Therapists' Implicit Bias toward Chinese International Students

by

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Abstract

This study examined therapists' implicit biases toward Chinese international students, including therapists' unfavorable perception, tendency to pathologize their struggles less than those of others, attribution of issues, and report of their own training sufficiency to work with Chinese international students. One-way ANOVA analyses indicated that therapists perceived Chinese international students more favorable and as experiencing higher symptom severity compared to White American students. The results also suggested that therapists may perceive Chinese international students' struggles as more attributable to external factors compared to those of White American students. In addition, the results showed that therapists did not perceive their multicultural training as insufficient to work with Chinese international students relative to training to work with American students. Using a variety of outcome measures, this study indicates that therapists do not perceive Chinese international students and Chinese American students differently. The implications of these findings and areas of further research in the field of counseling and implicit bias are discussed.

Keywords: implicit bias, therapist, Chinese, international student

Table of Contents

List of Tables

Chapter I

Introduction

Research Background

International students are a fast-growing population in the United States, who bring financial benefits to American higher education institutions and their own cultural backgrounds to enrich the diversity of American campuses (Bevis, 2002; Harrison, 2002; IIE, 2018a). International students from China comprise the largest group within the U.S. international student population, with a total of 363,341students enrolled in U.S. higher education in the year of 2017/2018.

Transitioning from one culture to another is not an easy process for international students. The more distance between two cultures, the more challenges take place in this process (Pedersen, 1991). Given the distance between Chinese culture and American culture, as well as the linguistic difference between Chinese language and English language, Chinese international students are facing a great amount of stress and difficulties living in the United States (Hsieh, 2006; Liu, 2009; Parr, Bradley, & Bingi, 1992; Yang & Clum, 1994). Researchers found that Chinese international students tended to struggle with language proficiency, academic stress, loneliness, social isolation, cultural value conflicts, financial stress, discrimination and prejudice, and living logistics (Galligan, 2016; Li, Heath, Jackson, Allen, Fischer, & Chan, 2017; Liao & Wei, 2014; Wu, 2011). Among different challenges, perceived discrimination has a unique influence on Chinese international students (Yeh & Indose, 2003). Stereotypical impressions from individuals in the host culture can lead to domestic students' decreased interest in establishing friendships with Chinese international students, and sometimes even lead to their

increased jealousy and feelings of being threatened (Fiske, Cuddy, Glick, & Xu, 2002; Fiske, Xu, Cuddy, & Glick, 1999; Ruble & Zhang, 2013). Often Chinese international students feel discouraged from taking initiatives in adjusting to the host culture not only due to language and cultural barriers but also due to a feeling of inferiority that is generated (Hsieh, 2006; Mallinckrodt & Leong, 1992). Depression, anxiety, and even posttraumatic stress symptoms are mental health outcomes of the discrimination and prejudice experienced by Chinese international students (Wei, Liang, Du, Botello, & Li, 2015).

Mental health counseling services on campus can serve as a great resource to help Chinese international students better adjust to the local culture and decrease the prevalence of mental health issues in this population. However, research has shown that there has been low utilization of mental health counseling services among international students, and even those who used the services tend to drop out after the first or intake session (Abe, Talbot, & Geelhoed, 1998; Anderson & Myers, 1985; Dillard & Chisolm, 1983; Nilsson, Berkel, Flores, & Lucas, 2004; Pedersen, 1991; Sandhu, 1994; Sue, McKinney, Allen, & Hall, 1974; Surdan & Collin, 1984). Researchers have made some efforts to better understand the barriers of utilizing the mental health counseling services among Chinese international students. They have found different contributing factors, including low exposure to the counseling services, low self-perceived need for the services, perceived shame associated with utilizing the services, stigmas related to mental health issues, gender, acculturation level, financial confidence, prior counseling experience, and openness to emotions (Hyun, Quinn, Madon, & Lustig, 2007; Komiya & Eells, 2001; Li, Wong, & Toth, 2013; Yoon & Jepsen, 2008; Zhang & Dixon, 2003). While researchers have focused on factors from clients that affect the utilization of mental health services, they

have not yet devoted enough attention to better understand the role of therapist factors in this equation (Heng, 2018; Leong & Chou, 1996).

The influence of therapist factors on the effectiveness of psychotherapy has been a popular topic among psychologists. As evidenced by a review of past research about therapist effect, it can account for up to 10% variance in therapy outcome (Baldwin & Imel, 2013; Saxon, Firth & Barkham, 2017). There were numerous research studies that examined how therapists can affect the treatment process. For instance, researchers found conflicting results about the effect of therapists' training, education, treatment modality, and clinical experience on producing positive therapy outcome (Beutler et al., 2010; Webb, DeRubeis, & Barber, 2010; Okiishi, Lambert, Nielsen, & Ogles, 2003; Okiishi et al., 2006; Podell, et al, 2013; Prout & DeBerard, 2017;). In addition, some researchers found that therapists' emotions and emotional awareness have potential positive effects on therapy outcome (Jennings & Skovholt, 1999; Shamoon, Lappan, & Blow, 2017; Yulis & Kiesler, 1968). Therapists' directness, gender, relationship status, religiosity, accent, racial identity attitudes, ethnicity, and attractiveness were found to affect therapy outcome (Berman, Stark, Cooperman, & Wilhelm, 2015; Cabral & Smith, 2011; Cash, Begley, McCown, & Weise, 1975; Cavior & Glogower, 1973; Ditmar, 1980; Fuertes et. al, 2012; Lewis & Walsh, 1978; McAleavey & Castonguay, 2014; Okiishi et al., 2003; Okiishi et al., 2006; Prout & DeBerard, 2017; Rae, 1975). The most researched therapist factors, empathy and ability to build therapeutic alliance, proved to play a major role in increasing the effectiveness of psychotherapy (Arnow et al. 2013; Cameron, Rodgers, & Dagnan, 2017; Elliott & Bohart, 2011; Goldman, Hilsenroth, Owen, & Levy, 2018; Graves et al., 2016; Mattos, Schmidt, Henderson, & Hogue, 2017; Moyers, Houck, Rice, Longabaugh, & Miller, 2016; Podell, et al, 2013; Rubel, Bar-Kalifa, Atzil-Slonim, Schmidt, & Lutz, 2018; Schwartz, Hilbert,

Schlegl, Diedrich, & Voderholzer, 2018; Tasca, Compare, Zarbo, & Brugnera, 2016). Given the important role therapists' attitudes toward clients play in producing therapy outcome, it is essential to further examine therapists' bias (implicit and explicit) towards clients and the effect of biases on the treatment process.

There are two kinds of biases: implicit bias and explicit bias (Boysen, 2009; Fazio, 1990; Greenward & Banaji, 1995). Explicit bias is a bias that occurs on our conscious level, is intentional, and can be measured by an individual's self-report. Implicit bias, on the other hand, is a bias that occurs without one's conscious intention, is automatic, and is difficult to be measured through self-report. Given the nature of these two biases, it is easy for one to monitor their explicit bias, but harder for one to change their implicit bias.

