Affective Cultural Countertransference Reactions to Asian American Clients: A Mixed Methods Exploratory Study

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ABSTRACT

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The primary aim of this study was to explore affective manifestations of cultural countertransference toward English-speaking Asian American clients in psychotherapy and to investigate the roles of therapist race and therapist racial attitudes. Fifty-six therapist participants completed measures of affective cultural countertransference toward and clinical assessments of a current client who is either White or Asian American. Participants also completed measures of racial attitudes toward Asian Americans as well as demographic questionnaires about themselves and their client. For the qualitative portion of data collection, five White psychologists were interviewed to further understand the relationship of these variables in White therapist-Asian American client dyads, the primary cross-cultural therapeutic relationship of interest. Thematic Analysis was used to explore qualitative data. Statistical results failed to show moderate or larger effect sizes for overall differences in cultural affective countertransference based on therapist-client race combination. Results suggest that White therapists experience similar levels of both positive and negative countertransference toward clients, regardless of race. Although qualitative data on White therapists reflected themes of racial biases consistent with Asian stereotypes of high competence and lack of sociability, quantitative comparisons distinguished that White therapists do not experience any more racial bias toward Asian clients than do Asian therapists.

In fact, there was a trend suggesting the latter may experience more. For Asian therapists, countertransference in intraethnic dyads was strongly associated with Asian racial biases. There were a couple trends reflected in the quantitative data that should be interpreted conservatively given this study's methodological limitations, but, nevertheless, warrant further investigation: Compared to Asian therapists, White therapists experience more negative countertransference toward both White and Asian clients. White therapists' negative countertransference also showed small to medium associations with their racial bias against Asians. Qualitative evidence supported and expanded upon these trends: There was a dominant countertransferential theme among White therapist participants to counter Asian clients' culturally-syntonic drives for achievement and performance. Independent of therapist-client race, negative countertransference showed significant negative relationships to GAF, prognosis, and working alliance, while positive countertransference was positively related to prognosis and working alliance, as expected. Countertransference was also found to be related to client diagnosis, but not therapist theoretical orientation. The clinical, research, and theoretical implications of these findings are explored and limitations discussed.

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Chapter I

INTRODUCTION

The primary aim of this study was to explore affective manifestations of cultural countertransference toward English-speaking Asian American[1] clients in psychotherapy and to investigate the roles of therapist race and therapist racial attitudes. As a specific type of countertransference applicable to mixed race psychotherapy dyads, cultural countertransference is a distinct and complex phenomenon that interacts with noncultural countertransference. La Roche (1999) states that cultural transference and countertransference involve powerful conflicts inherent in society itself, not just in the intrapsychic processes of the patient and therapist. Holmes (1999) highlights the importance of identifying and examining this type of countertransference:

> In our culture, race…is often used by members of another racial group to fend off their own intolerable characteristics…. It is popular to use a group for id disposal and superego-disposal. When a patient or a therapist is affected by rigid defenses against the recognition of racial prejudice, he or she is limited in the ego resources necessary for psychotherapeutic work…. The therapist's ego functioning is restricted, and his or her effectiveness is reduced. It bears noting that race-based errors occur in same race dyads. (p. 320)

Although many studies have examined the influence of therapist-client matching by race or ethnicity on psychotherapy process and outcome, findings suggest that, in the absence of language factors, therapist racial attitude or bias might be a significant moderating factor in negative and potentially detrimental countertransference reactions. The impact of the Asian American racial minority group, in particular, on cultural countertransference is of interest due to the group's atypical status as "model minorities." Are cultural countertransference reactions

[1] Note that throughout this paper, the terms *Asian American* and *Asian* will be used interchangeably.

different from those toward other minority populations? In other words, are the affective manifestations congruent with stereotypical racial biases documented in extant literature? In spite of ostensibly "positive" racial bias toward Asian Americans, White therapists, like their lay counterparts, are predicted to experience negative countertransference reactions due to a resentful prejudice stemming from competition for resources (realistic threat) and perception of this racial group as inscrutable and lacking sociability. Other interactions with therapist-patient match by race and gender will be considered, in addition to the impact of cultural countertransference on working alliance and consequential clinical assessments such as diagnosis, prognosis, and GAF scores.

To understand the cultural countertransference construct, however, we must first clarify and define noncultural countertransference. Over the past century, noncultural countertransference has been variably defined and operationalized in theoretical, clinical, and empirical literature. Gelso and Hayes (1998) delineated three major definitions starting with the classic and seminal Freudian (1910/1959) view: an analyst's inappropriate, neurotic displacement of material from a previous transferential relationship onto the client. It was an interference to be eliminated in its entirety due to its pernicious effect on the therapy. The second understanding is the totalistic definition (Fromm-Reichmann, 1950) in which countertransference encompasses virtually all the therapist's emotional reactions to the client, regardless of origin. It is viewed as unavoidable and potentially useful in treatment in gaining insight about how the client affects others. Finally, the current "moderate" view (Gelso & Carter, 1985) to be applied in this study is defined as the therapist's feelings and reactions to a client that arise during treatment, usually as a result of the therapist's own intrapsychic conflicts. These conflicts are not always, but often derivatives of developmental issues (e.g., related to a therapist's family of

origin, narcissism, role as a parent and romantic partner, unmet needs, grandiosity, and professional self-concept), either triggered by client characteristics or material offered by the client. In this integrative view, countertransference is universal and inevitable no matter how well-analyzed the therapist is and can potentially be constructive in treatment if understood and managed appropriately (Gelso & Carter, 1985, 1994; Gelso & Hayes, 1998). For example, a therapist who has struggled with and resolved issues with depression may work more effectively with depressed clients due to greater empathy. Remen, May, Young, & Berland (1986) suggest it is "the woundedness of the healer which enables him or her to understand the client and which informs the wise and healing action" (p. 85). Of course, countertransference reactions can also become destructive or obstructive when issues remain unacknowledged and are subsequently "acted out" through direct or indirect expression with the client.

The current research paradigm for the countertransference concept which will be used in this present study is the structural theory put forth by Hayes (1995). It outlines five dimensions: origins, triggers, manifestations, effects, and management factors. Within this paradigm, countertransference *origins*, usually therapists' unresolved conflicts (e.g., family issues, therapy-specific issues, narcissism, racism, attachment patterns, gender role attitudes, trait anxiety, homophobia); are *triggered* by client attributes, therapy content, and/or therapy process, which involve some degree of the therapist's perceptual subjectivity (e.g., physical appearance or visible cultural characteristics, client material, therapy process such as interruptions in therapy structure or schedule, client progress). This elicits affective (anxiety, anger, boredom, nurturing feelings, negative feelings), cognitive (distorted perceptions of client, inaccurate recall of client material, defensive or reactive mental activity, inappropriate changes in treatment planning and interventions), and behavioral (clinical approach, avoidance, or withdrawal) *manifestations* of

countertransference. Internal (affect and cognitions) and external (behaviors) reactions are not independent of each other as most external displays are preceded by internal reactions, but to study them empirically, they are considered separately. *Effects* are the ways in which countertransference promotes or hinders therapy process and outcome such as therapeutic ruptures, premature termination, and avoidance. *Management factors* are therapist behaviors and characteristics that help cope with and productively redirect their countertransference reactions for the client's benefit such as supervision, being in their own therapy, and reflecting on sessions. The latter of these five components of countertransference is beyond the scope of this present study. According to this paradigm, this study will investigate if countertransference originating in therapist racial bias (theorized to be higher in White therapists), triggered by Asian American clients' cultural characteristics, elicits negative affective manifestations. For exploratory, purposes, a number of effects of countertransference will be investigated. Gelso and Mohr (2001) define this type of *cultural countertransference* as "culture-related distortions of the client or rigid interpersonal behaviors rooted in [the therapist's] direct or vicarious experiences with members of the client's [racial/ethnic or sexual minority] group" (p. 59).

With the growth of minorities utilizing psychological services and the potential adverse consequences of countertransference, a deeper understanding of the therapist's feelings, and how they might contribute to the treatment of a client from a racial/ethnic minority group is crucial. Furthermore, in contrast to technical ones, relational factors such as countertransference and the use of the self as a therapeutic instrument have become notable even in theoretically heterogeneous orientations or those with a distinctly nonrelationship focus such as rational-emotive behavioral therapy. Fauth (2006) and Hayes (2004) cite the transtheoretical appeal of this concept in systems, cognitive, experiential, constructivist, and feminist approaches as well.

At a juncture in the field when all therapies are being deemed to have equal effectiveness with no specific effects, the therapeutic relationship takes on even greater significance as a potentially healing factor (see Luborsky et al., 2002). Not only has the American Psychological Association Division 29 Task Force's report on empirically supported therapeutic factors deemed the management of countertransference a "promising and probably effective" factor (Norcross, 2001), but recent meta-analytic reviews of psychotherapy outcome research have also revealed relational factors as the most powerful and common ones across therapies (see Lambert & Barley, 2002, for review of research). Given this broad, revitalized interest in relational factors such as countertransference, empirical support, refinement, or refutation of existing theoretical and clinical theories is needed with particular attention to application to cross-cultural psychotherapy.

Chapter II

LITERATURE REVIEW & SIGNIFICANCE

Despite a growing body of clinical literature on the phenomenology of cultural countertransference (for recent considerations, see Bonovitz, 2005; Cabaniss, Oquendo, & Singer, 1994; Gelso & Hayes, 2007; Gelso & Mohr, 2001; Hayes, McCracken, McClanahan, Hill, Harp, & Carozzoni, 1998; Holmes, 1999; Javier & Herron, 2002; La Roche, 1999; Layton, 2006; Lijtmaer, 2001; Perez Foster, 1998, 1999; Roland, 2005; Singer & Luborsky, 1977; Stampley, 2004; Yi, 1995), as a concept originating in psychoanalysis, research has been straggling behind due to difficulties defining, measuring/quantifying, and documenting such a subjective phenomenon (Fauth, 2006). Direct measurement is often difficult given therapists' lack of insight into contributing factors of their subjective experiences despite their ability to accurately report those subjective experiences (Nisbett & Wilson, 1977). With the exception of findings regarding gender moderation effects of countertransference (Gelso, Fassinger, Gomez, & Latts, 1995; Hayes & Gelso, 1991; Latts & Gelso, 1995; Lecours, Bouchard, & Normandin, 1995), research on powerful cultural origins of countertransference such as race and ethnicity, sexual orientation, religion, age, or disability is particularly scant. However, the extant research regarding psychotherapy with, psychological characteristics of, and prejudice toward Asian Americans provides some insight and direction for empirical cultural countertransference research.

In psychotherapy research with Asian Americans, researchers have found evidence of therapists' cultural biases in the treatment and evaluation of Asian Americans leading to over-

diagnosis of psychotic disorders and under-diagnosis of mood disorders, a lack of empathy, distorted perception, and psychopathologizing; while this population has been found to have the highest premature termination rates of all mental health service consumers, to report less satisfaction with treatment and progress in therapy than Whites, and to experience more frequent ruptures in the alliance (Lee & Mixson, 1995; Leong, 1986; Lu, 1996; Sue, 1988; Sue & Lam, 2002; Sue & Sue, 1990; Zane, Enomoto, & Chun, 1994). What role, if any, does cultural countertransference play in the creation of these undesirable phenomena and outcomes in psychotherapy? Multiple studies have proposed the operation of cultural biases on the part of therapists in diagnosis and assessment of Asian Americans (Hsu, Tseng, Ashton, McDermott, & Char, 1985; Li-Repac, 1980; Tseng & McDermott, 1981; Wampold, Casas, & Atkinson, 1981).

Does the atypical, non-Western presentation of Asian Americans in psychotherapy impact cultural countertransference and outcomes? Research suggests that Asian Americans (compared to Whites) have a lower tolerance of ambiguity and tend to prefer structure and practical, immediate solutions to problems, and Asians show a greater respect for the authority of the therapist (D. Sue, 1981; D. Sue & Kirk, 1972, Vernon, 1982). These preferences often arise as a source of problems for the patient as well as the therapist in a Western psychotherapy relationship that emphasizes the tolerance of ambiguity, collaboration, openness and assertiveness. Given that Asian cultural background has been found to influence the expression of symptoms among Asian American clients (Draguns, Leaman, & Rosenfeld, 1971; S. Sue & D. Sue, 1974) and that there is a tendency among Asian Americans to express symptoms via somatization (Kleinman & Sung, 1979; Marsella, Kinzie, & Gordon, 1973; Rahe, Looney, Ward, Tung, & Liu, 1978; S. Sue, & Morishima, 1982; Tseng, 1975), how does this influence therapist countertransferential feelings? Cabaniss, Oquendo, and Singer (1994) warn about the Western

psychotherapy values a White therapist often brings into treatment: individualism, rational and scientific thinking, free expression of thought, and tolerance of dissent. Compared to the East Asian values of collectivism, superstitious beliefs, self-control, and harmony, it is not difficult to see how an Asian American client who holds these values in psychotherapy (and often responds with silence when in disagreement with the authority figure, i.e., the therapist), would evoke cultural countertransferential feelings (sometimes in response to the client's cultural transference to the Western psychotherapeutic values). Tsui and Schultz (1985) state that silence, which is a common response in Asian American clients, promotes:

> The projection of the therapist's own feelings, arousing stereotypes that Asians are inscrutable or that they are nice and pleasant, attentive and docile. Since the client behaves in an ingratiating manner, following the lead of the therapist, the therapist may become increasingly frustrated, back away from the client, and withdraw further questions, experiencing concern about being too intrusive and thinking that perhaps the client is too fragile. (p. 565)

Other personality studies have found that Asian Americans tend to exhibit lower levels of verbal and emotional expressiveness than Whites (S. Sue & Kitano, 1973, S. Sue & Morishima, 1982). Leong warns that this characteristic may lead a therapist to conclude that the client is repressed, inhibited or shy. Researchers have hypothesized that cultural differences in the therapist-client dyad may result in less effective treatment most likely due to a series of therapist variables such as therapist prejudice or cultural bias, training bias, therapist lack of intercultural skills, and culture-specific knowledge about Asian Americans (D. Sue, 1981, and S. Sue & Morishima, 1982).

Leong, Kim, and Gupta (2011) propose that acculturation level in Asian American clients may also present a barrier to successful psychotherapy process and outcome. Acculturation involving cognitions, attitudes, behaviors, and/or cultural values is the adjustment process that occurs when two cultures or individuals interact (Chun, Organista, & Marin, 2003). Although

acculturation used to be considered a unidirectional process, the widely accepted acculturation model proposed by Berry (1980) considers two factors: (a) whether or not ethnic minorities maintain their traditional culture, and/or (b) the extent to which they embrace the host culture. Accordingly, four modes of acculturation can emerge: assimilation, integration, separation, and marginalization. Asian Americans highly assimilated into U.S. culture were found to be more likely to recognize a personal need for professional help and were more willing to seek out professional mental health services (Tracey, Leong, & Glidden, 1986), suggesting that highly acculturated Asian Americans are probably more tolerant of the stigma associated with receiving mental health services and are more open to disclosing personal issues (Fung & Wong, 2007). Tracey et al.(1986) found that Asian American students were more likely to perceive academic and vocational problems as presenting concerns appropriate for counseling, whereas White Americans were more likely to be comfortable disclosing or identifying emotional or interpersonal concerns as presenting problems in counseling. In therapy, this may be perceived by therapists as a tendency among Asian clients to be less emotional or less self-disclosing about deeply personal issues. Research also suggests that clients who display higher levels of acculturation exhibit a greater match between their etiology beliefs and their therapist's beliefs. Since therapy is a highly interactive process of communication, matching on factors such as world views and values can increase empathy and working alliance in the therapy process, allowing for better therapeutic processes and outcomes (B. Kim, Ng, & Ahn, 2005; Mallinckrodt, Shigeoka, & Suzuki, 2005). Leong, Wagner, and Kim (1995) assert that since different levels of acculturation can have a profound impact on a client's value orientation and psychological well-being, it is important to address the role of client acculturation in psychotherapy. Reinforcing previous research, their research found that that Asian Americans' acculturation status is an

important moderator of Asian American attitudes toward psychotherapy. Clinicians must take acculturation into account in their conceptualizations of the client's problems, treatment strategies, and goals for counseling (Atkinson & Gim, 1989; Atkinson, Whiteley, & Gim, 1990). Responding to Asian American clients on the basis of assumptions about their cultural heritage and identification can be just as damaging and insensitive as ignoring cultural differences and can result in underutilization of or premature termination from counseling.

