation with one's own group leads to stereotypes of being unsociable and lack of warmth. Literature shows that stereotypes associated with outgroups may be positive on either competence or warmth, but not on both (see Cuddy et al., 2007 for a review). For instance, Asians are stereotyped as being highly competent, but low in warmth. The intention of using competence-warmth to categorize outgroups is to maintain ingroup's status quo (Lin et al., 2005). Taking Asians as an example, Asians may be judged favorably on competence because White culture values competence. However, Asians being competent may posit a threat to White individuals in terms of limited social resources (e.g., job opportunities). Therefore, stereotypes of Asians being unsociable may justify discrimination against them (Lin et al., 2005). The SCM provides an explanation of social relations between ingroups and outgroups, but it does not specifically describe the impact of within-group differences. For instance, Asian individuals in the U.S. are not all citizens, and some subgroups are perceived as having lower status which may lead to perceived lower competence (e.g., immigrants and international students). For instance, international students are viewed as handicapped, deficient (Mestenhauser, 1983) and unintelligent due to lack of English language proficiency (Paige, 1990; Kim & Kim, 2010), which are different from stereotypes associated with Asian Americans. The question is whether people will shift their standards while judging members of subgroups due to lower expectations of members of subgroups. Current literature has not yet answered this question. Research is already scant in the area of White therapists' stereotypes of Asian clients; there is no study conducted on White therapists' shifting standards and the differential impact of Asian stereotypes (competence and sociability) on clinical judgment.

In addition to holding stereotypes of racial minority clients, White therapists may not be aware of the ways psychological theories and concepts perpetuate the culture-bound value systems of White culture, such as valuing autonomy and verbal communication, which are different from many racial minorities' cultural values (Sue et al., 1998; Sue & Sue, 2003). Since White culture is the dominant norm in U.S. society, it might be difficult for White therapists to see an alternative reality (i.e., worldviews of clients of Color). Scholars have established guidelines and standards of multicultural counseling competence to promote the importance of developing awareness, knowledge, and skills for treating racially diverse clients (Arredondo, et al., 1996; Sue, Arredondo, & McDavis, 1992). Research shows that multicultural counseling competence is related to multicultural case conceptualization, which in turn has impact on clinical judgment (Constantine, 2001a). Although the establishment of multicultural counseling competence provides White therapists a tool to overcome prejudice toward clients of Color, there are potential pitfalls. By focusing on teaching White therapists the knowledge of "typical" cultural experience of People of Color without examining the within-group differences, therapists might acquire new sets of "stereotypes" of their racially diverse clients. These new sets of expectations then serve as the new standards for making clinical judgment. As a result, they may apply the newly acquired knowledge or stereotypes to account for their racially diverse clients' symptoms due to the fears of appearing multicultural incompetent. This kind of fear is viewed as external motivation.

Research suggests that motivation also plays a major role in reducing stereotyping of members of racial minority groups. Plant and Devine (1998) distinguished between internal and external sources of motivation to respond without prejudice. Internal sources of motivation refer

to internal reasons, such as internalized and personally important nonprejudiced standards whereas

external sources of motivation reflect external reasons, such as social pressure to comply with nonprejudiced norms (Plant & Devine, 1998). Individuals who are more internally motivated to control prejudice exhibit less prejudice toward members of stereotyped groups than people who are more externally motivated (Devine et al., 2002). In other words, the impact of stereotypes on judgment is weaker for internally motivated individuals whereas the impact is greater for externally motivated individuals. Plant and Devine (2009) also found that people who are motivated to respond without prejudice will actively work on prejudice reduction. The current study will utilize the findings of research on motivation and apply them to investigate clinical judgment.

Purpose of the study

The tendency to overpathologize clients of Color exists as literature suggests, but the tendency to underestimate clients' of Color symptom severity also exists. The tendency of underestimating symptom severity may be influenced by stereotype endorsement (i.e., having lower standards of clients of Color) or compensating the cultural background of clients' of Color for symptom severity. The present study aims to explore the impact of client's race on White therapists' clinical judgment. In order to better understand the relationships among Asian stereotype endorsement, multicultural counseling competence, and clinical judgment, the present study seeks to examine if White therapists' endorsement of Asian stereotypes, their self-reported multicultural counseling competence, and their motivation to respond without prejudice have an impact on their clinical judgment. As previously mentioned, stereotypes influence people's interpretations of others' behaviors. Furthermore, people may shift their standards based on

stereotypes while making subjective judgments of different groups. Therefore, in this study, particular attention will be paid to the potential differences between White therapists' clinical judgment of Asian clients and White clients. The purpose is to explore whether White therapists' clinical judgment is in line with racial stereotypes. In other words, the current study explores whether White therapists judge Asian clients as more healthier compared to White clients due to lower standards (i.e., stereotypes) they have toward Asian clients. In order to further understand the mechanism behind White therapists' process of making clinical judgment of Asian clients, this study also explores whether White therapists evaluate their Asian clients differently in terms of symptom severity based on their residency status in the U.S. For instance, will White therapists use lower standards or expectations to judge an Asian international student client and therefore she is judged as healthier compared to an Asian-American client? Will White therapists compensate an Asian international student client's adjustment difficulties for symptom severity? In addition to exploring the impact of race (Asian clients versus White client) and residency status (Asian international student client versus Asian-American client) on White therapists' clinical judgment, the roles of White therapists' endorsement of Asian stereotype, multicultural counseling competence, motivation to respond without prejudice are also investigated.

Chapter II

Literature Review

The present study proposes that White therapists' clinical judgment is affected by the race of the client. To be more specific, the present study proposes that White therapist's clinical impression of Asian clients are influenced by their endorsement of Asian stereotypes, their level of multicultural counseling competence, and their motivation to control prejudice. This study explores the relationships among White therapists' Asian stereotype endorsement, their self-reported multicultural counseling competence, and their motivations to respond without prejudice, and the impact of these factors on White therapists' evaluation of symptom severity and client impression of an Asian international student client, an Asian American client, and a White client based on fictitious clinical vignettes.

The aim of this chapter is to examine the existing research on information processing, Asian stereotypes, and prejudice reduction. The first section of this chapter provides an overview of information processing as it provides knowledge of how people make judgments in general and clinical judgments in particular. The second section reviews Asian stereotypes, and examines their impact on people's attitudes toward Asians and perceptions of Asians' mental health. The third section focuses on sources of prejudice reduction, such as multicultural counseling competencies and motivation to respond without prejudice. The chapter concludes with the present study's proposed hypotheses and research questions.

Clinical Judgment

It is important to understand the assessment process because therapists' initial impressions influence the course of treatment, particularly in terms of prognostic decisions and formulation of treatment plans (Owen, 2008). Assessment includes anything therapists do to

gather client information and make clinical judgments (Haverkamp, 1994). Although accurate clinical judgments are crucial to the provision of effective therapy, therapists usually do not have the capacity or time to contemplate all sources of information to form accurate clinical judgments. Therapists are usually faced with a vast amount of information and would be overwhelmed if forced to form judgments based on all available information. The assessment process becomes even more complicated when therapists work with racially diverse clients whose backgrounds and cultural experiences are highly dissimilar to their own (Sue et al., 1992; Sue et al., 1998) due to the need to incorporate more unfamiliar information.

Therapists' clinical judgments are usually based on quickly-formed clinical impressions due to nature of cognitive processes (Owen, 2008). Fiske and Taylor (1984) suggested the idea that humans are cognitive misers as they tend to rely on simple and time efficient strategies when evaluating information and making decisions. These strategies are developed not out of laziness, but to help compensate for information processing limitations (Macrae & Bodenhausen, 2000, 2001). Therefore, individuals tend to stay close to their established beliefs when considering new information. Although these strategies serve the important cognitive function of simplifying information processing and decision-making, they often lead to overgeneralization, such as that all Asians are good at math. Stereotyping is one example of this phenomenon. According to Lippmann (1922), stereotypes refer to "pictures in our heads" that simplify people's perceptions of human groups. He argued, "For the most part we do not first see, and then define, we define first and then see" (Lippmann, 1922, p.81). Before moving on to stereotyping, it is important to first understand the more common and general strategies people use because they can provide an explanatory mechanism for stereotyping.

Information processing

Heuristics. According to Tversky and Kahneman (1974), people rely on heuristic principles to reduce the complex tasks of making predictions and judgments under uncertainty. Heuristics are thinking shortcuts that can help lessen the cognitive demanding of individuals when making judgments. Tversky and Kahneman (1974) identified three forms of heuristics: the representativeness, availability, and anchoring-adjustment heuristics.

The representativeness heuristic involves an evaluation of the probability that an object A belongs to class B, and probabilities are evaluated by the degree to which A is representative of B (Tversky & Kahneman 1973; Tversky & Kahneman, 1982). In other words, when A highly resembles B, the probability that A fits into B is judged to be high. For instance, a person who is being described as family-oriented, hardworking, compliant, skilled in math, and shy could more easily be assumed to be an Asian individual than a Black individual because these descriptions are highly representative of the social stereotypes of Asians.

The availability heuristic is the tendency to make an assessment of the probability of an event's occurrence based on how easily an example can be brought to mind (Tversky & Kahneman 1974). According to Tversky and Kahneman (1974), an event whose examples are more familiar will be judged to happen more frequently than an event of equal frequency whose examples are less retrievable. For instance, people tend to rate the chance of death by plane crash higher than the chance by car crash because the unusual events are more often reported in mass media, and therefore, it is easier to think of an example of plane crash (Fiske & Taylor, 2008). Similarly, the notion that Black Americans suffer more from schizophrenia (e.g., Mukherjee, Shukla, Woodle, Rosen, & Olarte, 1983; Trierweiler et al., 2000) can inflate therapists' estimates of likelihood of Black clients having schizophrenia.

The anchoring-adjustment heuristic describes cases in which one makes estimates by starting with some initial value, known as anchor, and then adjusts until an acceptable value is reached (Tversky & Kahneman, 1974). However, people have the tendency to adjust insufficiently from the original anchor (Tversky & Kahneman, 1974) and their adjustments are often close to the initial anchor (Epley et al., 2004). Jacowitz and Kahneman (1995) illustrated this tendency in their experiment. In one of the conditions, one group of participants was asked to indicate whether the numbers of female professors at University of California, Berkeley (UC Berkeley) was greater or less than 25, and in another group, participants were asked to indicate whether the numbers was greater or less than 130. Then, they were asked to estimate the numbers of female professors at UC Berkeley. The results indicate that individuals whose initial anchor was 130 estimated that UC Berkeley has 95 female professors while people whose original anchor was 25 estimated the numbers of female professors as 50. This tendency of making small adjustments from an original starting point creates an issue in clinical judgments. When anchoring-adjustment heuristic is engaged, therapists will show the tendency of making slight adjustments of their initial clinical impression in light of new information. For instance, when a therapist holds the stereotype that Asians are avoidant which serves as an anchor, he might not adjust from his original impression enough even after he learns that his Asian client adheres to the Asian value of being reserved.

Social schemas. Another common category of cognitive strategies people use to simplify perception and judgment is social schemas. A schema refers to cognitive structure that represents knowledge of a concept or an object, including its attributes and the relations among those attributes (Macrae & Bodenhausen, 2001). When people encounter an object, the schema of that object is activated, bringing to mind the information which is linked to the original concept by

association (Fiske & Taylor, 1991). This activation process is often automatic especially when time is limited. As a result of this process, people tend to make judgments that go beyond the information that is actually available. For instance, if an Asian student is first introduced to the class, an “Asian schema” may be activated, and this Asian student may be viewed as good at math or nerdy based on individuals’ previously established mental associations of Asians.

There are four types of schemas: person, self, event, and role schemas (Taylor & Crocker, 1981). Person schemas refer to people’s understanding of different types of people, focusing on their traits and goals. These schemas help people with encoding, memory, and inferences about other individuals. Self schemas refer to the beliefs and ideas people have about themselves which are important to a person’s overall self-concept. Event schemas or scripts describe appropriate sequences of events in well-known situations. Although many scripts are universal, such as swimming or riding a bike, different cultures supply people with different event schemas. Fiske and Taylor (1991), for example, in describing a cultural event schema, drew on an American Indian folk tale: “The story’s hero is shot by an arrow in battle, but feels nothing. His allies turn out to be ghosts. He returns home and tells the story. A black thing comes out of his mouth, and he dies at sunrise the next day” (p.119-120). Therapists who are familiar with American Indian culture might understand that the hero did not feel the arrow because he was in the company of ghosts and beyond normal pain, and that the black thing coming out of his mouth was his departing soul. However, most therapists who are not knowledgeable about American Indian cultural values will not understand this story if heard it in the session. The therapists who do not have the skill to process its symbolic meaning (e.g., death) of the story may miss something significant for the client due to the fact that it does not fit into the script of death or battle of other cultures.

A role schema is the cognitive structure that organizes one's knowledge and expectations about sets of behaviors that are expected of people in particular social positions. There are two types of roles: achieved and ascribed. Achieved roles are acquired by effort and intent, such as through education or occupation. Ascribed roles are acquired at birth, such as race and sex. Each of these characteristics carries certain role-based expectations for behaviors. Although schemas assist individuals to function in a social world that is overwhelming complex, people may overgeneralize the characteristics of certain groups based on their ascribed roles (Snyder, 1981; Operario & Fiske, 2001). Consequently, role schemas based on ascribed roles may be accountable for stereotyping. For instance, seeing an Asian client may activate therapist's schema of Asians based on race, so he overgeneralizes characteristics (e.g., shy) associated with Asians to his Asian client while failing to explore the reasons behind shyness.

It has been suggested that when a schema is more accessible, it will be activated faster than less accessible schemas. There are two factors that affect the accessibility of schemas: salience and priming (Fiske & Taylor, 1991). Salience is the degree to which a person stands out from others in a situation. The higher the salience of an object the more likely the schemas for that object will be made accessible. People tend to use schema cues that catch attention. For instance, the only female in an all-male work context is more likely to be gender-stereotyped than is a female in a balanced environment (Pettigrew & Martin, 1987). Priming refers to any experience immediately prior to a situation that causes a schema to be more accessible. People tend to use schemas that are already primed. For instance, participants primed with an Asian assistant in an experiment completed words using more stereotypic words related to Asians than participants primed with a White assistant (Gilbert & Hixon, 1991). These tendencies pose a danger to clinical evaluations because race is a salient factor and it serves as a cue (Fiske &

Taylor, 1991). When therapists are not aware of their tendencies, they may form their clinical impression based on racial stereotypes.

Schemas influence the encoding of new information, memory for old information, and the development of inferences when information is missing. They have an impact on people's impressions, judgments, and subsequent interactions with others. Although the schema concept assumes that individuals take an active role in constructing reality and attach meaning to processed stimuli, culture plays a crucial role. Schemas are largely shaped by societal-based norms and accepted knowledge (Fiske & Taylor, 1991). Therefore, individuals from different cultures have different schemas for persons, self, events, and roles. Relative to the clinical settings, therapists hold schemas of what human attributes go together, or what constellations of symptoms fit a particular mental disorder described in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR; American Psychiatric Association, 2000) based on their cultural backgrounds and training experiences. When therapists encounter a client cue that fits their schemas, they tend to expect that other aspects of the schema will also be associated with that client (Haverkamp, 1994). For instance, when a therapist who meets an Asian client who is socially shy that fits his "avoidant personality" schema may fall into an expectation that the client will exhibit a range of poor interpersonal skills. This tendency becomes problematic when therapists encounter clients who are dissimilar in terms of their own racial and cultural background. After activation of certain schemas during the initial assessment process, it may be difficult for therapists to adjust their initial impressions in light of new information due to time constraints or limited cognitive resources.

It may seem that people are not attuned to reality, and instead lean on heuristics and social schemas to make inferences or judgments; however, people do have the cognitive

resources and capacity to process complex information (Fiske & Taylor, 1991). It takes effort for people to become aware of their cognitive tendencies to simplify perception and decision making. After gaining awareness, it also takes a lot of effort and time for people to adjust from their first impressions of others or to take inconsistent information into consideration while making judgments (Epley & Gilovich, 2006). People will only engage in this kind of process when they are highly motivated to do so (Amodio et al., 2004; Sinclair & Kunda, 1999).

Types of bias in clinical setting

As previously stated, people tend to make insufficient adjustment from their original anchor or initial impression. Literature related to clinical settings shows that people have the tendency to actively seek or attend to information that is consistent with one's existing beliefs or stereotypes of other people (i.e., original anchor) (Snyder & Campbell, 1980; Snyder, Campbell, & Preston, 1982; Swann & Giuliao, 1987). Research has found that therapists tend to attend to information, gather information, and interpret information in a manner that supports their original hypotheses about the clients (Haverkamp, 1993, 1994; Pfeiffer et al., 2000; Strohmer et al., 1990). Additionally, therapists overlook relevant information that is not consistent with their initial impressions or hypotheses about the clients (Haverkamp, 1994; Pfeiffer et al., 2000; Owen, 2008). In clinical practice, this kind of tendency is problematic. When therapists hold the belief that certain racial group has more of certain kinds of symptoms and disorders, they will interpret and attend to information that supports their existing beliefs of that specific racial group. This tendency is termed as confirmatory bias.

Bias usually implies a prejudgment or prejudice. Lopez (1989) points out in his review of the psychotherapy bias literature that biased evaluations do not only occur in the direction toward the perception of greater disturbance, they also occur in the opposite direction, toward the

perception of lesser disturbance. There are two types of bias of clinical judgments: overestimating and underestimating symptom severity. Overestimating occurs when a therapist is unfamiliar with the nuances of an individual's cultural frame of reference and may incorrectly judge those normal variations in belief, behavior, or experience that are particular to the individual's culture as psychopathology (Leong & Lau, 2001). For instance, certain religious practices or beliefs may be misdiagnosed as hallucinations. Underestimating or minimizing bias can occur when a therapist indiscriminantly applies a cultural explanation to explain a client's presentation (Leong & Lau, 2001). For instance, attributing an extremely reserved interpersonal style and flat affect of an Asian client to a cultural communication norm rather than considering them as depressive symptoms or withdrawal. The tendency to either overestimate or underestimate symptom severity of clients of Color is related to therapists' endorsement of racial stereotypes.

Although existing literature indicates that there is an association between therapists' stereotypes of Black clients and clinical judgment (e.g. Mukherjee et al., 1983; Neighbors, Trierweiler, Ford, & Muroff, 2003; Sohler & Bromet, 2003; Strakowski et al., 1996; Trierweiler et al., 2000), research is scant in the area of Asian stereotype endorsement and clinical judgment. In order to examine therapists' clinical judgments and their potential bias toward Asian clients, it is important to examine what stereotypes exist about Asians and their potential impact on judgment. The following section first provides an overview of stereotypes including the mechanism of stereotype on judgment and then follows by a review of Asian stereotypes and their impact on people's perception of Asians.

Stereotypes

Overview of stereotypes

It has been known in the field of social psychology that humans are cognitive misers and they tend to rely on time efficient strategies to process information (Fiske & Taylor, 1984). One of these strategies is by using easily perceived features of individuals to categorize them into groups, which is known as stereotyping (Snyder, 1981; Fiske & Taylor, 1991; Operario & Fiske, 2001). The process of categorizing others based on their ascribed roles activates schematic processing of information of others. Culture conditions the way one views oneself, and also how one perceives other people (Sue & Sue, 2003). So, it is inevitable for everyone in a society to learn prevailing racial stereotypes even when they have limited direct experience with racial minority groups due to the fact that racial stereotypes are part of the social heritage (Brigham; 1971; Enrich, 1973; Sue, 2003). A stereotype may include beliefs with diverging evaluative implications toward a social category. For instance, the stereotype of Asians may simultaneously include the traits of being intelligent and nerdy which imply both positive and negative evaluation (Fiske et al., 2002; Ho & Jackson, 2001).

Many classic and contemporary social theorists have suggested that prejudice will inevitably emerge from stereotyping processes (Allport, 1954; Enrich, 1973; Snyder, 1981; Operario & Fiske, 2001). Stereotypes are usually referred to the beliefs people have about social groups, and prejudice is referred to their evaluations of the groups (Blair, 2002). The basic assumption is that stereotypes are heuristically or automatically applied to members of the stereotyped group. This automatic process involves the spontaneous activation of some well-learned set of associations or responses that a person has developed through repeated activation in memory (Devine, 1989). As previously mentioned, people are inclined to use time efficient

strategies to process information. However, this tendency is more prominent under certain circumstances. One condition is that individuals who have power over others or are at the top of the social hierarchy (e.g., White individuals) are more likely to use heuristics or social schemas to process information of the powerless or those who are low in social hierarchy (Depret & Fiske, 1993; Fiske, 1993). As for today, White individuals still dominate most of the social institutions and have the power over social policies in the U.S. In other words, White individuals have the power to distribute social resources to ingroup members and can also define norms in this society. As a result, they may pay less attention to racial minority groups because their fate or outcomes do not depend on them, so they may be more likely to use stereotypes. For instance, White therapists in training were found to be more susceptible to the influence of stereotypes when processing information about ethnic minorities (Wampold et al., 1981).