Therapists are not immune from biases, and sometimes these biases present themselves in different ways (e.g., microaggression) in therapy sessions. Numerous researchers have explored therapists' implicit and explicit biases toward minoritized clients and their effects on the therapy outcome. For instance, therapists tend to have negative perceptions of clients who identify as ethnic minorities, sexual orientation minorities, and gender minorities as a result of their own biases (Abreu, 1999; Boysen & Vogel. 2008; Owen, Tao, Imel, Wampold, & Rodolfa, 2014; Owen, Tao, & Radolfa, 2010; Shelton & Delgado-Romero, 2013). These negative perceptions include negative stereotypical impressions toward certain minority groups. In addition, Pearce (1994) found that compared to Asian, Jewish, and West Indian clients, counselors-in-training tended to perceive White clients as more helpful, friendlier, and warmer. Unsurprisingly, clients can perceive these biases in therapists, which negatively affects the working alliance between therapists and clients, clients' satisfaction in therapy, depth of the session, clients' psychological well-being, and therapy outcome (Owen et al., 2014; Owen et al., 2010; Shelton & Delgado-

Romero, 2013; Tao, Owen, Pace, & Imel, 2015). These therapists' negative implicit biases can often result in lower working alliance, lower clients' satisfaction, decreased session depth, decreased treatment effectiveness, and decreased client psychological well-being (Cabral & Smith, 2011; Constantine, 2007; Owen, Imel, Tao, Wampold, Smith, & Rodolfa, 2011; Owen et al., 2014; Owen et al., 2010; Tao et al., 2015; Shelton & Delgado-Romero, 2013).

One of the limitations of these research studies is the focus on therapists' biases toward minority clients who identify as Americans and the exclusion of international individuals. No known research has explored therapists' biases toward international students, including Chinese international students. It is possible that therapists' implicit biases toward Chinese international students is different from their biases toward American ethnic minorities, since very little graduate training exists to help therapists better understand and serve international students (Yoon & Portman, 2004).

To better understand Chinese international students' underutilization of mental health services, and to bridge the gap in literatures about therapist factors, an examination of therapists' implicit bias towards Chinese international students warrants our attention. A literature review on bias, prejudice, and discrimination generated four elements that could evidence potential negative therapist implicit bias towards Chinese international students.

The first element is stereotypical impressions towards Chinese international students. According to Pearce (1994), counselors-in-training tended to perceive White clients in a more favorable manner compared to how they perceive Asian, Jewish, and West Indian clients. In addition, several studies indicated that therapists' negative bias can be extended to clients who identify as ethnic minorities, sexual orientation minorities, and gender minorities, compared to clients who are with majority statuses (Abreu, 1999; Boysen & Vogel. 2008; Owen et al., 2014;

Owen et al., 2010; Shelton & Delgado-Romero, 2013). Research also shows that international students from Asia, Africa, Latin America, and the Middle East countries reported more experience of discrimination than their counterparts from European countries (Hanassab, 2006; Lee & Rice, 2007; Poyrazli & Lopez, 2007). Finally, Ruble and Zhang (2013) also found negative stereotypes toward Chinese international students among American students. These stereotypical impressions including socially awkward, shy, quiet, oblivious, and annoying.

The second factor is the tendency to pathologize Chinese international students' presenting concerns less than that of other groups. Sue (2010) suggested that the invisibility culture towards international students often contributed to negligence in recognizing the struggles and difficulties international students experienced, which indicated a perception of this group as unnoticeable and insignificant. For example, international students reported experiences of being ignored, talked over, and dismissed in their interaction with American students (Hsieh, 2007; Lee & Rice, 2007). In addition, research shows that international students' perspectives were often ignored and invalidated in classroom settings (Diangelo, 2006; Poyrazli & Grahame, 2007). Results from different research studies indicated that Asian international students tend to feel invisible, unwanted, and unacknowledged on campus (Houshmand, Spanierman, & Tafarodi, 2014; Hsieh, 2007; Kim & Kim, 2010). Furthermore, Asian international students reported experiences in which their American White peers were insensitive to their needs. Similarly, Constantine and colleagues (2005) found that Asian international students reported their concerns and difficulties were minimized and ignored. Hence, it is likely that Chinese international students' needs and struggles are not recognized, which can lead to therapists pathologize this population less than they pathologize Chinese American and White American students.

The third factor is therapists' problematic attribution of Chinese international students' struggles. Scholars proposed that people tend to attribute outgroup individuals' successes to external factors and failures to internal causes (Agroskin & Jonas, 2010; Fristche, Jonas, & Fankhanel, 2008; Heider, 1958; Pettigrew, 1979; Weiner, 1985). Research studies found this internal attribution of others' struggles in people's attitudes towards transgender individuals, ethnic minorities, individuals from lower SES, AIDS victims, elders, and immigrants (Anderson, 1992; Appelbaum, 2001; Cozzarelli, Wilkinson, & Tagler, 2001; Erber & Danker, 1995; Ferris, Yates, Gilmore, & Rowland, 1985; Hughes & Tuch, 2000; Hunt, 1996, 2007; Masuoka & Junnm, 2013; Sniderman & Hagan, 1985; Winter, 2008). This internal attribution bias towards outgroup members is also related to prejudice and discrimination towards the group (Gill & Andreychik, 2007; Gill et al., 2013). Research studies have evidenced this relationship when it comes to attitudes towards AIDS victims, transgender individuals, and immigrants (Dalbert, 2009; Furnham, 2003; Grant et al., 2011; Harell, Soroka, & Iyengar, 2017; Johnson, Mullick, & Mulford, 2002; Mulford & Lee, 1996; Symonds, 2010; Thomas, Amburgey, & Ellis, 2016). Given Chinese international students' outgroup status in the United States, in terms of nationality, ethnicity, culture, and native language, it is likely that therapists will present with an internal attribution tendency towards this group when it comes to challenges or problems. This tendency can serve as evidence for prejudice and negative bias towards this group.

The fourth factor is therapists' perception of their training sufficiency in treating Chinese international students. Psychology as a field has paid little attention to increasing therapists' cultural competency to work with international students. A majority of the effort in therapist training and education has focused to helping therapists learn how to work with minoritized Americans. Scholars have pointed out that international students' concerns and struggles were

not included in multicultural training programs or multicultural textbooks (Arthur, 2008; Diangelo, 2006; Fouad, 1991; Yoon & Portman, 2004). In addition, there has been limited literature that explores how to train therapists to provide appropriate treatment to international students. This lack of attention provided evidence for the lack of effort psychology as a field puts into better understanding international students. Hence, it is quite possible that therapists were not well prepared to work with Chinese international students in therapy.