On a societal level, among minority groups, Asian Americans are typically perceived as model minorities who are educationally and economically achieving and less likely to be disruptive or disorderly (Ho & Jackson, 2001; Wong, Lai, Nagasawa, & Lin, 1998; Yee, 1992), and not without some supportive data. Maddux, Galinsky, Cuddy, and Polifroni (2008) cite 2002 U.S. Census Bureau data that show ethnic groups with the highest median income and high school and college graduation rates were Asian American while also having the lowest incarceration rates among White, Black, Hispanic, and Native American groups. As model minorities, it may make it more difficult for therapists to detect biased attitudes toward Asian Americans than other minorities. In fact, as part of a review of a therapist self-rating scale of racial biases and prejudices, Paniagua, O'Boyle, Tan, and Lew (2000) found that therapists' unintended biases against Asian American clients (as well as American Indian) tended to be higher relative to African American, Hispanic, and White clients. And while contemporary research reveals plentiful positive or model minority qualities attributed to Asian Americans including intelligent, capable, ambitious, hard-working, mathematical, skillful, and self-disciplined, (Cuddy, Fiske, & Glick, 2007; Fiske, Cuddy, Glick, & Xu, 2002; Ho & Jackson, 2001; Kao, 2000; Lin, Kwan, Cheung, & Fiske, 2005; Yee, 1992), negative stereotypes also abound: attributes such as cunning, sly, selfish, nerdy, inscrutable, excessively competent,

socially deficient, and lacking interpersonal warmth and kindness (Cuddy et al., 2007; Fiske et al., 2007; Ho & Jackson, 2001; Takaki, 1989). How do these mixed stereotypes of Asian Americans influence cultural countertransference and psychotherapy? Is it distinct from cultural countertransference toward other minorities?

Consistent with the Stereotype Content Model (Fiske et al., 2002), Ho and Jackson (2001) found that those who endorsed the Asian American model minority stereotype (intelligent, ambitious, obedient) expressed admiration and respect for members of this group for their competence, but also hostility and jealousy due to feelings of competition and perceived lack of warmth. The central trait assumption of one test of racial bias against Asian Americans, the Scale of Anti-Asian American Stereotypes (Lin, Kwan, Cheung, & Fiske, 2005), is that the group is unfairly competent and is grounded in negative cognitions and affect that justify prejudice against the group (Glick & Fiske, 2001). Researchers theorize that attitudes and emotions toward even the positive model minority attributes are negative due to realistic threat, envious mixed prejudice (both respect and resentment), or the paradox of perceiving competence as negative when associated with Asian Americans. This phenomenon is similar to that seen with female professionals (Glick, Diebold, Bailey-Werner, & Zhu, 1997), Jews (Glick, 2002), or other socioeconomically or professionally successful minority groups who might be perceived by some as a threat to the majority. In contrast to the more obvious and contemptuous racial prejudice seen against Blacks (Lin et al., 2005) or theoretically distinct paternalized groups such as the elderly (Fiske et al., 2002), negative attitudes and emotions toward Asian Americans may arise from positive stereotypical characteristics since these traits pose a realistic threat to a group's success or status (i.e., fewer jobs, poorer grades). Rather than foster genial interracial relations, they couch social relations with Asian Americans in heightened feelings of

intimidation, resentment, envy, and prejudice. Lin et al. (2005) assert that "Asians are thus the targets of resentful, envious prejudice: grudgingly respected for their presumed competence but disliked for their alleged lack of sociability" (p. 44).

For White psychotherapists working with Asian American clients, these model minority stereotypes most likely activate similarly mixed positive and negative prejudicial feelings in the countertransference as well. McClure and Hodge (1987) offer the caveat that while positive regard and liking for a client (as might be expected in treatment of clients from a model minority group) may facilitate therapeutic process, strong affect of any kind likely indicates countertransference in which the therapist is distorting the client's personality which may ultimately become problematic. Though of a different nature, Asian therapists working with Asian American clients may also experience cultural countertransference reactions. While Comas-Diaz and Jacobsen (1991) describe interethnic (therapist and client from different backgrounds) countertransference reactions such as inappropriate exploration based on curiosity, guilt grounded in perceived collusion with the oppressive majority, denial of the therapeutic importance of ethnocultural differences or "cultural myopia," and aggression based on prejudice, they also identify intraethnic (same ethnic backgrounds) countertransference reactions that can include survivor guilt, defensive distancing, and overidentification (e.g., overprotecting clients through underdiagnosis and normalizing of maladaptive forms of behavior). Unfortunately, despite much interest in the clinical literature regarding these phenomena, with the exception of recent research concerning the role of homophobia in countertransference reactions, there is currently no published, empirical literature on the cultural origins of countertransference.

However, the two empirical studies on homophobia and therapist match on sexual orientation, along with theoretical considerations of cultural countertransference, provide some

relevant starting points for this study. Noncultural countertransference researchers have predominantly used analogue methodology not only due to the abstract nature of this phenomenon, but also because of therapists' very human reluctance to disclose their conflicts and vulnerabilities given the historical stigma associated with the neurotic origins of countertransference and its detrimental effects on therapy. Most likely for these reasons, the following two studies of countertransference toward gay/lesbian clients are also both analogues with counseling trainee populations and, therefore, inherently constrained in their external validity. In the first study of 34 male counselors, Hayes and Gelso (1993) examined male counselors' reactions to videotapes of gay and HIV-infected clients in which they measured the affective (self-report state anxiety), behavioral (ratio of avoidance to approach verbal responses to client), and cognitive (recall of certain words used by client) dimensions of countertransference manifestations. They reported that counselors experienced more state anxiety with HIV-positive clients, but none of the three countertransference manifestation measures differed across the sexual orientation conditions, as hypothesized. However, counselors' homophobia predicted their avoidance behavior with gay clients. In other words, "counselors' stereotypes about, fears of, and negative attitudes toward gay men seemingly contribute to counselors' circumventing gay clients' clinical content and affect" (p. 91). This study's findings are limited due to low statistical power. Although it had the largest sample size among laboratory studies on countertransference, the sample sizes of subgroupings became too small to yield significant results.

In the second study investigating 67 male and female therapists' countertransference reactions to videotaped lesbian clients, Gelso et al. (1995) found that homophobia levels were related to countertransferential avoidance behavior only (not cognitive or affective

manifestations) and with lesbian clients but not heterosexual clients. Their study also showed that female therapists had greater countertransferential recall problems with lesbian clients than male therapists, and both female and male therapists had equivalent recall with the heterosexual clients. In other words, although therapists were no more likely to experience countertransference with gay and lesbian clients than with straight clients, both studies found that the therapist variable of homophobia strongly predicted countertransference. It appears that only the interaction between the client and therapist's characteristics was predictive of countertransference reactions. However, the authors note that this lack of main effect for client sexual orientation runs counter to clinical literature and they theorize that therapist conflicted attitudes toward gay and lesbian clients or an unusually low homophobic sample may account for the findings. The effect of therapist sexual orientation was not examined due to privacy issues (the sample was recruited from their university's graduate training program).

Rosenberger and Hayes (2002) warn, however, that these findings must be interpreted with caution since therapist reactions may or may not be countertransference based, but rather based on the reality created in the therapeutic dyad or a reaction that emanates from therapist skill deficits. The only way to ultimately discern if a therapist's reaction has its origins in an unresolved conflict is for the therapist to examine himself or herself. Hayes and Gelso (2001) provide the following example: If a therapist has trouble concentrating in session with a client, it can be due to a poor night's sleep, noise from next door, having seen seven other clients throughout that day, or a countertransference reaction due to threatening material from the client that makes it difficult to focus. It is important to discern among these causes as each would require a different remediation: more sleep, asking your neighbor to keep the noise down, scheduling fewer clients in a day, or if it is a countertransference reaction, seeking out

supervision, engaging in personal therapy, or examining and reflecting on oneself. Hayes & Gelso assert that one of the reasons why research seeking to identify countertransference triggers has yielded mixed results is because researchers did not empirically account for individual differences in therapists' intrapsychic conflicts. As exemplified in the two previously cited studies, gay clients do not necessarily evoke increased countertransference reactions. Only when therapist homophobia is taken into account do homophobic therapists exhibit greater countertransference, as hypothesized. They conclude that countertransference triggers and origins always interact and cannot be considered in isolation. In practice, emotional reactions may warn therapists of possible underlying countertransference dynamics, but they must be considered in the contexts of both their conflicts and triggers. Therapist self-awareness is essential to detect conflicts, triggers, and countertransference reactions.

A lack of awareness and understanding of countertransference has been linked to countertherapeutic effects including detrimental influence on the therapist's interventions and techniques and understanding of the client (e.g., therapist withdrawal or overinvolvement; Gelso & Hayes, 1998; Singer & Luborsky, 1977; Strupp, 1980), and adverse effects on outcome or the therapeutic relationship (Gelso & Hayes, 2002; Hayes, Riker, & Ingram, 1997; Javier & Herron, 2002). Therapist ability to manage countertransference results in better therapeutic outcomes especially with cultural countertransferences (Gelso et al., 2002; Holmes, 1999; Jacobs, 1993; La Roche, 1999) and decreased (therapist) acting out behaviorally in session (Latts & Gelso, 1995; Robbins & Jolkovski, 1987). Clinical case studies found that cultural transferences/countertransferences need to be worked through assiduously and often before noncultural ones, especially if they are negative (Gelso & Mohr, 2001; Helms & Cook, 1999) and some researchers suggest that the high drop-out rate seen in cross-cultural therapy dyads

occurs because of the lack of attention to these cultural transferences/countertransferences (Gelso & Mohr, 2001; LaRoche, 1999; Perez Foster, 1999). In other words, therapists are not immune to cultural distortions even given their higher level of self-awareness during therapy. The therapist's personal reactions are crucial to therapy adherence and effectiveness given that therapist factors account for more variability in outcome than the techniques of manualized treatments (Wampold, 2001). When therapist factors are accounted for, the effects of techniques on outcome nearly disappear. Gelso and Hayes (2007) agree that "Wampold's conclusions are consistent with what every clinician knows: Some therapists are simply better than others…[but] investigations into personal therapist variables [such as countertransference] that might account for differential effectiveness have been limited" (p. 113).

Chapter III

HYPOTHESES & RESEARCH QUESTIONS

Based on insights from these empirical, theoretical, and clinical findings regarding the Asian American population and both noncultural and cultural countertransference, both broad and more specific hypotheses were proposed for this study. Since the empirical base of our understanding of cultural countertransference is scant, some exploratory research questions were also investigated.

Hypothesis 1

Hypothesis 1: In general, countertransference reactions will differ as a function of therapist and client race combination and interact with racial bias.

Hypothesis 2

Hypothesis 2a: Overall, White therapists experience greater affective countertransference toward Asian American clients (interethnic dyad) than toward White clients.

Research Question 1: Are any specific countertransferential affects experienced more or less than others toward Asian American clients (e.g., more threat than harm affects, mix of positive and negative affects)? If so, is the pattern related to and congruent with stereotypical beliefs about Asian Americans?

Hypothesis 2b: White therapists' affective countertransference toward Asian American clients varies with their racial bias.

Hypothesis 3

Hypothesis 3a: Relationships have been drawn between ethnic matching in psychotherapy dyads and decreased likelihood of premature termination (Fujino, Okazaki, & Young, 1994; Lau & Zane, 2000; Takeuchi, Sue, & Yeh, 1995), better prognosis, and less severe assessment (Lu, 1996; Russell, Fujino, Sue, Cheung, & Snowden, 1996). Is this mediated by countertransference?

Hypothesis 3b: Asian American therapists (intraethnicdyads) also experience countertransference toward Asian American clients but characterized by less negative countertransference and more positive affects than their White counterparts with Asian American clients.

Hypothesis 4

In terms of other variables implicated in the literature, countertransference has also been linked to diagnosis (Fauth & Hayes, 2006) and working alliance (Ligiero & Gelso, 2000).

Hypothesis 4: Countertransference, regardless of racial match between therapist and client, affects therapist clinical assessment of prognosis, diagnosis, Global Assessment of Functioning (GAF), and working alliance.

Research Question 2: Regardless of therapist or client race, does therapist theoretical orientation affect countertransference?

Research Question 3: Does therapist gender affect countertransference or racial bias toward Asian American clients?

Chapter IV

METHOD

Participants

Data collection occurred in three distinct phases due to unanticipated selection effects in the first phase that severely limited collection of data. Through all phases, recruitment of participants included emails to psychologists in personal network, and directors of training (or the equivalent) at licensed Marriage and Family Therapy degree-granting schools and clinical psychology and counseling professions training sites (schools, internships, postdoc/fellowships); as well as study postings on internet websites (mostly college psychology departments), and relevant internet listservs (e.g., select American Psychological Association divisions such as Clinical Psychology, Psychotherapy, and Ethic Minority Issues). A small minority of email recipients confirmed broadcasting emails to their departments. This added up to a minimum of 800 emails and postings, excluding an unknown number of forwarded emails to additional recipients. Attempts to recruit participants from the Asian American Psychological Association and the Hawaii Psychological Association were unsuccessful, partly due to time and resource constraints. In-person collection included visiting two Los Angeles-area Asian counseling clinics. To be eligible, participants had to be practicing psychotherapists (master's or doctoral level) of any racial or ethnic background. Although the primary therapist groups of interest were White and Asian American, all races were included for exploratory purposes. Since the language used in therapy has an impact on psychotherapy process and outcome (as well as serving as a gross indicator of client's acculturation level), participants were only eligible if therapy was

conducted in English with no translator. Participants were required to be treating at least two clients in individual psychotherapy, one Asian American and one Caucasian, or two Caucasian or two Asian. Subjects were instructed to select the Caucasian/White client immediately following the Asian American one in order to reduce selection effects. After the initial round of data collection, only ten therapists with White-White client pairs and seven therapists with White-Asian client pairs yielded usable data. Furthermore, of the 17 therapists, some were White, Asian, Latino, or Black/African-American. Only 12 participants were either White or Asian therapists. The biggest obstacles seemed to be finding, 1) practicing psychotherapists with at least one Asian client; and 2) psychotherapists with one Asian and one White client (most therapists with Asian clients, such as those in Asian counseling centers, exclusively had Asian clients). The study's design was revised after running into these severe recruitment challenges. While retaining data from the first round of data collection (omitting second client's data from each therapist so as not to count two clients' descriptions as independent), I then collected 44 more response sets with the same measures, but participants were asked to report on only one client, either Asian or White. After the second round of data collection, power was still inadequate for significance testing.

As an initially proposed contingency prior to any data collection, since an adequate sample size was not acquired to have at least 80% power for each level (particularly White therapists with Asian American clients, the primary intraethnic dyad of interest), the data was analyzed as a small sample quantitative study as done by Cutler (1958) and Rosenberger and Hayes (2002) in which findings serve of heuristic value. Gelso and Hayes (2002) recommend this method as part of the methodological triangulation of a phenomenon in which three types of

studies (laboratory analogues, qualitative research, and small sample quantitative), despite their own limitations, add usefully to more traditional methods to learn about countertransference.