Due to people's nature of favoring ingroup members, stereotypes associated with outgroup members tend to be negative which may lead to lower expectations (Fiske & Taylor, 2008). For instance, when one holds the stereotype that Black individuals are lazy, one will not expect a Black individual to succeed in what he or she does. This tendency can be problematic in clinical settings. If White therapists use different standard to judge clients of Color, they are not providing consistent and effective treatment for clients of Color. Biernat and her colleagues proposed the shifting standards model to describe this phenomenon (Biernat, 2003; Biernat et al., 2009; Biernat & Kobrynowicz, 1997; Biernat & Manis, 1994; Biernat et al., 1991). They suggest that people tend to use stereotypes as a standard when they make subjective judgments about members of stereotyped groups. Furthermore, people implicitly compare individuals with members of a salient group, but not to general population (Biernat & Kobrynowicz, 1997; Biernat et al., 2009). For instance, a woman might be judged subjectively better at math than the

comparable man while objective standard (e.g., math SAT score) indicates that the man has higher score. There are different gender stereotypes associated with men and women. According to Biernat et al. (2009), the woman in this example is being judged against a lower standard of math ability which is consistent with gender stereotypes that women are not good at math. In other words, the woman in this example would be subjectively judged better at math according to the lower math standards people hold for women, and not for men.

The tendency to shift standards appears in many different contexts, such as sports (Biernat & Vescio, 2002), military promotions (Biernat, Crandall, Young, Kobryniewicz, & Halpin, 1998), and hiring decisions (Biernat & Fuegen, 2001). Researchers who are interested in social cognition in clinical setting also found the same phenomenon (Gushue, 2004; Gushue et al., 2008). Clients of Color (e.g., Black or Latino) are judged to be healthier in terms of functioning or symptom severity than the comparable White clients by White therapists. Based on the shifting standards model, it is likely that White therapists tend to use lower standards to judge clients of Color due to negative stereotypes associated with them.

Stereotypes guide individuals' evaluations and judgments toward people in a social category as if all the members in that group possess traits included in the stereotypes which are specifically related to the group (Barden, Maddux, Petty, & Brewer, 2004; Greenwald & Banaji, 1995). In other words, when one encounters an individual who is a member of a particular group, the perceiver ascribes qualities associated with that group to the individual target which serves as an anchor (Fiske, 1993). For instance, the process of schematic thinking for a therapist in conceptualizing his Asian client begins at the moment that the client is identified as an Asian, which consciously or unconsciously brings up the therapist's schema representing his conceptualization of Asians. This kind of process can have consequences, but the consequences

are more severe in a clinical setting because the therapist's clinical impression will influence treatment. For instance, a therapist who ascribes trait of being intelligent to his Asian student client due to schematic thinking will have the tendency to not adjust enough from the original anchor when new information is presented or gathered. Once the therapist formulates the hypothesis regarding his Asian student client, he is susceptible to confirmatory bias, and then may underestimate his Asian student client's struggles with school and therefore fail to provide the support or resources the client needs.

Research has investigated the link between endorsing stereotypes about racial minority groups and clinical judgment, but has been primarily focusing on White therapists and Black clients (e.g., Abreu, 1999; Rosenthal, 2004). It is not surprising that research has focused almost exclusively on Black stereotypes because Black Americans represent one of the oldest racial minority groups in the United States, and many stereotypes ascribed to this group have been among the most pervasive and negative in U.S. society (Dovidio, Evans, & Taylor, 1986). However, from a historical perspective, the stereotyping of Asians represents a rather interesting phenomenon because people have used both negative and seemingly positive stereotypes, and expressed mixed attitudes toward this group.

Asians as a racial/ethnic group is quite heterogeneous with over twenty ethnic groups (e.g., Chinese, Japanese, Filipino, Korean, Cambodian, Asian Indians, etc.), and each with its own unique linguistic, cultural, and sociodemographic backgrounds, and immigration histories in the United States (Leong & Lau, 2001). Furthermore, there are variations of residency status (i.e., subgroups) among Asians, such as refugees, international students, new immigrants, first generation, second generation, etc. Most of the literature has treated Asians as a homogeneous group; however, treating Asians as a single category can lead people to the formation of

erroneous conclusions. It has been found that the diversity between ethnic groups and subgroups to be associated with a variety of differences in mental health service utilization, academic performance, employment, and adjustment (Leong, & Lau, 2001). For instance, although Asians are stereotyped as academically successful, there are differences in achievement and attainment across Asian ethnic groups and subgroups (Ngo & Lee, 2007). The experiences of Asian international students are different from Asian Americans who have been in the U.S. for multiple generations.

There are four major groups within the Asian categorization: East Asians, Southeast Asians, South Asians, and Pacific Islanders (Mio, Nagata, Tsai, & Tewari, 2007). The following section will review the literature of Asian stereotypes and their impacts as it pertains to the large, heterogeneous group of Asians while specifying the specific ethnic groups or subgroups when it is possible. The review will then focus on the impact of Asian stereotypes on White Americans' attitudes and perceptions of Asians insofar as that they belong to a group which has power in this society. In this review, although the terms Asian and Asian American will be used interchangeably, it does not mean these two groups are synonymous. Recent Asian immigrants, Asian international students, and Asians who were born in the United States have different experiences (Wong & Halgin, 2006). Although they are easily being categorized as one group due to shared physical features, there are general and specific stereotypes associated with them. For instance, Asian international students share the general stereotype of intelligent, but they are also stereotyped as handicapped and deficient (Mestenhauser, 1983). International students are also viewed as psychologically distressed (Leuong & Chou, 1996) and socially and culturally maladjusted (Spencer-Rodgers, 2001). Before discussing the influences of Asian stereotypes, it is important to first examine what kind of Asian stereotypes U.S. society holds toward this group.

Asian stereotypes

The “model minority” stereotype is the most prevailing stereotype about Asians in the United States today. However, the image of Asians in the past was not as “positive” as it seems now. Negative stereotypes about Asians had persisted in the United States since Chinese laborers first immigrated during the California Gold Rush of the late 1840s and the building of the Transcontinental Railroad of the 1860s. Chinese immigrants were seen as “nothing more than starving masses, beasts of burden, depraved heathens, and opium addicts” (Chan, 1991, p.45). Racial tensions rose during the 1880s especially between Chinese and White laborers which led to acts of prejudice, discrimination, and violence (e.g. Rock Springs massacre in Wyoming, see Sorti, 1991 for review). From the early days of Chinese immigration, discriminatory laws formalized the racial prejudice against Chinese in the United States (Takaki, 1989; Chan, 1991; Ngai, 2005). For instance, in 1860, California banned Asians from public schools. In 1882, the Chinese Exclusion Act was signed into law which outlawed the immigration of Chinese into the United States. The early stereotypes that depicted Asians as a “yellow peril” were not limited to Chinese, but were directed toward other Asian ethnic groups as well (Abreu, Ramirez, Kim, & Haddy, 2003). For instance, California passed the Alien Land Law in 1913 to prevent first-generation Japanese immigrants from owning land in the United States. In 1942, Japanese Americans were interned in camps on the West coast which was due to the misconceived notion that Japanese Americans would forever retain their loyalty to the Japanese Emperor. Those stereotypes reflect the notion that Asians in the U.S. have been, and still are, being treated as “perpetual foreigners” who forever associate with their countries of origin or decent (Takaki, 1989; Chan, 1991; Abreu et al., 2003; Sue & Sue, 1999, 2003).

Since the 1960s, Asian Americans have been portrayed by the popular press and the media as a successful minority and that Asian Americans were succeeding through making efforts on their own despite their racial background and discrimination they have experienced. It seemed to be a sudden and radical departure from the previous negative stereotypes. Some scholars (e.g., Sue & Kitano, 1973; Osajima, 1988; Suzuki, 1989; Hurh & Kim, 1989) attempted to explain the emergence of this social construct (i.e., model minority) by examining sociocultural and historical changes. They suggested that the model minority image was created as a product of the changing racial climate in the 1960s rather than reflecting any changing characteristics of Asians (Sue & Kitano, 1973). This image has served as evidence of the success meritocracy in U.S. society (Osajima, 1988), and at the same time, as a function to discredit the protest and demands of other minority groups, such as African Americans, in the mid 1960s (Suzuki, 1989).

The label “model minority” was coined by Peterson (1966) in his article titled “Success story, Japanese-American style.” He described Japanese Americans as “better than any other group in our society, including native-born Whites” (p.21). At the end of the same year, an article titled “Success Story of One Minority Group in U.S.” that focused on Chinese Americans appeared in *U.S. News and World Report*. Both of the articles made the comparison between Japanese or Chinese Americans and African Americans, and praised Japanese or Chinese Americans as the model minority group who had close family ties, were serious about education, and were law-biding. Since then, Asian Americans have been perceived as a group that enjoys extraordinary achievements in education and occupational upward mobility (Wong & Halgin, 2006). Although there is substantial variation among Asian Americans in terms of cultural background and achievements, Asian Americans as a group are still widely perceived as being a

model minority. Data from the U.S. Census Bureau seem to support this perception (U.S. Census Bureau, 2009a). As of 2007, Asian Americans had the highest median income and highest college and graduate school graduation rates of any ethnic group in the United States.

The popular stereotypical perception of Asian Americans as a model minority has led researchers to investigate this stereotype (e.g., Pittinsky, Shin, & Ambady, 2000; Wong, Lai, Nagasawa, & Lin, 1998). Research supports the existence of a positive or model minority stereotype regarding Asians, comprising such traits as being intelligent, capable, industrious, self-disciplined, mathematical, obedient, family oriented, and courteous (Fiske et al., 2002; Ho & Jackson, 2001; Lin et al., 2005; Pittinsky et al., 2000; Wong et al., 1998). The model minority stereotype tends to lead people to evaluate Asian Americans as competent, especially related to the academic setting. For instance, Wong et al. (1998) found in their study that students from different racial backgrounds (i.e., African Americans, Hispanic Americans, Native Americans, and White Americans) viewed Asian Americans as more likely to succeed in their careers than are other students from different racial backgrounds. Pittinsky et al. (2000) also found similar results in their study. They directed the participants in their study to review a college application of an Asian American high school senior, which included the score on the math scholastic aptitude test. In a recall test, cues of the applicant's racial category resulted in participants recalling significantly higher math performance than to a control condition for which no racial category was cued.

Although studies suggest that Asian Americans are perceived as a model minority, there is also evidence of negative stereotypes toward Asians. Asians are also perceived as being cunning, sly, nerdy, socially awkward, and unassimilated (Cuddy et al., 2007; Fiske et al., 2002; Ho & Jackson, 2001; Kang, 2001; Lin et al., 2005). Kang (2001) found in a telephone poll of

1,216 Americans, whose racial categories were not reported, that 24% of the participants still believe that Chinese Americans are more loyal to China than the United States, and 24% believe that Chinese Americans are taking away jobs from other Americans. Stereotypes toward Asians are mixed and ambivalent. Research suggests that stereotypes more likely contain ambivalent beliefs, with a mixture of negative and positive attributes (Operario & Fiske, 2001). Therefore, it is not surprising that attitudes toward Asian Americans are also ambivalent. Because Asian stereotypes contain ambivalent beliefs, it would be important to investigate how Asian stereotypes influence clinical judgment. It is unclear how those ambivalent beliefs operate in a clinical setting and how they influence clinical judgment.

Impact of Asian stereotypes

General attitudes toward Asians. Intuitively, one may think that endorsement of negative stereotypes will be linked to negative attitudes and emotions while endorsement of positive stereotypes will lead to positive attitudes and emotions; however, it does not function this way for Asian stereotypes. Although negative Asian stereotypes have been shown to be linked to negative attitudes (e.g., Lin et al., 2005), research indicates that endorsement of the positive stereotype of Asian competence is associated with both positive and negative attitudes and emotions toward them (Ho & Jackson, 2001). For instance, Lin et al. (2005) found that White Americans' endorsement of the stereotypes of Asian Americans as highly competent but not sociable is related to envious anti-Asian prejudice, which involves both respect and resentment. Ho and Jackson (2001) also demonstrated in their study that White Americans showed admiration toward Asians whom they perceived as being family oriented and industrious, but reported feeling hostile and jealous toward Asians whom they believed to have traits associated with model minority stereotypes (e.g., intelligent and mathematical).

The stereotype content model (SCM) (Fiske et al., 2002; Fiske et al., 1999) suggests that the mixed attitudes toward Asians do not represent a conflict between positive versus negative attitudes, but rather refer to Asians being rated as high on one dimension (competence) and low on the other (warmth) as a way to justify discrimination against an outgroup that otherwise plays by the rules of a meritocracy (Lin et al., 2005). The SCM principles claim that outgroups often fall into two mixed clusters: paternalized groups (e.g., elderly people, disabled people) liked as warm but disrespected as incompetent and envied groups (e.g., wealthy people, Jewish people) respected as competent but disliked as lacking warmth (Fiske et al., 2002; Fiske et al., 1999; Lin et al., 2005). Consistent with the SCM, researchers demonstrated in their studies that Asian people fall in the category of envied groups that are respected as competent but disliked as lacking warmth (e.g., Fiske et al., 2002; Fiske et al., 1999; Lin et al., 2005).

Although the SCM illustrates the phenomenon of the mixed attitudes toward Asians, it does not provide the underlying mechanism that could account for the relationship between negative attitudes and emotions that result from positive Asian stereotypes. Maddux, Galinsky, Cuddy and Polifroni (2008) suggest that realistic threat might be one of the psychological mechanisms that can explain why individuals endorse positive Asian stereotypes while expressing negative attitudes toward them. Asians are perceived by U.S. society as a successful minority group that enjoys extraordinary academic and financial achievement, but this perception may induce feelings of competition and threat to one's own group. According to realistic conflict theory (Sherif, 1966), prejudice against outgroups result from direct competition for finite resources. When a competent outgroup (i.e., Asian) is competing with mainstream society for finite resources (e.g., educational and economic opportunities), envy, anger, and discrimination will occur (Cuddy et al., 2007).

Perceptions of Asian mental health. The prevailing positive stereotypes about Asians, especially the model minority stereotype, lead people to believe that Asians experience few, if any, adjustment difficulties in the United States, and they are perceived as free from mental health problems (Sue, 1994; Wong & Halgin, 2006). However, research has shown that Asian Americans do suffer from a range of mental health problems (e.g., Kessler et al., 1994; Kinzie et al., 1990; Sue & Morishima, 1982; Uba, 1994). Asian American women aged 15-24 and over the age of 65 have the highest female suicide mortality rate among women across all racial/ethnic groups (Centers for Disease Control and Prevention, 2001). Although Asians experience distress, they tend to underutilize mental health services, and when treatment is sought, they prematurely terminate at a much higher rate than nonminority clients (Leong, & Lau, 2001; Sue, 1993).

As previously mentioned, stereotypes affect people's attitudes and judgments toward others, so one can assume that therapists are not immune from stereotyping. However, research investigating the link between White therapists' endorsement of Asian stereotypes and their clinical impression of Asian clients is scant. Most research on social judgment in general and clinical judgment in particular has focused primarily on Black Americans as if racial prejudice were strictly a Black-White concern. In Li-Repac's (1980) early study, five Chinese and five White therapists in training viewed videotaped interviews of Chinese and White clients, and rated the clients on a number of personality and symptom dimensions. Results indicated that the White therapists tended to view the Chinese clients as more depressed and inhibited, with more interpersonal skill deficits than did the Chinese American therapists. It seems that the White therapists' evaluations of the Chinese clients are associated with negative Asian stereotypes, such as lacking social skills. Although the result of Li-Repac's early study implies that White therapists' endorsement of Asian stereotypes might affect their clinical impressions of the

Chinese clients, one needs more evidence to make that claim. The full impact of Asian stereotypes on White therapists' clinical judgment can only be surmised. The model minority stereotype may have a different impact on White therapists' clinical judgment than on their social judgments. As mentioned earlier, positive Asian stereotypes can lead to negative attitudes due to perceived threat to one's own group, but they might not lead to negative attitudes in a clinical setting due to lacking competition and threat. It is plausible that the power differential between therapist and client may lead White therapists to act in a more paternalistic manner than feeling envy toward their Asian clients. Further investigation in this area is needed.

Attitudes toward discrimination against Asians. Although aggravated assaults toward Asians and incidents involving bodily harm, harassment, racial slurs, and religious prejudices with bias-motivated crimes increasing in brutality (National Asian Pacific American Legal Consortium, 2002), Asians are perceived as being immune from discrimination due to their model minority image. Incidents involving aggravated assaults toward Asian Americans increased by 23%, and threats and intimidation increased by 34% between 1998 and 1999 (Liang, Li, & Kim, 2004). Moreover, there were nearly 250 incidents against Asian Americans in the 3 months immediately following the 9/11 terrorist attacks in 2001 (National Asian Pacific American Legal Consortium, 2002). The perception of Asian Americans being immune from discrimination can lead to people's indifference toward Asians as victims of racial intolerance (Delucchi, & Do, 1996). Delucchi and Do conducted a qualitative study to examine the reactions of the college administration at the University of California in response to racial incidents involving Asian Americans and African Americans. They found that when the incidents involved Asian Americans, reactions from administrators were less willing to condemn the incidents as racist.

Given the aforementioned discussions of the impact of Asian stereotypes on people's attitudes and perceptions toward Asians, it is important to discuss potential methods to overcome stereotyping and prejudice in clinical setting.

Prejudice Reduction

Over the past three decades, scholars in counseling psychology have been promoting the integration of multicultural perspective into the counseling profession and addressing the importance of developing multicultural counseling competence (e.g., Arredondo et al., 1996; Carter, 2003; Hill, 2003; Sue, 2001; Sue et al., 1992; Sue et al., 1982; Sue et al., 1998). With the fast-growing population of racial and ethnic minorities in the United States (U. S. Census Bureau, 2009b), it is inevitable for therapists to encounter racially diverse clients. The question is whether therapists can provide culturally appropriate services to racially diverse clients. Research has shown that members of minority groups (e.g., Asian Americans or Latino Americans) tend to underuse traditional mental health facilities, or to terminate prematurely (U.S. Department of Health and Human Services, 2001). The implication is that traditional psychological theories or techniques which are developed from a predominantly Euro-American context may not be appropriate for racial and ethnic minorities (Hill, 2003; Sue, 2001; Sue, 2004; Sue et al., 1992). White therapists who do not recognize the ethnocentric beliefs, values, and assumptions which serve as the basis of traditional psychological theories will impose these ethnocentric based concepts on racial and ethnic minority groups (Sue, 2004; Sue et al., 1998). As previously mentioned, endorsing stereotypes of minority groups can have impact on clinical judgment, so it is vital for therapists to be aware of their own assumptions and biases regarding racial minority groups. Without such awareness, therapists may perpetuate oppression against

clients of racial minority groups during psychotherapy process (Helms, 1984; Burkard & Knox, 2004).

In a similar vein of trying to reduce prejudice, researchers in social psychology have focused a great deal of effort on investigating prejudice and stereotyping. Many studies have revealed that stereotypes can be activated automatically upon exposure to a member of a stereotyped group, and the perceivers often remain unaware of the activation of the stereotypes and its subsequent influence on judgment (see Devine, 2001; Fiske & Taylor, 2008; Operario & Fiske, 2001 for reviews). Based on this inevitability of a prejudiced perspective, the assumption is that as long as stereotypes exist, prejudice will follow (Allport, 1954; Enrich, 1973; Hamilton, 1981; Bargh, 1999). This may result in discriminatory responses, such as Asians being judged as sly and unassimilated (Cuddy, et al., 2007; Ho & Jackson, 2001) and treated with hostility (National Asian Pacific American Legal Consortium, 2002). However, researchers have indicated that it is important to distinguish between stereotype activation and stereotype application (Devine, 1989; Gilbert & Hixon, 1991). Stereotype activation refers to the extent to which a stereotype is activated and accessible, and stereotype application refers to the extent to which a stereotype is used to make judgments and evaluations about a member of the stereotyped group (Kunda & Sinclair, 1999).

The following review will first focus on automatic and controlled processes to provide the basis for discussing methods of prejudice reduction. Summary of multicultural counseling competency will then follow to present the conceptual framework of reducing stereotype application in clinical setting. The review will then continue with discussions of motivations to be nonprejudiced to illustrate the controlled process of prejudice reduction.

Automatic and controlled processes

Earlier work in social psychology indicated that racial bias in the form of stereotyping and prejudice tended to be prevalent at automatic level (e.g., Fazio, Jackson, Dunton, & Williams, 1995; Greenwald et al., 1998). The automatic activation of stereotypes and prejudice is triggered by an external stimulus cue, such as “the mere presence” (Chen & Bargh, 1997, p.546) of physical features of individuals of stereotyped groups. The assumption is that automatic processes are fixed and impervious to the perceiver’s awareness and intentions (Devine, 1989; Dovidio & Fazio, 1992). It was suggested that such automatic biases of stereotyped groups were present in all individuals but were immune from prevention due to their automatic nature (Bargh, 1999).

If prejudice is inevitable and cannot be prevented, there will be no need to investigate ways to control prejudice. However, there is growing evidence showing that it is possible to control stereotype application. Another line of research has focused on the controlled processes which are referred as effortful and self-conscious processes. Devine (1989) proposed a model to distinguish stereotype activation and application. She pointed out the distinction between having knowledge of culturally shared stereotypes and personally accepting the stereotypes. Although one may have knowledge of culturally shared stereotypes, his or her personal beliefs may or may not be congruent with the stereotypes. Devine demonstrated in her studies that high- and low-prejudice individuals (i.e., participants who scored on the upper and lower third of the distribution of scores on Modern Racism Scale) are equally knowledgeable of the cultural stereotypes due to common socialization experience, and showed similar stereotype-congruent evaluations when under automatic priming conditions (i.e., controlled stereotype-related processes were absent). However, when participants were instructed directly to list their thoughts

about Black Americans under anonymous conditions, low-prejudice participants listed more positive than negative thoughts while high-prejudice participants listed more negative than positive thoughts. Devine argued that low-prejudice participants inhibited the automatically activated stereotype-congruent thoughts (e.g., affirmative action sucks, or Blacks are lazy), and replaced them with thoughts that reflect equality and negations of Black stereotypes (e.g., affirmative action will restore historical inequities, or my father says all Blacks are lazy, I think he is wrong). However, the question is whether the seemingly reduced stereotype application truly reflects internal personal beliefs or the degree of social desirability.