Statement of the Problem and Research Hypotheses

Chinese international students face more challenges compared to their American counterparts and are in need of the assistance of mental health treatment. Despite this need, Chinese international students tend to underutilize mental health services on campus. It is essential for scholars and practitioners to understand different factors, including therapist factors, that contribute to this underutilization. But research studies have exclusively focused on clients' internal factors and no known research studies have examined therapist factors on this issue. Several scholars proposed that it is essential for therapists to reflect on and increase their self-awareness of values and biases when working with international students to provide more effective and culturally sensitive treatment (Arredondo, 1998; Arthur, 2008; Jacob & Greggo, 2001). Hence, this study was designed to examine one of the potential therapist factors in providing mental health counseling services to Chinese international students. More specifically, because prior research shows that therapists' implicit bias has a negative effect on therapy process, therapy outcome, and essentially the clients, this study will focus on exploring therapists' implicit bias toward Chinese international students.

Below are the hypotheses of this study:

- Therapists will rate the Chinese-international-student client in a less favorable manner compared to how they rate the Chinese-American-student and White-American-student clients.

- Therapists will pathologize the Chinese-international-student client more than they pathologize the Chinese-American-student client and the White-American-student client.

- Therapists will perceive the Chinese-international-student client as more responsible for their presenting concerns than how they perceive a White-American-student and Asian-American-student clients. Therapists will perceive the circumstance as less responsible for Chinese-international-student client's presenting concerns.

- Therapists will report their training as less sufficient in preparing them to provide treatment to a Chinese-international-student client than that to Chinese-American-student and White-American-student clients.

Significance of the Study

Even though multiple research studies have explored barriers for Chinese international students to utilize the mental health counseling services (Hyun et al.; Komiya & Eells, 2001; Li et al., 2013; Yoon & Jepsen, 2008; Zhang & Dixon, 2003), they tended to focus on the contributing factors from the client's side. It is possible that therapist factors influence clients' utilization of the mental health services. This exploration of implicit bias as a potential therapist factor on clients' underutilization of services can help scholars and practitioners to better understand Chinese international students' experience in therapy.

9

Increasingly, social science researchers are attending to the influence of therapists' implicit biases on therapy process, therapy outcome, and clients (Owen et al., 2014; Owen et al., 2010; Shelton & Delgado-Romero, 2013; Tao, Owen et al., 2015). However, these research studies examined therapists' implicit biases toward American clients with minority status. To date, no known research has examined therapists' implicit biases toward international students, including Chinese international students. Hence, by exploring therapists' implicit biases toward Chinese international students, this study will bring more light into this area. This continuous effort can potentially expand our knowledge about therapists' implicit biases toward different populations.

Although psychology as a field has put forth a great amount of effort into multicultural training to help therapists better understand their bias against minority groups in America, so far it has paid little attention to help increase therapists' awareness of their biases toward international students (Arthur, 2008; Yoon & Portman, 2004). It is possible that therapists harbor biases that are not within the scope of their training and are not discussed. By providing more detailed information about therapists' implicit bias toward Chinese international students, this study can help inform scholars when developing training programs that target increasing therapists' multicultural counseling competency in working with Chinese international students.

Chapter II

Literature Review

Chinese International Students

More and more students from different countries all over the world are coming to the United States for their undergraduate and graduate education. According to Open Door (IIE, 2018a), there are 1,094,792 international students currently studying in American higher educational institutions. Since 1948, the percentage of international students enrolled in U.S. higher education institutes increased from 1.1% to 5.5%. Among international students' places of origin, China has been a leading country-of-origin with 363.341 total of students enrolled in U.S. higher education in the year of 2017/2018, which represents an increase of 3.6% from the year prior and 33.2% of the international student population (IIE, 2018b). International students not only bring financial benefits to the United States higher education, but also bring their own cultural backgrounds to enrich the American campuses by increasing diversity and cultural awareness (Bevis, 2002; Harrison, 2002).

Difficulties experienced by Chinese international students. Adjusting to a new environment and a new culture can be a very difficult process. Schlossberg pointed out that cross-cultural transition involves challenges on individuals' assumptions about the world, themselves, and others (as cited in Arthur, 2008, p. 279). Given the cultural distance between Chinese and American culture, Chinese international students face challenges managing conflicting values in addition to completing their own developmental tasks (Han, Han, Luo, Jacobs, & Jean-Baptiste, 2013; Jones & Kim, 2015; Pedersen, 1991; Quach, Todd, Hepp, & Mancini, 2013). Numerous researchers have explored the difficulties experienced by Chinese international students studying and living in the United States.

Academic success is one of the major stressors for Chinese international students because it is one of their main goals for coming to America. With international students' expectations for themselves to perform as well as they did in their home country academically, as well as the expectations for academic success from family and sponsors back home, academic stress can create substantial adjustment difficulties for them (Chen, 1999; Mori, 2000; Pedersen, 1991). Liberman's (1994) research study showed that Asian international students experienced difficulty adjusting to the interactive teaching style and critical thinking approach in Western education system. Other researchers also found that Chinese international students facing challenges in their process of transitioning to American academic expectations (Constantine, Kindaichi, Okazaki, Gainor, & Baden, 2005; Galligan, 2016; Hsu, 2003; Lu & Han, 2010). The result of Heng's (2018) qualitative study indicated that Chinese international students experience academic challenges, specifically in language and communication, adjusting to "western" thinking style, and managing classroom expectations. Heng also found that Chinese international students' personal history as well as the sociocultural context—different cultural expectations between living in China and living in America—contributed to these challenges.

Language barrier is another source of the adjustment difficulties experienced by Chinese international students. Having a different native language in a different society can impact their academic performance, social connection, and overall adjustment. For example, studies have shown that English language proficiency was positively correlated with international students' academic success (Andrade 2006; Chen, 1999; Constantine et al., 2005; Mori, 2000; Poyrazli, Arbona, Bullington, & Pisecco, 2001; Poyrazli & Kavanaugh, 2006; Stoynoff, 1997; Yeh & Inose 2003; Zhang & Brunton, 2007). Furthermore, English proficiency can affect international students' social life: English language proficiency was positively correlated with international

students' local social connections, and was a predictor for sociocultural adjustments of international students (Andrade 2006; Barratt & Huba, 1994; Chen, 1999; Mori, 2000; Poyrazli et al., 2001; Wu, 2011; Yeh & Inose 2003; Zhang & Goodson, 2011). Although English proficiency is one of the biggest challenges faced by international students in general, it did not predict Chinese international students' adjustments in Swagler and Ellis's (2003) research study. Rather, communication apprehension as well as social contacts with individuals from the host culture and with individuals from similar cultural backgrounds were significant predictors for Chinese international students' overall adjustment. Yao (2016) also found that among Chinese international students, English language proficiency can either serve as a bridge or a barrier for their social connection with domestic students, which affects their sense of belonging on campus. In addition, low English language proficiency can be a main source of frustration for Asian international students when they attempt to build social connection with domestic peers (Briguglio & Smith, 2012; Li, Chen, & Duanmu, 2010).