Though not part of the original design, in order to enrich the data, findings and trends found in the quantitative portion were used to develop a five-question semi-structured interview to illuminate the original research questions, primarily concerning White therapists with Asian American clients. For this qualitative portion, I contacted some previous participants who had consented to follow-up and recruited through personal networking (n=5). Five, White male psychologists agreed to participate. Three of the five were early career therapists while the other two had 20+ years of experience.

Instruments

Therapist Appraisal Questionnaire (Appendix C). Although anxiety has justifiably received the most empirical attention as a manifestation of countertransference (for discussion of anxiety as countertransference, see Cohen, 1952; Fauth & Hayes, 2006; Gelso et al., 1995; Hayes et al., 1998; Hayes & Gelso, 1991, 1993, 2001; Latts & Gelso, 1995; Sharkin & Gelso, 1993; Sullivan, 1954; Yulis & Kiesler, 1968) and most studies have almost exclusively operationalized affective countertransference as state anxiety (e.g., Spielberger, Gorsuch, and Lushene's State-Trait Anxiety Inventory, 1970), it only measures one of many affects that are implicated in countertransference (Hayes et al., 1998). Since this research is in its infancy, researchers have recommended using multivariate measures of countertransference and evaluating novel approaches to investigating countertransference reactions. To do so in this study, an extended version (6 experimental items relevant to this study added to original 16) of the Therapist Appraisal Questionnaire (TAQ, created by Fauth, Hayes, Park, and Friedman, 1999) was

administered as a unique indicator of affective countertransference. This measure was adapted from the social psychological literature, where it was originally developed via factor analysis by Cooley and Klingler (1989).The TAQ consists of three subscales including Threat (i.e., how worried, fearful, anxious therapists felt during therapy session), Harm (i.e., how angry, guilty, disgusted therapists felt during therapy session), and Challenge (i.e., how hopeful, pleased, energetic therapists felt during therapy session). A total of 22 affects the therapist participant may experience during a session with a client were self-rated on a 5-point Likert-type scale (0=*not at all*, 5=*a great deal*) with a possible total score between 0-110. The Threat and Harm scales have been found to be moderately correlated as negative countertransference while the Challenge subscale can be interpreted as positive stress. The TAQ's normative reliability has been reported to range from alpha =.71 to .90 (Fauth et al., 1999) and in this study was .74 (*N*=56). In terms of construct validity, the Challenge and Negative Stress scores were associated with self-efficacy and prognosis (as predicted by the transactional theory of stress) as well as hesitance, GAF score, and anxiety in countertransference research (Fauth, 2006; Fauth et al., 1999).

The Scale of Anti-Asian American Stereotypes (Appendix D). The SAAAS (Lin et al., 2005) is a 25-item, self-rated Likert-type (0=*strongly disagree*, 5=*strongly agree*) measure that was used to assess the therapist's racial attitudes toward Asian Americans; specifically, endorsement of stereotypes regarding the interpersonal dimensions of (excessive) competence and (deficient) sociability that determine the mixed envious prejudicial attitude toward Asian Americans. As the SAAAS's authors note, this instrument is distinct from others such as Ho and Jackson's (2001) Attitudes Toward Asian Americans or Henry and Sears' (2002) Symbolic and Modern Racism Scale which measure societal-level prejudice (e.g., *It is annoying when Asian Americans speak in*

their own languages; *Asian Americans increase the "brain power" of the United States*; *Asian Americans are taking jobs that rightfully belong to US-born Americans*) rather than interpersonal attitudes toward the personality traits of Asian Americans. This particular measure of racial attitude was selected over other these and Hunt and Espinoza's Prejudice Against Asian Americans (2004) scales precisely because it emphasizes interpersonal traits rather than societal relations and social policies. The scale's authors state that the central trait assumption of their instrument is that Asian Americans are unfairly competent, a combination of negative affect and cognitions that reinforce prejudice against them. The authors identify robust correlations with other validated scales that also purport to measure prejudice on an interpersonal level such as the Ambivalent Sexism Inventory (Glick and Fiske, 1996) and the Subtle Prejudice Scale (Pettigrew & Meertens, 1995). The SAAAS yields Sociability and Competence scores, as well as a combined total anti-Asian American prejudice score. Lin et al. found a strong alpha coefficient for the total SAAAS score (α=.94) as well as for the sociability (α = .91) and competence (α = .92) subscales. In this study, the alpha coefficient was .89 (*N*=48). Psychometric information and means and ranges for total SAAAS score and both subscales by therapist race can be found in Tables 9 and 11.

Lin et al. performed an exploratory factor analysis using a principal components model with varimax rotation to examine the factor structure of the SAAAS and derive the final SAAAS. They then performed a confirmatory factor analysis to confirm the factor structure, and finally, cross-validated the results from the confirmatory factor analysis with another sample. A Sociability factor with an eigenvalue of 29.77 accounted for 24.2% of the variance, and a Competence factor with an eigenvalue of 5.49 accounted for 4.5% of the variance. A third factor (eigenvalue = 4.35, accounting for 3.5% of the variance) resembled a dimension of Foreignness,

but too few of the these items met the .50 criterion for rotated factor loadings so it was omitted. Following the initial exploratory analysis, a shorter scale from a pool of 122 factor-analyzed items was created, and only items not cross-loading on other factors and loading .50 or higher on the Sociability or Competence factors were retained. An unweighted least-squares factor analysis determined the factor structure for the remaining 13 Sociability and 12 Competence items in the SAAAS. A Competence factor with an eigenvalue of 11.07 accounted for 42.31% of the variance, and a Sociability factor with an eigenvalue of 1.96 accounted for 5.82% of the variance. Item loadings for the two factors were in the expected direction and moderately high (.40 or greater). No cross-loading was greater than .26, and the two factors were unambiguous in their item composition. Correlational analyses of scores revealed that total scores on the Competence and Sociability subscales were significantly and positively correlated, $r = .71$, $p < .001$. Finally, two sets of LISREL VIII analyses comparing a one-factor model with a two-factor model indicated a preference for the two-factor model ($\Delta\chi^2(1) = 426.66$, $p < .001$). In terms of construct validity, the SAAAS was significantly correlated with the Ambivalent Sexism Inventory ($r = .54$, $p < .001$) which shares with the SAAAS that both forms of prejudice endorse the outgroup trading off warmth and competence. There was also a high correlation with Pettigrew and Meertens Subtle Prejudice Scale, $r = .57$, $p < .001$.

Other effect and outcome variables (Appendix B). Additional variables implicated in the extant countertransference literature were also measured through therapist-rated, one-item questions including assessment of working alliance, diagnosis, prognosis, and Global Assessment of Functioning (GAF) score. The GAF is used to assess a client's social, psychological, and occupational functioning on a scale ranging from 0 to 100 with higher scores reflecting more adaptive functioning. Although the GAF is subjective and not extremely reliable, it is widely

used for treatment planning and referral. Validity of the GAF is stronger in that it diverges among diagnostic groups and converges with other measures of occupational and social functioning (see Fauth & Hayes, 2006, for review). Level of client acculturation was estimated by one therapist-rated Likert scale item, ranging from 1 to 5 (1: *Minimal Acculturation/Marginalization* – 5: *High Acculturation/Assimilation).*

Qualitative Questions. For the qualitative portion of data collection, a semi-structured interview, 5 White participants were given instructions to refer only to East Asian American or Pacific Islander adult psychotherapy clients who were recently or currently in individual or group psychotherapy with the participant. These five questions were developed as a result of the combination of the original research hypotheses, as well as in response to the preliminary observed results and trends found in the quantitative findings. As Stampley & Slaght (2004) have observed, despite the obvious benefits of parallel quantitative research, countertransference is difficult to document since it is a subjective phenomenon, and requires a qualitative component to fully illuminate findings. Participants were asked five questions:

1. Please describe one memorable countertransference experience you've had with an Asian American adult psychotherapy client.

Question 1 was posed first, by design, as a general inquiry about a participant's most memorable countertransference experience with an Asian American client. The choice of the participant's particular memory was interpreted to be a suggestion of his/her most cogent association with psychotherapy with Asian American clients. This question was designed, in part, to elicit information that might also shed more light on Hypothesis 1 as well as Research Question 1 in qualitative form.

2. Have you experienced any noticeable difference working with Asian American clients compared to White clients? If so, describe.

Question 2 is a direct inquiry regarding any differences a therapist might feel or perceive with Asian American clients, whether in countertransferential feelings or otherwise (therapist behavior, diagnoses or prognoses assigned, etc.). It was intended to be qualitatively analogous to Hypothesis 2a.

3. Relative to White clients, do you experience Asian American clients as generally more quiet, reticent, and/or less self-disclosing? If so, how do you understand this presentation?

Referencing current findings regarding Asian American stereotypes (specifically, lack of sociability and interpersonal inhibition), Question 3 inquires about the participant's endorsement of these stereotypes with his/her Asian American psychotherapy clients, as well as his/her explanations or attributions for such a presentation (e.g., due to competition, deferral to authority). It qualitatively parallels Hypothesis 2b.

4. Relative to White clients, do you find that Asian Americans display less affect? If so, what is your usual response or feeling toward your Asian American client?

Like the previous question, Question 4 references current literature findings on the perception of Asian Americans as inscrutable and inquires about the participant's endorsement of this stereotype as well as his/her countertransferential response to this racial bias, if present.

5. Have you ever experienced a disconnect between what an Asian American client was reporting (or affectively displaying) and your own countertransferential feelings? If so, please describe or give an example. Did you follow-up or explore what was occurring? What happened?

Questions 5 is an inquiry into the participant's experience of one type of a therapeutic situation that might occur with a client whom the therapist perceives as a stereotypical Asian American (e.g., deferential, lacking social skills, inscrutable, sly, etc.). It also explores the possible behavioral manifestations (typically, avoidance) of such a countertransferential experience.

Procedure

Through an e-mail link, participants were linked to an online survey that landed them on the informed consent and description of research page (Appendix A). If participants consented electronically, they were directed to the Demographic Questionnaire (Appendix B), then the TAQ (Appendix C), and, finally, the SAAAS (Appendix D). The TAQ was given twice consecutively, one for each of two clients they selected. During the first round of quantitative data collection, participants were instructed to select two clients, one White and one Asian, preferably consecutive clients on the same day of treatment to partially control for selection effects. During the second round, participants were instructed to select only one client, either a White or Asian American client (i.e., the TAQ was administered only once). Upon completion, participants were thanked and given an opportunity to request study results, if desired. For the qualitative portion, five currently practicing White psychologists recruited through personal networking were interviewed either in-person or over the phone. Interviews lasted approximately

20-30 minutes and were recorded and transcribed later. Results of the study and feedback were sent to participants via e-mail to those who requested it.

Chapter V

RESULTS

Quantitative

Demographics and Preliminary Analyses

The sample size was too small and did not achieve the desired level of power to perform statistical significance probability analyses, especially after the sample was further subdivided into groups by race. As a result, for most analyses, one-way or factorial ANOVAs were performed for the μ_p^2 statistic (i.e., effect size) so that the small sample size would not be an issue. Unlike significance tests, effect size estimates are independent of sample size. In accordance with Cohen's (1988) suggested guidelines, throughout all analyses using the μ_p^2 statistic, .01 constituted a small effect size, .06 a medium effect size, and .14 a large effect size. Any medium or larger effect size was considered a noteworthy finding that indicates that the magnitude of difference between groups is at least of a standardized medium size or the relationship between two variables is at least of moderate strength. When effect sizes were of substantial size, it was assumed that statistically significant probabilities were not found most likely because the sample size was too small to detect a difference. 95% confidence intervals were used throughout.

Overall, the demographic characteristics of participants (*N*=56) skewed toward primarily CBT-oriented (50%), young (mean age=32.9), White (70%), early career (less than five years experience) therapists. Out of 56 total therapists, there were 39 White, 9 Asian American, 2 Black, and 4 Latino (2 missing racial background data). Demographic information of the

participants is presented in Table 1. As most research questions were focused on the differences between White and Asian therapists (with White or Asian clients), in order to determine if these two groups, White (*n*=39) and Asian therapists (*n*=9), are, in fact, comparable, demographic variables were analyzed between groups to identify any possible covariates. Demographic information for White and Asian therapists is presented in Tables 2 and 3, respectively.

Table 1

Demographic Characteristics of Participants (Therapists) (N = 56)

Characteristic		*M*	*SD*
Age		32.89	8.29
		n	*%*
Gender			
	M	25	45
	F	31	55
Race			
	White (non-Latino)	39	70
	Asian	9	16
	Black	2	4
	Latino/a	4	7
	Other	0	0
Years in Practice			
	Less than 5	38	68
	5 to 10	14	25
	10 to 15	2	4
	15 to 20	0	0
	20+	2	4
Theoretical Orientation			
	Cognitive-Behavioral	28	50
	Psychodynamic	10	18
	Behavioral	4	7
	Interpersonal	4	7
	Systems	2	4
	Humanistic/Existential	3	5
	Other	5	9

Note. Totals of percentages are not 100 because of rounding and missing data

Table 2

Demographic Characteristics of White Participants (Therapists) (n = 39)

Characteristic		*M*	*SD*	Range
Age		32.38	9.18	24-57
		n	*%*	
Gender				
	M	19	49	
	F	20	51	
Years in Practice				
	Less than 5	27	69	
	5 to 10	10	26	
	10 to 15	0	0	
	15 to 20	0	0	
	20+	2	5	
Theoretical Orientation				
	Cognitive-Behavioral	26	67	
	Psychodynamic	4	10	
	Behavioral	2	5	
	Interpersonal	2	5	
	Systems	0	0	
	Humanistic/Existential	0	0	
	Other	5	13	

Note. Totals of percentages are not 100 because of rounding and missing data

Table 3

Demographic Characteristics of Asian Participants (Therapists) (n = 9)

Characteristic		*M*	*SD*	Range
Age		36.33	7.00	23-46
		n	*%*	
Gender				
	M	4	44	
	F	5	56	
Years in Practice				
	Less than 5	7	78	
	5 to 10	0	25	
	10 to 15	2	22	
	15 to 20	0	0	
	20+	0	4	
Theoretical Orientation				
	Cognitive-Behavioral	0	0	
	Psychodynamic	4	44	
	Behavioral	2	22	
	Interpersonal	0	7	
	Systems	2	22	
	Humanistic/Existential	1	11	
	Other	0	0	

Note. Totals of percentages are not 100 because of rounding and missing data

T tests and ANOVAs were performed for the continuous/ordinal variables, Therapist Age and Years in Practice, to obtain effect sizes of mean differences. The effect sizes were small (Age μ_p^2 = .031, Years in Practice μ_p^2 = . 001) and, therefore, did not indicate variables that need to be controlled for in future analyses comparing these two groups. Since some analyses compare White (*n*=8) and Asian therapists (*n*=6) of Asian American clients only, the same tests were performed to compare these two groups as well. Again, the effect sizes were small (Age μ_p^2 = .030, Years in Practice μ_p^2 = .001) indicating that the groups are comparable without controlling for these potential covariates. Results are presented in Tables 4 and 5.