Following this line of research, the assumption is that stereotype activation is automatic and inevitable, such that merely seeing a member of a stereotyped group will activate stereotypes associated with that group. However, whether the individuals will apply those stereotypes is another question. On the one hand, research has proposed that stereotype application can be controlled if individuals have motivation to inhibit the automatic processes (Amodio et al., 2004; Gordon & Anderson, 1995; Legault; Green-Demers, Grant, & Chung, 2007; Plant & Devine, 1998). On the other hand, other research suggested that by promoting therapists' awareness of own biases, knowledge of the worldview of racially diverse client, and skills of implementing appropriate interventions will help therapists provide efficacious and culturally appropriate services (Sue et al., 1992; Arrendondo et al., 1996). In other words, the chances of stereotype application in clinical setting will be reduced.

Multicultural counseling competence and training

As previously mentioned, racial and ethnic minorities are fast growing in the United States over the years with Asians and Latinos as the two fastest-growing minority groups (Population Reference Bureau, 2009; U. S. Census Bureau, 2009b). There are more and more

chances for therapists to be exposed to racial and ethnic minority clients, and the question at stake is whether therapists can provide culturally appropriate services. To be more specific, it is important to investigate whether therapists can adequately and properly incorporate cultural information of their culturally diverse clients into their clinical judgment. Based on the aforementioned review of automatic stereotype activation, one may suspect that therapists may not always be competent in serving their racial and ethnic minority clients if they are not aware of their stereotypes and biases toward racial minority groups. In addition to holding pre-existing beliefs of racial and ethnic minority clients, therapists may not be aware of the ways culture influences symptom expressions. For instance, if therapists are not aware that in Chinese culture, emotional communication takes place not in words that symbolize emotion but instead through metaphors that are often associated with the body (Cheung, 1995), they may overlook the underlying message (e.g., despair) of their Asian clients' somatic complaints.

Psychological theories and concepts have been criticized for their perpetuation of culture-bound value systems (i.e., White culture) that contradict the value systems of many racial and ethnic minorities (Sue et al., 1998; Sue & Sue, 2003). Advocates of multicultural counseling competence believe that in order to provide efficacious and culturally appropriate services, therapists need to be multiculturally competent (e.g., Arredondo, 1999; Sue, Bingham, Porche-Burke, & Vasquez, 1999). Multicultural counseling competencies are outlined into a matrix consisting of three dimensions and three characteristics. The three dimensions are: (a) beliefs and attitudes, (b) knowledge, and (c) skills (Sue et al., 1992; Arrendondo et al., 1996). The three characteristics are (a) counselor awareness of own assumptions, values, and biases, (b) understanding the worldview of the culturally different client, and (c) developing appropriate interventions, strategies, and techniques (Sue et al., 1992; Arrendondo et al., 1996).

As previously mentioned, it is inevitable for individuals to learn prevailing stereotypes in the society (Brigham; 1971; Enrich, 1973; Sue, 2003). White therapists are more likely to be influenced by stereotypes when processing information about racial minority clients due to their power status in U.S. society (Fiske, 1993). Moreover, the ethnocentric monoculturalism approach keeps White therapists from recognizing the ethnocentric basis of their belief, values, and assumptions (Sue et al., 1999; Sue, 2004). In other words, there is a greater chance that White therapists are not aware of their automatic stereotype activation and prejudice of racial minorities because White culture is the dominant norm in U.S. society which prevents White individuals from seeing an alternative reality (i.e., racial minorities' worldviews). Automatic activation of stereotypes has the potential to lead well-intentioned White therapists to have a prejudiced impression of their racial minority clients (Devine, 1989; Wittenbrink, Judd, & Park, 2001). Given the aforementioned review of the impact of stereotypes on judgments, the need to develop awareness of one's own worldview and racial bias inherited from that worldview, and its potential pernicious effect on the counseling process is essential for developing multicultural counseling competencies (Sue et al., 1992).

Most of multicultural education has been focused primarily on minority clients' cultural experiences (Carter, 2003). Although acquiring knowledge and developing skills are important, the knowledge pool is often too vast and complex. Due to limitations of human cognitive capacity, it is impossible to become an expert in every culture. It might be more feasible for therapists to adhere to a general principle that they can use while treating clients of Color that is to be aware of one's own biases and assumptions toward clients of Color. Also, therapists are encouraged to recognize their positions as individuals with a worldview, which shapes their interactions with others (American Psychological Association, 2002). By having this kind of

self-awareness, one might be more cautious while applying multicultural knowledge in treating clients of Color. In addition to developing self-awareness, therapists also need to be aware of how their biases play a role in their clinical judgment. By having these kinds of awareness, therapists might refrain themselves from stereotype application. As previous mentioned, people have the tendency to shift standards. Gushue et al. (2008) tested in their study that whether White family therapists' shift their standards of judgment on perceptions of family functioning based on the ascribed culture of the family (Latino versus White), and how multicultural knowledge or awareness moderated the relationship. They found that participants with higher levels of self-reported multicultural awareness tended to evaluate Latino and White families as having similar levels of functioning, whereas those with lower levels of self-reported multicultural awareness tended to judge the Latino family as healthier than the White family. Their finding implies that those White participants with lower levels of multicultural awareness have different expectations for White and Latino families. In other words, they have lower expectations for Latino family, which reflects the influence of racial stereotypes. Another interesting finding of this study is that they found that participants with higher levels of multicultural knowledge rated Latino family as healthier than the White family. In other words, those White participants with higher levels of multicultural knowledge might use their knowledge of racism or multicultural issues to compensate for the Latino family's struggles.

Although therapists may have multicultural awareness and knowledge, it is unclear whether and when they utilize them in clinical setting. As previously mentioned, therapists are usually under time constraints, receiving a tremendous amount of information within a short period of time which compromising their cognitive capacity, and it might be easier for therapists to fall back to the less cognitively consuming social schemas and heuristics to make clinical

evaluations. Therefore, it is important to investigate what assists them not to apply stereotypes and prejudice while making clinical judgments. Research examining individuals' motivation to be nonprejudiced can help us understand the mechanism of self-regulation of prejudice.

Motivation to be nonprejudiced

Prejudice reduction is a multistep process (Devine, 1989; Devine & Monteith, 1993; American Psychological Association, 2002). One first needs to be aware of his or her stereotypic attitudes and biases, and then learn that responding and evaluating members of stereotyped groups in prejudiced ways is inappropriate (Devine, Plant, & Buswell, 2000). Next, the individual needs to adopt nonprejudiced beliefs and then internalize those standards into one's self-concept (Plant & Devine, 1998). However, developing personal standards and internalizing those beliefs does not guarantee that people will respond without prejudice across all situations (Monteith, Devine, & Zuwerink, 1993). People who claim to be nonprejudiced still display race biases when they are assessed with implicit measures which theoretically bypass conscious control (Fazio et al., 1995; Greenwald & Banaji, 1995; Greenwald et al., 1998). One possibility is that people's more positive changes in the explicit self-report racial attitudes reflects the pressure from external or normative factors that discourage prejudice (Devine et al., 2002; Plant & Devine, 1998). Another possibility is that reduction in prejudice likely results from real changes in attitudes, but the task is to bring the automatic or implicit responses in line with nonprejudiced personal standards (Legault et al., 2007; Devine et al., 2002; Hausmann & Ryan, 2004).

Monteith (1993) proposed that people learn to control prejudiced responses through self-regulatory outcomes that follow from awareness of failures to control stereotyping. Researchers found that low-prejudice individuals who reported discrepancies between their personal

nonprejudiced values toward outgroup members and their prejudiced actual responses experienced compunction or guilt (Devine, Monteith, Zuwerink, & Ellicot, 1991; Monteith et al., 1993; Zuwerink, Monteith, Devine, & Cook, 1996). These negative feelings heighten self-focus and act as a cue for the need to correct one's responses. Individuals who experience prejudice-related discrepancy will then direct their attention to monitor when and why it occurred (Monteith, 1993; Monteith et al., 2002). These self-regulatory outcomes should help individuals to exert control over potentially prejudiced responses in subsequent situations.

Literature shows that the more internalized or self-determined a goal or value is, the more consistent one will be in acting in accordance with it (e.g., Deci & Ryan, 1985, 2000; Ryan & Connell 1989). It was suggested that the reasons individuals regulate prejudice can be placed along a continuum of self-determination, such that they vary in the extent to which they are internalized (Legault et al., 2007). Legault, Green-Demers, and Eadie (2009) argued that only self-determined (i.e., intrinsic motivated) individuals can successfully inhibit stereotype application. In other words, individuals who are intrinsically motivated (e.g., satisfaction from being nonprejudiced) inhibit stereotype application more successfully compared to people who are extrinsically motivated.

Along the same line of self-determination theory, Plant and Devine (1998) distinguished between internal and external motivation. They suggested that people could be motivated to respond without prejudice for internal reasons or for external reasons. Internal motivation refers to internalized and personally important nonprejudiced standards, whereas external motivation reflects social pressure to comply with nonprejudiced norms. They developed the Internal and External Motivation to Respond Without Prejudice Scale (the IMS and EMS, respectively) to assess the sources of motivation. Their research indicated that IMS and EMS are largely

independent. In other words, individuals can be motivated to respond without prejudice primarily for internal reasons, primarily for external reasons or for both internal and external reasons, or they may not be motivated for either reason. Researchers (Plant & Devine, 1998; Plant, Devine, & Brazy, 2003) demonstrated in their studies that participants who were primarily motivated to respond without prejudice for external reasons only regulated prejudice in the presence of others who they assumed to be nonprejudiced. When they providing their responses in private, these participants reported high levels of racial bias. Similarly, participants who were more internally motivated showed less implicit prejudice, whereas those who were more externally motivated displayed more implicit prejudice (Hausmann & Ryan, 2004). In a follow-up study, Devine et al. (2002) found that high internal, low external (high IMS, low EMS) participants displayed lower levels of implicit racial bias than did all other participants (i.e., high IMS-high EMS, low IMS-high EMS, and low IMS-low EMS participants).

Although literature shows that people who are highly motivated show less prejudice toward members of stereotyped groups, it is not clear whether and when they will actively work to reduce prejudice. Plant and Devine (2009) argued that it is people's motivation specifically and not their attitudes toward stereotyped groups that determines their efforts toward prejudice reduction. In other words, even when people are aware of their prejudice, they might not actively regulate their prejudice if they are not motivated to do so. Their efforts of prejudice reduction should therefore reflect the intentions underlying their motivation. In order to support this argument, Plant and Devine (2009) investigated intentions underlying people's motivation to respond without prejudice. Although both highly internally and externally motivated individuals show similar effort in prejudice reduction in short term, those who are motivated by external reasons may not be able to regulate prejudice in the long term (Buts & Plant, 2009). Plant and

Devine (2009) further proposed that the underlying intention for internal motivation is to free of prejudice whereas for external motivation is to hide prejudice.

In Plant and Devine's (2009) study, they explored White individuals' interest in a 5-minute computer program that would help them reduce prejudice in anticipation of an interracial interaction. They also manipulated the framing of the program such that participants in one condition learned that the program decreased detectable prejudice, which is a type of prejudice that would put one at risk for others' disapproval. In the other condition, participants learned that the program was designed to decrease undetectable prejudice, which is a type of prejudice that is not noticeable to others, but would violate personal nonprejudiced standards. As predicted, those primarily internally motivated participants (high IMS-low EMS) showed interests in the program when they were made aware of their implicit prejudice.

They found that those participants who were primarily externally motivated (low IMS-high EMS) spent time in the program which helped them reduce detectable prejudice, but they only spent little time if the program helped them reduce undetectable form of prejudice. In other words, they were only interested in reducing prejudice that would be detected by others. Their intention is to hide prejudice (Plant & Devine, 2009). The results further illustrated the underlying intention of those primarily externally motivated participants. Those primarily externally motivated participants maintained same level of interests in the program even when the long-term outcome of reducing detectable form of prejudice would increase undetectable prejudice.

Plant and Devine (2009) also argued that for those participants who showed both high internal and external motivation (high IMS-high EMS), the internal motivation should be the primary source for their motivation to respond without prejudice. As expected, those participants

showed interests in both undetectable and detectable prejudice reduction program regardless of their external motivation level. When they were led to believe the long-term outcome of reducing detectable prejudice would increase undetectable prejudice, they showed little interest in the program. In other words, they prioritized the intention to be free of prejudice over the intention to hide prejudice (Plant & Devine, 2009). They also found that those participants who were unmotivated (low IMS-low EMS) only spent little time on the prejudice reduction program.

The most important finding of Plant and Devine's (2009) study is that people who are motivated to respond without prejudice will actively work to overcome prejudice. Also as anticipated, they found that attitudes alone did not determine whether and when people will actively pursue prejudice reduction. It was people's motivation and specifically their levels of both internal and external motivation that provided information of whether and when they actively regulate their prejudice. One of the implications of the results is that the intention to be free of prejudice is likely to increase the likelihood of long-term success of prejudice reduction. Highly internally motivated participants' lack of interest in reducing detectable prejudice when it was associated with long-term increase in undetectable prejudice implied their effort of enduring focus on freeing themselves from prejudice. As previously mentioned, the more internalized a goal or value is, the more consistent one will be in acting in accordance with it in both public and private situations (Deci & Ryan, 1985, 2000; Hausmann & Ryan, 2004; Ryan & Connell 1989). In contrast, highly externally motivated participants showed the same level of interest in reducing detectable prejudice when it was associated with long-term increase in undetectable prejudice. As a result, they may not effectively regulate subtle prejudice or in private situation, a situation that external pressure is absent (Butz & Plant, 2009).

Another important implication of Plant and Devine's (2009) study is the importance of increasing the awareness of prejudice when encouraging prejudice reduction. When highly internally motivated participants were provided with evidence that they exhibited prejudice, they showed elevated interest in the prejudice reduction program. This line of research and the research on multicultural counseling competence inform each other. Multicultural counseling competence promotes awareness of one's assumptions and biases, and by highlighting one's awareness, one is more likely to actively regulate one's prejudice when it is internally motivated. As a result, those individuals may invest time and energy in knowledge and skill building in order to serve clients of Color in a nonprejudiced way.

Aforementioned research on prejudice reduction investigates the regulation process of stereotype expression and ways levels of internal and external motivation affect the regulation process. It will be informative to integrate this line of research with study of clinical judgment for it provides additional information on what assist people with prejudice reduction.

Summary/Statement of Problem

As stated throughout this chapter, people have the tendency to rely on stereotypes while making judgments due to limitations of cognitive capacity. Researchers have been trying to understand the mechanism behind stereotyping and how it affects people's judgment. Biernat and her colleagues proposed the shifting standards model to illustrate this human tendency of relying on stereotype to make judgments (Biernat, 2003; Biernat et al., 2009; Biernat & Kobrynowicz, 1997; Biernat & Manis, 1994; Biernat et al., 1991). They suggest that people tend to use stereotypes as a standard when they make subjective judgments about members of stereotyped groups. Furthermore, people unconsciously shift their standards based on stereotypes they hold for particular groups.

The tendency to shift standards was also found in clinical setting. Researchers found that White therapists shift their standards of judgment on perceptions of client functioning based on the ascribed race of the client (Black versus White) (Gushue, 2004). It would be important to investigate White therapists in particular because White individuals are considered to be more likely to use stereotypes due to their power status in U.S. society in general (Fiske, 1993). The majority of the research to date has focused on White therapists and Black clients, and the research on White therapists and Asian clients is scant. Since the research on White therapists and Asian clients is scant, it would be important to explore the potential impact of the race Asian on White therapists' clinical judgment. It would inform us whether White therapists shift their standards for Asian clients.

Stereotyping of Asians represents an interesting and complex phenomenon as illustrated by the Stereotype Content Model (SCM) that Asians are respected as competent but disliked for lack of warmth (Lin et al., 2005). It would be important to investigate how White therapists' endorsement of Asian stereotypes influences their clinical judgment due to ambivalent nature of Asian stereotypes. Furthermore, subgroup variations exist in Asian population. One of the variations is their residency status in the United States, such as international student, immigrant, and citizen. Literature indicates that although international students share stereotypes which are associated with Asian Americans, such as intelligent and hardworking (Spencer-Rodgers, 2001), there are specific negative stereotypes associated with international students, such as handicapped and deficient (Mestenhauser, 1983) or lacking of English language proficiency (Kim & Kim, 2010). The tendency to shift standards might be the most prominent with Asian international students due to the lowest expectations of this group as the shifting standards model would predict. In addition to investigating the impact of Asian stereotype endorsement, this

study also investigated whether White therapists judge a White American, an Asian Americans, or an Asian international student differently.

It is worthwhile to investigate what factors might mitigate the phenomenon of shifting standards in clinical setting. The literature on multicultural counseling competence provides a conceptual framework which promotes therapists gaining knowledge of the worldview of clients of Color, awareness of one's own biases and assumptions, and skills for implementing appropriate treatments (Arredondo, et al., 1996; Sue et al., 1992; Sue et al., 1998). One of the goals of current study is to examine the role of multicultural counseling competence in this phenomenon.

Research also shows that motivation plays an important role in reducing stereotyping of members of racial minority groups (e.g., Plant & Devine, 1998; Devine et al., 2002). Plant and Devine (1998) distinguished between internal and external motivations to respond without prejudice. In general, more internally motivated individuals show less prejudice toward stereotyped groups compared to externally motivated individuals when they endorse those stereotypes (Plant & Devine, 2002). They found that individuals who are motivated to respond without prejudice will actively work to reduce prejudice (Plant & Devine, 2009). By increasing awareness of one's racial bias, motivated therapists are more likely to invest time and energy in acquiring knowledge and skills of treating clients of Color, and refraining from stereotyping. The current study also investigated the roles of internal and external motivation on White therapists' tendency to shift standards. By including multicultural counseling competence and motivations to respond without prejudice in the current study, one will know more about whether and when White therapists regulate their prejudice in clinical setting.

In summary, the current study investigated whether White therapists shift standards in clinical settings based on race/residency status of the client. It also examines the impact of Asian stereotype endorsement, multicultural counseling competence, and motivation to respond without prejudice on White therapists' clinical judgment.

Hypotheses and Research Questions

This review of the literature has attempted to provide a substantial context for the present study which seeks to explore the impact of client's race/residency status on clinical judgment. Furthermore, the present study also explores the relationships among Asian stereotype endorsement, self-reported multicultural counseling competence, and motivation to respond without prejudice on White therapists' clinical judgment. Given the findings of previous research of the shifting standard model that people tend to have lower expectations of clients' of Color mental health, the hypotheses are as following:

Hypothesis 1. White psychology trainees will show less concern for symptom severity and more optimistic prognoses to the target client when she was reported to be Asian than when she was reported to be White.

Hypothesis 2. White Psychology trainees will show less concern regarding symptom severity and more optimistic prognoses to the target client when she was reported to be an Asian international student compared to an Asian American student.

Although there is substantial literature of Asian stereotype endorsement, multicultural counseling competence, motivation to respond without prejudice, and White therapists' clinical judgment, there is no study directly investigates the relationship among those variables. Moreover, the existing literature of clinical judgment is mostly about White therapists and Black clients. The current study attempts to integrate existing literature to examine the relationship

among those variables and particularly to explore the potential impact of these variables on White therapists' clinical judgment of Asian clients. Since there is no direct support from the literature, research questions are proposed as following:

Research Question 1. White psychology trainees were randomly assigned to read one of the clinical vignettes of White, Asian American, or Asian international student target client. The following research question is proposed to rule out the possibility that White trainees' self-reported multicultural counseling competence, Asian stereotype endorsement, motivation to respond without prejudice, and social desirability differ significantly among three conditions.

Does the race of the target client influence White psychology trainees' self-reported multicultural counseling competence, Asian stereotype endorsement, motivation, and social desirability?

Research Question 2. The present study seeks to understand the relationships among White psychology trainees' self-reported level of multicultural counseling competence, Asian stereotype endorsement, and internal/external motivation to respond without prejudice and their impact on initial clinical judgment. Thus, the present study poses the following research question:

Does the impact of multicultural counseling competence, Asian stereotype endorsement, motivation on White trainees' initial clinical judgment regarding ratings of concern for symptom severity and prognosis differ based on target client race?

Chapter III

Method

Pilot Study

Two pilot studies were conducted. The first pilot study was conducted for developing the clinical vignettes. The second pilot study was conducted to assess the strength of the clinical vignettes for the main study.

Pilot Study 1

Participants

Participants in the pilot study 1 were 30 White trainees in counseling psychology from a private university in the northeast.

Procedure

The writer sent an e-mail to an APA accredited counseling psychology graduate programs to invite White trainees to participate in an online survey of Asian stereotypes.

Instrument

The survey consisted of 30 descriptions of Asian stereotypes (e.g., Asians are quiet). Those descriptions were based on literature on Asian stereotypes or values (e.g., Lin et al., 2005; Kim, Atkinson, & Yang, 1999). Participants were asked to rate how stereotypical of the description is in the U.S. using a Likert-type scale (See Appendix A).

Results

Out of 30 descriptions, 16 descriptions were rated by more than 50% of the participants as either stereotypical or very stereotypical of Asians (see Table 1).