Chinese international students also encounter stress related to their sociocultural adjustment. Social isolation, loneliness, and homesickness are part of the challenges they face living in the United States. Compared to their domestic counterparts, international students reported feeling less affiliated and connected to their campus (Lee & Rice, 2007; Smith & Khawaja, 2011). Redmond and Bunyi (1993) also found that Asian international students tended to be less integrated to their campus than did their fellow international students from European countries. In addition, Asian international students often experience insufficient social support in America being from a collectivistic culture and being far away from their family and friends, which can result in feeling emotionally deprived (Lee, Koeske, & Sales, 2004; Liberman, 1994). Being in a new culture, with the lack of familiar friends and linguistic environment, international

students reported feeling lonely living in America (Constantine et al., 2005; Galligan, 2016; McClure, 2007; Sherry, Thomas, & Chui, 2010; Wu, 2011). Although establishing a local support system can be a great solution to Chinese international students' social isolation, there are barriers for them to form their social connections locally. The large cultural distance between Chinese and American culture often leads to negative social interactions between Chinese international students and domestic students (Hanassab, 2006; Lee & Rice, 2007; Redmond & Bunyi, 1993; Smith & Khawaja, 2011). This could result in Chinese international students' tendency to socialize more frequently with their fellow international students from China and other countries than with their American peers (Cheung, 2010; Gareis, 2012; Glass, Gómez, & Urzua 2014; Trice, 2004). Domestic students' assumption of their own cultural superiority can be contributing factor to Chinese international students' social integration difficulty (Hsieh, 2006). Research found that domestic students are often disinterested in forming friendships with international students, which discouraged Chinese international students from initiating social connections with domestic students (Gareis, 2012; Glass et al., 2014; Lacina, 2002; Lee & Rice 2007; Marginson, 2012; Rose-Redwood & Rose-Redwood, 2013; Ward, Bochner, & Furnham, 2001). In addition, domestic students tend to expect Chinese international students to assimilate to the host culture and are less likely to socialize with those who are not (Imamura & Zhang, 2014; Smith & Khawaja, 2011).

Discrimination is another main contributor to Chinese international students' adjustment difficulties. Research studies found that international students from countries in Asia, Africa, Latin America, and the Middle East reported more perceived discrimination in the United States than that experienced by domestic students and international students from European countries (Hanassab, 2006; Lee & Rice, 2007; Poyrazli & Lopez, 2007). More specifically, international

students who were from East Asia, India, Latin America, and the Middle East

reported experiences of being treated as inferior, receiving direct verbal insult, being

discriminated against when seeking employment, and being physically attacked in America.

These experiences occurred in international students' social interaction on-campus with faculty

and administrative staff as well as in their social interaction off-campus, such as housing and

shopping (Bonazzo & Wong, 2007; Poyrazli & Grahame, 2007). In another study, Asian

international students reported experience of microaggression, including being socially avoided

and excluded, ridiculed for their accent, disregarded of their values and needs, and treated as

invisible and unwanted (Houshmand et al., 2014). It is possible that racism among individuals

from host country contributed to these reported experiences among Asian international students.

For example, Brown and Jones (2013) as well as Mills (2018) reported that international students

had experiences of racism in Australia and United Kingdom. Lee (2015) also pointed out that

international students in the United States encountered neo-racism: international students of

color were treated unfairly based on their countries of origin in addition to their skin color.

Regarding stereotypical impressions toward Chinese international students, both Heng's

(2018) and Ruble and Zhang's (2013) research studies revealed a mix of positive and negative

stereotypical impressions. These stereotypical impressions including smart, hardworking,

studious, polite, dependent and passive, with low English proficiency, only friends with other

Chinese students, socially awkward, shy, quiet, oblivious, uncritical thinkers, rote learners, loud,

and annoying. These stereotypical impressions could lead to American students' increased

communication anxiety and decreased levels of willingness to communicate with Chinese

international students. In addition, the stereotypes of Chinese international students being smart

and hardworking can lead to American students' feelings of jealousy and being threatened

because of the perceived competitiveness (Fiske et al., 2002; Fiske et al., 1999). Hsieh (2006) also pointed out that the assumption of the superiority of American culture from some individuals in the host culture (a form of prejudice) can discourage Chinese international students from participating in the host society, make them feel inferior, and restructure their own identities based on this exclusion from the host society. Lowinger, He, Lin, and Chang (2014) also found other consequences of these stereotypical impressions toward Chinese international students: perceived discrimination can predict Chinese international students' procrastination behavior, which could lead to more academic stress. Because of Chinese international students' tendency to minimize discrimination they experienced to protect their self-esteem and self-efficacy in the short term (Owen, 2002), combined with the tendency of avoiding interpersonal conflicts and introverted inclinations of Chinese culture (Yip, 2005), it is possible that the perceived discrimination and prejudice reported so far is an underrepresentation of the real magnitude of discrimination and prejudice experienced by Chinese international students.

Chinese international students' mental health struggles. As a result of various adjustment difficulties living in the United States, Chinese international students struggle with mental health issues. Mitchell, Greenwood, and Guglielmi (2007) found that compared to their domestic peers, international students were more likely to endorse suicidal ideation, report experience being harassed, have previous hospitalization experience due to psychiatric issues, present with cultural concerns and academic concerns, report difficulty with emotional expression, present with grief issues and loneliness, and be diagnosed with adjustment disorder. Cheung's (2010) study also revealed that almost half of the Chinese international student participants reported experience of depression symptoms. Similarly, Han and colleagues (2013) found that Chinese international students were at great risk of developing mental health problems

due to cross-cultural adjustment issues, with symptoms including anxiety and depression. In Nilsson and colleagues' (2004) study, depression was the most common complaint among international students with 34% endorse rate. Furthermore, serious mental health issues exist among Chinese international students, including psychotic breaks, suicidality, schizophrenia, severe depression, and anxiety-phobia related syndromes (Oropeza, Fitzgobbon, & Baron, 1991). Cheng, Leong, and Geist (1993) also found that Asian international students tended to present with more obsessive-compulsive symptoms compared to their American domestic counterparts. Contributing factors to these mental health issues include maladaptive perfectionism, low self-esteem, intercultural competence, etc. (Wang, Heppner, Fu, Zhao, Li, & Chuang, 2012; Wei et al, 2007; Wilton & Constantine, 2003). Following is a more detailed discussion about influential factors on Chinese international students' mental health issues.

As mentioned earlier in this chapter, academic challenges are one of Chinese international students' major struggles. Research studies found that academic stress was negatively associated with Chinese international students' positive emotions, predicted long-term psychological distress, and affected their socialization in the host country (Heng, 2018; Liao & Wei, 2014; Lu & Han, 2010; Rasmi, Safdar, & Lewis, 2009). However, Misra and Castillo (2004) did not find difference between international students and American students in experienced academic stress. With the finding that American students reacted more behaviorally to the academic stress they encountered, it is possible that some of international students' academic performance related distress went undetected (Misra & Castillo, 2004). Functional and positive relationship with advisor can be a protective factor for the aforementioned mental health symptoms among Chinese international students (Han et al., 2013; Hyun et al., 2007).