Table 4a

Age Differences in Therapists by Race

	Therapist								
	White			Asian					
	n	*M*	*SD*	*n*	*M*	*SD*	*t(46)*	*p*	μ_p^2
Age	39	32.38	9.18	9	36.33	7.00	-1.208	.23	.031

Table 4b

Age Differences in Therapists of Asian Clients by Therapist Race

	Therapist								
	White			Asian					
	n	*M*	*SD*	*n*	*M*	*SD*	*t(12)*	*p*	μ_p^2
Age	8	33.38	11.70	6	36.83	8.68	-.607	.55	.030

Table 5a

Differences in Years in Practice by Therapist Race

	Therapist								
	White			Asian					
	n	*M*	*SD*	*n*	*M*	*SD*	*t(46)*	*p*	μ_p^2
Years in Practice	39	1.46	.94	9	1.44	.88	.050	.96	.000

Table 5b

Differences in Years in Practice in Therapists of Asian Clients by Therapist Race

	Therapist								
	White			Asian					
	n	*M*	*SD*	*n*	*M*	*SD*	*t(12)*	*p*	μ_p^2
Years in Practice	8	1.75	1.39	6	1.67	1.03	.123	.90	.001

Contingency tables (a.k.a. Crosstab analyses) were performed for the possible categorical covariates, Therapist Gender and Theoretical Orientation. The number of theoretical orientation categories was reduced to two, Cognitive-Behavioral vs. All Others, from the original seven, as CBT had the largest percentage of participants (54%). Between White and Asian therapists of clients of both races, although gender had only a small effect size (Cramer's V = .033), therapist theoretical orientation had a strong association, Cramer's V = -.520, according to proposed guidelines put forth by Lea & Parker (1997). The same pattern was reflected between White and Asian therapists of Asian American clients as well (Gender Cramer's V = -.125, Theoretical Orientation Cramer's V = -.645). Although Therapist Race and Theoretical Orientation had strong effect sizes for all clients as well as only Asian clients, Theoretical Orientation did not correlate significantly with any of the three Countertransference subscale scores (Asian clients only: Threat $r = .10$, $n = 15$, $p = .71$; Harm $r = .07$, $n = 15$, $p = .81$; Challenge $r = -.09$, $n = 15$, $p = .74$; All clients: Threat $r = .10$, $n = 48$, $p = .50$; Harm $r = .23$, $n = 48$, $p = .12$; Challenge $r = -.17$, $n = 48$, $p = .26$) and was, therefore, dropped from consideration as a potential covariate, i.e., it did not qualify as a confounding variable that needed to be controlled in subsequent analyses. These results are presented in Tables 6 and 7.

Table 6a

Gender Differences in Therapists by Therapist Race

	Therapist						
	White		Asian				
Gender	*n*	%	*n*	%	$\chi^2(1)$	*p*	Cramer's φ
M	19	40	4	8	0.05	.82	.033
F	20	42	5	10			

Table 6b

Gender Differences in Therapists of Asian Clients by Therapist Race

	Therapist						
	White		Asian				
Gender	*n*	%	*n*	*%*	$\chi^2(1)$	*p*	Cramer's φ
M	3	21	3	21	0.22	.64	-.125
F	5	36	3	21			

Table 7a

Differences in Therapist Theoretical Orientation by Therapist Race

	Therapist						
	White		Asian				
Theoretical Orientation	*n*	%	*n*	%	$\chi^2(1)$	*p*	Cramer's φ
CBT	26	54	0	0	13.09	.00	-.52
All Other Orientations	13	27	9	19			

Table 7b

Differences in Theoretical Orientation in Therapists of Asian Clients by Therapist Race

	Therapist						
	White		Asian				
Theoretical Orientation	*n*	%	*n*	%	$\chi^2(1)$	*p*	Cramer's φ
CBT	5	36	0	0	5.83	.02	-.645
All Other Orientations	3	21	6	43			

Demographic characteristics of participants' clients (*N*=56) skewed toward the young (54% aged 18-29), single (70%), those with high school graduate level education or less (60%), and in lower to lower-middle SES groups (77%). Their demographic information is presented in Table 8.

Table 8

Demographic Characteristics of Participants' Clients (N = 56)

Characteristic		*n*	%
Age			
	18-29	31	54
	30-39	4	7
	40-49	10	18
	50-59	8	14
	60+	3	5
Gender			
	M	32	57
	F	24	43
Race			
	White (non-Latino)	42	74
	Asian	15	26
Relationship Status			
	Single	40	70
	Married/Partnered	10	18
	Divorced	3	5
	Widowed	1	2
Highest Level of Education			
	Less than HS/GED	5	9
	HS/GED	29	51
	College Degree	16	28
	Advanced Degree	6	11
SES			
	Lower	17	30
	Lower-Middle	27	47
	Upper-Middle	10	18
	Upper	2	4

Note. Totals of percentages are not 100 because of rounding and missing data

Psychometric information, and score means, standard deviations, and ranges for each of the three countertransference subscales and the racial bias measure, by therapist race, can be found in Tables 9 through 11.

Table 9

Psychometric Properties of Instruments

Measure	*n*	No. of items	Score Range	α	Normative Reliability
TAQ	56	22	22-132	0.739	.71-.90
SAAAS	48	25	25-150	0.893	.91-.94

Note. TAQ=Therapist Appraisal Questionnaire, SAAAS=Scale of Anti-Asian American Stereotypes

Table 10

Therapist Appraisal Questionnaire (TAQ) Means, Standard Deviations, and Ranges by Therapist Race

		Total (Range 22-132)			Harm (Range 12-72)			Threat (Range 4-24)			Challenge (Range 6-36)		
Therapist Race	*n*	*M*	*SD*	Min-Max	*M*	*SD*	Min-Max	*M*	*SD*	Min-Max	*M*	*SD*	Min-Max
White	39	59.95	9.6	42-85	26.49	8.27	16-48	11.54	2.89	7-19	21.92	5.36	9-32
Asian	9	55.33	10.81	43-75	22.78	4.79	17-31	10.44	1.24	9-13	22.11	5.56	16-31
All	56	59.21	10.55	38-85	26.23	7.93	16-48	11.38	2.89	7-19	21.61	5.29	9-32

Table 11

Scale of Anti-Asian American Stereotypes (SAAAS) Means, Standard Deviations, and Ranges by Therapist Race

		Total (Range 25-150)			Sociability (Range 13-78)			Competence (Range 12-72)		
Therapist Race	*n*	*M*	*SD*	Min-Max	*M*	*SD*	Min-Max	*M*	*SD*	Min-Max
White	34	68.18	15.95	40-97	35	10.1	20-55	33.18	7.3	19-45
Asian	8	75.5	20.23	47-100	36.5	9.87	24-50	39	10.8	23-50
All	48	67.25	16.91	40-100	34.33	9.68	20-55	32.92	8.58	19-50

Although the inclusion of only English-speaking psychotherapy dyads implies a certain minimal level of acculturation among clients, the one-item acculturation measure was also correlated with racial bias and countertransference toward Asian clients to further rule out this potentially powerful confounding variable. No significant correlations were found among these variables, although in Asian American intraethnic dyads, Total SAAAS (M = 69.80, SD = 22.82) and the Competence subscale (M = 35.80, SD = 22.82) approached significance with Acculturation (SAAAS r = -.74, n = 5, p = .15, Competence r = -.84, n = 5, p = .07).

Results of Hypothesis Testing

Hypothesis 1: In general, countertransference reactions will differ as a function of therapist and client race combination, and racial bias will vary with therapist race.

This overall hypothesis was not confirmed. Factorial ANOVA analyses showed no significant interactions or main effects for therapist or client race on Total, Threat, Harm, or Challenge countertransference scale scores. Overall, no substantial (i.e., medium or larger) associations were found between affective countertransference and therapist-client race combinations in this sample, and this is most likely not attributable to lack of power or the small sample size. There was a small to medium effect sizes for the main effect of therapist race on Harm countertransference, μ_p^2 = .032. However, as previously noted, effect sizes of this magnitude will not be interpreted as a significant result in and of themselves in order to maintain a conservative stance toward interpretation of statistics and findings in this small, exploratory study. They will be discussed as trends if qualitative findings reinforce interpretations or conclusions. Means, standard deviations, and effect sizes for these variables are presented in Table 12.

Table 12a

Means and Standard Deviations for Total Countertransference as a Function of Therapist and Client Race

	Client					
	White			Asian		
Therapist	*n*	*M*	*SD*	*n*	*M*	*SD*
White	31	47.29	8.19	8	46.13	8.22
Asian	3	41.67	10.79	6	45.67	10.07

Table 12b

Summary Table for Two-Way Analysis of Variance Results of the Effects of Therapist and Client Race on Total Countertransference

Source	*df*	*F*	*p*	μ_p^2
Therapist Race	1	0.77	.39	.017
Client Race	1	0.17	.69	.004
Therapist Race x Client Race	1	0.55	.46	.012
Within cells	44			

Table 12c

Means and Standard Deviations for Threat Countertransference as a Function of Therapist and Client Race

	Client					
	White			Asian		
Therapist	*n*	*M*	*SD*	*n*	*M*	*SD*
White	31	11.68	2.89	8	11.00	3.02
Asian	3	10.33	0.58	6	10.50	1.52

Table 12d

Summary Table for Two-Way Analysis of Variance of Threat Countertransference as a Function of Therapist and Client Race

Source	*df*	*MS*	*F*	*p*	μ_p^2
Therapist Race	1	5.17	0.70	.41	.016
Client Race	1	0.40	0.05	.82	.001
Therapist Race x Client Race	1	1.08	0.15	.70	.003
Within cells	44	7.43			

Table 12e

Means and Standard Deviations for Harm Countertransference as a Function of Therapist and Client Race

	Client					
	White			Asian		
Therapist	*n*	*M*	*SD*	*n*	*M*	*SD*
White	31	26.45	7.92	8	26.63	10.11
Asian	3	22.33	6.81	6	23.00	4.24

Table 12f

Summary Table for Two-Way Analysis of Variance of Harm Countertransference as a Function of Therapist and Client Race

Source	*df*	*MS*	*F*	*p*	μ_p^2
Therapist Race	1	91.23	1.44	.24	.032
Client Race	1	1.07	0.02	.90	.000
Therapist Race x Client Race	1	0.37	0.01	.94	.000
Within cells	44	63.19			

Table 12g

Means and Standard Deviations for Challenge Countertransference as a Function of Therapist and Client Race

	Client					
	White			Asian		
Therapist	*n*	*M*	*SD*	*n*	*M*	*SD*
White	31	21.90	5.36	8	22.00	5.73
Asian	3	20.00	6.93	6	23.17	5.12

Table 12h

Summary Table for Two-Way Analysis of Variance of Challenge Countertransference as a Function of Therapist and Client Race

Source	*df*	*MS*	*F*	*p*	μ_p^2
Therapist Race	1	0.83	0.03	.87	.001
Client Race	1	16.2	0.54	.47	.012
Therapist Race x Client Race	1	14.34	0.48	.49	.011
Within cells	44	29.94			

To address whether racial bias varies with therapist race, the partial eta squared effect size was obtained for the t-test comparing differences in racial attitudes between White and Asian therapists. Again, although it was of a small-to-medium magnitude ($\mu_p^2 = .03$), this effect size, by itself, will be considered conservatively as an insignificant finding. Therefore, in this sample, racial bias does not have a noteworthy association with therapist race, and this finding is most likely not attributable to lack of power. Means, standard deviations, and effect sizes are presented in Table 13.

Table 13

Differences in Racial Attitudes Between White and Asian Therapists

White		Asian				
M	*SD*	*M*	*SD*	*t(40)*	*p*	μ_p^2
68.18	15.95	75.5	20.23	-1.11	0.273	0.03

Hypothesis 2a: Overall, White therapists experience greater affective countertransference toward Asian American clients than toward White clients.

Research Question 1: Are any specific countertransferential affects experienced more or less than others toward Asian American clients (e.g., more threat than harm affects, mix of positive and negative affects)? If so, is the pattern related to and congruent with stereotypical beliefs about Asian Americans?

This hypothesis was not confirmed. Partial eta squared effect sizes of *t* statistics were obtained to examine whether White therapists experience greater affective countertransference toward Asian American clients than toward White clients. Among White therapists, no

substantial associations were found between any countertransference measure (including both positive and negative types) and Asian client race (μ_p^2 = .00, .01, .00, and .00, respectively). Complete results are presented in Table 14. This finding will most likely be true even in larger sample sizes with more power.

Table 14

Countertransference Differences in White Therapists by Client Race

	Client						
	White		Asian				
TAQ Subscale	*M*	*SD*	*M*	*SD*	*t(37)*	*p*	μ_p^2
Total	60.03	9.60	59.63	10.25	.11	.92	.000
Threat	11.68	2.89	11.00	3.02	0.59	.56	.009
Harm	26.45	7.92	26.63	10.11	-.05	.96	.000
Challenge	21.90	5.36	22.00	5.73	-.05	.96	.000

Hypothesis 2b: White therapists' affective countertransference toward Asian American clients varies with their racial bias.

This hypothesis was partially confirmed. To test whether White therapists' affective countertransference toward Asian American clients varies with their racial attitudes, Pearson product-moment correlations between SAAAS and countertransference subscale scores were examined. Although Pearson product-moment correlations are most commonly used as an inferential statistical significance test that is highly dependent on sample size, *r* is also widely used as an effect size (Cohen, 1988). It is benchmarked using Cohen's guidelines:.10 small, .30 medium, .50 large. Although all correlations were nonsignificant (as expected, given the small sample size), as effect sizes, *r* revealed medium to large associations between all three racial bias scores and Total and Harm countertransference scores (*r* ranging from .33 - .59; see Table 15).

There is most likely no association between White therapists' Threat and Challenge countertransference and racial bias toward Asian Americans (effect sizes are all under $r \leq .19$), regardless of sample size/more power. For exploratory purposes, Pearson product-moment correlational analyses were also performed on Asian therapists' countertransference toward Asian American clients. Although there is not enough power with such a small sample size, a significant correlation was found between Asian therapists' Harm countertransference toward Asian American clients and their racial bias about Asian Sociability. The size of the effect is large ($r = .93$, $n = 5$, $p = .02$, two-tailed) and most likely has practical significance. All other relationships among subscales of the SAAAS and the countertransference measure showed medium to large effect sizes, indicating substantial associations that may be statistically significant given a larger sample size (r ranging from .40 - .85).

Table 15

Intercorrelations for Racial Attitude and Countertransference Toward Asian Clients as a Function of Therapist Race

Measure	1	2	3	4	5	6	7
1. SAAAS	-	-	-	.55	.37	.12	.18
2. Sociability SAAAS	-	-	-	.51	.33	.12	.19
3. Competence SAAAS	-	-	-	.59	.41	.12	.15
4. Total Countertransference	.69	.80	.56	-	-	-	-
5. Harm Countertransference	.85	.93*	.74	-	-	-	-
6. Threat Countertransference	.53	.65	.40	-	-	-	-
7. Challenge Countertransference	.50	.62	.37	-	-	-	-

Note. Intercorrelations for White therapists (n=7) are presented above the diagonal, and intercorrelations for Asian therapists (n=5) are presented below the diagonal.

* p<.05 (two-tailed).

Hypothesis 3a: Relationships have been drawn between ethnic matching in psychotherapy dyads and decreased likelihood of premature termination (Fujino, Okazaki, & Young, 1994; Lau & Zane, 2000; Takeuchi, Sue, & Yeh, 1995), better prognosis, and less severe assessment (Lu, 1996; Russell, Fujino, Sue, Cheung, & Snowden, 1996). In this study, does therapist and client race combination affect these same clinical variables in the same way?

This hypothesis was mostly confirmed, with one proviso. To see if past findings in the literature were replicated in this study, factorial ANOVA analyses were conducted to examine the effects of therapist and client race on number of sessions (proxy for premature termination), client prognosis, and client GAF score. A medium effect size ($\mu_p^2 = .07$) indicates a moderate association for therapist race on number of sessions with client. In other words, 7% of the variance in the main effect for number of sessions with client (and its associated error) can be explained by the variance in therapist race. White therapists tend to have more sessions with clients than Asian therapists, but the sample was too small to detect a statistically significant difference. Although therapist race does appear to have an effect on number of sessions with client, as expected, results from previous studies on the combination of therapist and client race (specifically, intraethnic dyads) were not replicated. Consistent with past research, the moderate effect size for the interaction term between therapist and client race for client prognosis, $\mu_p^2 = .05$, suggests that clients in intraethnic dyads receive higher prognosis scores, but the power was simply inadequate to detect a difference in this study (5% of the variance in prognosis is accounted for by the interaction between therapist and client race). Consistent with current literature, the moderate effect size of the interaction term between therapist and client race for client GAF score, $\mu_p^2 = .08$, suggests that a statistically more powerful study would conclude that clients in intraethnic dyads receive higher GAF scores. In this sample, 8% of the variance in

client GAF score can be explained by the interaction between therapist and client race. Means, standard deviations, and effect sizes are presented in Tables 16-18.