Table 1. *Pilot Study 1 (N = 30)*

	Very Stereotypical	Stereotypical	Somewhat Stereotypical	Neutral	Somewhat Not Stereotypical	Least Stereotypical	Not Stereotypical at all
Item 1*	43.3%	40.0%	13.3%	3.3%	0%	0%	0%
Item 2*	26.7%	40.0%	23.3%	10.0%	0%	0%	0%
Item 3*	50.0%	33.3%	13.3%	3.3%	0%	0%	0%
Item 4*	23.3%	40.0%	13.3%	20.0%	3.3%	0%	0%
Item 5*	33.3%	40.0%	16.7%	10.0%	0%	0%	0%
Item 6*	36.7%	26.7%	23.3%	10.0%	3.3%	0%	0%
Item 7*	40.0%	43.3%	10.0%	0%	3.3%	3.3%	0%
Item 8	6.7%	20.0%	50.0%	13.3%	6.7%	3.3%	0%
Item 9	6.7%	26.7%	43.3%	23.3%	0%	0%	0%
Item 10*	26.7%	43.3%	23.3%	6.7%	0%	0%	0%
Item 11*	20.0%	33.3%	30.0%	10.0%	6.7%	0%	0%
Item 12	6.7%	6.7%	36.7%	40.0%	3.3%	6.7%	0%
Item 13	10.0%	23.3%	26.7%	30.0%	10.0%	0%	0%
Item 14	20.0%	26.7%	26.7%	26.7%	0%	0%	0%
Item 15*	10.0%	40.0%	30.0%	6.7%	10.0%	0%	3.3%
Item 16*	16.7%	43.3%	33.3%	6.7%	0%	0%	0%
Item 17	6.7%	16.7%	16.7%	33.3%	13.3%	10.0%	3.3%
Item 18*	20.0%	33.3%	26.7%	10.0%	6.7%	3.3%	0%
Item 19*	13.3%	36.7%	43.3%	3.3%	3.3%	0%	0%
Item 20*	20.0%	30.0%	36.7%	10.0%	3.3%	0%	0%
Item 21*	33.3%	43.3%	13.3%	10.0%	0%	0%	0%
Item 22*	20.0%	43.3%	30.0%	6.7%	0%	0%	0%
Item 23	6.7%	30.0%	36.7%	23.3%	3.3%	0%	0%
Item 24	6.7%	16.7%	20.0%	40.0%	10.0%	3.3%	3.3%
Item 25	13.3%	20.0%	30.0%	30.0%	3.3%	0%	3.3%
Item 26	6.7%	16.7%	40.0%	26.7%	6.7%	0%	3.3%
Item 27	3.3%	36.7%	30.0%	26.7%	0%	0%	3.3%
Item 28	6.7%	6.7%	33.3%	30.0%	16.7%	6.7%	0%
Item 29	3.3%	20.0%	36.7%	33.3%	3.3%	0%	3.3%
Item 30	3.3%	3.3%	6.7%	40.0%	13.3%	16.7%	16.7%

*: over 50% of participants rated as very stereotypical or stereotypical

Conclusion

Based on the results of the pilot study 1, the writer incorporated the descriptions that were rated by over 50% of the participants as very stereotypical or stereotypical descriptions of Asians into the clinical vignettes.

Pilot Study 2

Participants

Participants were 101 graduate students in an APA accredited counseling or clinical psychology program from a private university in the northeast. 23 participants were excluded due to not self-identified racially as White, yielding an overall sample of 78 participants (12 males and 66 females). There are three conditions: 25 participants were in the Asian international student target client condition, 28 participants were in the Asian American student target client condition, and 25 participants were in the White student target client condition. 52.6% of the participants were in counseling psychology program and 47.4% of the participants were in clinical psychology program.

Procedure

The writer sent an e-mail to an APA accredited counseling and clinical psychology graduate programs to invite White trainees to participate in an online survey of clinical judgment. Participants were randomly assigned to read one of the three clinical vignettes (Asian international student target client, Asian American student target client, or White student target client) and were asked to fill out the Initial Clinical Impressions Inventory-Revised (ICII, ICIR-R; Gushue, 2004; Gushue & Clark, 2009).

Instruments

Clinical vignettes. The three vignettes that were used in the present study were developed by the writer based on the result of pilot study 1. The descriptions from pilot study 1 that were rated by over 50% of the participants as very stereotypical or stereotypical descriptions of Asians were integrated into the vignette. The vignettes presented information about a fictitious female student (e.g., age, symptoms) while the stereotypic inferences driving sentences were also

included (e.g., "She was a straight-A student."-intelligent). Three vignettes were used: one in which the client identifies as a White student, the other one the client identified as Asian American student, and the third one the client identifies as an Asian international student. In all three vignettes, the client is presenting to the emergency room accompanied by her roommate with depressive symptoms. The client has recently relocated to New York City enroll in a doctoral program at an Ivy League School and reports emotional difficulties and pressure from home. In addition to information about the client's presenting issue, the vignettes also include some information about the client's educational, family, and social history. Embedded in the description of the client's history are cues to alert the participants to the clients' racial background and residency status. In other words, except for the race/residency status (the client is Asian international student from China, the client is Asian American student from Berkeley, CA, or the client is White student from Berkeley, CA), all other information in the vignettes is identical (See Appendix B, Appendix C and Appendix D).

Initial Client Impression Inventory-Revised (ICII-R; ICII; Gushue, 2004; Gushue & Clark, 2009). The ICII was originally 17-item self-report scale that measures therapists' level of concern about a client's symptomatology and overall mental health. Participants are asked to indicate how likely they think the client is suffering from several types of mental disorders (e.g., anxiety, depression, etc) and their level of concern regarding the client's capacity for judgment, suicidality, social functioning, and ability to communicate on a 7-point Likert scale (*1 = strongly disagree, 7 = strongly agree*). Summing all items provides a total score for participants' initial impressions of client symptomatology with higher scores indicating higher levels of concern of symptoms. In a previous vignette study on racial bias among White therapist trainees, the Cronbach's alpha for the ICII was .85 (Gushue, 2004).

Gushue conducted a pilot study to determine initial reliability and validity of the revised version of the ICII (ICII-R) (as cited in Clarke, 2009). Prior to the pilot study, a research team of 10 counseling psychology graduate students and 2 licensed counseling psychologists were invited to review the original 17-item ICII to determine the appropriateness of each item. The result of the review was a revised scale of 18-items which measures the same areas of the ICII. The Likert scale and scoring method remained the same as with the ICII. Participants in the pilot study were 56 graduate students in psychology who self-identified as White (52.7%), Asian/Pacific Islander (23.6%), Black/Non-Hispanic (14.5%), Hispanic (5.5%), and other (3.6%). The participants received a packet that contained the case vignette used in Gushue (2004), the ICII-R, the Clinical Judgment Scale (CJS; Houts & Galante, 1985), and a demographic questionnaire. Exploratory factor analyses were conducted to test for an underlying factor structure. The analyses supported one-factor structure and 5 items were removed from the scale as a result (Clark, 2009). The result of the analyses is a 13-item ICII-R. Preliminary psychometric information was obtained using the 13-item ICII-R and the CJS. Reliability analyses yielded a Cronbach's alpha of .89 for the ICII-R and .86 for the CJS. As for convergent validity, ICII-R was found to be positively correlated with the CJS ($r = .46, p < .01$). (See Appendix E).

Manipulation

Participants were randomly assigned to read one of the three clinical vignettes (Asian international student, Asian American student, or White student). In the vignettes, all the information was identical except the race/residency status of the target client.

Manipulation Check. In order to verify the manipulation, at the end of the survey, participants were asked to write down the race/residency status of the target client after filling out the ICII-R.

Results

Initial Client Impression Inventory-Revised (ICII-R). Analyses were conducted to ascertain the mean, standard deviation, observed minimum/maximum scores, scale minimum/maximum scores, skewness, kurtosis, and internal reliability using coefficient alpha for participants' scores on the ICII-R. The results can be found in Table 2. Internal reliability for the ICII-R was $\alpha = .76$.

Table 2. *Preliminary Analyses for Pilot Study 2 (N = 78)*

	M	SD	Observed Minimum	Observed Maximum	Scale Minimum	Scale Maximum	Skewness	Kurtosis	Reliability (α)
ICII-R	52.41	7.39	33	65	13	91	-.54	-.05	.76

Note: ICII-R = Initial Clinical Impressions Inventory-Revised

An analysis of variance (ANOVA) was conducted to test for differences in ratings of concern for symptom severity among three conditions. The target client's race was identified as the predictor variable and the ICII-R was the criterion variable. The ANOVA revealed that there were significant differences in participants' level of concern for symptom severity based on whether the participant was responding to a White target client, an Asian American target client or an Asian international student target client ($F(2, 75) = 7.92, p < .001$). A planned contrast comparison was done in ANOVA to investigate differences in ratings of concern for symptom severity among the two contrasts (first contrast: White target client vs. Asian target clients;

second contrast: Asian American target client vs. Asian international student target client). A *t*-test revealed significant differences for the first contrast ($t(75) = -3.73; p < .001$). In other words, participants would judge Asian individuals as healthier compared to White individual.

Although the planned contrast comparison revealed the significant differences in participants' levels of concerns for symptom severity between White target client and Asian target clients, one does not know whether the differences were between White and Asian American or between White and Asian international student. Therefore, the post-hoc tests were conducted in ANOVA. Due to differences in the sample sizes among the three conditions, post-hoc tests Gabriel, Hochberg's GT2, and Games-Howell were used. All three post hoc tests showed that participants would judge Asian international student or Asian American target client as healthier compared to White target client at the .05 level of significance.

Manipulation Check. All the participants answered correctly on the question of the race/residency status of the target client according to their randomly assigned condition.

Conclusion

Based on the results of pilot study 2, it appeared that the clinical vignettes were effective enough to obtain the expected effect, which is consistent with literature review.

Main Study

Participants

Participants were recruited by e-mails to APA accredited counseling and clinical psychology graduate programs obtained from the APA website. A random national sample of 196 accredited programs in counseling and clinical psychology was invited to participate. Data were collected via SurveyMonkey online. The complete response rate is 69%. 637 participants opened the survey link but only 439 were either qualified or completed the survey. The writer

excluded the participants who did not racially identify as White or left at least one complete scale unanswered. The survey consisted of 6 scales. Because of the specific nature of the hypotheses, only those participants who self-identified racially as White were included in the analyses, as the majority of the research that underlies the theoretical foundation of this study has been conducted with White samples and evidence exists that White individuals tend to rely more on stereotypes to make subjective judgments (Depret & Fiske, 1993; Fiske, 1993). Moreover, 90% of APA members are White individuals (American Psychological Association, 2008). Of these participants, approximately 20% were men and 80% were women. More than half of the participants (53.8 %) identified their socioeconomic status as being middle class; followed by upper middle class (29.6%), working class (15%) and upper class (.9%). The average age of participants was 28.08 ($SD = 6.04$) and on average, participants have 2.2 years ($SD = 2.21$) of clinical training experience. More than half of the participants (59.2%) reported they were in clinical psychology; followed by counseling psychology (33.9%) and school psychology (6.8%). Participants were asked to report the number of multicultural counseling or psychotherapy courses that they had completed and the number of multicultural conferences, workshops, or training activities that they had attended. The mean reported number of multicultural counseling/psychotherapy courses completed was 1.2 ($SD = 1.35$) and the mean number of multicultural conferences, workshops, or training activities was 1.67 ($SD = 2.82$) (see Table 3).

Table 3. *Demographic characteristics of participants (N = 439)*

	N	Mean	SD	Percentage
<u>Condition</u>				
Asian international student	156	---	---	35.5
Asian American	156	---	---	35.5
White	127	---	---	28.9
<u>Gender</u>				
Male	89	---	---	20.3
Female	350	---	---	79.7
<u>Age</u>	432	28.08	6.04	---
<u>Socioeconomic Status</u>				
Working class	66	---	---	15.0
Middle class	236	---	---	53.8
Upper-Middle class	130	---	---	29.6
Upper class	4	---	---	.9
<u>Field</u>				
Counseling psychology	149	---	---	33.9
Clinical psychology	260	---	---	59.2
School psychology	30	---	---	6.8
<u>Years in Clinical Training</u>	427	2.20	2.21	
<u>No. of Multicultural Courses</u>	432	1.20	1.35	
<u>No. of Multicultural Training</u>	432	1.67	2.82	

Procedure

In order to recruit participants, the writer sent an invitation e-mail to 196 APA accredited counseling and clinical psychology graduate programs. The e-mail explained to the potential participants that they were being asked to complete a survey assessing therapists' clinical judgment and were provided the link to SurveyMonkey online survey. The online survey included the following instruments: Informed Consent, Participants' Rights, one of the three clinical vignettes (randomly assigned by SurveyMonkey algorithm: 33.33% White student target client; 33.33% Asian American student target client; 33.34% Asian international student target client), the Initial Clinical Impressions Inventory-Revised (ICII, ICIR-R; Gushue, 2004; Gushue & Clark, 2009), the Clinical Judgment Scale (CJS; Houts & Galante, 1985), the Scale of Anti-Asian American Stereotypes (SAAAS; Lin et al., 2005), the Multicultural Counseling Knowledge and Awareness Scale (MCKAS; Ponterotto, Gretchen, Utsey, Rieger, & Austin, 2002), the Internal and External Motivation to Respond Without Prejudice Scale (IMS /EMS; Plant & Devine, 1998), the Marlowe-Crowne Social Desirability Scale Form C (M-C SDS Form C; Reynolds, 1982), and a Demographic Questionnaire. The order of the instruments, except Informed Consent, Participants' Rights, and the vignettes, were randomized by SurveyMonkey algorithm.

Instruments

Clinical vignettes. Please see the pilot study 2 for a description. (See Appendix B, Appendix C, and Appendix D for clinical vignettes).

Initial Client Impression Inventory-Revised (ICII-R; ICII; Gushue, 2004, 2009). Please see the pilot study 2 for a description. The current study yielded a Cronbach's alpha of .73. (See Appendix E for ICII-R).

Clinical Judgment Scale (CJS; Houts & Galante, 1985). The CJS is a 19-item instrument that measures therapists' global clinical impressions of a client along the dimension of pessimism-optimism for clinical prognosis. Responses on all items are in the form of 7-point bipolar scales. Individual items are summed to yield a total score with higher scores indicating more pessimistic prognoses and lower scores indicating more optimistic prognoses. Participants were asked to make judgments about prognosis with and without treatment, expectations of client motivation and cooperation, expectations about therapeutic effectiveness, client's level of understanding of the problem, etc. The CJS was rationally constructed based on clinical judgment dimensions that have been empirically related to treatment outcome. Two studies of therapists' clinical impressions of a hypothetical client reported Cronbach's alphas of .80 (Houts & Galante, 1985) and .84 (Houts & Graham, 1986). Houts and Graham (1986) reported that the CJS was positively correlated with the Health Sickness Rating Scale (Luborsky, 1962), a measure of clinical judgments of psychopathology which is also related to treatment prognosis. For the purpose of this study, item #5 ("How physically attractive is this patient?") will be dropped as there are no visual cues that would allow participants to answer this question (See Appendix F). The current study yielded a Cronbach's alpha of .80.

Scale of Anti-Asian American Stereotypes (SAAAS; Lin et al., 2005). The SAAAS is a 25-item scale developed to assess endorsement of Asian stereotypes using a 6-point Likert type scale (*1 = strongly disagree, 6 = strongly agree*). The range of possible total scores is 25 to 150. Higher scores indicate relatively high prejudice toward Asian Americans. It consists of two subscales: Competence (12 items, possible range of scores = 12 - 72) and Sociability (13 items, possible range of scores = 13 - 78). Both exploratory and confirmatory factor analyses supported this two-factor structure (Lin et al., 2005). The Competence subscale measures beliefs about

Asian Americans' competence (e.g., Asian Americans enjoy a disproportionate amount of economic success). The Sociability subscale measures beliefs about Asian Americans' sociability (e.g., Asian Americans do not usually like to be the center of attention at social gatherings).

Lin et al. (2005) conducted six studies to create the SAAAS and demonstrated the validity of the scale. The participants were all White students from universities in Northwestern region in Study 2, 3, 4, and 6. In Study 1, 78% of the participants were White and in sample 2 of Study 5, 77% of the participants were White. Alpha coefficients for scores on the Competence and Sociability subscales, and the total scale were .92, .91, and .94 respectively. The current study's alpha coefficients for scores on the Competence and Sociability subscales, and the total scale were .87, .89, and .92 respectively. The two subscales are positively correlated ($r = .71, p < .001$). Lin et al. (2005) tested the validity of the SAAAS by comparing the scale with the Ambivalent Sexism Inventory (ASI; Glick & Fiske, 1996). Both the ASI and the SAAAS suggest that the stereotype dimensions of competence and sociability guide mixed perceptions that nontraditional women/Asian Americans are viewed as competent but not socially warm. The correlation showed that the two scales are positively related ($r = .54, p < .001$). The SAAAS was also positively correlated with the Subtle Prejudice Scale ($r = .57, p < .001$) (SPS; Pettigrew & Meertens, 1995). Lin et al. (2005) also examined the predictive validity of the SAAAS by demonstrating that negativity of impressions was correlated with the low-sociability stereotype ($r = .32, p < .01$) and the entire SAAAS ($r = .26, p < .01$) (See Appendix G).

Multicultural Counseling Knowledge and Awareness Scale (MCKAS; Ponterotto et al., 2002). The MCKAS was derived from the Multicultural Counseling Awareness Scale (MCAS; Ponterotto et al., 1996). The MCKAS is a 32-item instrument that assesses self-reported

multicultural counseling knowledge and awareness. Participants indicate their responses to the items on a 7-point Likert scale (*1 = not at all true, 7 = totally true*). The range of possible total scores is 32 to 224. Higher total scores indicate a higher level of self-reported multicultural competence. It consists of two subscales: Knowledge (20 items, possible range of scores = 20-140) and Awareness (12 items, possible range of scores = 12-84). Confirmatory factor analysis supported this two-factor structure (Ponterotto et al., 2002). The Knowledge subscale assesses general knowledge related to multicultural counseling (e.g., I am familiar with the “culturally deficient” and “culturally deprived” depictions of minority mental health and understand how these labels serve to foster and perpetuate discrimination). The Awareness subscale measures subtle Eurocentric worldview bias by tapping into therapists’ attitudes and beliefs about working with diverse clients (e.g., I believe that all clients must view themselves as their number one responsibility).

The MCKAS was validated in two studies. The first study was conducted with a sample of 525 mostly White (83%) students and professionals in counseling and counseling psychology. The participants in the second study were 199 counselors-in-training recruited from five universities in the Northeast, and were White/Not Hispanic (45%), African American (18%), Hispanic American (16%), Asian American/Pacific Islander (2%), and Native American (1%). Ponterotto et al. (2002) reported the internal consistency for the Knowledge and Awareness subscales to be .85 and .85 respectively. The current study yielded a Cronbach's alpha of .80 and .91 for the Knowledge and Awareness subscales respectively. Convergent validity for the MCKAS was examined through correlations with the Multicultural Counseling Inventory (MCI, Sadowsky, Taffe, Gutkin, & Wise, 1994), and the Knowledge and Awareness subscales were positively correlated with similar subscales of the MCI. Criterion-related validity was supported

by positive correlation between the scores of Knowledge subscale and the scores of Ethnic Identity subscale of the Multigroup Ethnic Identity Measure (MEIM, Phinney, 1992). The Knowledge subscale scores is negatively correlated with Social Desirability Scale scores (Crowne & Marlow, 1960) which demonstrated discriminant validity (See Appendix H).

Internal and External Motivation to Respond Without Prejudice Scale (IMS/EMS; Plant & Devine, 1998). The IMS and EMS assess self-reported motivation to respond without prejudice to Black people. For the purpose of this study, Black people will be replaced by Asians. Participants indicate their responses to the items on a 9-point Likert scale (*1 = strongly disagree, 9 = strongly agree*). The IMS consists of 5 items which measure internal motivation which stems from internalized and personal standard about being nonprejudiced (e.g., I attempt to act in nonprejudiced ways toward Asians because it is personally important to me). The EMS consists of 5 items which measure external motivation to respond without prejudice and example item include “Because of today’s PC (politically correct) standards I try to appear nonprejudiced toward Asians.”

Plant and Devine (1998) used three samples in their study, which consisted mostly White introductory psychology students (94%, 84%, and 85% respectively), to develop the scales. Both exploratory and confirmatory factor analyses supported this two-factor structure that they are two distinct constructs (Plant & Devine, 1998). In the exploratory factor analyses, the first factor accounted for 28% of the variance (eigenvalue of 5.33) and consisted of items that reflected internal motivation to respond without prejudice. The second factor accounted for 20% of the variance (eigenvalue of 3.74) and included items that assessed external motivation to respond without prejudice. In the confirmatory factor analysis of two-factor solution, goodness-of-fit index (GAF) equaled .96 and adjusted goodness-of-fit index (AGFI) equaled .93. The IMS and

EMS were moderately correlated (-.14 to -.15). Cronbach's alphas were in the range of .81 to .85 for the IMS and from .76 to .80 for the EMS. The current study yielded a Cronbach's alpha of .81 and .84 for the IMS and the EMS respectively. Both scales showed 9-week test-retest reliability (IMS $r = .77$; EMS $r = .60$). Plant and Devine (1998) established convergent and discriminant validity by testing 300 mostly White introductory psychology students (88 %). According to Plant and Devine (1998), people who are internally motivated to respond without prejudice should have more positive attitudes and less negative feelings toward the target group. As expected, the IMS was found to be positively correlated with the Attitude Toward Blacks Scale (ATB; Brigham, 1993) and the Pro-Black Scale (Katz & Hass, 1988), and negatively correlated with the Modern Racism Scale (MRS; McConahay, Hardee, & Batts, 1981) and the Anti-Black Scale (Katz & Hass, 1988). In addition, the IMS was positively correlated with the Humanitarianism-Egalitarianism Scale (HE; Katz & Hass, 1988), and negatively correlated with the Right-Wing Authoritarianism Scale (RWA; Altemeyer, 1981) and the Protestant Ethic Scale (PE; Katz & Hass, 1988). Plant and Devine (1998) proposed that the EMS measures something other than generalized fear and anxiety over negative reactions from others. As expected, the EMS was only modestly positively correlated with the Fear of Negative Evaluation Scale (FNE; Watson & Friend, 1969; Leary, 1983a) and the Interaction Anxiousness Scale (IAS; Leary, 1983b). The IMS and EMS were found to be unrelated to the Marlowe-Crowne Social Desirability Scale (Crowne & Marlowe, 1960) and the Self-Monitoring Scale (Snyder & Gangestad, 1986) (See Appendix I).