A language barrier can be contributing factor to Chinese international students' mental health struggles. Research studies showed that international students' English proficiency was predictive of their academic adjustment, social adjustment, and experienced acculturative stress (Duru & Poyrazli, 2007; Poyrazli et al., 2001; Poyrazli & Kavanaugh, 2006; Poyrazli, Kavanaugh, Baker, & Al-Timimi, 2004; Yeh & Inose, 2003). In addition, international students' English proficiency can serve as a source for psychological challenges, including depression, anxiety, self-esteem, and psychological adjustment in the host country (Barratt & Huba, 1994; Kones & Kim, 2015; Sumer, Poyrazli, & Grahame, 2008; Zhang & Goodson, 2011). As part of the international student group, Chinese international students also experience mental health challenges related to their language proficiency. For instance, Yao (2016) found that low English proficiency in Chinese international students can serve as a barrier for building social connections on campus and hence decrease their sense of belonging living in America. In addition, research studies discovered that Chinese international students' English and host country language proficiency were significant predictors of their local social connection and global competence, which can affect their social and academic adjustment in the host country (Cao, Zhu, & Meng, 2017; Meng, Zhu, & Cao, 2018). Furthermore, Dao, Lee, and Chang' (2007) study revealed that Chinese international students' English language proficiency was positively related to their depression symptoms.

Social isolation in an unfamiliar environment can also negatively affect Chinese international students' mental health. Research showed that international students' social support and social connectedness can predict depression, anxiety, and acculturative stress (Sumer et al., 2008; Yeh & Inose, 2003). In addition, among Chinese international students, local social contact and satisfaction with their social support network can serve as a protective factor against

18

adjustment difficulties and perceived discrimination (Swagler & Ellis, 2003; Ye, 2006). Wei and colleagues (2015) also found that social connection with their own ethnic group can buffer the association between depression and perceived language discrimination in Chinese international students. Furthermore, a balanced social support from host culture and other Chinese international students has a positive association with Chinese international students' initial overall adjustment in the United States (Wang et al., 2012).

According to Jones and Kim (2015), similarities between international students' home culture and host culture can influence their psychological adjustment as well—the more differences between the two cultures, the more difficult the adjustment process for international students. With the large distance between Chinese and American culture, the acculturation process is another source of mental health issues for Chinese international students living in the United States. For instance, Constantine and colleagues (2005) found that conflicts between international students' own cultural value and the host country's cultural value can result in experience of loneliness, sadness, and anxiety. Other research studies also revealed a positive relationship between acculturative stress and depression symptoms among Asian international students (Dao et al., 2007; Lee et al., 2004; Yang & Clum, 1995; Ying & Han, 2006; Wilton & Constantine, 2003). In addition, Wang and Mallinckrodt's (2006) research showed that Chinese international students' attachment style together with their acculturation process to the mainstream American culture served as a significant predictor for their psychological adjustments living in the United States. Similarly, Li and colleagues (2013) discovered that Chinese international students' cultural assimilation to the host culture can predict their psychological well-being.

Discrimination can also have a negative effect on Chinese international students' mental health. Research studies about international students showed that perceived discrimination was predictive of depression symptoms, identity issues, homesickness, adjustment issues, and acculturation difficulties (Jung, Hecht, & Wadsworth, 2007; Poyrazli & Lopez, 2007; Sodowsky & Plake, 1992; Surdan & Collins, 1984). Other researchers also found positive relationship between Asian international students' experience of perceived discrimination and various psychological distress (Atri, Sharma, & Cottrell, 2006; Wei, Ku, Russell, Mallinckrodt, & Liao, 2008; Wong, Tsai, Liu, Zhu, &Wei, 2014). In addition, according to Porazli and Lopez (2007), Asian international students experienced higher level of perceived discrimination compared to their counterparts from European countries. More specifically, Wei and colleagues' (2015) research study showed that when Chinese international students perceived the discrimination and prejudice based on stereotypical impressions, they became at higher risk for depression, anxiety, and posttraumatic stress symptoms.

In summary, Chinese international students face more challenges adjusting to and living in the United States than their American domestic peers. These challenges result in various mental health issues in this population, which makes mental health service an important pillar in supporting Chinese international students' success in American higher education institutions.

Mental health counseling services and Chinese international students. Given Chinese international students' challenges living in the United States and mental health issues experienced as a result, mental health counseling services on campus could be a very helpful resource for this population. However, both Nilsson and colleagues (2004) as well as Hwang and colleagues (2014) reported that an underutilization of mental health counseling services among international students. Other researchers also found that international students were reluctant to

seek out help from mental health counseling services on campus even when the service is free (Abe et al., 1998; Dillard & Chisolm, 1983; Pedersen, 1991; Sandhu, 1994; Surdan & Collin, 1984). More specifically, compared to domestic students in the United States, international students were less likely to self-refer to mental health counseling services; rather, they were more likely to be referred by a faculty or a staff member (Mitchell et al., 2007). Consistent with the these findings, other researchers also discovered that Chinese international students were less likely to seek out help from the mental health services compared to domestic students (Cheung, 2010; Mau & Jepsen, 1988, 1990). Li and colleagues (2017) conducted a qualitative research and found that compared to mental health counseling services, Chinese international students tended to seek out help from peers and other on-campus organizations. Furthermore, even when Asian international students seek out mental health treatment, they were more likely to focus on academic complaints despite their emotional difficulties (Cheng et al., 1993).

Among those international students who sought out help, researchers have different findings regarding their dropout rates. Anderson and Myers (1985) as well as Sue and colleagues (1974) found that there was a higher dropout rate among international students compared to that among domestic students. However, Nilsson and colleagues (2004) found that even though one third of international students who utilized the mental health services tended to no-show for follow-up sessions, the rate was similar to that of domestic minority students. Hwang and colleagues (2014) had most promising findings about dropout rates: among the international students who sought out help, 77% attended follow-up sessions. Regardless, it is clear that international students underutilize the mental health counseling services on campus despite the amount of struggles they experience.

Contributing factors to the underutilization of mental health services among

Chinese international students. There are some similarities between the barriers for Chinese international students and those for domestic students to utilize mental health services, such as stigma about mental health, gender, and perceived needs. However, some barriers are unique to Chinese international students—level of acculturation, low exposure to the services, language proficiency concerns, and so on (Eisenberg, Hunt, & Speer, 2012). To better understand Chinese international students' low utilization of the mental health services, researchers have conducted studies to examine the specific factors and barriers.

Lack of knowledge about the mental health counseling services is one of the barriers found by researchers. In Yoon and Jepsen's (2008) study, Asian international students reported less exposure to mental health counseling. Han and colleagues (2013) also found that 27% of Chinese international students were not aware of the mental health counseling services available on campus, which contributed to the low utilization of the service.