Table 16a

Means and Standard Deviations for Number of Sessions as a Function of Therapist and Client Race

	Client					
	White			Asian		
Therapist	*M*	*SD*	*n*	*M*	*SD*	*n*
White	27.19	19.42	31	25.13	30.01	8
Asian	13.67	10.97	3	9.83	6.97	6

Table 16b

Summary Table for Two-Way Analysis of Variance Results of the Effects of Therapist and Client Race on Number of Sessions

Source	*df*	*MS*	*F*	*p*	μ_p^2
Therapist Race	1	1263.60	3.07	.09	.065
Client Race	1	53.00	0.13	.72	.003
Therapist Race x Client Race	1	4.74	0.01	.92	.000
Within cells	44	412.03			

Table 17a

Means and Standard Deviations for Prognosis as a Function of Therapist and Client Race

	Client					
	White			Asian		
Therapist	*M*	*SD*	*n*	*M*	*SD*	*n*
White	4.06	1.12	31	3.25	1.28	8
Asian	4.00	1.00	3	4.50	0.84	6

Table 17b

Summary Table for Two-Way Analysis of Variance Results of the Effects of Therapist and Client Race on Prognosis

Source	*df*	*MS*	*F*	*p*	μ_p^2
Therapist Race	1	2.14	1.72	.20	.038
Client Race	1	0.15	0.12	.73	.003
Therapist Race x Client Race	1	2.63	2.11	.15	.046
Within cells	44	1.25			

Table 18a

Means and Standard Deviations for GAF as a Function of Therapist and Client Race

	Client					
	White			Asian		
Therapist	*M*	*SD*	*n*	*M*	*SD*	*n*
White	63.76	10.15	25	51.71	15.93	7
Asian	71.67	10.40	3	77.25	9.14	4

Table 18b

Summary Table for Two-Way Analysis of Variance Results of the Effects of Therapist and Client Race on GAF

Source	*df*	*MS*	*F*	*p*	μ_p^2
Therapist Race	1	1459.68	11.45	.00	.246
Client Race	1	54.51	0.43	.52	.012
Therapist Race x Client Race	1	405.62	3.18	.08	.083
Within cells	35	127.53			

Hypothesis 3b: Asian American therapists also experience countertransference toward Asian American clients, but characterized by less negative countertransference and more positive affects than their White counterparts with Asian American clients.

This hypothesis was partially confirmed. To test whether Asian intraethnic dyads are characterized by less negative and more positive countertransference, *t* tests and effect sizes were obtained. Though the *t* test failed to reach statistical significance in this small sample, the moderate effect size, $\mu_p^2 = .05$, suggests that a future study with more power may find that Asian therapists experience less Harm countertransference with Asian clients than their White counterparts. Effect sizes for Total ($\mu_p^2 = .024$), Threat ($\mu_p^2 = .011$), and Challenge ($\mu_p^2 = .013$) countertransference were small indicating that no significant differences would likely be found even in studies with larger samples. Complete results are presented in Table 19.

Table 19

Countertransference Differences toward Asian Clients by Therapist Race

	Therapist						
	White		Asian				
TAQ Subscale	*M*	*SD*	*M*	*SD*	*t(12)*	*p*	μ_p^2
Total	59.63	10.25	56.67	9.97	0.54	.60	.024
Threat	11.00	3.02	10.50	1.52	0.37	.72	.011
Harm	26.63	10.22	23.00	4.24	0.82	.43	.053
Challenge	22.00	5.73	23.17	5.12	-0.30	.70	.013

Hypothesis 4: Countertransference, regardless of ethnic match between therapist and client, affects therapist clinical judgment of prognosis, diagnosis, GAF, and working alliance.

This hypothesis was mostly confirmed. To test Hypothesis *4*, Pearson product-moment correlational analyses were performed among GAF, prognosis, working alliance, and all countertransference subscale scores. Results showed that Harm countertransference was negatively related to GAF (r = -.35, n = 47, p = .02), prognosis (r = -.48, n = 56, p = .00) and working alliance (r = -.45, n = 56, p = .00). Challenge countertransference was positively related to prognosis (r = .37, n = 56, p = .01) and working alliance (r = .46, n = 56, p = .00). A minimum of 80% power was achieved for all correlations except Harm countertransference with GAF. This correlation can be interpreted as a medium effect size indicating a moderate association between these two variables regardless of sample size. The complete correlation table is presented in Table 20.

Table 20

Intercorrelations for GAF, Prognosis, and Working Alliance on Countertransference and Racial Attitude

Measure	1	2	3
1. GAF	-		
2. Prognosis	.45 **	-	
3. Working Alliance	.10	.55 **	-
4. Harm Countertransference	-.35 *	-.48 **	-.45 **
5. Threat Countertransference	-.10	-.07	.16
6. Challenge Countertransference	.13	.37 **	.46 **

* p<.05 (two-tailed)
** p<.01 (two-tailed)

One-way ANOVA analyses were performed to examine the effects of countertransference on diagnosis. Although categories of diagnoses were necessarily collapsed for statistical analyses due to inadequate subgrouping sizes, the expected trend was evident with psychotic (*n*=6) and personality (*n*=7) disorders having the highest levels of countertransference (*M* = 65.17, *SD* = 11.44 and *M* = 65.71, *SD* = 9.38, respectively). Adjustment disorders (*n*=8) had the lowest levels of countertransference, *M* = 51.38, *SD* = 6.23. One way ANOVAs for the effects of the three subscales of countertransference on the collapsed diagnosis groupings (Mood, Anxiety, and All Others) resulted in moderate to large effect sizes, Threat μ_p^2 = .09, Harm μ_p^2 = .06, and Challenge μ_p^2 = . 09. In this sample, there were moderate to large associations between countertransference and diagnosis. Mood disorders (*M* = 63.44, *SD* = 8.77) had higher Total countertransference than Anxiety (*M* = 54.69, *SD* = 9.48) and All Other disorders (*M* = 58.89, *SD* = 11.33), and also had higher Threat countertransference (*M* = 11.69, *SD* = 2.87) than Anxiety disorders (*M* = 10.62, *SD* = 2.43) and All Other disorders (*M* = 10.96, *SD* = 2.94). Mood (*M* = 26.75, *SD* = 6.32) and All Other disorders (*M* = 27.59, *SD* = 9.14) had higher Harm countertransference than Anxiety disorders (*M* = 22.77, *SD* = 6.33). Mood disorders (*M* = 24.00, *SD* = 4.08) had higher Challenge countertransference than Anxiety (*M* = 21.31, *SD* = 4.87) and All Other disorders (*M* = 20.33, *SD* = 5.78). Means, standard deviations, and effect sizes are presented for all variables in Table 21.

Table 21a

Means and Standard Deviations for Total Countertransference as a Function of Diagnosis

Diagnosis	*n*	*M*	*SD*
Mood	16	63.44	8.77
Anxiety	13	54.69	9.48
All Others	27	58.89	11.33

Table 21b

Summary Table for One-Way Analysis of Variance Results of the Effects of Diagnosis on Total Countertransference

	SS	*df*	*MS*	*F*	*p*	μ_p^2
Between Group	554.06	2	277.03	2.64	.08	.090
Within Groups	5571.37	53	105.12			

Table 21c

Means and Standard Deviations for Threat Countertransference as a Function of Diagnosis

Diagnosis	*n*	*M*	*SD*
Mood	16	11.69	2.87
Anxiety	13	10.62	2.43
All Others	27	10.96	2.94

Table 21d

Summary Table for One-Way Analysis of Variance Results of the Effects of Diagnosis on Threat Countertransference

	SS	*df*	*MS*	*F*	*p*	μ_p^2
Between Group	39.65	2	19.82	2.51	.09	.086
Within Groups	419.48	53	7.92			

Table 21e

Means and Standard Deviations for Harm Countertransference as a Function of Diagnosis

Diagnosis	*n*	*M*	*SD*
Mood	16	26.75	6.32
Anxiety	13	22.77	6.33
All Others	27	27.59	9.14

Table 21f

Summary Table for One-Way Analysis of Variance Results of the Effects of Diagnosis on Harm Countertransference

	SS	*df*	*MS*	*F*	*p*	μ_p^2
Between Group	210.16	2	105.08	1.71	.19	.061
Within Groups	3251.83	53	61.36			

Table 21g

Means and Standard Deviations for Challenge Countertransference as a Function of Diagnosis

Diagnosis	*n*	*M*	*SD*
Mood	16	24.00	4.08
Anxiety	13	21.31	4.87
All Others	27	20.33	5.78

Table 21h

Summary Table for One-Way Analysis of Variance Results of the Effects of Diagnosis on Challenge Countertransference

	SS	*df*	*MS*	*F*	*p*	μ_p^2
Between Group	136.59	2	68.29	2.58	.09	.089
Within Groups	1404.77	53	26.51			

Research Question 2: Regardless of therapist or client race, does therapist theoretical orientation affect countertransference?

One-way ANOVA analyses were performed and associated effect sizes obtained to examine the effects of therapist theoretical orientation on countertransference. No moderate or larger effect sizes were found. In this sample, therapist theoretical orientation does not appear to have a substantial association with countertransference regardless of sample size. Means and standard deviations are presented in Table 22, and effect sizes in Table 23.

Table 22

Means and Standard Deviations for Countertransference as a Function of Therapist Theoretical Orientation

	Orientation	
	Cognitive-Behavioral (*n*=28)	All Others (*n*=28)
Total CT		
M	58.71	59.71
SD	11.13	10.12
Negative CT		
M	38.11	37.11
SD	10.32	8.95
Harm CT		
M	26.79	25.68
SD	8.93	6.92
Threat CT		
M	11.32	11.43
SD	2.91	2.92
Challenge CT		
M	20.61	22.61
SD	5.85	4.56

Note. CT=Countertransference

Table 23a

Summary Table for One-Way Analysis of Variance Results of the Effects of Therapist Theoretical Orientation on Total Countertransference

	SS	*df*	*MS*	*F*	*p*	μ_p^2
Between Group	14.00	1	14.00	0.12	.73	.002
Within Groups	6111.43	54	113.18			
Total	202480.00	56				

Table 23b

Summary Table for One-Way Analysis of Variance Results of the Effects of Therapist Theoretical Orientation on Harm Countertransference

	SS	*df*	*MS*	*F*	*p*	μ_p^2
Between Group	17.16	1	17.16	0.27	.61	.005
Within Groups	3444.82	54	63.79			
Total	41997.00	56				

Table 23c

Summary Table for One-Way Analysis of Variance Results of the Effects of Therapist Theoretical Orientation on Threat Countertransference

	SS	*df*	*MS*	*F*	*p*	μ_p^2
Between Group	0.16	1	0.16	0.02	.89	.000
Within Groups	458.96	54	8.50			
Total	7705.00	56				

Table 23d

Summary Table for One-Way Analysis of Variance Results of the Effects of Therapist Theoretical Orientation on Challenge Countertransference

	SS	*df*	*MS*	*F*	*p*	μ_p^2
Between Group	56.00	1	56.00	2.04	.16	.036
Within Groups	1485.36	54	27.51			
Total	27686.00	56				

Research Question 3: Does therapist gender affect countertransference or racial bias toward Asian American clients?

To test Research Question *3*, partial eta squared effect sizes of *t* tests were obtained for gender differences in countertransference and racial attitude in therapists of Asian clients. Large effect sizes indicate a strong magnitude of differences on Total and Harm countertransference scores based on therapist gender. *T* tests were nonsignificant most likely due to the small sample size. Specifically, male therapists appear to experience more Total and Harm countertransference toward Asian clients (μ_p^2 = .156 and .168, respectively) than female therapists do. Threat and Challenge countertransference toward Asian American clients showed no considerable differences in effect size based on therapist gender. There were no noteworthy effect sizes for differences in racial bias toward Asian clients based on therapist gender. Gender does not appear to affect racial bias toward Asian American clients. Results of analyses for these variables are presented in Table 24.

Table 24

Countertransference and Racial Attitude Differences in Therapists of Asian Clients by Therapist Gender

	Therapist						
	Male		Female				
Measure	*M*	*SD*	*M*	*SD*	*t(13)*	*p*	μ_p^2
Total Countertransference	64.33	11.38	56.22	8.93	1.55	.15	.156
Threat Countertransference	11.50	2.17	11.00	3.32	0.32	.75	.008
Harm Countertransference	30.17	10.36	23.33	6.34	1.62	.13	.168
Challenge Countertransference	22.67	7.79	22.00	3.00	0.24	.82	.004
SAAAS	70.80	23.21	67.50	19.88	0.27	.79	.007
Sociability SAAAS	36.40	11.78	34.25	11.40	0.33	.75	.010
Competence SAAAS	34.40	11.50	33.25	9.75	0.19	.85	.003

Note. Males *n*= 6, Females *n*= 9.

Qualitative

Qualitative data were analyzed using inductive Thematic Analysis (Braun & Clarke, 2006; Hayes, 2000; see also Boyatzis, 1998), a qualitative method described as a "poorly demarcated, rarely acknowledged, yet widely used qualitative analytic method within psychology…that offers an accessible and theoretically flexible approach" (Braun & Clarke, p. 77). Thematic Analysis is different from other qualitative analytic methods that describe patterns across data such as thematic DA, thematic decomposition analysis, IPA, grounded theory, and content analysis. Unlike thematic analysis, both IPA and grounded theory are theoretically bounded. Braun and Clarke (2006) go on to critique:

> The goal of grounded theory analysis is to generate a plausible – and useful – theory of the phenomena that is grounded in the data. However, in our experience, grounded theory seems increasingly to be used in a way that is essentially grounded theory 'lite' – as a set of procedures for coding data very much akin to thematic analysis. Such analyses do not appear to fully subscribe to the theoretical commitments of a 'full-fat' grounded theory, which requires analysis to be directed towards theory development…. A 'named and claimed' thematic analysis means researchers need not subscribe to the implicit theoretical commitments of grounded theory if they do not wish to produce a fully worked-up grounded-theory analysis…. Content analysis is another method that can be used to identify patterns across qualitative data, and is sometimes treated as similar to thematic approaches. However, content analysis tends to focus at a more micro level, often provides (frequency) counts, and allows for quantitative analyses of initially qualitative data. (p. 98)

Braun and Clarke delineate a practical and succinct 'manual' for using thematic analysis. Some of the issues relevant to this study are described here. Although these methods also share some similarities with Thematic Analysis such as their search for patterns across data sets rather than within individual datum items such as an interview from one person, Thematic Analysis is not tied to any pre-existing theoretical framework. The method used in this study was essentialist or realist which illustrates experiences, meanings, and realities of participants, rather than

constructionist which explores how events, realities, meanings, and experiences are the effects of influences within society, or contextualist, which lies between constructionist and essentialist methods.

In Thematic Analysis, what counts as a theme is prevalence, within an individual datum as well as across the entire data set. Although repeated instances of a theme are typical, repetition of a theme does not necessarily make it more important. Braun and Clarke also refer to the "keyness" of a theme, which is not determined by quantity, but by its relevance to the overall research question. Prevalence can be determined by the level of the data item (i.e., does a theme occur anywhere in each participant's interview), by the number of participants who reflected the theme across the entire data set or each individual occurrence, which can be multiple times in an individual's interview. Most importantly, however, there is no predetermined way of determining prevalence, as it can be done in many ways as long as it is consistently done throughout the analysis. Braun and Clarke describe some rhetorical conventions for representing prevalence such as "the majority of participants," "many participants," or "a number of participants." In addition, a researcher can choose between a rich thematic description of the entire data set that highlights the predominant themes, in which some complexity and detail is necessarily lost, which might be useful in an under-researched area, or a more detailed account of one or more selected themes. Since research on countertransference toward Asian American clients is still in its infancy, the former method was used in this paper. For the same reason, an inductive, rather than theoretical or deductive, method was used, in which the identified themes are linked to the data itself, although some theoretical ideas were presented prior to analysis due to existing literature as well as results from the quantitative analyses.