The Marlowe-Crowne Social Desirability Scale Form C (M-C SDS Form C; Reynolds, 1982). The M-C SDS Form C was based on the Marlowe-Crowne Social Desirability Scale (M-C SDS; Crowne & Marlowe, 1960). It was constructed by Reynolds (1982) in an effort to provide a

shorter version of the original 33-item scale. The M-C SDS Form C is composed of 13 true/false items which assess an individual's tendency to present oneself in a socially desirable manner. It was constructed by Reynolds (1982) in an effort to provide a shorter form to the original 33-item scale. Each item is scored with a 1 or 2, depending on whether it is keyed for social desirability as a true or a false answer. For instance, if the participant answers *false* to the item "I sometimes feel resentful when I don't get my way," the response will be scored with 2 point because *false* is the socially desirable response. The range of possible total scores is 2 to 26. Higher total scores indicate higher tendency to respond in socially desirable ways.

The M-C SDS is the most widely used scale to assess the impact of social desirability on self-report measures (Leite & Beretvas, 2005; Loo & Loewen, 2004). Crowne and Marlowe (1960) developed the M-C SDS by selecting a pool of items from personality inventories, excluding psychopathological content. An internal consistency analysis of the M-C SDS revealed a KR-20 .88 coefficient for the total test score and a test-retest procedure revealed a KR-20 .89 coefficient (Crowne & Marlowe, 1960). Similar findings have been found by other researchers such as Constantine and Ladany (2000) who found a Cronbach's alpha of .86. The divergent validity was examined by the correlation between the M-C SDS and Edwards Social Desirability Scale (Edwards, 1957). The correlation coefficient is .35, which is significant at the .01 level. The Edwards scale was created based on items of the Minnesota Multiphasic Personality Inventory (MMPI, Hathaway & McKinley, 1940, 1942; McKinley & Hathaway, 1940, 1942) and consequently was associated more with psychopathology compared to the M-C SDS.

Despite its popularity, a practical difficulty with the M-C SDS is its length (Fischer & Fick, 1993). Several short forms of the M-C SDS have been created to assess social desirability with fewer items. These short versions of the M-C SDS are the result of factor analyses (Ballard,

1992; Hays, Hayashi, & Steward; Reynolds, 1982; Strahan & Gerbasi, 1972). Research supported the use of the M-C SDS Form C (Andrews & Meyer, 2003; Reynolds, 1982). The correlation between the M-C SDS Form C and the full scale ranged from .91 to .97 (Andrews & Meyer, 2003; Fischer & Fick, 1993; Loo & Thorpe, 2000; Reynolds, 1982). The M-C SDS Form C was normed with a sample of 608 mostly White (81.2%) students. Reynolds (1982) reported an acceptable level of reliability of .76. The current study yielded a Cronbach's alpha of .77. Concurrent validity was examined through correlation between the M-C SDS Form C and the full version. The M-C SDS Form C correlated strongly with the M-C SDS ($r = .93, p < .001$) (See Appendix J).

Demographic Questionnaire. A personal demographic sheet collected personal information about the participants, such as their age, sex, and social class. Participants were also asked questions about their training in multicultural counseling, such as their field of study (clinical psychology or counseling psychology), years of therapy experience, number of multicultural training courses, workshops, or seminars they have taken, the type of the multicultural training they have received (experiential or didactic), and the estimated percentage of their clientele that identifies as Asian/Asian American (See Appendix K).

Chapter IV

Results

The present study explored the relationship between White psychology trainees' level of self-reported multicultural counseling competence, Asian stereotypes endorsement, internal and external motivation to respond without prejudice and their initial clinical judgments with regard to ratings of concern for symptom severity and prognosis of an Asian international student, an Asian American student or a White student fictitious client. Data were collected via SurveyMonkey online and a random national sample of 196 American Psychological Association accredited programs in Counseling and Clinical Psychology was invited to participate. Participants were 439 White trainees in counseling, clinical or school psychology. Of these participants, approximately 20% were men and 80% were women. More than half of the participants (53.8 %) identified their socioeconomic status as being middle class. The average age of participants was 28.08 ($SD = 6.04$) and on average, participants had 2.2 years ($SD = 2.21$) of clinical training experience (Table 1). Participants were asked to read a fictitious clinical vignette and complete questionnaires that measured their initial clinical impressions of the client described in the vignette, their level of multicultural counseling competence, Asian stereotypes endorsement, internal and external motivation to respond without prejudice, social desirability, and a personal demographic information. The data were analyzed using the IBM Statistical Package for the Social Sciences, version 19.

Preliminary Analyses

In an effort to ascertain whether there were any significant differences in participant responses based on demographic information, analyses of variance (ANOVAs) were conducted examining the potential impact of participants' gender, age, socioeconomic status, current

pursuing degree, and academic discipline on each of the measured variables. Results revealed a main effect for age on Clinical Judgment Scale ($F(31, 400) = 1.6, p < .05$) such that younger participants were more likely to give more pessimistic prognoses than older participants. As a result, participants' age was taken into account in the principle analyses that included the Clinical Judgment Scale. Psychometric data were obtained for each of the variables and are presented below. Of note, the Marlowe-Crowne Social Desirability Scale Form C had reliability alpha coefficient that fell below the suggested cut-off of 0.70. Effort was made to improve the reliability of this scale and the alpha coefficient improved with elimination of one item. The alpha coefficient for the corrected scale is listed.

Analyses were conducted to ascertain the mean, standard deviation, observed minimum/maximum scores, scale minimum/maximum scores, skewness, kurtosis, and internal reliability using coefficient alpha for participants' scores on the scales used in this study for the whole sample (Table 4) and for the three conditions (Table 5, 6, and 7).

Table 4. *Preliminary Analyses for Main Study: Whole sample (N = 439)*

	M	SD	Observed Minimum	Observed Maximum	Scale Minimum	Scale Maximum	Skewness	Kurtosis	Reliability (α)
ICII-R	55.00	7.02	30	73	13	91	-.32	.61	.73
CJS	57.79	7.88	30	79	19	133	-.34	.74	.80
MCKAS total	174.32	21.56	106	224	32	224	-.10	-.35	.90
SAAAS total	69.47	17.07	31	135	25	150	.08	.24	.92
IMS	38.71	6.68	11	45	5	45	-1.39	1.82	.81
EMS	21.28	9.48	5	45	5	45	.22	-.64	.84
M-C SDS Form C	17.96	2.73	2	24	2	26	.30	-.86	.77
MCKAS Awareness	70.25	8.33	41	84	12	84	-.59	.09	.80
MCKAS Knowledge	104.07	16.63	52	140	20	140	-.19	-.36	.91
SAAAS Sociability	35.33	9.31	14	66	13	78	.12	-.19	.89
SAAAS Competence	34.14	9.36	12	69	12	72	-.001	.27	.87

Note: ICII-R = Initial Clinical Impressions Inventory-Revised; CJS = Clinical Judgment Scale; MCKAS = Multicultural Counseling Knowledge and Awareness Scale; SAAAS = Scale of Anti-Asian American Stereotypes; IMS = Internal Motivation Scale; EMS = External Motivation Scale; M-C SDS Form C = The Marlowe-Crowne Social Desirability Scale Form C.

Table 5. *Preliminary Analyses for Main Study: Asian International Student Target Client (N = 156)*

	M	SD	Observed Minimum	Observed Maximum	Scale Minimum	Scale Maximum	Skewness	Kurtosis	Reliability (α)
ICII-R	54.59	7.08	36	71	13	91	-.12	-.19	.73
CJS	56.67	8.35	30	78	19	133	-.32	.83	.82
IMS	38.67	6.03	17	45	5	45	-.93	.34	.74
EMS	21.70	9.29	5	45	5	45	.11	-.68	.83
M-C SDS Form C	16.14	2.96	12	23	2	26	.46	-.67	.77
MCKAS Awareness	69.98	8.09	42	84	12	84	-.67	.31	.81
MCKAS Knowledge	103.66	16.46	52	140	20	140	-.27	-.01	.91
SAAAS Sociability	36.38	8.70	18	63	13	78	-.20	-.44	.89
SAAAS Competence	33.65	8.45	12	54	12	72	-.27	-.08	.85

Note: ICII-R = Initial Clinical Impressions Inventory-Revised; CJS = Clinical Judgment Scale; MCKAS = Multicultural Counseling Knowledge and Awareness Scale; SAAAS = Scale of Anti-Asian American Stereotypes; IMS = Internal Motivation Scale; EMS = External Motivation Scale; M-C SDS Form C = The Marlowe-Crowne Social Desirability Scale Form C.

Table 6. *Preliminary Analyses for Main Study: Asian American Target Client (N = 156)*

	M	SD	Observed Minimum	Observed Maximum	Scale Minimum	Scale Maximum	Skewness	Kurtosis	Reliability (α)
ICII-R	54.89	7.73	30	73	13	91	-.39	.97	.78
CJS	57.28	8.00	30	74	19	133	-.41	.43	.82
IMS	39.06	6.71	11	45	5	45	-1.73	3.31	.81
EMS	20.87	9.77	5	45	5	45	.35	-.47	.85
M-C SDS Form C	16.78	2.95	12	23	2	26	.07	-.99	.75
MCKAS Awareness	69.98	8.60	41	84	12	84	-.58	.01	.82
MCKAS Knowledge	103.66	16.56	55	140	20	140	-.03	-.48	.91
SAAAS Sociability	34.38	9.76	15	65	13	78	.27	-.15	.89
SAAAS Competence	33.65	9.97	12	69	12	72	.13	.24	.89

Note: ICII-R = Initial Clinical Impressions Inventory-Revised; CJS = Clinical Judgment Scale; MCKAS = Multicultural Counseling Knowledge and Awareness Scale; SAAAS = Scale of Anti-Asian American Stereotypes; IMS = Internal Motivation Scale; EMS = External Motivation Scale; M-C SDS Form C = The Marlowe-Crowne Social Desirability Scale Form C.

Table 7. *Preliminary Analyses for Main Study: White Target Client (N = 127)*

	M	SD	Observed Minimum	Observed Maximum	Scale Minimum	Scale Maximum	Skewness	Kurtosis	Reliability (α)
ICII-R	56.87	5.50	41	70	13	91	.01	.25	.62
CJS	59.79	6.74	42	79	19	133	.13	.31	.74
IMS	38.32	7.41	14	45	5	45	-1.36	1.26	.88
EMS	21.28	9.42	5	42	5	45	.21	-.75	.85
M-C SDS Form C	15.68	2.88	12	23	2	26	.57	-.48	.77
MCKAS Awareness	70.74	8.32	43	84	12	84	-.52	.05	.78
MCKAS Knowledge	103.60	16.99	59	135	20	140	-.32	-.53	.90
SAAAS Sociability	36.46	9.41	14	66	13	78	.33	.23	.89
SAAAS Competence	35.40	9.55	12	69	12	72	.17	.76	.88

Note: ICII-R = Initial Clinical Impressions Inventory-Revised; CJS = Clinical Judgment Scale; MCKAS = Multicultural Counseling Knowledge and Awareness Scale; SAAAS = Scale of Anti-Asian American Stereotypes; IMS = Internal Motivation Scale; EMS = External Motivation Scale; M-C SDS Form C = The Marlowe-Crowne Social Desirability Scale Form C.

Correlations among all the variables included in the analyses were calculated and are illustrated in Table 8. In an effort to establish convergent validity with the two measures of clinical judgment, a Pearson correlation analysis was utilized to examine the relationship between the ICII-R and the CJS. The result of this analysis revealed a significant moderate correlation ($r = .48, p < .01$) which provides some evidence for convergent validity and is consistent with previous psychometric data obtained for these measures. Although the result revealed a significant correlation between M-C SDS Form C and IMS ($r = .14, p < .01$), the correlation is rather weak. The IMS measures internal motivation which stems from internalized and personal standard about being nonprejudiced and the M-C SDS form C assesses an individual's tendency to present oneself in a socially desirable manner. The result also revealed significant moderate correlations between the two subscales of the SAAAS (Sociability and Competence) ($r = .67, p < .01$) and the two subscales of the MCKAS (Awareness and Knowledge)

($r = .43, p < .01$), which are consistent with previous psychometric data obtained for these subscales.

Table 8. *Variable Inter-correlations (N = 439)*

Subscales	1	2	3	4	5	6	7	8	9	10	11
1. ICIIR	1.00										
2. CJS	.48**	1.00									
3. MCKAS total	-.21**	-.20**	1.00								
4. SAAAS total	.19**	.19**	-.36**	1.00							
5. IMS	-.10*	-.23**	.34**	-.39**	1.00						
6. EMS	.01*	.10*	-.18**	.28**	-.11*	1.00					
7. M-C SDS Form C	.02	-.01	-.07	-.01	.14**	-.03	1.00				
8. MCSAS Awareness	-.31**	-.19**	.72**	-.42**	.27**	-.19**	-.13**	1.00			
9. MCKAS Knowledge	-.12*	-.16**	.94**	-.26**	.31**	-.14**	-.03	.43**	1.00		
10. SAAAS Sociability	.14**	.16**	-.36**	.91**	-.38**	.24**	.02	-.39**	-.28**	1.00	
11. SAAAS Competence	.22**	.19**	-.29**	.91**	-.33**	.26**	-.03	-.37**	-.19**	.67**	1.00

Note: *indicates that the correlation is significant at the .05 level; **indicates that the correlation is significant at the .01 level. ICII-R = Initial Clinical Impressions Inventory-Revised; CJS = Clinical Judgment Scale; MCKAS = Multicultural Counseling Knowledge and Awareness Scale; SAAAS = Scale of Anti-Asian American Stereotypes; IMS = Internal Motivation Scale; EMS = External Motivation Scale; M-C SDS Form C = The Marlowe-Crowne Social Desirability Scale Form C.

Analyses Testing Hypotheses

Hypothesis 1 and 2. White psychology trainees will show less concern for symptom severity and more optimistic prognoses to the target client when she was reported to be Asian than when she was reported to be White (Hypothesis 1). White Psychology trainees will show less concern regarding symptom severity and more optimistic prognoses to the target client when she was reported to be an Asian international student compared to an Asian American student (Hypothesis 2).

Analysis for ratings of concern regarding symptom severity. An analysis of variance (ANOVA) was conducted to test for differences in ratings of concern for symptom severity among three conditions. The target client's race was identified as the predictor variable and the ICII-R was the criterion variable. The ANOVA revealed that there were significant differences in participants' level of concern for symptom severity based on whether the participant was responding to a White, an Asian American or an Asian international student client ($F(2, 436) = 7.89, p < .001$). A planned contrast comparison was done to investigate differences in ratings of concern for symptom severity between the two contrasts (first contrast: White target client vs. Asian target clients; second contrast: Asian American target client vs. Asian international student target client). A t -test revealed significant differences for the first contrast: White target client vs. Asian target clients ($t(436) = -4.08; p < .001$). In other words, participants would judge the Asian target clients as healthier compared to the White target client (Hypothesis 1). However, the t -test revealed no significant differences for the second contrast: Asian American client vs. Asian international student client ($t(436) = -1.55, ns$). In other words, participants did not show different levels of concern for symptom severity when the target client was reported to be an Asian American or an Asian international student (Hypothesis 2).

Analysis for ratings of prognosis. An ANOVA was also conducted to test for differences in ratings of prognosis among three conditions with the target client's race was identified as the predictor variable and the CJS was the criterion variable. The ANOVA revealed that there were significant differences in participants' prognostic ratings based on whether the participant was responding to a White, an Asian American or an Asian international student client ($F(2, 436) = 6.12, p < .05$). A planned contrast comparison was also done in ANOVA to investigate differences in ratings of prognosis among the two contrasts (first contrast: White target client vs.

Asian target clients; second contrast: Asian American target client vs. Asian international student target client). A *t*-test revealed significant differences for the first contrast: White target client vs. Asian target clients ($t(436) = -3.43; p < .05$). In other words, participants gave more optimistic ratings of prognosis when the target clients were reported to be Asian individuals compared to be White individual (Hypothesis 1). However, the *t*-test revealed no significant differences for the second contrast: Asian American target client vs. Asian international student target client ($t(436) = -.683, ns$). In other words, the participants did not show differences in the prognostic ratings when the target client was reported to be an Asian American or an Asian international student (Hypothesis 2).

Although the planned contrast comparisons revealed the significant differences in participants' ratings of concerns and prognosis for White target client versus Asian target clients, one does not know whether the differences were between White and Asian American target client or between White and Asian international target client. Therefore, another research question (Research Question 1) was proposed.

Research Question A1. How White psychology trainees' initial clinical judgment regarding ratings of concern for symptom severity and prognosis for Asian American target client or Asian international student target client differ from White target client?

Analysis. Post-hoc tests were conducted in the analysis of variance (ANOVA) to explore the differences in ratings of concern for symptom severity and prognosis among the three conditions. Due to differences in the sample sizes among the three conditions, post-hoc tests Gabriel, Hochberg's GT2, and Games-Howell were used. All three post hoc tests showed that participants showed less concern for symptom severity and more optimistic ratings of prognosis to the Asian international student than the White target client at the .05 level of significance. All

other comparisons were not significant (e.g., Asian American student versus White student; Asian American student versus Asian international student).

Research Question 1. Does the race of the target client influence White psychology trainees' self-reported multicultural counseling competence, Asian stereotype endorsement, motivation to respond without prejudice, and social desirability?

Analysis. In order to explore whether White psychology trainees' level of self-reported multicultural counseling competence, Asian stereotype endorsement, internal/external motivation to respond without prejudice, and social desirability differ significantly among the three conditions, the multivariate analyses of variance were conducted separately with client race as the fixed factor and the two subscales MCKAS (Awareness and Knowledge) as the criterion variables, the two subscales of SAAAS (Sociability and Competence) as criterion variables, and IMS, EMS and M-C SDS Form C as criterion variables. The results of the analyses were not significant, MCKAS, $F(2, 436) = .17, ns$, SAAAS, $F(2, 436) = 2.39, ns$, Awareness of MCKAS, $F(2, 436) = .42, ns$, Knowledge of MCKAS, $F(2, 436) = .38, ns$, Sociability of SAAAS, $F(2, 436) = 1.99, ns$, Competence of SAAAS, $F(2, 436) = 2.31, ns$, IMS, $F(2, 436) = .44, ns$, EMS, $F(2, 436) = .36, ns$, M-C SDS Form C, $F(2, 436) = 5.05, ns$. In other words, White psychology trainees' level of self-reported multicultural counseling competence, Asian stereotype endorsement, internal/external motivation to respond without prejudice, and social desirability do not differ significantly among the three conditions.

Research Question 2. Does the impact of multicultural counseling competence, Asian stereotype endorsement, motivation on White trainees' initial clinical judgment regarding ratings of concern for symptom severity and prognosis differ based on target client race?

Analysis for ratings of concern for symptom severity. Simultaneous multiple regression analyses were conducted with all the predictor variables, including the two subscales MCKAS (Awareness and Knowledge), the two subscales of SAAAS (Sociability and Competence), IMS and EMS, and target client race, and the ICII-R as the criterion variable for the whole sample. In order to control for sociability desirability, M-C SDS Form C was also used as a predictor variable. The overall model significantly predicted ratings of concern for symptom severity, overall $R^2 = .15$, $F(8, 429) = 9.21$, $p < .05$ (see Table 9). Examination of individual Beta weights revealed that target client race, $\beta = .19$, $t = 4.16$, $p < .05$, Awareness of MCKAS, $\beta = -.26$, $t = -4.87$, $p < .05$, and Competence of SAAAS, $\beta = .19$, $t = 3.00$, $p < .05$, significantly contributed to the overall model. In other words, higher levels of multicultural awareness and lower levels of Asian competence stereotype endorsement were related to less concern for symptom severity. In order to test if there were interaction effects, the interaction terms were created using the variables that showed main effects from above analyses, such as target client race, and scores on Awareness and on Competence. Simultaneous multiple regression analyses were then conducted with all the predictor variables including interaction terms. Results revealed that the overall model significantly predicted ratings of concern for symptom severity, overall $R^2 = .16$, $F(10, 427) = 8.02$, $p < .05$ (see Table 10). Examination of individual Beta weights revealed that Awareness, $\beta = -.47$, $t = -3.54$, $p < .05$, and Competence, $\beta = .30$, $t = 2.14$, $p < .05$, significantly contributed to the overall model. However, examination of individual Beta weights revealed no interaction effects between Awareness and target client race (awarexrace, $\beta = .74$, $t = 1.75$, *ns*) or between Competence and target client race (compxrace, $\beta = -.21$, $t = -.97$, *ns*). These results did not change when the predictors were centered.