Acculturation level is another potential contributing factor to the underutilization of mental health services. Zhang and Dixon (2003) found a positive relationship between Asian international students' level of acculturation to mainstream American culture and their attitudes toward utilizing mental health services. They discovered that more acculturated Asian international students experience higher confidence in mental health professionals. Li, Marbley, Bardley, and Ian's (2015) research study also revealed a positive relationship between Chinese international students' acculturation level and their attitudes toward seeking out professional mental health help. In addition, these researchers found that the stronger their Chinese identity, the less likely Chinese international students would seek out counseling services. However, Wu's (2011) disagreed with these findings. This research study found that there was no significant

relationship between Chinese international students' acculturation level and their attitudes toward utilizing mental health services. Hence, it is unclear how much influence Chinese international students' acculturation level has on their likelihood of seeking out mental health treatment.

Another internal barrier is Chinese international students' self-perceived seriousness of the struggles. Mau and Jepsen (1990) found that even though there was no difference in the issues encountered by Chinese international students and domestic students, Chinese international students tended to perceive these issues as less serious compared to their American domestic peers. This differential perception resulted in less frequent use of mental health services among Chinese international students than that among American students. Similarly, a research study conducted by Yoon and Jepsen (2008) showed that Asian international students tended to have less self-perceived need for mental health counseling compared to their domestic counterparts. These findings indicate that it is likely for Chinese international students to struggle with the similar, if not more serious, issues as domestic students; however, Chinese international students tend to see their problems as less serious and are more likely to handle the struggles by themselves instead of seeking out help from mental health services.

Researchers also found other factors that could potentially contribute to the underutilization of mental health services among Chinese international students. For instance, Li and colleagues (2015) found that Chinese international students' English proficiency was positively associated with their willingness to seek out mental health treatment. Previous experience in mental health treatment is also an important predictor for the likelihood of utilizing mental health services among Chinese international students (Komiya & Eells, 2001; Li et al., 2013; Wu, 2011). In addition, Spencer and Chen (2004) discovered that as English language

learners, international students who had experience of discrimination based on language were 2.2 times more likely to see out informal services (e.g. fortune teller) versus formal services (e.g. counseling center) for mental health issues compared to those without language discrimination experience. Other predicting factors including financial confidence, academic stress, romantic relationship status, openness to emotions, perceived masculine norms, social connections with American peers, religious consultation experience, and gender (Cheung, 2010; Gallian, 2016; Hyun et al., 2007; Komiya & Eells, 2001; Li et al., 2013; Wu, 2011).

Chinese international students' stigma about mental health treatment is considered by some researchers as an important contributing factor to their underutilization of mental health services. For instance, Li and colleagues (2013) proposed that Asian international students' unwillingness to use mental health services could be influenced by their stigma about mental health issues as well as their collectivistic cultural background. They found that Asian international students were more likely to seek out help from individuals in their community rather than from mental health counseling services. Yoon and Jespen's study (2008) also showed that Asian international students tended to experience more discomfort and shame about utilizing mental health counseling services compared to American students. Contrary to these findings, Galligan (2016) discovered that Chinese international students tended to view counseling in America as more developed, more professional, more effective, and the therapists as more trustworthy compared to the counseling services and therapists in their home country. In the same regard, Mau and Jepsen (1988) discovered that Chinese international students were equally open to seeking out mental health counseling as their domestic counterparts; however, they were less ready to start seeing a mental health counselor. Mau and Jepsen (1990) also did not find differences between Chinese international students and American domestic students in terms of

their first choice of helpers, even though Chinese international students use the counseling services less frequently compared to the domestic students.

With these various findings about barriers for Chinese international students to utilize mental health services, it is easy to see a theme in these research studies: they tend to focus on internal factors of this population instead of discovering external barriers. These research studies put emphasis on barriers stemming from Chinese international students, and did not pay much attention to factors from external environment, such as therapists. Leong and Chou (1996) pointed out that there were more research studies about international students that focused on client variables and their problems in the process of seeking and utilizing mental health services than studies that focused on therapist variables. Unfortunately, more than twenty years later, this is still true—Heng (2018) argued that research studies about Chinese international students tended to picture deficit images of them or "frame their cultural background as baggage" rather than trying to understand the sociocultural context of the issues (p. 23). Maybe it is time for researchers to start examining and analyzing external factors that contribute to Chinese international students' underutilization of mental health services. As proposed by Yoon and Portman (2004), we should focus on "discovering ways to improve environmental support rather than assigning all problems to international students (in essence blaming the victims)" in research (p. 37).

When we raise the question "how to increase Chinese international students' use of the mental health services when they are in need of help," it is unavoidable to consider the other part of the equation—the important role played by mental health professionals. Some scholars have proposed potential therapist factors that are potential barriers for Chinese international students to utilize mental health services. Sue and Zane (1987) as well as Mori (2000) pointed out that the

lack of bilingual therapists and the low multicultural counseling competency among therapists to provide culturally appropriate forms of treatment could have contributed to the underutilization of mental health services among international students. Yoon and Portman (2004) also suggested potential therapist factors that could deter international students from seeking out mental health support—"an overemphasis on such problems (international students' adjustment problems) may create a tendency among counselors to stereotype international students as problematic and deficient. This may lead counselors to patronize the students" (p. 38). Similarly, other scholars argued that therapists' unawareness of their own biases and prejudice toward minoritized groups could create impasses for these clients and potentially explain the underutilization of mental health services and premature termination among certain population (Burkard & Knox, 2004; Kearney, Draper, & Baron, 2005). It is possible that therapists' lack of multicultural counseling competence to work with Chinese international students, along with the potential implicit biases they harbor toward this population, serve as barriers for Chinese international students to utilize mental health services.

To make up for this lack of attention on therapist factors in research studies about international students, Arthur (2008) urged mental health counselors to make efforts in examining their own multicultural competencies when providing treatment to international students from different cultures. As he stated, "counselors need to reflect on their attitudes toward working with international students from particular cultural backgrounds in order to consider how their personal beliefs may inadvertently bias professional relationship" (p. 18). However, even though the field of counseling psychology has been making numerous efforts to increase therapists' multicultural counseling competency, graduate programs have not been providing sufficient training to prepare therapists to work with international

students (Yoon & Portman, 2004). According to Yoon and Portman (2004), most of the textbooks that focus on or include multicultural counseling issues tend to address how to provide culturally appropriate treatment to Americans who are members of minoritized groups, such as ethnic minority groups, sexual orientation minority groups, gender minority groups, etc. The textbooks also tend to generalize these treatment modalities to therapy with international students, which is inappropriate given the great amount of cultural and experiential differences between international students and American minority groups (Yoon & Portman, 2004).

Hence, to better support Chinese international students on the U.S. campuses, it is essential for researchers and practitioners to look into and understand the influence of the therapist factors on the underutilization of the mental health services in this population.