Braun and Clarke propose five phases of Thematic Analysis: 1) Familiarizing yourself with your data; 2) Generating initial codes; 3) Searching for themes; 4) Reviewing themes; 5) Defining and naming themes; and 6) Producing the report (for fuller description of each step, see Braun & Clarke, 2006). In an inductive fashion, a thematic analysis of responses to each of the five questions (rather than for each individual respondent) was performed to identify and categorize recurrent themes in the data. Through repeated readings, themes were grouped in analytic categories with direct quotes listed under each heading to illustrate the theme as well as to indicate the number of times the theme occurred. Finally, the data were reviewed to confirm provisional definitions and names of categories and to collapse, exclude, or rename categories (for examples, see Ellis & Kitzinger, 2002; Frith & Gleason, 2004; Tierney & Fox, 2010; Toerien & Wilkinson, 2004). Similar to Kitzinger and Willmott (2002), the data itself lent itself to names of themes and direct quotes from transcribed interviews were used as illustrations of each theme. This inductive thematic analysis resulted in four key themes of Racial Bias and two key themes of Cultural Countertransference. Key Racial bias themes included Asians' Lack of Sociability (lack of interpersonal warmth), Excessive Competence, Inscrutability, and Deference to Authority. All five of the participants described racial bias themes of Excessive Competence and Inscrutability, while Lack of Sociability and Deference to Authority were less prevalent, but still cited by at least 2 of the 5 therapists. The key countertransference theme was the therapist's drive to counter Asians' culturally-syntonic goals for performance and achievement. Examples of each key Racial Bias theme is presented in Table 25 and key Cultural Countertransference themes are presented in Table 26.

Table 25

Key Themes of Racial Bias and Representative Examples

Racial Bias	
Inscrutability	Competence
Client would say that he was fine, when it seemed to me he was still having some fairly severe symptoms	[Client] kept wanting to go out and start school, too much school, like five classes at once, and work at the same time; he was pretty stubborn
Some [Asians] express certain emotions differently, less overt or demonstrative	Obsessed with getting a degree from some sort of university
Thought [client] would be more forthcoming…a lot more isolation of affect than most of my Caucasian patients, with Whites I would expect more self-disclosure at this stage of therapy	Strong reaction to [Asians] with schizophrenia… "psychosis" was not in my network of associations for "Asian"
[Asians] do display affect a little differently perhaps in a more subtle way than Southern European American, and more like Northern European Americans	Felt for [client] in his difficulty finding a job after college graduation and the fear of disappointing his family...because I envisioned his parents being extremely strict and unwilling to accept anything but the best successes for their son
Lack of emotive material…I wonder if [client] would be more emotionally expressive or convey that emotionality in a different manner [with a therapist of the same ethnicity]	
[Client] doesn't appear to be that depressed in session, probably cultural differences in self-expression for a man about my age	
It is possible that AA clients may be generally more reserved than clients from other cultures	

Table 25 (cont.)

Key Themes of Racial Bias and Representative Examples (cont.)

Racial Bias	
Authority	Lack of Sociability
[Client] didn't want to follow my treatment recommendations…he wouldn't take feedback on his plan and he ultimately wound up in the hospital again	Hampers smooth interaction…more difficult to engage [client]…than he should have been
Slight distrust from the client about me and the therapy	Delay in rapport development…it took several sessions and some extra openness and self-disclosure on my part before it seemed that [the client] was comfortable with me
I hate it, but more is ascribed to my being a 'doctor'...I wish [client] would feel more free in rejecting my interpretations	[Client] felt less comfortable sharing with group

Table 26

Key Themes of Countertransference and Representative Examples

Countertransference	
Theme	
Drive to counter culturally-syntonic drives for performance	Strong reaction wanting [client] to be willing to look at underlying presses associated with this fairly consuming desire given that it seemed to sideline many other aspects of life that might possibly improve his life
	Sympathetic to pressures
	Admiring [client's] drive but worrying that he was taking on too much for his condition
	[Client] was stubborn…he wouldn't take feedback on his plan
	It seems pretty obvious to me what is holding this client back therapeutically
Frustration; requiring more patience	Me being an outsider to [Asians'] way of experiencing/viewing things, I tried to be more patient and focus on building trust, to show willingness to learn more about their way of seeing things
	I got "stuck"… I always feel tired…frustration at pace of treatment
	It took several sessions and some extra openness and self-disclosure on my part
	It made me feel that [client] needed the extra patience from me

Chapter VI

DISCUSSION

The primary aim of this study was to explore affective manifestations of cultural countertransference toward English-speaking Asian American clients in psychotherapy and to investigate the roles of therapist race and racial attitudes. Conservative interpretation of statistical results failed to show moderate or larger effect sizes for overall differences in cultural affective countertransference based on therapist-client race combination. Results also suggested that White therapists experience similar levels of both positive and negative countertransference toward clients, regardless of race.

Although qualitative data from White therapists reflected themes of racial biases consistent with Asian stereotypes of high competence and lack of sociability, quantitative comparisons indicated that White therapists do not experience any more racial bias toward Asian clients than do Asian therapists. In fact, there was a trend suggesting the latter group may experience more. For Asian therapists, countertransference in intraethnic dyads was strongly associated with Asian racial biases. This and other trends in the quantitative data should be interpreted cautiously given this study's methodological limitations, but, nevertheless, warrant further investigation. Compared to Asian therapists, White therapists experience more negative countertransference toward both White and Asian clients. White therapists' negative countertransference also showed small to medium associations with their racial bias against Asians.

Qualitative evidence supported and expanded upon these trends: There was a highly prevalent key countertransferential theme among White therapist participants to counter Asian clients' culturally-syntonic drives for achievement and performance. Independent of therapist-client race, negative countertransference showed significant negative relationships to GAF, prognosis, and working alliance, while positive countertransference was positively related to prognosis and working alliance, as expected. Countertransference was also found to be related to client diagnosis, but not therapist theoretical orientation.

In short, although the conservative interpretation of quantitative results failed to show relationships among the therapist-client race, racial bias, and countertransference variables, small to moderate statistical trends coupled with qualitative evidence suggest, for both White and Asian therapists with Asian American clients, racial bias and negative countertransference may, indeed, interact. For White therapists, racial bias was related to negative countertransference and these therapists experienced more negative countertransference toward Asian clients than Asian therapists. Asian therapists experienced more racial bias than White therapists, and this racial bias was related to both positive and negative types of countertransference. Positive and negative countertransference were related to various clinical assessments as well as working alliance.

Prior to discussing the individual findings, some reflections on the design flaws of this study should be discussed and contextualized. Despite the unexpected shortage of quantitative data due to severe selection effects in participant recruitment, I chose to contextualize this study's limitations and, while cautioning readers about its compromised generalizability, proceeded with statistical analyses that focused on effect sizes (which are not affected by sample

sizes) after controlling for potential covariates.[2] I also remained conservative with any conclusions. Note that Hayes and Gelso's (1993) homophobia study cited in the literature review also faced statistical limitations. Their study's power was limited due to similar issues with small sample size, which only became smaller with subgroupings, and it limited their ability find statistically significant effects. However, their study provided support to a later study with a larger sample and corroborated important clinical and empirical findings. With the goal of collecting more in-depth information about this under-researched topic, qualitative data was also collected in this study to help refine or modify the quantitative results. Though not planned from the initial design stage of the study, this type of mixed methods (usually exploratory) design has been a useful and growing approach due to its synergy of the advantages of both quantitative and qualitative designs (see the *Journal of Mixed Methods Research*; for examples, also see Boisvert, Martin, Grosek, & Clarie, 2008; Dickson, Lee, & Riegel, 2011; Jehn & Jonsen, 2010).

Another study design issue impacting most of this study's results can be located in the countertransference subconstructs measured in the TAQ instrument. Throughout most analyses, Harm countertransference seemed to validly represent negative countertransference, as expected, but Threat countertransference did not. The four items in Threat countertransference, *confident, eager*, *fearful*, and *anxious*, may not have thoroughly or accurately captured the subconstruct of countertransference indicating a threat to the therapist's personally meaningful goals or needs. Furthermore, the moderate correlation cited by the scale's authors between the Threat and Harm subscales was not replicated in this study. The apparent orthogonality of these two negative countertransference subconstructs likely means that the Threat subscale was not valid for this

[2] It could be argued from a statistical point of view that one of the most remarkable parts of this study is the enormous selection bias. However, not only is this beyond my knowledge purview, but it is beyond the purview of this study as a primarily psychological study.

study's purposes. Though all statistical results were presented in the preceding section, results regarding Threat countertransference will not be interpreted in the discussion for most hypotheses except for the first.

The statistical finding in this study that, in general, affective countertransference does not vary with therapist and client race runs counter to current literature. However, the literature, as noted before, is largely in case study form or clinical psychoanalytic writings rather than quantitative or empirical studies such as this one. In contrast, the qualitative evidence in this study strongly suggests the presence of cultural countertransference in White therapists with Asian clients. Unfortunately, comparative data on other Asian and White inter- and intraethnic psychotherapy permutations were not explored. The pattern of quantitative findings in this study closely paralleled the empirical research on countertransference with gay clients which found that countertransference manifestations did not vary across sexual orientation conditions (Gelso et al., 1995; Hayes & Gelso, 1993). Researchers in those studies were also surprised to find that client sexual orientation had no main effects on countertransference.

The lack of main effects in the present study may be attributable to conflicted therapist attitudes toward Asian American clients, an unusually low degree of racism in the sample, or socially desirable responding by participants. Conflicted attitudes toward Asian Americans would not be surprising particularly given the mixed nature of the stereotypes regarding this "model minority." Asian Americans are not only perceived as possessing negative qualities such as lack of social skills/interpersonal warmth alongside positive qualities such as diligence and intelligence, but also envied and begrudgingly respected for having a disproportionate level of competence or success, success that challenges that of White Americans in the classroom and the workplace. An equally plausible explanation for this (lack of) statistical finding is that, unlike in

rich, narrative descriptions found in qualitative accounts, the countertransference construct is not being accurately or fully captured in the instrument (i.e., the TAQ). Note that this is precisely the principal justification for the predominantly qualitative catalog of current countertransference research. Finally, an alternative explanation may be that race is a misleading or incomplete proxy for ostensible differences in interethnic psychotherapeutic dyads. In other words, there may, indeed, be variables leading to differential outcomes in mixed race dyads as the literature suggests, but race itself is not the critical factor: There may be yet unidentified factors that partially mediate or moderate an illusory relationship between race and psychotherapy process and outcomes variables. In this study, within-group differences along the dimension of client level of acculturation did not seem to account for the discrepant findings. Not only was it partially controlled for by the participant exclusionary criteria, but its impact was also examined on both racial bias and countertransference; it did not emerge as having a significant relationship with either variable. However, among Asian therapist-Asian client dyads only, the therapist's racial bias regarding excessive competence approached significance in the expected direction. In other words, the more assimilated the client was perceived to be, the less racial bias the therapist reported. This and other potentially significant variables not investigated in this study such as SES deserve further consideration in future studies.

Both sexual orientation studies cited above also found that the therapist variable of homophobia strongly predicted countertransference and only the interaction between the client's sexual orientation and therapist's homophobia was predictive of countertransference reactions. Although this interaction was only predictive of behavioral countertransference, not affective or cognitive manifestations, Fauth and Hayes (2006) found that therapists' positive and negative affective countertransference predicted their positive (more positive diagnostic evaluations of the

client) and negative (increased distancing from and hesitance with client) countertransference behavior, respectively. Therefore, since affective countertransference seems to precede behavioral countertransference manifestations (as theory would also predict), the lack of a behavioral measure of countertransference in this study's design was not anticipated to be problematic. Although an analogous interaction effect was hypothesized and tested with racial bias interacting with therapist race, a statistically substantial interaction effect on affective countertransference was not found. Further research is needed to examine if this was due to the exclusion of a behavioral countertransference measure, but the small to medium effect sizes still warrant consideration here due to corresponding qualitative evidence.

Specifically, in White therapists, countertransferential feelings that indicate harm to the therapists' personally meaningful goals or needs, such as anger, disappointment, disgust, sadness, guilt, boredom, curiosity, and resentfulness, seem to be associated with their endorsement of racial biases about Asian Americans. Said another way, belief in stereotypical racial attitudes toward Asian Americans about their excessive competence and lack of sociability is associated with feeling harmed by the client and unable to manage these reactions. It was not associated with threatening or challenging countertransferential feelings. In terms of validation of constructs purported to be measured in these subscales, it seems logical that White therapists who believe in the Asian competence stereotypes would feel harm countertransference, but the lack of connection with the threatening type is perhaps due to the psychotherapeutic situation. Asian Americans have been found to be overly deferential to the authority of therapists which may serve to decrease the activation of the hypercompetitive, overly achieving Asian American stereotype and the realistic threat posed by it. Maddux, Galinsky, Cuddy, and Polifroni (2008) demonstrated that realistic threat significantly mediates the relationship between racial bias

toward Asian Americans and subsequent negative attitudes and emotions toward them. If no realistic threat is perceived in the therapeutic relationship for these reasons, the hypothesized threatening countertransference may not occur. Therefore, although the stereotyped characteristics of Asian American clients as excessively competent may not be perceived as personally competitive and imminently threatening, they may still induce feelings of harm to the therapist's self-image, goals, or needs. Indeed, Hayes et al. (1998) concluded in their qualitative study of experienced therapists' countertransference experiences:

> Most triggers were the results of the therapists' subjective perceptions. For example, countertransference was stimulated by the therapists' phenomenological evaluations of the progress of therapy, appraisals of the client, comparisons of the client to others, or perceptions of a certain level of emotional arousal in the client or therapist. Thus, the lenses through which therapists saw the world largely dictated whether and when countertransference was stimulated. (p. 478)

The qualitative results support this interpretation. Observed in the majority of White therapists interviewed, a key racial bias theme was of Asian American clients' competence (or drive toward high achievement) and therapists' typical countertransference was either a desire to counterbalance it or paternalistic feelings exemplified in statements such as this: "It seems pretty obvious to me what is holding this client back therapeutically [his focus on achievement outside therapy]."