Table 9. *Simultaneous Multiple Regression with whole sample: Ratings of Concern for Symptom Severity by Self-Reported Multicultural Awareness and Knowledge, Sociability and Competence Asian Stereotypes Endorsement, Internal and External Motivation, Social Desirability and target client race (N = 437)*

Variable	B	SE B	Beta	<i>t</i>	<i>p</i>
MCKAS Awareness	-.22	.05	-.26	-4.87	.00*
MCKAS Knowledge	.002	.02	.004	.07	.94
SAAAS Sociability	-.06	.05	-.08	-1.25	.21
SAAAS Competence	.14	.05	.19	3.00	.00*
IMS	.01	.05	.01	.12	.91
EMS	.02	.04	.02	.42	.67
M-C SDS Form C	-.01	.11	-.003	-.06	.95
Client race	1.65	.40	.19	4.16	.00*

Note: $R = .38$; $R^2 = .15$; $F = 9.21$; ($p < .05$); *indicates significance at the .05 level; MCKAS Awareness = Multicultural Awareness (MCKAS); MCKAS Knowledge = Multicultural Knowledge (MCKAS); SAAAS Sociability = Sociability Asian Stereotype endorsement (SAAAS); SAAAS Competence = Competence Asian Stereotype endorsement (SAAAS); IMS = Internal Motivation Scale; EMS = External Motivation Scale; M-C SDS Form C = The Marlowe-Crowne Social Desirability Scale Form C.

Table 10. *Simultaneous Multiple Regression with interaction terms: Ratings of Concern for Symptom Severity by Self-Reported Multicultural Awareness and Knowledge, Sociability and Competence Asian Stereotypes Endorsement, Internal and External Motivation, Social Desirability, target client race, awarexrace, and comxrace (N = 437)*

Variable	B	SE B	Beta	<i>t</i>	<i>p</i>
MCKAS Awareness	-.40	.11	-.47	-3.54	.00*
MCKAS Knowledge	.003	.02	.01	.15	.89
SAAAS Sociability	-.06	.05	-.08	-1.32	.19
SAAAS Competence	.23	.11	.30	2.14	.03*
IMS	-.004	.05	-.004	-.08	.94
EMS	.02	.03	.02	.47	.64
M-C SDS Form C	-.03	.11	-.01	-.23	.81
Client race	-3.09	4.44	-.35	-.70	.49
awarexrace	.09	.05	.74	1.75	.08
comxrace	-.05	.05	-.21	-.97	.33

Note: $R = .40$; $R^2 = .16$; $F = 8.02$; ($p < .05$); *indicates significance at the .05 level; MCKAS Awareness = Multicultural Awareness (MCKAS); MCKAS Knowledge = Multicultural Knowledge (MCKAS); SAAAS Sociability = Sociability Asian Stereotype endorsement (SAAAS); SAAAS Competence = Competence Asian Stereotype endorsement (SAAAS); IMS = Internal Motivation Scale; EMS = External Motivation Scale; M-C SDS Form C = The Marlowe-Crowne Social Desirability Scale Form C; awarexrace = Awareness multiplied by target client race; comxrace = Competence multiplied by target client race.

Analysis for ratings of concern for symptom severity with subset groups. Since there were no interaction effects, in order to better understand how the predictor variables relate to ratings of concern for symptom severity for each condition, simultaneous multiple regression analyses were conducted with the two subscales MCKAS (Awareness and Knowledge), the two subscales of SAAAS (Sociability and Competence), and IMS and EMS as predictor variables and the ICII-R as the criterion variable for each of the subsets of the sample (i.e., participants who responded to a White target client, participants who responded to an Asian American target client, and participants who responded to an Asian international target student). In order to control for sociability desirability, M-C SDS Form C was also used as a predictor variable.

Asian International Student Target Client. Results revealed that for participants who responded to an Asian international student target client, the overall model significantly predicted ratings of concern for symptom severity, overall $R^2 = .15$, $F(7, 147) = 3.59$, $p < .05$ (see Table 11). Examination of individual Beta weights revealed that Awareness of MCKAS, $\beta = -.24$, $t = -2.47$, $p < .05$, significantly contributed to the overall model. In other words, for those participants who responded to an Asian international student target client, higher levels of self-reported multicultural awareness were related to less concern regarding the Asian international student target client's symptoms.

Asian American Target Client. Results also revealed that for participants who responded to an Asian American student client, the overall model significantly predicted ratings of concern for symptom severity, overall $R^2 = .21$, $F(7, 148) = 5.55$, $p < .05$ (see Table 12). Examination of individual Beta weights revealed that Awareness of MCKAS, $\beta = -.39$, $t = -4.26$, $p < .05$, and Competence of SAAAS, $\beta = .21$, $t = 2.18$, $p < .05$, significantly contributed to the overall model. In other words, for those participants who responded to an Asian American target client, higher

levels of multicultural awareness were related to less concern regarding the Asian American target client's symptoms. For those participants who responded to an Asian American target client, lower levels of competence Asian stereotypes endorsement were related to less concern regarding the Asian American target client's symptoms.

White Target Client. Results revealed no significant differences for participants who responded to a White target client ($F(7, 119) = .42, ns$).

Table 11. *Simultaneous Multiple Regression: Ratings of Concern for Symptom Severity by Self-Reported Multicultural Awareness and Knowledge, Sociability and Competence Asian Stereotypes Endorsement, Internal and External Motivation, and Social Desirability: Asian International Student Target Client (N = 155)*

Variable	B	SE B	Beta	<i>t</i>	<i>p</i>
MCKAS Awareness	-.21	.08	-.24	-2.47	.02*
MCKAS Knowledge	-.03	.04	-.06	-.71	.48
SAAAS Sociability	-.02	.09	-.03	-.24	.81
SAAAS Competence	.14	.10	.17	1.51	.13
IMS	.02	.10	.02	.24	.81
EMS	.02	.06	.03	.34	.73
M-C SDS Form C	.18	.20	.08	.96	.34

Note: $R = .38$; $R^2 = .15$; $F = 3.59$; ($p < .05$); *indicates significance at the .05 level; MCKAS Awareness = Multicultural Awareness (MCKAS); MCKAS Knowledge = Multicultural Knowledge (MCKAS); SAAAS Sociability = Sociability Asian Stereotype endorsement (SAAAS); SAAAS Competence = Competence Asian Stereotype endorsement (SAAAS); IMS = Internal Motivation Scale; EMS = External Motivation Scale; M-C SDS Form C = The Marlowe-Crowne Social Desirability Scale Form C.

Table 12. *Simultaneous Multiple Regression: Ratings of Concern for Symptom Severity by Self-Reported Multicultural Awareness and Knowledge, Sociability and Competence Asian Stereotypes Endorsement, Internal and External Motivation, and Social Desirability: Asian American Target Client (N = 156)*

Variable	B	SE B	Beta	<i>t</i>	<i>p</i>
MCKAS Awareness	-.35	.08	-.39	-4.26	.00*
MCKAS Knowledge	.03	.04	.07	.84	.41
SAAAS Sociability	-.11	.08	-.14	-1.39	.17
SAAAS Competence	.17	.08	.21	2.18	.03*
IMS	-.07	.09	-.06	-.72	.48
EMS	.03	.06	.04	.52	.60
M-C SDS Form C	-.23	.20	-.09	-1.15	.25

Note: $R = .46$; $R^2 = .21$; $F = 5.55$; ($p < .05$); *indicates significance at the .05 level; **indicates significance at the .01 level; MCKAS Awareness = Multicultural Awareness (MCKAS); MCKAS Knowledge = Multicultural Knowledge (MCKAS); SAAAS Sociability = Sociability Asian Stereotype endorsement (SAAAS); SAAAS Competence = Competence Asian Stereotype endorsement (SAAAS); IMS = Internal Motivation Scale; EMS = External Motivation Scale; M-C SDS Form C = The Marlowe-Crowne Social Desirability Scale Form C.

Analysis for ratings of prognosis. Simultaneous multiple regression analyses were conducted with all the predictor variables, including the two subscales MCKAS (Awareness and Knowledge), the two subscales of SAAAS (Sociability and Competence), IMS and EMS, and target client race, and the CJS as the criterion variable. In order to control for sociability desirability, M-C SDS Form C was also used as a predictor variable. Because preliminary analysis had revealed a significant difference in participants' age on the CJS, age was also included as a predictor variable. The overall model significantly predicted ratings of prognosis, overall $R^2 = .11$, $F(9, 421) = 6.03$, $p < .05$ (see Table 13). Examination of individual Beta weights revealed that target client race, $\beta = .16$, $t = 3.43$, $p < .05$, Competence of SAAAS, $\beta = .13$, $t = 1.99$, $p < .05$, and Age, $\beta = -.01$, $t = -2.07$, $p < .04$, significantly contributed to the overall model. In order to test if there were interaction effects, the interaction terms were created using the variables that showed main effects from above analyses, such as target client race, Age, and scores on Competence. Simultaneous multiple regression analyses were then conducted with all the predictor variables including the interaction terms.

Results revealed that the overall model significantly predicted ratings of prognosis, overall $R^2 = .17$, $F(12, 418) = 7.19$, $p < .05$ (see Table 14). Examination of individual Beta weights revealed that Competence, $\beta = .57$, $t = 4.00$, $p < .05$, and Age, $\beta = -.35$, $t = -3.13$, $p < .05$, significantly contributed to the overall model. Examination of individual Beta weights also revealed that interaction terms of Competence multiply by target client race (comp_xrace, $\beta = -.75$, $t = -3.46$, $p < .05$) and Age multiply by target client race (age_xrace, $\beta = .56$, $t = 2.40$, $p < .05$) significantly contributed to the overall model. These results did not change when the predictors were centered.

In order to better understand the interaction terms, two graphs were created by using the mean of competence (mean = 34.14) and age (mean = 28.08) to divide the scores into *low competence/high competence* categories (49.7 % of participants fell under *low competence* and 50.3% fell under *high competence*) (see Figure 1) and *younger/older* categories (68.7% of participants fell under *younger* and 31.7% fell under *older*) (see Figure 2). From Figure 1, one is able to see that White trainees who reported low Asian Competence stereotype endorsement gave the most optimistic prognosis to Asian international student, a more optimistic prognosis to Asian American target client, and the least optimistic prognosis to the White American student. However this pattern of effects were not found for those reported high Asian Competence stereotype endorsement. Figure 2 shows that White trainees who are older gave the most optimistic prognosis to Asian international student, However, for those White trainees who are younger, they showed the most optimistic prognosis to Asian American, more optimistic prognosis to Asian international student, and the least optimistic prognosis to White target client.

Table 13. *Simultaneous Multiple Regression with whole sample: Ratings of Prognosis by Self-Reported Multicultural Awareness and Knowledge, Sociability and Competence Asian Stereotypes Endorsement, Internal and External Motivation, Social Desirability and target client race (N = 430)*

Variable	B	SE B	Beta	<i>t</i>	<i>p</i>
MCKAS Awareness	-.05	.05	-.05	-1.00	.32
MCKAS Knowledge	-.03	.03	-.06	-1.07	.29
SAAAS Sociability	-.01	.06	-.02	-.25	.80
SAAAS Competence	.11	.05	.13	1.99	.04*
IMS	-.18	.06	-.15	-2.87	.05
EMS	.01	.04	.01	.21	.84
M-C SDS Form C	.05	.13	.02	.40	.69
Client race	1.57	.46	.16	3.43	.00*
Participant's Age	-.13	.06	-.10	-2.07	.04*

Note: $R = .34$; $R^2 = .11$; $F = 6.03$; ($p < .05$); *indicates significance at the .05 level; MCKAS Awareness = Multicultural Awareness (MCKAS); MCKAS Knowledge = Multicultural Knowledge (MCKAS); SAAAS Sociability = Sociability Asian Stereotype endorsement (SAAAS); SAAAS Competence = Competence Asian Stereotype endorsement (SAAAS); IMS = Internal Motivation Scale; EMS = External Motivation Scale; M-C SDS Form C = The Marlowe-Crowne Social Desirability Scale Form C.

Table 14. *Simultaneous Multiple Regression with interaction terms: Ratings of Prognosis by Self-Reported Multicultural Awareness and Knowledge, Sociability and Competence Asian Stereotypes Endorsement, Internal and External Motivation, Social Desirability, compxrace, and agexrace (N = 430)*

Variable	B	SE B	Beta	<i>t</i>	<i>p</i>
MCKAS Awareness	-.05	.05	-.05	-.87	.38
MCKAS Knowledge	-.03	.02	-.05	-1.03	.31
SAAAS Sociability	-.02	.05	-.03	-.40	.69
SAAAS Competence	.48	.12	.57	4.00	.00*
IMS	-.40	.16	-.34	-2.55	.05
EMS	.02	.04	.02	.43	.67
M-C SDS Form C	.01	.12	.003	.06	.95
Client race	-1.21	4.17	-.12	-.29	.77
Participants' Age	-.45	.14	-.35	-3.13	.00*
compxrace	-.18	.05	-.75	-3.46	.00*
agexrace	.18	.07	.56	2.40	.02*

Note: $R = .41$; $R^2 = .17$; $F = 7.19$; ($p < .05$); *indicates significance at the .05 level; MCKAS Awareness = Multicultural Awareness (MCKAS); MCKAS Knowledge = Multicultural Knowledge (MCKAS); SAAAS Sociability = Sociability Asian Stereotype endorsement (SAAAS); SAAAS Competence = Competence Asian Stereotype endorsement (SAAAS); IMS = Internal Motivation Scale; EMS = External Motivation Scale; M-C SDS Form C = The Marlowe-Crowne Social Desirability Scale Form C; compxrace = Competence multiplied by target client race; agexrace = Age multiplied by target client race.

Figure 1. Interaction effects of Asian competence stereotype endorsement and target client race on ratings of prognosis (CJS scores)

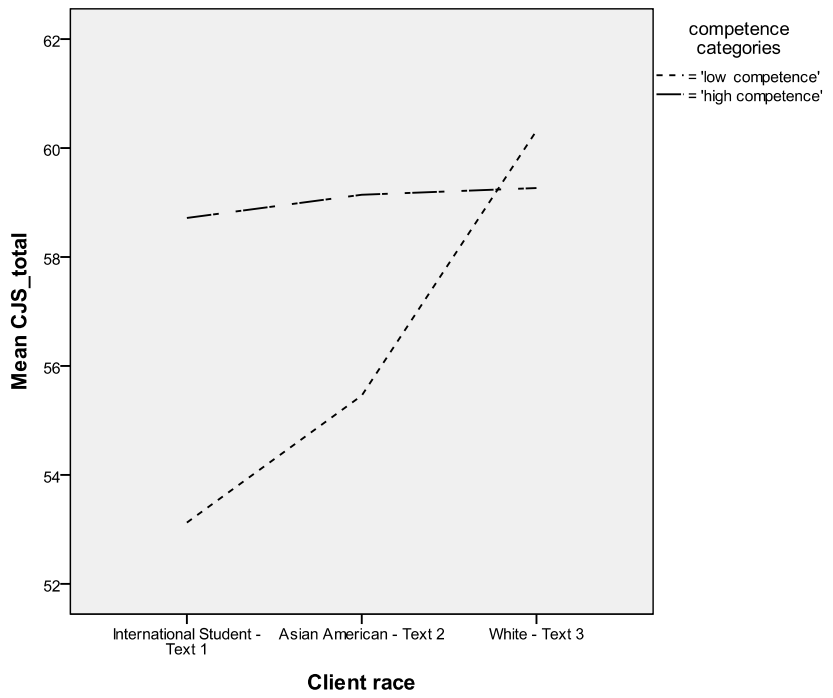
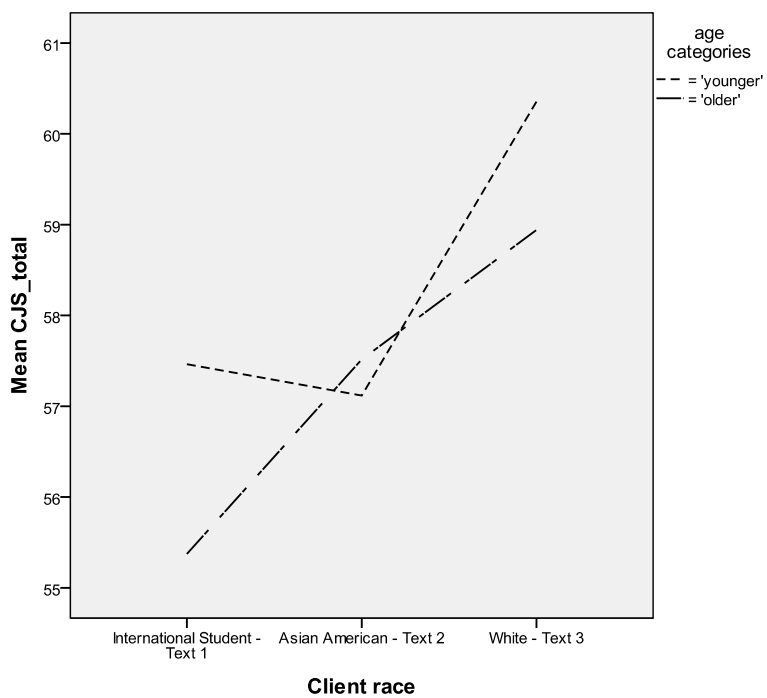


Figure 2. Interaction effects of participants' age and target client race on ratings of prognosis (CJS scores)



Chapter V

Discussion

The current study aimed to contribute to the growing understanding of the phenomenon of shifting standards while making subjective clinical judgments in clinical settings. Specifically, this study explored the impact of different factors (e.g., race of the client) on White therapists' tendency to shift standards while evaluating clients of Color. Although the existing literature shows that clients of Color, especially Black clients, suffer from being overpathologized (e.g., Strakowski, McElroy, Keck, & West, 1996; Trierweiler et al., 2000), biased evaluations do not only occur in one direction. Biased evaluations not only occur in the direction of greater disturbance, they also occur in the opposite direction, toward the perception of lesser disturbance, which is underestimating symptom severity of clients of Color (Lopez, 1989). Research has found that in high emergency situations, White individuals offered more help at a faster rate to White victims than to comparable Black victims (Kunstman & Plant, 2008). This tendency was associated with White individuals' interpretation of the emergency as less severe and themselves as less responsible to help Black victims rather than White victims. In other words, the interpretation of Black victims' less severe conditions justified their lack of help. If White therapists evaluate the symptoms of clients of Color as less severe to comparable White clients, it would mean less help and treatment for clients of Color.

Therefore, the current study investigated whether White therapists shift standards in making subjective clinical judgments based on race and residency status of the client. In other words, this study examined whether White therapists show less concern regarding symptom severity and have more optimistic prognosis regarding a fictitious client when she was reported to be Asian than when she was reported to be White. Furthermore, this study explored the

potential relationships among White psychology trainees' level of self-reported Asian stereotype endorsement, multicultural counseling competence, and motivation to respond without prejudice and their impact on White therapists' initial clinical judgment.

Impact of Client Race/Residency Status

For a sample of White psychology trainees in counseling and clinical psychology, the current study used a fictitious college counseling center intake report as a stimulus to investigate the impact of reported client race/residency status (Asian American, Asian international student, or White American) on ratings of concern for symptom severity and prognosis. According to shifting standards model of social judgment, when people make subjective judgments about individuals from groups about which social stereotypes exist, they make judgment based on their internalized stereotype-based expectations for that group (Biernat & Kobrynowicz, 1997; Biernat & Manis, 1994; Biernat et al., 1991). In other words, individuals from negatively stereotyped groups (e.g., People of Color) face a different set of judgment criteria and outcomes than individuals from positively stereotyped groups (e.g., White Americans). Following the shifting standards model, it was hypothesized that the Asian target clients (Asian American and Asian international student) would be judged to be healthier and to have more optimistic prognoses, than the White target client due to lower expectations/standards for Asian individuals. Also, it was predicted that the Asian international student target client would be judged to be healthier and to have more an optimistic prognosis than the Asian American target client due to the existence of even lower standards for Asian international students. In other words, the meaning of the clinical judgment is really "healthy and optimistic *for Asian individuals.*" According to the shifting standards model, one would predict that White target client would be judged as sicker and having a more pessimistic prognosis due to higher standards for White individuals. In

other words, the meaning of the clinical judgment is really "sick and pessimistic *for White individuals*."

Results revealed significant differences in ratings of concern for symptom severity and prognosis among three conditions in the direction predicted by the shifting standards model. White trainees in the current study judged Asian individuals to be healthier and to have a more optimistic prognosis than the White target client. Specifically, post hoc tests revealed significant differences in the ratings of concern for symptom severity and prognosis between Asian international student and White target client. In other words, White trainees judged Asian international student to be healthier and to have a more optimistic prognosis than White target client.

However, there were no significant differences in ratings of concern and prognosis between Asian American and Asian international student. This finding may be due to limitations of this study insofar as when the writer developed the clinical vignettes, the writer asked participants to rate how stereotypical of the statements relate to Asian individuals, but did not ask participants to differentiate between stereotypes associated with Asian Americans and Asian international students. In addition, there were also no significant differences in ratings of concern and prognosis between Asian American client and White client. This finding might be due to the prevailing positive stereotypes (e.g., model minority stereotype) associated with Asian Americans, which lead to higher standards being associated with Asian Americans.

Why is it important to study the impact of client's race on White therapists' clinical judgment? As mentioned earlier, if White therapists shift their standards while judging clients' of Color symptoms as less severe to comparable White clients', it would mean less help and treatment for clients of Color. Although existing literature indicates that there is an association

between White therapists' stereotypes of Black or Latino clients and clinical judgment (e.g. Gushue, 2004; Gushue et al., 2008; Mukherjee et al., 1983; Neighbors, Trierweiler, Ford, & Muroff, 2003; Trierweiler et al., 2000), research is scant in the area of Asian stereotype endorsement and clinical judgment. The current study aimed to contribute to the literature by investigating Asian clients with White therapists. The result of this study is consistent with the literature; that is, White therapists in training shift their standards while making subjective clinical judgments of an Asian target client. Specifically, White trainees judged Asian target client as healthier and having more optimistic prognoses than the comparable White target client. What factors might mitigate this phenomenon of shifting standards in clinical setting? Before answering this question, it is important to find out what other factors might contribute to this phenomenon.