Therapist Factors

As an important part of the equation in mental health treatment, therapist factors can make a difference in different aspects of the treatment process—a review of past research about therapist effect showed that it can account for up to 10% variance in therapy outcome (Baldwin & Imel, 2013; Saxon et al., 2017). Below is a discussion about specific therapist factors and their effects on mental health treatment.

The technical aspect of therapist factors, including training, education, and clinical experience, are one set of factors that potentially contribute to therapy outcome. However, research studies have contradicting findings about the effects of this set of therapist factors. Some researchers found positive, although weak, relationship between therapists' training, skill, experience, educational degree and their therapy outcome (Beutler et al., 2010; Prout & DeBerard, 2017). Podell and colleagues (2013) also found that therapists' level of clinical experience can serve as a positive predictor for therapy outcome when using CBT for treatment

of anxiety among youth. On the contrary, other researchers found that therapists' level of training did not have significant effect on their treatment outcome (Newman, 2015; Okiishi et al., 2003; Okiishi et al., 2006). In addition, researchers have conflicting findings about the effect of therapists' adherence to treatment protocol on therapy outcome—some find it as a weak predictor for treatment outcome while the others find it serve as a significant predictor (Podell et al., 2013; Webb et al., 2010). Researchers also did not find therapists' theoretical orientation as predictive of their treatment outcome (Okiishi et al., 2003; Okiishi et al., 2006).

Therapists' emotions and emotional awareness can have potential effects on therapy outcome. For instance, Shamoon and colleagues (2017) found that therapists' awareness about and ability to manage their anxiety during therapy sessions had a positive relationship with treatment outcome. In addition, Yulis and Kiesler (1968) found that therapists' low anxiety level and their ability to manage anxiety can lead to better engagement with clients during sessions as well as to less countertransference. In their analysis of peer-nominated master therapist characteristics, Jennings and Skovholt (1999) had similar findings: good therapists demonstrated awareness of their emotional health, which positively affected their clinical work with clients.

Other therapist factors also can make a difference in producing therapy outcome. Previous research studies found that therapists' directness in sessions and women's gender can positively affect therapy outcome (McAleavey & Castonguay, 2014; Okiishi et al., 2003; Okiishi et al., 2006; Prout & DeBerard, 2017). In addition, Berman et al. (2015) discovered that therapists' relationship status and religiosity were predictive of their assessments on clients' suicide risk. Their study also demonstrated effect of therapists' license status and weekly caseload on their decisions about hospitalization of clients with suicide risks. Therapists' accent, racial identity attitudes, ethnicity, and attractiveness can also affect clients' perception and

ratings of their competency in providing mental health treatment, which can in turn influence

therapeutic relationship as well as treatment outcome (Cabral & Smith, 2011; Cash et al., 1975;

Cavior & Glogower, 1973; Ditmar, 1980; Fuertes et. al, 2012; Lewis & Walsh, 1978; Rae, 1975).

When discussing therapist factors in mental health treatment, one cannot ignore

therapists' empathy and their ability to build therapeutic alliance. Researchers have provided

evidence that is supportive of the positive relationship between therapists' empathy in treatment

process and therapy outcome (Elliott & Bohart, 2011; Kurtz & Grummon; 1972; Moyers et al.,

2016; Truax, 1996). Jennings and Skovholt (1999) also found that therapists' strong relationship

building skill was one of the shared characteristics among peer-nominated master therapists. In

addition, Podell and colleagues' (2013) research study revealed that therapists who were more

collaborative and empathetic during the treatment process can produce better therapy outcome.

Similarly, William and Chambless's (1990) study found that client-rated therapist empathy was

predictive of therapy outcome when providing treatment to clients with agoraphobia concerns. A

great amount of research study findings also evidenced the strong positive relationship between

therapeutic alliance in the treatment process and therapy outcome (Arnow et al. 2013; Cameron

et al., 2017; Falkenstrom, Granstrom, & Holmqvist, 2013; Goldman et al., 2018; Graves et al.,

2016; Mattos et al., 2017; Rubel et al., 2018; Schwartz et al., 2018; Tasca, Compare, Zarbo, &

Brugnera, 2016). Regardless of treatment modality utilized, this relationship exists when

providing mental health services to different populations with different presenting concerns.

Given the important role therapists' attitudes toward clients play in producing therapy

outcome, we should further examine therapists' bias (implicit and explicit) towards clients and

its effect in the treatment process.

Implicit bias and explicit bias. Before examining therapists' bias towards clients in therapy, an overview of implicit and explicit bias can provide a theoretical framework and reference for further discussion.

As a result of socialization and internalization, we learn to harbor biases toward certain groups of individuals. According to scholars, there are two kinds of bias. Explicit bias is a form of bias that is on our conscious level, is intentional, and can be measured by individual's self-report (Boysen, 2009). This kind of bias can be accessed through consciousness and includes beliefs, judgments, and stereotypical impressions toward certain groups. The other kind of bias is implicit bias, which occurs without one's conscious intention (Greenward & Banaji, 1995). Implicit bias is automatic and is uncontrollable, which means it is hard to measure through self-report (Fazio, 1990). Some scholars proposed that implicit bias is formed through internalization of the social knowledge presented to individuals regarding characteristics of other social groups (Aberson, 2017; Dunham, Baron, & Banaji, 2007). In addition, it is possible that implicit bias is developed during early childhood and remains stable throughout one's adult life. Given the different characteristics of explicit bias and implicit bias, they have different effects on human behavior. According to Aberson (2017), implicit bias "represent(s) attitudes that drive behaviors under spontaneous processing," while explicit bias "guide(s) behaviors under deliberate processing" (p. 265). Hence, under certain circumstances implicit bias can have a stronger effect that is uncontrollable on individual's judgments and behaviors, which warrant more effort in understanding how it affects minoritized individuals' daily life.

Numerous research studies were conducted to explore the influence of implicit bias. One of the areas that researchers focused on was how human perception is affected by implicit bias. As one of the pioneer researchers in this field, Devine (1989) conducted a study regarding

individuals' implicit biases against Black Americans using the priming technique. He found that in the presence of Black Americans, participants had automatically activated negative stereotypical impressions towards this population, which was indicative of implicit biases. However, participants who scored lower on prejudice were able to inhibit these negative implicit biases against Black Americans and replace them with thoughts that could reflect equality. Similarly, Todd and colleagues (2016) found that the presence of a young Black American boy's face induced more negative stereotypical impressions than positive ones. In their study, Hugenberg and Bodenhausen (2003) also discovered that implicit bias can affect individuals' perception of others' emotions. They used computer generated animated human face with different emotions and asked participants to rate the perceived emotions, then used Implicit Association Test (IAT) to assess participants' implicit bias. This study found that those who scored higher on implicit biases against Black Americans tended to be more ready to perceive anger in Black faces compared to White faces.