> *[Client] was obsessed with getting a degree or diploma from some sort of college or university. Though he had a strong preference for math, it didn't seem to matter terribly what field the degree was in as long as he got it…it seemed to sideline many other aspects of life that with attention might possibly improve his life.*

> *Feeling very sympathetic to the pressures placed on him [due to client's difficulty finding a job after college graduation]…. I noticed myself feeling especially bad for him because I envisioned his parents being extremely strict and unwilling to accept anything but the best successes for their son…. I may have felt less strongly*

> *sympathetic for an African-American or Caucasian student who was struggling to find work because I would envision their parents as more understanding.*
>
> *I do remember having a strong reaction to the first patient I encountered who was Asian American with schizophrenia that seemed divergent from my countertransference with patients of other ethnicities/races…. I remember mostly a sense of disorientation -- "psychosis" was not in my network of associations for "Asian"*[3]
>
> *One guy I saw for individual psychotherapy was pretty stubborn. He didn't want to follow treatment recommendations. He kept wanting to go out and start school—too much school, like five classes at once—and work at the same time…. He wouldn't take feedback on his plan…. I remember admiring his drive, while considering possible cultural values around education and work, but worrying that he was taking on too much for his condition [schizophrenia].*

The last therapist, while mindful of distinguishing between the diagnostic symptom of poor insight in schizophrenic clients and possible cultural influences, fails to fully recognize the specific nature of the client's desires as a possible manifestation of Asian values (excessive competence and drive for achievement, in addition to the view of mental illness in Asian American culture as a "luxury" of the idle or a defect to be overcome with hard work). His relatively strong cultural countertransferential drive to oppose his client's goals may also have added intensity due to the client's presentation which seems contrary to the Asian stereotype of being deferential to authority. Would this therapist's countertransference have been as intense, angry, or worried if the client's, admittedly, unrealistic desire was to live independently? Furthermore, would the therapist have felt less disgusted or disappointed if the client was White and refused to follow treatment recommendations? These are questions that deserve further study. Shonfeld-Ringel (2001) recommends that, in situations such as these, therapists validate

[3] Although a sense of disorientation is a common countertransferential experience with patients with schizophrenia, this mid-career therapist, who works solely in a severe mental illness unit, made a clear distinction that the countertransferential experience felt different than with non-Asian patients.

the minority client's expertise in the cross-cultural therapeutic relationship. Even when White therapists advocate a collaborative and egalitarian model of treatment, they often unconsciously use their power to encourage client acculturation to Western values, particularly for treatment goals of individuation and autonomy. This tendency in therapists has serious implications considering that perception of empathy in cross-cultural treatment has been cited as the sole significant predictor for a counselor's credibility with Asian American clients (Akutsu et al., 1990).

Qualitative data indicated another interaction between racial bias and cultural countertransference in White therapists. The second key countertransference theme was one of requiring extra patience and feelings of frustration in response to a racial bias theme of the client's inscrutability. Therapists reported feeling "stuck" and "always tired," needing to "be more patient and focus on rapport-building and trust," having to "show willingness to learn more about [Asian Americans'] way of seeing things," "frustration at pace of treatment, "[feeling] that [the client] needed the extra patience from [the therapist]," "[client] seemed frustrating…but just slightly," and "[client] needed extra patience from me." In fact, inscrutability was the most frequently endorsed racial bias theme.

> *Client would say that he was fine, when it seemed to me he was still having some fairly severe symptoms.*
>
> *Some [Asian Americans] express certain emotions differently, less overt or demonstrative*
>
> *Thought [client] would be more forthcoming…a lot more isolation of affect than most of my Caucasian patients…. With Whites I would expect more self-disclosure at this stage of therapy*

> *Quiet style and slower self-disclosure…communication barrier [despite patient's fluent English]*
>
> *It's possible that Asian American clients may be generally more reserved than clients from other cultures*
>
> *Delay in rapport-building [unlike therapist's experience with Caucasian or African American clients], took some extra openness and self-disclosure on my part before he was comfortable with me…slowness to open up at first seemed frustrating…but just slightly*
>
> *[Client] doesn't appear to be that depressed in session, probably cultural differences in self-expression for a man about my age*
>
> *Lack of emotive material… I wonder if [client] would be more expressive emotionally in a different manner [with a therapist of the same ethnicity]*
>
> *Asian Americans display affect a little differently perhaps in a more subtle way than Southern European American, and more like Northern European Americans.*

Given this qualitative evidence, the lack of association between racial bias and therapist race was a surprising and inconsistent statistical finding. It can be attributed to many of the same factors as the lack of effects between countertransference and therapist race (e.g., socially desirable responding, lack of therapists' self-awareness regarding such biases, and conflict about racial attitudes). In addition to racial bias themes of excessive competence and inscrutability, the other key racial bias theme mentioned most by therapists was a lack of sociability: "[hampered] smooth interaction…more difficulty engaging [client] than he should have been" and "required extra sessions before it seemed that [the client] was comfortable." One therapist described his client's "quiet style," and how he appeared "less comfortable sharing with the group."

This study's conclusions regarding clinical assessments of Asian clients paralleled research (cited previously) that therapists in intraracial dyads tend to give better prognosis and higher GAF scores. The lowest mean prognosis score was given by White therapists to Asian clients, while the highest was given by Asian therapists to Asian clients. This same pattern was seen with GAF scores, with more than a 20-point gap between the mean score given by White therapists to Asian clients and Asian therapists to Asian clients. With prognosis and GAF scores, there appears to be a clear therapist-client race interaction at work. One hypothesis is that greater trust, increased rapport, and cultural match may enable therapists in intraethnic dyads to assess their clients' functioning within a culturally appropriate context, and this effect is most pronounced when the client is a minority group member. Fujino et al. (1994) found that match was a significant predictor of outcome variable most often for Asian American women and least often for White American men, while Russell et al. (1996) found that ethnically-matched therapists judged clients to have higher psychological functioning than mismatched therapists; this effect did not hold for White clients. Russell et al. and Sue and Sue (1987) propose that cultural biases affect therapists' interpretations of psychological functioning in Asian Americans because they do not understand the cultural response sets and cultural backgrounds which make their evaluations questionable. They cite one study in which five Chinese American and five White American male therapists rated Chinese and White male clients on functioning (Li-Repac, 1980). White therapists rated the Asian clients as anxious, awkward, confused, nervous, more depressed, more inhibited, less socially poised, and having lower capacity for interpersonal relationships, while the Asian therapists rated the same clients as alert, ambitious, adaptable, honest, and friendly. White therapists rated White clients as affectionate, adventurous, sincere, and easy-going, whereas Asian therapists rated the same clients as active, aggressive, rebellious,

outspoken, more severely disturbed (than did White therapists). Clinical assessments of minority clients, in particular, seem to be influenced by therapist race.

Although it failed to reach a substantial size, the small to medium effect size indicating that, compared to Asian therapists, White therapists may experience more negative countertransference with all clients, is given added credibility by a second finding that Asian American therapists experience less negative countertransference with Asian American clients than White therapists do with Asian clients. In other words, there is most likely a therapist race effect on negative countertransference that warrants further exploration. The most likely hypothesis is that White therapists feel more freedom to feel, acknowledge, and/or report negative countertransferential feelings, in general. This may be due to intrapsychic factors in the therapist (perhaps related to their status as a member of the majority group), or clients may experience more transferential feelings toward White therapists than Asian therapists, which evokes countertransferential feelings in the White therapist (i.e., countertransference as projective identification). Since there is an inherent asymmetry of power in any therapeutic relationship, these dynamics would only be more pronounced in intercultural dyads in which the therapist belongs to the majority group and the client to a minority. This same hypothesis may also explain why male therapists in this study tended to experience more negative countertransference toward Asian American clients than female therapists. Essentially, male therapists may not only feel more self-determination than female therapists, but also be more likely to be the object of a client's projections given their dominant group identity.

Statistical results also suggested that White therapists experience similar levels of both positive and negative countertransference toward clients, regardless of race. This may be because therapists are trained to be aware of countertransferential reactions, particularly toward clients of

different races. However, in light of the qualitative evidence, the more likely explanation is that White therapists are responding in socially desirable ways because they are in a profession that has expectations for high self-awareness and freedom, even immunity, from positively or negatively biased feelings based on race. Paniagua et al.'s (2000) previously cited study suggests that clinicians may overestimate their lack of racial bias against Asian Americans (perhaps due, in part, to the model minority stereotype), and may require thoughtful and purposeful reflection to detect possible disavowed prejudices and idealizations. Albeit an older study (with participants from a different political and cultural zeitgeist) Bloombaum, Yamamoto, and James (1968), found that practicing psychotherapists reflected the same degree of cultural stereotyping toward Asian Americans as was found in the general population. Of course, "therapists' reluctance to publicly share their vulnerabilities and conflicts is understandably human…doing so [an] act of beneficence that requires tremendous courage" (Gelso & Hayes, 2007, p. 113).

Asian therapists experienced more countertransference toward Asian clients, the more they endorsed Asian racial bias stereotypes. The unexpected finding that Asian therapists endorse Asian racial stereotypes more than their White counterparts notwithstanding, the association of racial bias with countertransference in Asian therapists is consistent with hypotheses. Particularly if Asian therapists perceive a realistic threat of competition with other Asian Americans, threatening and harmful countertransferential feelings would be related to their level of endorsement of the overcompetence stereotype. Although not a negative relationship as would be expected, positive countertransference had the smallest magnitude effect size with the competence racial bias (compared to the negative countertransference measures). Note that this finding does not negate the literature on the link between Asian matched race dyads and better outcomes, but it does complicate the nature of this relationship. For future research, it may be

productive to investigate if Asian American therapists do, indeed, hold more racially biased attitudes toward Asian American clients than their White counterparts, as the small effect size in this study suggests. Although therapeutic outcomes in intraethnic dyads have been researched, the racial attitudes in same race therapist-client dyads have not. One hypothesis is that this trend comes from the openness that Asian Americans may feel to judge and speak frankly about members of their own in-group, particularly regarding politically incorrect stereotypes which, nevertheless, typically originate from a grain of truth (but has then been indiscriminately generalized to all members of the group). Members of an in-group often feel exclusive "permission" to speak candidly about their group (even in pejorative terms) while non-members may not.

Negative countertransference had a negative impact on GAF, prognosis, and working alliance while positive countertransference positively impacted prognosis and working alliance, as expected. This is not only empirically, but also theoretically consistent as GAF scores are sometimes used as a measure for cognitive countertransference due its subjective nature and connection to therapists' clinical biases (Wisch & Mahalik, 1999). Despite its questionable reliability due to this biased nature, GAF scores are clinically important given their widespread use as an aid in treatment and referral planning. Fauth and Hayes (2006) interpreted the link between positive countertransference and GAF scores as, the more of an opportunity for personal gain, the more positively therapists rated client's functioning. Regardless of whether positive cultural countertransference can lead to better prognoses or diagnoses, just as a negative valence in countertransference can be obstructive and harmful in therapy, even positive cultural countertransference can work against productive change if it, for example, helps clients avoid difficult issues around culture and race. Stampley and Slaght (2004) warn that unexamined

cultural countertransference may function defensively for the therapist, appearing to be a clinical problem when it interferes with the therapeutic relationship. Given that many studies have established working alliance as critical to successful therapy (although a causal direction has not been established) and that higher countertransference, whether positive or negative, has been linked to poorer working alliances in brief therapy (Ligiero & Gelso, 2002), it is important to examine the precise nature of this relationship between countertransference and working alliance in future studies.

In contrast to research that shows decreased likelihood of dropout and increased length of therapy for ethnically-matched client-therapist dyads (Flaskerud & Hu, 1994; Fujino et al., 1994; Lau & Zane, 2000; Sue et al., 1991; Takeuchi, Sue, & Yeh, 1995), White therapists had more sessions with all clients, in general, than Asian therapists. However, researchers in these studies also hypothesized that ethnic match is particularly important for clients who are limited in their English, which was not the case for participants' clients in this study (all dyads were English-speaking). Other explanations may be that number of sessions was a poor proxy for premature termination, or that Asian therapists tend to work in settings in which longer-term therapy is not possible or the norm, such as in Asian community counseling centers.

A couple previous studies that specifically examined the impact of diagnosis in therapy may explain the association found between countertransference and client diagnosis. Rossberg et al. (2010) found negative correlations between higher patient symptom scores and therapists' feelings of being important and confident, positive correlations between higher patient symptom scores and therapists' feelings of being bored, on guard, overwhelmed, and inadequate. Brody and Farber (1996) found that countertransference reactions varied with patient diagnosis. Specifically, patients with depression primarily evoked positive countertransference such as

compassion and nurturing (and an absence of anger), while patients with borderline features evoked anger and frustration (and an absence of liking), but also engaged them more, often with rescue fantasies. McIntyre & Schwartz (1998) concur that since depressed clients often display indecisiveness, worthlessness, overdependence, and a need for psychological help, countertransference reactions take the form of salience, submissiveness, responsibility, and friendliness. Patients with schizophrenia evoked a mix of anxiety, hopelessness, a sense of challenge (as opposed to boredom), compassion, and desires to dispense advice and refer them elsewhere (but an absence of anger and annoyance). Although categories of diagnoses were necessarily collapsed in this study, the pattern of relationship between diagnosis and countertransference was approximated here. Depression (compared to anxiety and other disorders) was associated with positive countertransference and lower levels of anger. It was also associated with a negative countertransference that included feelings of confidence, worry, fear, and anxiety, which can be interpreted as compassion and nurturing feelings. It should be noted that in the qualitative data, client diagnosis was a potentially confounding factor. Particularly regarding themes such as client inscrutability, therapists working with clients with schizophrenia diagnoses could have been observing and having countertransferential reactions to negative schizophrenia symptoms rather than racial biases.

Therapist theoretical orientation did not appear to have an association with countertransference in this study. However, theoretical orientation was largely divided down (therapist) racial lines. The predominant theoretical orientation among Asian American therapists in this study was psychodynamic while the majority of White therapists were CBT. Faller, Wagner, Weiss, and Lang (2002) found that cognitive-behaviorally oriented therapists rated the working alliance and prognosis higher, had stronger feelings of sympathy, and rated the patient's

motivation as more favorable than psychodynamic therapists (no difference on feelings of anger). However, this difference was, in part, due to the tendency of psychodynamic therapists to not only make positive judgments, but to use the full range of the scale including negative judgments. Two other studies (Messer, & Winokur, 1980; Raue, Putterman, Goldfried, & Wolitzky, 1995) found that psychodynamic therapists rate therapy significantly lower than cognitive-behavioral ones, and researchers proposed that psychodynamic therapists have heightened sensibilities to interpersonal problems within the therapeutic relationship. The psychodynamically oriented also possess a predominantly tragic view of reality where conflict and difficulties are inevitable, whereas cognitive-behavioral therapists emphasize the possibility of healthy functioning. This may be an unrecognized factor in any significant differences found between White and Asian therapists. Although this possibility was not explored here, it would be not only an interesting variable to study in future research, but also most likely a fruitful one given the large effect size associated with the theoretical orientation differences between White and Asian therapists.

Clinical recommendations based on this research are one of this study's most important functions, especially given the enduring number of obstacles still preventing Asian Americans from utilizing mental health services (Bauer, Chen, & Alegria, 2010; Chung, 2010; David, 2010; Kim, Jang, Chiriboga, Ma, & Schonfeld, 2010; Le Meyer, Zane, Cho, & Takeuchi, 2009; Leong, Kim, & Gupta, 2011; Leong & Lau, 2001; Luu, Leung, & Nash, 2009; Nguyen & Lee, 2012; Sorkin, Nguyen, & Ngo-Metzger, 2011; Snowden, Masland, Peng, Lou, & Wallace, 2011; Spencer, Chen, Gee, Fabian, & Takeuchi, 2010; Sue et al., 1991; Tung, 2011). Based on the findings here, both White and Asian therapists of English-speaking Asian American clients should conscientiously and diligently work toward overcoming any racial biases and the

corresponding negative countertransferential reactions activated by them (Asian therapists also experience positive countertransferential reactions which may equally jeopardize the therapeutic relationship). For an Asian American client, having a White or Asian therapist may not make any difference in terms of biased racial attitudes or cultural countertransferential reactions. However, in terms of outcomes, the tendency for White therapists to experience more negative countertransference with Asian clients than Asian therapists may adversely impact influential clinical assessments particularly of minorities like Asian Americans. However, one can also speculate that whatever differences might occur over a clinical course, they would be negligible in the presence of a strong therapeutic alliance established early on in therapy, an alliance that might be facilitated by a discussion of cultural differences.