Impact of Multicultural Counseling Competence, Asian stereotype Endorsement, and Motivation

Based on literature, multicultural counseling competence and motivation to respond without prejudice are related to prejudice reduction. Also, based on the shifting standards model, the comparison standards are related to stereotypes associated with particular groups. Therefore, multicultural counseling competence, Asian stereotype endorsement and motivation are included in the current study. The following sections summarized the impact of those variables, which was found significant in the current study, on the ratings of prognosis and concern regarding symptom severity.

Ratings of prognosis. Interaction effects with Asian competence stereotype endorsement and participants' age were found to moderate the observed differences in ratings of prognosis by client race. Thus, Asian competence stereotype endorsement and participants' age were differentially related to ratings of prognosis, depending on the race ascribed to the target.

Interaction effects on ratings of prognosis: Asian competence stereotype endorsement and client race. The differences in judgment standards (giving more optimistic prognosis to Asian individuals) is associated with lower levels of Asian competence stereotype endorsement (see Figure 1). At the same time, those with higher levels of Asian competence stereotype endorsement tend to rate the prognosis equally, regardless of the race/residency status attributed to the client. Thus, the results suggest that White trainees with higher levels of Asian competence stereotype endorsement tended to judge comparable Asian individuals and White individual as having similar prognosis, whereas those with lower levels of Asian competence stereotype endorsement tended to give Asian individuals more optimistic prognoses. Specifically, those with lower levels of Asian competence stereotype endorsement tended to give the most optimistic prognosis to Asian international student, more optimistic prognosis to Asian American, and less optimistic prognosis to White target client. Seen from a shifting standards perspective, those with higher levels of Asian competence stereotype endorsement appear to use more equivalent standards to judge prognosis of Asian and White individuals. On the other hand, those who endorsed lower levels of Asian competence stereotype tended to judge Asian clients as having more optimistic prognosis compared to White client. This pattern may reflect different expectations based on differing cognitive schemas for Asian and White clients.

The overall effect was consistent with the shifting standards model (i.e., a client of Color was judged more favorably because of an implicit comparison with racial stereotypes). However, the interaction effect found in this sample is contrary to the predictions made by the shifting standards model (Biernat & Kobrynowicz, 1997; Biernat & Manis, 1994; Biernat et al., 1991). It predicts that less prejudiced people would tend to judge a target of color more critically; that is, more equivalent to subjective judgments made about White individuals. The results of this study

suggest the opposite. Figure 1 indicates that it was White trainees in the higher Asian competence stereotype group gave similar ratings of prognosis to the three conditions. It was White trainees in the lower Asian competence stereotype group who most differed in their ratings of prognosis among the Asian international student, Asian American, and White target client, suggesting the use of different standards for judging prognosis.

How would one explain this effect, which is contrary to the predicted outcome? It could be that these White trainees simply responded to racial cues in a way they thought was socially appropriate. However, results for regression analyses revealed no significance of social desirability. Also, Table 8 indicates that Asian competence stereotype endorsement was not associated with social desirability.

If the effect found in this sample is not due to social desirability, what else might explain it? As mentioned earlier, individuals from negatively stereotyped groups (e.g., People of Color) face a different set of judgment outcomes than individuals from positively stereotyped groups (e.g., White Americans). However, Asians as a racial group are unique insofar as there are seemingly positive stereotypes associated with them (i.e., model minority stereotype). Research supports the existence of a positive or model minority stereotype regarding Asians, comprising such traits as being intelligent, capable, industrious, self-disciplined, mathematical, obedient, family oriented, and courteous (Fiske et al., 2002; Ho & Jackson, 2001; Lin et al., 2005; Pittinsky et al., 2000; Wong et al., 1998). The model minority stereotype tends to lead people to evaluate Asian Americans as competent, especially related to the academic setting. One could hypothesize that White trainees who endorse higher levels of Asian competence stereotype would judge Asian individuals and White individuals as having a similar prognosis due to the positive stereotypes associated with both racial groups. However, White trainees who endorsed

lower levels of Asian competence stereotype might use more negative stereotypes associated with Asian individuals (e.g., quiet, withdrawing) as judgment standards, which led to a more optimistic prognosis for Asian individuals due to lower standards compared to White individuals. For instance, it would be considered as "normal" for Asian individuals to be quiet which might lead to less concern regarding symptom severity (i.e., social withdrawal) from the therapists. Therefore, participants would give Asian internationals the most optimistic prognosis (the lowest standards), Asian American the more optimistic prognosis, and White target client the less optimistic prognosis (the highest standards).

Another explanation could be that White trainees who reported lower levels of Asian competence stereotype in this sample showed higher levels of multicultural counseling competence. As Table 8 indicates that Asian competence stereotype endorsement was negatively associated with both multicultural awareness and multicultural knowledge. In other words, those who reported lower levels of Asian competence stereotype reported higher multicultural counseling competence. However, using multicultural counseling competence to explain the dramatic pattern of ratings of prognosis (Asian individuals were giving more optimistic prognosis) might seem contradict to the concept of multicultural counseling competence. That is, people with higher levels of multicultural counseling competence should be more aware of their prejudice and assumptions toward clients of Color and therefore their judgments of Asian individuals should be similar to their judgments of White clients. This pattern of results is similar to a finding with a sample of White family counselors in which those with higher levels of multicultural knowledge were also seen to rate a family of Color as significantly more healthy than a White family as compared with those who showed lower multicultural knowledge (Gushue et al., 2008).

It was suggested by Gushue and his colleagues (Gushue, 2004; Gushue et al., 2008) that those reported higher multicultural counseling competence might incorporate the factors of discrimination and societal prejudice into the cognitive schemas through which they interpret racial information. Thus, clinical judgment about clients of Color becomes "healthy considering all they have to contend with" (Gushue et al., 2008). If clients of Color are judged as healthier, no wonder they would receive more optimistic prognosis.

Interaction effects on ratings of prognosis: Participants' age and client race. The differences in judgment standards (giving more optimistic prognosis to Asian individuals) is also associated with participants' age (see Figure 2). For those who are older tended to give Asian individuals more optimistic prognoses. Specifically, those who are older tended to give the most optimistic prognosis to Asian international student, more optimistic prognosis to Asian American, and less optimistic prognosis to White target client. For those who are younger also tended to give Asian individuals more optimistic prognoses compared to White target client. However, they tended to give the most optimistic prognosis to Asian American, an optimistic prognosis to Asian international student, and the least optimistic prognosis to White target client. How could one explain why participants tended to give relatively more optimistic prognosis to Asian American target client if they are younger, but gave relatively less optimistic prognosis to Asian American if they are older?

According to research, older adults show greater implicit prejudice than younger adults (Nosek, Banaji, & Greenwald, 2002; Stewart, von Hippel, & Radvansky, 2009). The current study utilized the situation model to assess implicit prejudice. The situation model is a representation that is a combination of the ideas presented in a text along with the inferences generated by the comprehender (Radvansky, Copeland, & von Hippel, 2010). The clinical

vignettes in the current study contain information about a fictitious client (e.g., age, symptoms) while the stereotypic inferences driving sentences are also included (e.g., "She was a straight-A student."-intelligent). As indicated above, participants tended to give a relatively more optimistic prognosis to the Asian American target client if they were younger, but gave a relatively less optimistic prognosis to the Asian American if they were older. This result is consistent with the literature that older people may exhibit greater prejudice (von Hippel, Silver, & Lynch, 2000). In other words, older participants would give Asian Americans relatively less optimistic prognoses due to higher standards associated with positive stereotypes (e.g., the model minority stereotypes).

Ratings of concern for symptom severity. Main effects were found for reported client race, multicultural awareness, and Asian competence stereotype endorsement. Results revealed that higher multicultural awareness was related to less concern for symptom severity for the whole sample. In other words, White trainees who reported higher level of multicultural awareness would judge clients (Asian international student, Asian American, or White American) as healthier. Results also revealed lower Asian competence stereotype endorsement was related to less concern for symptom severity for the whole sample. In other words, White trainees who reported lower level of Asian competence stereotype endorsement would judge clients (Asian international student, Asian American, or White American) as healthier. Although the main effects were found, there were no interaction effects. In other words, multicultural awareness and Asian competence stereotype endorsement did not moderate the observed differences in ratings by client race, so one can not compare the ratings of concern for symptom severity across the three conditions. Although the general direction for the results of the whole sample is consistent with the results of ratings of prognosis, that is lower level of Asian competence stereotype

endorsement or higher level of multicultural awareness was related to less concern regarding symptom severity, one cannot say White trainees gave relatively more or less concern to which group (Asian international student, Asian American student, or White student) due to lack of interaction effects.

Since there were no interaction effects, analyses were done with each of the subsets of the sample. For White trainees who responded to Asian international student, results revealed that for White trainees who reported higher level of multicultural awareness would judge Asian international student as healthier. For White trainees who responded to Asian American target client, results revealed that White trainees who reported higher level of multicultural awareness and lower level of Asian competence stereotype endorsement would judge Asian American target client as healthier. No significant results were found for those who responded to White target client.

Summary. The results indicate the unique aspects of the dimensions of self-reported Asian stereotype endorsement and participants' age may have different effects on the way in which schema-driven racial expectations influence White trainees' initial ratings of prognosis. Although no interaction effects were found for ratings of concern for symptom severity, the regression analyses of the subsets of the sample indicate similar findings for each condition, that is higher levels of multicultural counseling competence and lower levels of Asian competence stereotype endorsement were related to less concern regarding symptom severity. In other words, Asian international student and Asian American target client was judged separately as healthier or having more optimistic prognosis.

One new finding of the current study is about the differential impact of levels of Asian competence stereotype endorsement on ratings of prognosis. Although the shifting standards

model predicts that less prejudiced people would tend to judge a target of color more critically; that is, more equivalent to subjective judgments made about White individuals, the results of this study suggested the opposite. Results revealed that it was White trainees in the higher Asian competence stereotype group who gave similar ratings of prognosis among the Asian international student, Asian American, and White target client. One might be curious about whether White trainees who endorse higher levels of Asian competence stereotype would judge Asian individuals and White individuals as having similar prognosis due to positive stereotypes associated with both racial groups. The model minority stereotype tends to lead people to evaluate Asian Americans as competent, especially related to the academic setting. Therefore, the standards associated with Asians tend to be higher for those who endorse higher level of Asian competence stereotype. On the other hand, results revealed that White trainees who were in the lower Asian competence stereotype group shifted their standards while rating prognosis among the Asian international student, Asian American, and White target client. One possible explanation is that for White trainees who endorsed lower levels of Asian competence stereotype might use other negative stereotypes associate with Asian individuals as judgment standards which led to more optimistic prognosis for Asian individuals due to lower standards compared to White individuals. Although the model minority stereotype is prevalent in the US society, there are other negative stereotypes associated with Asian individuals, such as perpetual foreigners.

Another interesting and new finding of the current study is the differential impact of participants' age on ratings of prognosis. Results revealed that White trainees who are younger tended to give relatively more optimistic prognosis to Asian American target client (due to lower standards), but for those who are older gave relatively less optimistic prognosis to Asian American target client (due to higher standards). This pattern of results might suggest that older

adults show greater implicit prejudice than younger adults (Nosek et al., 2002; Stewart et al., 2009), which may be due to the greater difficulty that older people may have in inhibiting their unintentionally activated stereotypes and associated evaluations (von Hippel et al., 2000).

Implications

The results discussed above have important implications for training, practice, and future research in counseling and clinical psychology regarding multicultural assessment.

Training. Trainees certainly need to be aware of the effects of stereotyping on their clinical judgment, such that if they endorse higher levels of stereotypes of clients of Color, they might judge clients of Color as healthier and having more optimistic prognosis. In other words, they might use lower standards/expectation as judgment standards for clients of Color. For those who reported lower positive Asian stereotype endorsement (i.e., negative Asian stereotype endorsement), this recommendation applies training with multicultural assessment. However, Asians are a unique racial group, that is, there are seemingly positive stereotypes associated with them. Thus, for people who endorse higher levels of positive Asian stereotypes, the judgment standards for this racial group might be higher standards/expectations which will lead to similar judgments made toward White individuals. Although it appears to be a desirable pattern that White participants did not show different pattern of judgment while judging White and Asian individuals, the reason for it might be due to endorsement of positive Asian stereotypes. In other words, the seemingly positive stereotypes were incorporated into the cognitive schemas through which they interpret racial information of Asian individuals. Thus, it is important for trainees to be aware of not only the impact of their negative stereotyping of clients of Color, but also the mechanism behind "positive" stereotyping. It is also important to assist trainees develop more flexible and complex cognitive schemas. The goal is to train future therapists to critically analyze

their own assumptions regarding different racial groups and to be able to apply the schemas that are appropriate for the client's racial background.

Practice. Following from the previous section on training, the results of the impact of age have implications on practice. As therapists mature in their clinical experiences, they also mature in terms of age. One could suspect that with aging, one has more exposure to societal stereotypes and thus might incorporate more stereotypes into their cognitive schemas. Therefore, the above recommendations also applies here; that is, therapists certainly need to be aware of the effects of stereotyping on their clinical judgment at different stages of their careers. Also, while making clinical judgments, it is recommended that therapists be aware of the possible cognitive schemas they use to process racial information. In addition, they need to continue to critically analyze their own assumptions about different racial groups and to monitor the changes of their assumptions throughout their career.

Research. The results also suggest a number of implications for future research in the area of clinical judgment. In this study, the shifting standards model was used as a general framework to examine the impact of differing cognitive schemas on judgments about the same set of information. It would be beneficial to investigate other negative stereotypes associated with Asians and other potential positive stereotypes associated with other racial groups, including Whites, and their impact on clinical judgment. It is also important to investigate when therapists utilize positive stereotypes and when they apply negative stereotypes while making clinical judgments. This line of research will give more information about the impact of both negative and positive stereotyping on clinical judgment and the mechanism behind shifting standards of judgment. Second, although the current study confirmed the prediction of shifting standards model (Asian individuals were been given more optimistic prognosis compared to

White individuals), the current study did not find significant differences between ratings of concern for symptom severity and prognosis for Asian international student and Asian American target client. Asians as a categorization is quite heterogeneous and is comprised of many ethnic groups (Mio et al., 2007). Using the same standards to evaluate all the Asian ethnic groups might lead to misjudgment. Using different measures of stereotypes associated with different Asian ethnic groups or groups with different residency status would allow us to better assess and conceptualize this racial group. Third, the current study did not find significant differences between ratings of concern for symptom severity and prognosis for the Asian American client and the White client. It may relate to the prevailing positive stereotypes associated with Asian Americans and which led to higher standards associated with Asian Americans. Future research could focus on the impact of model minority stereotype on clinical judgment and whether the standards associated with model minority stereotype differ from the standards associated with White individuals. Fourth, the current study did not find interaction effects for multicultural counseling competence and reported client race as reported in other studies (Gushue, 2004; Gushue, Constantine, & Sciarra, 2008). Future studies could also use other measures of multicultural competence (e.g., D'Andrea, Daniels, & Heck, 1991; Sadowsky et al., 1994). Fifth, motivation is a well-studied construct; however, the current study did not find either main effect or interaction effect of motivation to respond without prejudice. Future studies may use other measures of motivation, such as Motivation to Control Prejudiced Reactions Scale (Dunton & Fazio, 1997) or Motivation to be Nonprejudiced Scale (Legault et al., 2007).

Limitations

The current study has a number of important limitations, and the findings reported must be interpreted with caution. First, this study used measures of self-reported multicultural

competence and Asian stereotype endorsement; thus, the results reflect participants' beliefs about their level of multicultural competence and Asian stereotype endorsement, but not the competence or the stereotype endorsement itself. Therefore, the results discussed earlier are related to White trainees' perceptions of their levels of multicultural competence and Asian stereotype endorsement. Second, the current study used trainees as participants. One cannot be sure to what extent can the results of this study be generated to therapists in the field. These results need to be replicated with a sample of therapists in the field. Third, the measures of Asian stereotype endorsement used in this study was designed to be used for attitudes toward Asian Americans and may not be suitable for general Asian populations. Furthermore, during the pilot study for developing the clinical vignettes used in the study, the researcher did not differentiate stereotypes between Asian Americans and Asian international students. Therefore, the lack of significant differences between ratings of Asian international student and Asian American target client need to be interpreted with caution. Fourth, this study used an clinical vignette, which may not be similar in many important ways to the actual session with face-to-face interactions. Some of the results reported here might be altered in a live session. Fifth, there might be regional differences associated with White trainees' self-reported multicultural counseling competence and Asian stereotype endorsement. However, this study did not ask participants to specify which region of the US they are from in the demographic questionnaire. Also, this study did not ask participants to specify whether they were born in the US or whether they are from another country (e.g., European countries). There might be differences in the level of Asian stereotype endorsement since the scale that was used in this study measures White Americans' Asian stereotype endorsement. White Europeans, however, might have different type of stereotypes associated with Asian individuals.

Conclusion

Being able to make a multiculturally appropriate assessment of clients is challenging. Therapists are in the constant battle between avoiding treating every client the same without taking culture into consideration and avoiding stereotyping while taking culture into consideration. The main purpose of the current study is to promote awareness. If therapists are becoming more aware of their implicit biases toward different racial groups and their tendency to shift standards of judgment based on those implicit biases, therapists will be more careful and sensitive while evaluating their clients.

The current study investigated the impact of reported client race on the process of forming initial clinical judgment regarding ratings of concern regarding symptom severity and prognosis through a clinical vignette of a fictitious counseling center intake report about a client whose race/residency status varied among Asian international student, Asian American, and White American. Consistent with the shifting standards model of social judgment, there was a significant difference in ratings of prognosis by the client's reported race, that is the Asian target clients were given more optimistic prognosis compared to White target client. In other words, participants used a different set of standards to judge Asian individuals. In addition, it was found that this difference was moderated by the participants' levels of Asian stereotype endorsement and their age. Shifts in judgment standards were found to be more evidence for participants with lower Asian competence stereotype endorsement. Also, although the general direction of the results for interaction effects of age and reported client race is consistent with the prediction of the shifting standards model (i.e., Asians were given more optimistic prognosis), the differences existed for the Asian American target client. Younger participants tended to give Asian American target client relatively more optimistic prognosis compared to older participants. It is

hoped that this study contributes to the understanding of multicultural competence, the impact of stereotyping in clinical setting, and mechanism behind changing standards of judgment for different racial groups.

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Appendix A

Please rate the representativeness of the following statements of Asian stereotypes in the U.S. There are no absolutely right or wrong answers. Please answer based on your common knowledge.

Very Stereotypical	Stereotypical	Somewhat Stereotypical	Neutral	Somewhat Not Stereotypical	Least Stereotypical	Not Stereotypical at all
1	2	3	4	5	6	7

1. _____ Asians need to achieve academically in order to make their families proud.
2. _____ It will be hard for Asians to question a person in an authority position.
3. _____ Asians put high priority on academic achievement
4. _____ Asians tend to think about their groups before themselves.
5. _____ Asians are quiet.
6. _____ Asians follow expectations of their families.
7. _____ Asians are intelligent.
8. _____ In order to get ahead of others, Asians can be overly competitive.
9. _____ Asians do not like to be the center of attention at social gathering.
10. _____ Asians are hardworking and diligent.
11. _____ Asians tend to socialize with people of their own group.
12. _____ Asians tend to resolve psychological problems on their own.
13. _____ Asians tend to report somatic symptoms of psychological problems.
14. _____ Asians are shy.
15. _____ Asians tend to go to Ivy League schools.
16. _____ Asians are reserved.
17. _____ Asians are not good leaders.
18. _____ Asians are nerdy.
19. _____ Family reputation is Asians' primary social concern.
20. _____ Asians tend to consider their family needs before considering their own needs.
21. _____ Asians tend to have very good grades.
22. _____ A lot of Asians are either studying or working all the time.
23. _____ Asians commit less time to socializing than others do.
24. _____ Asians are not as social as other groups of people.
25. _____ Asians are submissive.
26. _____ Asians are polite.
27. _____ Asians are passive.
28. _____ Asians are obsessed with competition.
29. _____ Asians are stoic.
30. _____ Asians are devious.

APPENDIX B

Intake Summary

Presenting problem:

Ms. Mei Ling Chen, a 25 year-old female international student from China, presents to the counseling center accompanied by her roommate. Her roommate reports that the client has stopped going to school for the past few weeks, and has started to lock herself in the room for the past few days. She complains about having headaches, dry mouth, and abdominal distress. She has low appetite, and states that eating makes her feel worse physically. She feels tired easily which she attributes to her difficulties with falling and staying asleep. She stays at home most of the time and seems to lose interests in things she used to enjoy. Prior to being brought to the counseling center, her roommate asked her about the reason she stopped going to school. She told her roommate that there was nothing she could do to change the situation. She thinks that people in her program laugh at her “behind her back” because she is not “smart” enough to be in the program.

Client history:

Mei Ling was born and raised in Beijing, China. She received her bachelor’s degree from Beijing University. She came to New York City by herself six months ago to pursue a master's degree from Columbia University. She is close to her roommate. She mainly socializes with students from China. She also reports that she has always being shy and scared to talk to strangers. However, this tendency was intensified after she came to the United States. She avoids situations which require her speaking English in public. She especially feels frustrated in classes which require active participation. Although she tries to speak up in class, her professors often imply that she is quiet. Her classmates frequently ask her to either repeat or clarify what she said in class. She feels shame and humiliated whenever that happens. She was a straight-A student, but found herself struggling with her current classes. She feels upset because she thinks she is at disadvantage. She said, “I need to be aggressive in the U.S. to succeed.”

Mei Ling denies history of self-harm, but indicates that she would not mind “being dead.” When asked to clarify, she states that she will never hurt herself because she does not want to bring shame to her family.

Mei Ling’s father is an engineer, and her mother was a professor at Beijing University. She has two younger sisters (11-year-old and 10-year-old) whom she practically raised after her mother passed away nine years ago. She feels guilty about leaving them to her father, but at the same time feels relieved. Her father always has high expectations of her. He pushes her to excel academically while expecting her to take care of her two younger sisters. She feels that no one understands what she is going through and states, “What happens in the family stays in the family.”

APPENDIX C

Intake Summary

Presenting problem:

Ms. Emily Chen, a 25 year-old Asian American female, presents to the counseling center accompanied by her roommate. Her roommate reports that the client has stopped going to school for the past few weeks, and has started to lock herself in the room for the past few days. She complains about having headaches, dry mouth, and abdominal distress. She has low appetite, and states that eating makes her feel worse physically. She feels tired easily which she attributes to her difficulties with falling and staying asleep. She stays at home most of the time and seems to lose interests in things she used to enjoy. Prior to being brought to the counseling center, her roommate asked her about the reason she stopped going to school. She told her roommate that there was nothing she could do to change the situation. She thinks that people in her program laugh at her “behind her back” because she is not “smart” enough to be in the program.

Client history:

Emily was born and raised in Berkeley, California. She received her bachelor’s degree from U.C. Berkeley. She came to New York City by herself six months ago to pursue a master's degree from Columbia University. She is close to her roommate. She mainly socializes with Asian Americans. She also reports that she has always being shy and scared to talk to strangers. However, this tendency was intensified after she came to New York City. She avoids situations which require public speaking. She especially feels frustrated in classes which require active participation. Although she tries to speak up in class, her professors often imply that she is quiet. Her classmates frequently ask her to either repeat or clarify what she said in class. She feels shame and humiliated whenever that happens. She was a straight-A student, but found herself struggling with her current classes. She feels upset because she thinks she is at disadvantage. She said, “I need to be aggressive in this culture to succeed.”

Emily denies history of self-harm, but indicates that she would not mind “being dead.” When asked to clarify, she states that she will never hurt herself because she does not want to bring shame to her family.

Emily’s father is an engineer, and her mother was a professor at U.C. Berkeley. She has two younger sisters (11-year-old and 10-year-old) whom she practically raised after her mother passed away nine years ago. She feels guilty about leaving them to her father, but at the same time feels relieved. Her father always has high expectations of her. He pushes her to excel academically while expecting her to take care of her two younger sisters. She feels that no one understands what she is going through and states, “What happens in the family stays in the family.”

Appendix D Intake Summary

Presenting problem:

Ms. Emily Anderson, a 25 year-old white female, presents to the counseling center accompanied by her roommate. Her roommate reports that the client has stopped going to school for the past few weeks, and has started to lock herself in the room for the past few days. She complains about having headaches, dry mouth, and abdominal distress. She has low appetite, and states that eating makes her feel worse physically. She feels tired easily which she attributes to her difficulties with falling and staying asleep. She stays at home most of the time and seems to lose interests in things she used to enjoy. Prior to being brought to the counseling center, her roommate asked her about the reason she stopped going to school. She told her roommate that there was nothing she could do to change the situation. She thinks that people in her program laugh at her “behind her back” because she is not “smart” enough to be in the program.

Client history:

Emily was born and raised in Berkeley, California. She received her bachelor’s degree from U.C. Berkeley. She came to New York City by herself six months ago to pursue a master's degree from Columbia University. She is close to her roommate. She mainly socializes with white individuals. She reports that she has always being shy and scared to talk to strangers. However, this tendency was intensified after she came to New York City. She avoids situations which require public speaking. She especially feels frustrated in classes which require active participation. Although she tries to speak up in class, her professors often imply that she is quiet. Her classmates frequently ask her to either repeat or clarify what she said in class. She feels shame and humiliated whenever that happens. She was a straight-A student, but found herself struggling with her current classes. She feels upset because she thinks she is at disadvantage. She said, “I need to be aggressive in this culture to succeed.”

Emily denies history of self-harm, but indicates that she would not mind “being dead.” When asked to clarify, she states that she will never hurt herself because she does not want to bring shame to her family.

Emily’s father is an engineer, and her mother was a professor at U.C. Berkeley. She has two younger sisters (11-year-old and 10-year-old) whom she practically raised after her mother passed away nine years ago. She feels guilty about leaving them to her father, but at the same time feels relieved. Her father always has high expectations of her. He pushes her to excel academically while expecting her to take care of her two younger sisters. She feels that no one understands what she is going through and states, “What happens in the family stays in the family.”

APPENDIX E
Initial Client Impression Inventory-Revised

Please read the intake report. Using the scale below, please circle the number that best describes the extent to which you agree or disagree with each of the statements that follows. Please respond based on your clinical hunches about the information presented on the intake report. Circle the appropriate response for each question:

- | Strongly
Disagree | Disagree | Somewhat
Disagree | Neutral | Somewhat
Agree | Agree | Strongly
Agree |
|---|----------|----------------------|---------|-------------------|-------|--------------------------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 1. I am concerned about the client's ability to communicate effectively. | | | | | | |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 2. I think that the client may be depressed. | | | | | | |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 3. I think that the client might pose a danger to others. | | | | | | |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 4. I am concerned about the client's overall social functioning. | | | | | | |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 5. I believe that the client has the ability to cope with his/her emotions in a healthy way. | | | | | | |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 6. I believe that psychiatric medication will be helpful to this client. | | | | | | |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 7. I am concerned about the client's sense of self-esteem | | | | | | |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 8. I would recommend the client for psychotherapy. | | | | | | |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 9. I am concerned about the client's judgment. | | | | | | |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 10. I think that the client should be considered for inpatient treatment. | | | | | | |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 11. I am concerned that the client may be psychotic (e.g., distorting reality, experiencing hallucinations and/or delusions). | | | | | | |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 12. What is your overall level of concern for this client's mental health? | | | | | | |
| Not concerned
1 | 2 | 3 | 4 | 5 | 6 | Extremely concerned
7 |

13. Many clinics require an initial estimate of the duration of treatment. How long do you think the client will require treatment?

No treatment	3 months	6 months	12 months	18 months	2 years	More than 2 years
1	2	3	4	5	6	7

APPENDIX F
Clinical Judgment Scale

We are interested in your global impressions of and reactions to the client described in the intake report. For the following questions, please indicate your response by circling the number that corresponds to the phrase which best describes your clinical assessment and expectations.

1. Which phrase best describes the severity of this client's problem?

- 1- not at all severe
- 2- not very severe
- 3- slightly severe
- 4- moderately severe.
- 5- somewhat severe
- 6- very severe
- 7- extremely severe

2. Estimate the client's prognosis without treatment.

- 1- extremely good
- 2- very good
- 3- good
- 4- fair
- 5- poor
- 6- very poor
- 7- extremely poor

3. Estimate the client's prognosis with treatment.

- 1- extremely good
- 2- very good
- 3- good
- 4- fair
- 5- poor
- 6- very poor
- 7- extremely poor

4. Which phrase best describes the client's level of social skills?

- 1- extremely high
- 2- very high
- 3- high
- 4- average
- 5- low
- 6- very low
- 7- extremely low

5. How open (self-disclosing) is this client?

- 1- extremely self-disclosing
- 2- very self-disclosing

- 3- somewhat self-disclosing
 - 4- average
 - 5- somewhat closed
 - 6- very closed
 - 7- extremely closed
6. Which phrase best describes the extent to which this client's communications are trustworthy?
- 1- extremely trustworthy
 - 2- very trustworthy
 - 3- trustworthy
 - 4- some trust; some doubt
 - 5- doubtful
 - 6- very doubtful
 - 7- extremely doubtful
7. Indicate the degree to which the client understands his problem.
- 1- perfectly understands
 - 2- mostly understands
 - 3- slightly understands
 - 4- some understanding; some confusion
 - 5- slightly confused
 - 6- mostly confused
 - 7- totally confused
8. Which phrase best describes the extent to which the client is "in touch with reality" in daily living?
- 1- completely in touch
 - 2- very in touch
 - 3- mostly in touch
 - 4- partially in touch; partially out of touch
 - 5- mostly out of touch
 - 6- very out of touch
 - 7- totally out of touch
9. Overall, how intelligent is this client?
- 1- extremely intelligent
 - 2- very intelligent
 - 3- somewhat intelligent
 - 4- of average intelligence
 - 5- somewhat dull
 - 6- very dull
 - 7- extremely dull
10. How task oriented is this client in therapy?
- 1- extremely task oriented
 - 2- very task oriented

- 3- somewhat task oriented
- 4- in between
- 5- somewhat diffuse
- 6- very diffuse
- 7- extremely diffuse

11. Which phrase best describes this client's motivation to pursue treatment?

- 1- extremely motivated
- 2- very motivated
- 3- somewhat motivated
- 4- average
- 5- somewhat unmotivated
- 6- very unmotivated
- 7- extremely unmotivated

12. Overall, how likeable is this client?

- 1- extremely likeable
- 2- very likeable
- 3- somewhat likeable
- 4- indifferent
- 5- somewhat dislikeable
- 6- very dislikeable
- 7- extremely dislikeable

13. How cooperative would this client be in future therapy with you?

- 1- extremely cooperative
- 2- very cooperative
- 3- somewhat cooperative
- 4- in between
- 5- somewhat resistant
- 6- very resistant
- 7- extremely resistant

14. Which phrase best describes the likelihood that this client would agree to continue in treatment with you to a mutually satisfactory conclusion?

- 1- extremely likely
- 2- very likely
- 3- somewhat likely
- 4- 50%-50%
- 5- somewhat unlikely
- 6- very unlikely
- 7- extremely unlikely

15. Overall, which phrase best describes how effective you think you would be in treating this client?

- 1- extremely effective
- 2- very effective
- 3- somewhat effective
- 4- neither effective nor ineffective
- 5- somewhat ineffective
- 6- very ineffective
- 7- extremely ineffective

16. Which phrase best describes how comfortable you would feel treating this client?

- 1- extremely comfortable
- 2- very comfortable
- 3- somewhat comfortable
- 4- indifferent
- 5- somewhat uncomfortable
- 6- very uncomfortable
- 7- extremely uncomfortable

17. Which phrase best describes the likelihood that you would continue seeing this client in therapy to a mutually satisfactory conclusion?

- 1- extremely likely
- 2- very likely
- 3- somewhat likely
- 4- 50%-50%
- 5- somewhat unlikely
- 6- very unlikely
- 7- extremely unlikely

18. Which phrase best describes the extent to which you would find doing therapy with this client rewarding?

- 1- extremely rewarding
- 2- very rewarding
- 3- somewhat rewarding
- 4- indifferent
- 5- somewhat unrewarding
- 6- very unrewarding
- 7- extremely unrewarding

APPENDIX G
The Scale of Anti-Asian American Stereotypes

Below are a number of statements with which you will agree or disagree. There are absolutely no right or wrong answers. Use the specified scale to indicate the number that best matches your response to each statement.

strongly disagree	moderately disagree	slightly disagree	slightly agree	moderately agree	strongly agree
1	2	3	4	5	6

1. Asian Americans seem to be striving to become number one. (C)
2. Asian Americans commit less time to socializing than others do. (S)
3. In order to get ahead of others, Asian Americans can be overly competitive. (C)
4. Asian Americans do not usually like to be the center of attention at social gathering. (S)
5. Most Asian Americans have a mentality that stresses gain of economic power. (C)
6. Asian Americans can sometimes be regarded as acting too smart. (C)
7. Asian Americans put high priority on their social lives. (S)^a
8. Asian Americans do not interact with others smoothly in social situations. (S)
9. As a group, Asian Americans are *not* constantly in pursuit of more power. (C)^a
10. When it comes to education, Asian Americans aim to achieve too much. (C)
11. Asian Americans tend to have less fun compared to other social groups. (S)
12. A lot of Asian Americans can be described as working all of the time. (C)
13. The majority of Asian Americans tend to be shy and quiet. (S)
14. Asian Americans are not very “street smart.” (S)
15. Asian Americans know how to have fun and can be pretty relaxed. (S)^a
16. Most Asian Americans are not very vocal. (S)
17. Asian Americans are a group *not* obsessed with competition. (C)^a
18. Asian Americans spend a lot of time at social gatherings. (S)^a
19. oftentimes, Asian Americans think they are smarter than everyone else is. (C)
20. Asia Americans enjoy a disproportionate amount of economic success. (C)
21. Asian Americans are not social as other groups of people. (S)
22. Asian Americans are motivated to obtain too much power in our society. (C)
23. Most Asian Americans function well in social situations. (S)^a
24. Many Asian Americans always seem to compare their own achievements to other people’s.
(C)
25. Asian Americans rarely initiate social events or gatherings. (S)

Notes: S = sociability item, C = competence item. ^a indicates a reverse-scored item (7, 9, 15, 17, 18, 23).

Scoring instructions are as follows: Sociability and competence scores on the Scale of Anti-American Stereotypes can be calculated separately by adding up the score for all items on the relevant subscale after reverse-scoring the items listed below. The sociability and competence subscales also can be combined to form a total anti-Asian American prejudice score. Sociability score = total of all the sociability items: 2, 4, 7, 8, 11, 13, 14, 15, 16, 18, 21, 23, 25. Competence score = total of all the competence items: 1, 3, 5, 6, 9, 10, 12, 17, 19, 20, 22, 24.

APPENDIX H
Multicultural Counseling Knowledge and Awareness Scale

Instructions: Using the following scale, rate the truth of each item as it applies to you.

1	2	3	4	5	6	7
not at all true			somewhat true			totally true

1. I believe all clients should maintain direct eye contact during counseling. (A)
2. I check up on my minority/cultural counseling skills by monitoring my functioning—via consultation, supervision, and continuing education. (K)
3. I am aware some research indicates that minority clients receive “less preferred” forms of counseling treatment than majority clients. (K)
4. I think that clients who do not discuss intimate aspects of their lives are being resistant and defensive. (A)
5. I am aware of certain counseling skills, techniques, or approaches that are more likely to transcend culture and be effective with any clients. (K)
6. I am familiar with the “culturally deficient” and “culturally deprived” depictions of minority mental health and understand how these labels serve to foster and perpetuate discrimination. (K)
7. I feel all the recent attention directed toward multicultural issues in counseling is overdone and not really warranted. (A)
8. I am aware of individual differences that exist among members within a particular ethnic group based on values, beliefs, and level of acculturation. (K)
9. I am aware some research indicates that minority clients are more likely to be diagnosed with mental illness than are majority clients. (K)
10. I think that clients should perceive the nuclear family as the ideal social unit. (A)
11. I think that being highly competitive and achievement oriented are traits that all clients should work towards. (A)
12. I am aware of differential interpretations of nonverbal communication (e.g., personal space, eye contact, handshakes) within various racial/ethnic groups. (K)
13. I understand the impact and operations of oppression and the racist concepts that have permeated the mental health professions. (K)
14. I realize that counselor-client incongruities in problem conceptualization and counseling goals may reduce counselor credibility. (K)
15. I am aware that some racial/ethnic minorities see the profession of psychology functioning to maintain and promote the status and power of the White establishment. (K)
16. I am knowledgeable of acculturation models for various ethnic minority groups. (K)
17. I have an understanding of the role culture and racism play in the development of identity and world views among minority groups. (K)
18. I believe that it is important to emphasize objective and rational thinking in minority clients. (A)
19. I am aware of culture-specific, that is culturally indigenous, models of counseling for various racial/ethnic groups. (K)
20. I believe that my clients should view the patriarchal structure as ideal (A)

21. I am aware of both the initial barriers and benefits related to the cross-cultural counseling relationship. (K)
22. I am comfortable with differences that exist between me and my clients in terms of race and beliefs. (K)
23. I am aware of institutional barriers which may inhibit minorities from using mental health service. (K)
24. I think that my clients should exhibit some degree of psychological mindedness and sophistication. (A)
25. I believe that minority clients will benefit most from counseling with a majority counselor who endorses White middle class values and norms. (A)
26. I am aware that being born a White person in this society carries with it certain advantages. (A)
27. I am aware of the value assumptions inherent in major schools of counseling and understand how these assumptions may conflict with values of culturally diverse clients. (K)
28. I am aware that some minorities see the counseling process as contrary to their own life experiences and inappropriate or insufficient to their needs. (K)
29. I am aware that being born a minority in this society brings with it certain challenges that White people do not have to face. (A)
30. I believe that all clients must view themselves as their number one responsibility. (A)
31. I am sensitive to circumstances (personal biases, language dominance, stage of ethnic identity development) which may dictate referral of the minority client to a member of his/her own racial/ethnic group. (K)
32. I am aware that some minorities believe counselors lead minority students into non-academic programs regardless of student potential, preferences, or ambitions. (K)

Notes: The following items are reverse scored: 1, 4, 7, 10, 11, 18, 20, 24, 25, and 30. The Knowledge items are designated by the symbol K after the item, and the Awareness items are designated by the symbol A after the item.

APPENDIX I
Internal and External Motivation to Respond Without Prejudice

Instructions: The following questions concern various reasons or motivations people might have for trying to respond in nonprejudiced ways toward Asians. Some of the reasons reflect internal-personal motivations whereas others reflect more external-social motivations. Of course, people may be motivated for both internal and external reasons; we want to emphasize that neither type of motivation is by definition better than the other. In addition, we want to be clear that we are not evaluating you or your individual responses. All your responses will be completely confidential. We are simply trying to get an idea of the types of motivations that people in general have for responding in nonprejudiced ways. If we are to learn anything useful, it is important that you respond to each of the questions openly and honestly. Please give your response according to the scale below.

1	2	3	4	5	6	7	8	9
strongly disagree								strongly agree

1. Because of today's PC (politically correct) standards I try to appear nonprejudiced toward Asians. (EMS)
2. I attempt to act in nonprejudiced ways toward Asians because it is personally important to me. (IMS)
3. I try to hide any negative thoughts about Asians in order to avoid negative reactions from others. (EMS)
4. If I acted prejudiced toward Asians, I would be concerned that others would be angry with me. (EMS)
5. According to my personal values, using stereotypes about Asians is OK. (IMS) (R)
6. I am personally motivated by my beliefs to be nonprejudiced toward Asians. (IMS)
7. I attempt to appear nonprejudiced toward Asians in order to avoid disapproval from others. (EMS)
8. Because of my personal values, I believe that using stereotypes about Asians is wrong. (IMS)
9. I try to act nonprejudiced toward Asians because of pressure from others. (EMS)
10. Being nonprejudiced toward Asians is important to my self-concept. (IMS)

Notes: (R) indicates reverse coded items.

APPENDIX J
The Marlowe-Crowne Social Desirability Scale Short Form C
Personal Reaction Inventory

Listed below are a number of statements concerning personal attitudes and traits. Read each item and decide whether the statement is *true* or *false* as it pertains to you personally.

1. It is sometimes hard for me to go on with my work if I am not encouraged. (F)
2. I sometimes feel resentful when I don't get my way. (F)
3. On a few occasions, I have given up doing something because I thought too little of my ability. (F)
4. There have been times when I felt like rebelling against people in authority even though I knew they were right. (F)
5. No matter who I'm talking to, I'm always a good listener. (T)
6. There have been occasions when I took advantage of someone. (F)
7. I'm always willing to admit it when I make a mistake. (T)
8. I sometimes try to get even rather than forgive and forget. (F)
9. I am always courteous, even to people who are disagreeable. (T)
10. I have never been irked when people expressed ideas very different from my own. (T)
11. There have been times when I was quite jealous of the good fortune of others. (F)
12. I am sometimes irritated by people who ask favors of me. (F)
13. I have never deliberately said something that hurt someone's feelings. (T)

Notes: *True* = 1; *False* = 2. The following items are reverse scored: 5, 7, 9, 10, 13.

APPENDIX K
Demographic Questionnaire

1. Sex: Male Female
2. Age: _____
3. Race:
 - Asian or Pacific Islander
 - Black/African American
 - Latino/Hispanic
 - Native American
 - White/Caucasian
 - Bi- or multi-racial (please specify) _____
4. Socioeconomic status:
 - Working class Upper-Middle class
 - Middle class Upper class
5. Please check the highest degree that you obtained:
 - Bachelors
 - Masters
 - Doctoral
6. In what field is your degree? _____
7. In what field are you currently studying in?
 - Counseling psychology
 - Clinical psychology
8. What kind of degree are you currently pursuing?
 - Masters
 - Doctoral
9. Please report the number of courses in multicultural counseling/psychotherapy that you have completed: _____
10. The number of courses that is didactic _____
11. The number of courses that is experiential _____
12. Please report the number of workshops/conferences/training activities in multicultural counseling/psychotherapy that you have attended: _____
13. The number of workshops/conferences/training activities that is didactic _____
14. The number of workshops/conferences/training activities that is experiential _____
15. Are you currently in clinical training? Yes No
16. How many years of clinical experience in graduate level (e.g., fieldwork, practicum, externship, etc.) do you have? _____
17. How many years of clinical experience do you have in addition to clinical experience related to training? _____
18. Approximately what percentage of your current clientele identifies as Asian individuals?
_____%