Generally, increased outreach for clinical services to the Asian population and the culturally responsive training of therapists (particularly on issues of countertransference and assessment), especially when not ethnically matched with the client, is recommended. Ideally, culturally responsive training of therapists should increase the therapist's awareness of their own cultural biases (and reduce the imposition of the therapist's worldview on their client), the mindfulness of the collision of diagnostic symptoms and cultural issues, and the willingness to raise the issue of cultural differences between the client and therapist (even though the client may not want to) so that feelings do not remain covert, unacknowledged, and potentially misattributed to diagnosis or prognosis. Perez Foster (1998) warns that a therapist's countertransferential reactions will all eventually be discernible to clients, and at the very least, create an impasse in the therapy, and at worst, lead to premature termination. She asserts that "these silent communications are the phenomena that manifest in the high premature dropout rate for ethnic clients" (p. 255).

Gelso and Hayes (2007) propose five therapist characteristics of self-insight, anxiety management, empathy, self-integration, and conceptual skills (together, compromising the Countertransference Factors Inventory, Van Wagoner, Gelso, Hayes, & Diemer, 1991), believed to be important in the regulation of countertransference reactions. Research has been mixed but generally supportive of these five specific therapist characteristics. Combined with a clear theoretical orientation, it may facilitate in-session management of countertransference so that behavioral manifestations are less likely to occur (Rosenberger & Hayes, 2002). A number of studies confirm that when therapists use empathy, establish trust, and provide culture-specific psychoeducation, Asian American clients not only remain in treatment longer, but are eventually willing to engage in deeper relational exploration (Shonfeld-Ringel, 2001). Although didactic (e.g., increased minority representation and culturally-sensitive teaching materials, supervision) and post-treatment efforts (e.g., self-analysis) are the most frequently recommended approaches to race and countertransference, Holmes (1999) emphasizes that neither is sufficient alone.

Limitations and Future Directions

A small sample exploratory study such as this, with limited power, a primary reliance on effect sizes only, and a lack of a randomized control group, has poor external validity and cannot be generalized to the greater population. In addition, the participants were recruited mostly from an internet- and email-using population and the therapists working with Asian clients may represent a distinct population, e.g., those who work in community psychology or with predominantly Asian clients. Obviously, limiting this study's statistical analyses to effect sizes

only restricts us to making conclusions about the magnitude of differences between groups or the relationship between variables and does not add to our knowledge about estimates of probability. Furthermore, although Cohen's (1988) benchmarks for what constitutes small, medium, and large effects are well-accepted and widely used, even Cohen himself voiced concerns over their blanket use, especially when even small effect sizes can translate into large practical or clinical differences. Some of the conclusions found in this study may be artifacts of the sample. For example, early career, young therapists may be more susceptible to socially desirable responding particularly on sensitive social issues such as racial attitude, be less aware of their affective countertransference reactions due to inexperience, be more likely to experience noncultural countertransference originating from skill deficits, and be less experienced with Asian American clients, regardless of their own ethnicity. The predominance of early career therapists may be problematic in this research design particularly since researchers found a significant relationship between years of professional experience and degree of countertransference (McIntyre & Schwartz, 1998). One variable that was not examined carefully in this study (beyond the level of a descriptive demographic) is SES. Since SES can often be related to number of sessions (e.g., community clinic versus private office settings, insurance coverage of services) as well as race, this would be an important variable to investigate further as it relates to cultural countertransference.

Despite the respectable validity and reliability documented in the literature of the instruments used in this study to measure the primary constructs of countertransference and racial bias, it would also be worth investigating the relative merits of others in future studies due to significant operationalization issues. The TAQ measures only affective forms of countertransference which may have contributed to the lack of statistical findings in this present

study (cf. sexual orientation countertransference studies which found some significant results with behavioral measures). The SAAAS, due to its strong face validity, may have elicited socially desirable responding, particularly in White therapists who likely feel more pressure to respond with politically correct responses to questions clearly measuring racial stereotypes. This tendency may have contributed to a difference in response styles between White and Asian therapists, making the SAAAS a possibly inconsistent measure of racial bias depending on the race of the therapist. Regarding the qualitative data, the lack of Asian therapist participants excluded comparisons between White and Asian therapists. Given more resources, an Asian comparison group to expand our understanding of the data would be beneficial. Both quantitative and qualitative data relied exclusively on self-report data and thereby restricted this study's reliability and validity, particularly for sensitive, potentially stigmatizing phenomena such as racial bias and countertransference. Future research would benefit from other forms of data collection that do not rely exclusively on therapist self-report or on ratings by therapists at all. Direct measurement of the client's transference may help to clarify questions regarding the origins of therapist countertransference and be controlled in future studies. Speaking of biases in research, this researcher's background as an Asian American female may have introduced bias in the creation and interpretation of this study. Just as was recommended for therapists dealing with cross-cultural issues, researchers who study these and related phenomena need to be equally assiduous about their own cultural biases.

Remedies for the limited quantitative data may be difficult to find even in future studies given the numerous permutations of White-Asian therapy dyads, in addition to the exclusionary criteria (English-speaking dyads only) in a population that is already small at the outset (i.e., Asian clients in psychotherapy). Depending on resources, future studies may need to limit their

scope to one aspect of this study in order to focus on more extensive data collection that would yield enough power to make conclusions about statistical significance. Fauth (2006), however, proposes that since countertransference is often idiosyncratic and manifested in varied, myriad, and sometimes subtle ways (Gelso & Hayes, 1998), researchers should utilize an idiographic approach in studies with small numbers of participants to capture the necessary depth in a clinically relevant matter though field studies which combine quantitative and qualitative methods.

This study stands in contrast to the majority of studies on countertransference which are laboratory analogues, case studies, or limited to qualitative data only. The presence of medium to large effect sizes supports further research with greater power, but with a shift away from traditional inferential testing toward a more thoughtful and descriptive approach to interpreting results. The primary importance of this research, as intended, is informing subsequent research in this under-researched area and it has been successful in a number of ways. Although the conservative interpretation of statistical analyses did not confirm this study's primary hypothesis, the statistical trends coupled with the qualitative evidence indicate a relationship between racial bias and countertransference in both intra- and interethnic dyads with Asian American clients. Given the reliable relationship found between countertransference and clinically important assessments such as GAF, prognosis, working alliance, and diagnosis, in this study as well as in extant literature, a clearer picture of the influence of racial bias is now needed. The hope is that by aggregating across qualitative research, case studies, and small sample quantitative research, researchers and clinicians can develop heuristics that can be applied to many cases, even for a subjective phenomenon such as cultural countertransference.

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APPENDIX A

Informed Consent

Teachers College, Columbia University
525 W. 120th Street
New York, NY 10027

Statement of Informed Consent

DESCRIPTION OF RESEARCH: As part of research being conducted by an advanced doctoral student at Teachers College, Columbia University, you are invited to participate in a study investigating therapist reactions to their clients. The purpose of this research is to improve our understanding of therapist contributions to psychotherapy outcome. Surveys about therapist experience during and after psychotherapy sessions will be administered. Your participation is entirely voluntary and will require approximately 20 minutes to complete.

RISKS AND BENEFITS: There are no known risks to answering the questions contained in this study beyond those encountered in normal daily living. You may experience some psychological discomfort when answering questions that require reflection about your values, personality, feelings, and behavior. Your participation will inform current understanding about psychotherapy and guide future research in the identification of more effective methods of alleviating psychological suffering. You may choose not to participate at any time without jeopardy to future medical care, employment, student status or other entitlements.

DATA STORAGE TO PROTECT CONFIDENTIALITY: All questionnaires will be identifiable by randomly assigned code numbers only and will not be traceable to any respondent. IP addresses will not be collected or stored. Please be certain to close all browser windows upon completion so that others will not be able to browse back to your responses. Your name will not appear on any materials connected with this study, with the exception of this consent form which will be stored separately from your responses. Any information derived from the research project that personally identifies you will not be voluntarily released or disclosed without your separate consent, except as specifically required by law.

TIME INVOLVEMENT: Your participation will require approximately 20 minutes to answer surveys regarding psychotherapy sessions with two different clients.

HOW RESULTS WILL BE USED: The data from this study will be used for academic papers and may also be published in journal articles and/or presented at conferences. The results will help design future research ultimately aimed at improving psychotherapy delivery and outcome.

QUESTIONS: Please direct any questions about the purposes or procedures of this research to Sherrie Kim at smk2107@columbia.edu, or the sponsoring faculty member, Dr. Barry Farber at farber@tc.columbia.edu or (212) 678-3125. If you have comments or concerns regarding the conduct of this research or questions about your rights as a research participant, please contact the Teachers College, Columbia University Institutional Review Board/IRB. You can call the IRB at (212) 678-4105 or write to IRB at Teachers College, Columbia University, Box 151, 525 W. 120th Street, New York, NY, 10027.

COPY OF THIS INFORMATION: Please print a copy of this consent form for your information.

If you have read and understood this consent form and you are willing to participate in this study, please electronically "sign" by typing your name and clicking on the check box below.

If you would like a summary of the findings of the study when they are available, please type your name and address below (your survey responses will not be linked to this information):

APPENDIX B

Demographic Questionnaire

Therapist Information

Age _____ **Gender** ☐ M ☐ F
Race (Check all that apply)
☐ White/Caucasian ☐ Asian ☐ Black/African American ☐ Latino/a
☐ American Indian/Alaska Native ☐ Other (please specify)
_____
Ethnicity (if applicable) _____

Theoretical orientation (please select one dominant orientation)
☐ Psychodynamic/Psychoanalytic ☐ Cognitive-Behavioral ☐ Behavioral
☐ Interpersonal ☐ Systems ☐ Humanistic/Existential ☐ Biological ☐ Other_____
Training (anticipated, if still in training) ☐ Master's ☐ Ph.D/Psy.D. ☐ M.D.
Years in practice ☐ 0-5 years ☐ 5-10 yrs ☐ 10-20 yrs ☐ 20+ yrs

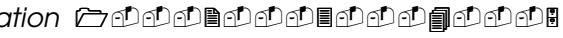
Instructions: For the first set of questionnaires (Client #1), please refer to one Asian American client currently in psychotherapy with you. For the second set (Client #2), refer to the White/Caucasian client you see immediately following this Asian American client (if Asian client is last of the day or next client is not White/Caucasian, select next White/Caucasian client you do see, even if on next business day). If uncertain about client's demographics, estimate or make educated guess based on your perception.

Client #1

Client Gender ☐ M ☐ F
Age ☐ 18-29 ☐ 30-39 ☐ 40-49 ☐ 50-59 ☐ 60+
Race ☐ White/Caucasian ☐ Asian ☐ Black/African American ☐ Latino/a ☐ American Indian/Alaska Native ☐ Other (please specify)_____
Ethnicity (if applicable) _____
Level of acculturation
None/Minimal acculturation *Highly acculturated/Americanized*
Relationship status ☐ Single/Never Married ☐ Married/Partnered ☐ Divorced ☐ Widowed
Highest level of education ☐ Less than High School ☐ High School/GED ☐ College
SES (approximate) ☐ Lower ☐ Middle ☐ Upper
Diagnosis/es _____
Current Global Assessment of Functioning/GAF _____
Approximate # of months in treatment with you _____
Rate this client's current prognosis *Poor* *Excellent*
Rate your working alliance with this client *Poor* *Excellent*

Client #2

Client Gender ☐ M ☐ F
Age ☐ 18-29 ☐ 30-39 ☐ 40-49 ☐ 50-59 ☐ 60+

Race ☐ White/Caucasian ☐ Asian ☐ Black/African American ☐ Latino/a ☐ American Indian/Alaska Native ☐ Other (please specify)_____
Ethnicity (if applicable) _____
Level of acculturation
None/Minimal acculturation  *Highly acculturated/Americanized*
Relationship status ☐ Single/Never Married ☐ Married/Partnered ☐ Divorced ☐ Widowed
Highest level of education ☐ Less than High School ☐ High School/GED ☐ College
SES (approximate) ☐ Lower ☐ Middle ☐ Upper
Diagnosis/es _____
Current Global Assessment of Functioning/GAF _____
Approximate # of months in treatment with you _____
Rate this client's current prognosis *Poor*
 *Excellent*
Rate your working alliance with this client *Poor*
 *Excellent*

APPENDIX C

Therapist Appraisal Questionnaire

Directions: Please complete the sentence, "When working with my client, I felt..." according to your reactions in your session this week toward this particular client. It is important that you rate the items based on the therapy session you conducted with this particular client this week, rather than on your feelings about therapy in general or any of your other clients.

Please indicate your agreement with each item according to the following scale:

Not at All	Slightly	Somewhat	Moderately	Quite a bit	A Great Deal
0	1	2	3	4	5

When working with my client, I felt...

1.	Happy.	0	1	2	3	4	5	12.	Sad.	0	1	2	3	4	5
2.	Confident.	0	1	2	3	4	5	13.	Hopeful.	0	1	2	3	4	5
3.	Angry.	0	1	2	3	4	5	14.	Pleased.	0	1	2	3	4	5
4.	Energetic.	0	1	2	3	4	5	15.	Anxious.	0	1	2	3	4	5
5.	Disappointed.	0	1	2	3	4	5	16.	Guilty.	0	1	2	3	4	5
6.	Eager.	0	1	2	3	4	5	17.	Frustrated.	0	1	2	3	4	5
7.	Worried.	0	1	2	3	4	5	18.	Bored.	0	1	2	3	4	5
8.	Disgusted.	0	1	2	3	4	5	19.	Indifferent.	0	1	2	3	4	5
9.	Excited.	0	1	2	3	4	5	20.	Disinterested.	0	1	2	3	4	5
10.	Exhilarated.	0	1	2	3	4	5	21.	Curious.	0	1	2	3	4	5
11.	Fearful.	0	1	2	3	4	5	22.	Resentful.	0	1	2	3	4	5

APPENDIX D

Scale of Anti-Asian American Stereotypes

The Scale of Anti–Asian American Stereotypes (SAAAS)
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.

0	*1*	*2*	*3*	*4*	*5*
strongly disagree	*moderately disagree*	*slightly disagree*	*slightly agree*	*moderately agree*	*strongly agree*

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

APPENDIX E

Institutional Review Board Letter of Approval

TEACHERS COLLEGE
COLUMBIA UNIVERSITY

OFFICE OF SPONSORED PROGRAMS

Institutional Review Board

May 18, 2011

Dear Sherrie,

Thank you for submitting your study entitled, "*Affective Countertransference Reactions Toward Asian American Clients;*" the IRB has determined that your study is **Exempt** from review [Category **2**].
Please keep in mind that the IRB Committee must be contacted if there are any changes to your research protocol. The number assigned to your protocol is **11-258**. Feel free to contact the IRB Office [212-678-4105 or mbrooks@tc.edu] if you have any questions.

Best wishes for your research work.

Sincerely,

Karen Froud, Ph.D.
Assistant Professor of Speech and Language Pathology
Chair, IRB

cc: File, OSP

APPENDIX F

Recruitment E-mail

Subject Line: Research Study on Psychotherapists

Dear Training Director,

I am recruiting participants for my dissertation study sponsored by Teachers College, Columbia University. I would greatly appreciate if you could take the time to forward this email to clinical psychology/MSW/MFT trainees or clinical staff.

Thank you for your help,

Sherrie Kim, M.S.
Doctoral Candidate
Teachers College, Columbia University

****

As part of a doctoral dissertation at Teachers College, Columbia University, I am conducting a study on psychotherapists and their experience of their clients. If you are a practicing psychotherapist (master's, doctoral, M.D.) or currently receiving supervised clinical training AND *you currently have at least one Asian American client/patient,* you are invited to participate in a brief survey. Your time and contribution to our understanding would be sincerely appreciated. Please click on the link below to participate or for more information about this study. Thank you.

APPENDIX G

Recruitment Listserv/Board Posting

Subject Line: Research Study on Psychotherapists

Are you a practicing psychotherapist (master's, doctoral, M.D.) or currently receiving supervised clinical training? Are you also currently treating any Asian American clients/patients? If so, you are invited to participate in a brief survey study regarding your reactions and attitudes toward clients following psychotherapy. Please click here to be linked to the study or for more information about this study. Thank you.