Implicit bias also has an effect on the quality of individuals' social interactions. McConnell and Leibold' (2001) research study showed that participants who had more negative implicit biases against Black Americans, as evidenced by their IAT results, tended to have more negative social interaction with Black Americans than with White Americans. Furthermore, implicit bias can affect individuals' perception of attractiveness—a study found that with more negative implicit biases against Black Americans, individuals tended to associate attractiveness more with White features than with Black features (Rudman & McLean, 2016).

Furthermore, implicit bias also has an effect on individuals' behavior and decision-making process. For example, implicit bias can influence employers' recruitment decision-making process. Bertrand and Mullainathan (2004) sent resumes with stereotypical Black

31

American names versus White American names to employers across different occupations, industries, and different sizes of company. They found that resumes with Black American names received 50% less call back than those with White American names. In addition, employers tended to be more responsive to the resume quality with White American names compared to those with Black American names. Researchers in Sweden and Netherlands conducted similar studies, which had similar results: resumes with Swedish name were favored over those with stereotypical Arab-Muslim name, and resumes with native Dutch name were favored over names indicative of individuals' immigrant status (Blommaert, van Tubergen, & Coenders, 2012; Rooth, 2010). During the employment process, Black Americans also face more employment scrutiny than their White counterparts (Wirts, 2017). Regarding the influence of implicit bias on individual's cognitive processing, Payne (2005) found that even though the same level of implicit biases was activated, those who had better executive control were less likely to express the negative stereotypes activated than those with poor executive control. Similarly, Salvatore and Shelton (2007) found that activated implicit biases can reduce one's cognitive ability. These findings indicate that implicit biases are always present, but some learn and use cognitive control to not make these biases explicit to others (Dovidio & Gaertner, 1991).

Implicit bias can also negatively affect other aspects of minority groups' life. For instance, a study showed that Black Americans received more violent forms of arrest than soft hand control by police officers (Fridell & Lim, 2016). In the same regard, Nance (2017) found that schools that had more students who identified as ethnic minority tended to use more intense measures of surveillance than those with more ethnic majority students, which was not supported by legitimate safety concerns. Moreover, implicit bias can affect minority individuals' education experience and academic success. For example, van den Bergh, Denessen, Hornstra, Voeten, and

Hollan (2010) used IAT to assess implicit bias of teachers towards certain student groups in Netherlands. They found that teachers' implicit bias led to their negative expectations of these students, which resulted in worse academic performance. Glock, Kneer, and Kovacks (2013) also conducted a study about the effect of teachers' implicit bias in Germany. To assess participants' implicit bias, they used pictures of children that were indicative of different immigrant statuses and test participants' association of the pictures with positive and negative adjectives. These researchers found that teachers demonstrated less positive implicit bias towards immigrant students than that towards non-immigrant students, which lead to lower expectations for immigrant students as well as worse academic performance among these students. Utilizing the IAT to examine participants' implicit bias, Peterson, Rubie-Davies, Osborne, and Sibley (2016) also discovered that in New Zealand, teachers' positive implicit bias towards certain student groups can result in better academic performance in these groups.

The field of healthcare has rich literature regarding healthcare providers' implicit bias. Matthew's (2015) review of implicit bias among healthcare professionals demonstrated that when treating patients who identified as ethnic minorities, clinicians' implicit bias was related to poorer treatment decisions for heart disease, pediatric urinary tract infections, and other diseases. Hall and colleagues (2015) also conducted a review of 15 research studies about implicit bias among healthcare professionals. 14 of the studies reviewed utilized IAT and 1 of them utilized sequential priming to test participants' implicit bias. The results of the review demonstrated the existence of implicit bias against Black, Latino, and individuals with darker skin color among healthcare professionals. This implicit bias was found to have an association with the quality of interaction between patients and providers, providers' treatment decision-making, patients' adherence to treatment, and patients' health outcomes. Similarly, Blair and colleagues (2013)

found that healthcare professionals harbored implicit bias towards African American patients, which negatively affected their clinical relationship and the treatment process. Zestcott, Blair, and Stone (2016) also examined this issue by reviewing previous studies about implicit bias. They discovered that healthcare providers showed more negative implicit bias towards African American, Latino/a American, and Native American patients than they did toward White American patients. In addition, this review revealed the content of healthcare professionals' implicit bias towards African American patients—they view this population as less compliant and less cooperative compared to White American patients. Regarding the effect of the aforementioned implicit bias, these researchers also found that healthcare professionals' negative implicit bias can predict poor interpersonal communication with minoritized patients and inaccurate medical judgment, which decreased patients' engagement during the treatment process as exemplified by less follow-up and worse adherence to treatment.

Implicit bias towards ethnic minority patients is not the only implicit bias harbored by healthcare professionals. Findings from previous research studies showed that healthcare providers exhibit negative implicit bias towards overweight/obese patients (Phelan et al., 2014; Waller, Lampman, & Lupfer-Johnson, 2012). Researchers also found that healthcare providers perceive overweight/obese patients as more lazy, with less intellectual ability, and more worthless compared to how they perceive patients with average weight (Schwartz, O'Neal, Chambliss, Brownell, Blair, & Billington, 2003). In addition to implicit bias based on body weight, researchers also discovered that healthcare professionals harbored implicit bias based on sexual orientation of the patients—they exhibited implicit bias favoring heterosexual patients compared to lesbian and gay patients (Burke et al., 2015; Sabin, Riskind, & Nosek, 2015). Furthermore, previous studies showed that healthcare professionals harbor negative implicit

based towards patients with lower socioeconomic status (Haider, Schneider, Sriram, Dossick, et al., 2015; Haider, Schneider, Sriram, Scott, et al., 2015).

To summarize, implicit bias can show up in different aspects of our daily lives and can affect us without our conscious awareness.

Implicit bias in mental health treatment. Implicit biases against individuals with different minority statuses can also take place in the therapy room. Therapists are humans and are not immune from bias toward different groups of individuals. However, there are limited research studies examining implicit bias and its effect among mental health professionals (Boysen, 2010).

Abreu (1999) conducted one of the early research studies about implicit bias in mental health field. In the first part of this study, the researcher utilized priming procedure to examine therapists' implicit bias towards African American clients by utilizing high or low words related to stereotypes and asked participants to respond to a case vignette. The result revealed that therapists tended to rate African American client as more hostile than how they rate the client in the low prime condition, which indicated negative implicit bias towards African American clients. In the second phase of this study, the researcher asked participants to respond to a case vignette with information about the client's ethnic background (i.e., African American or White American). The researcher did not find negative explicit bias from the therapist towards the African American client. On the contrary, therapists rated the African American client more positively compared to the ratings in the first part of this study. This research project demonstrated how therapists can control and decrease their negative explicit bias towards clients from minority groups; however, they do not have much conscious control and still harbor negative implicit bias towards these clients, despite potential good intentions in their awareness.

Pearce (1994) had similar findings in her research study conducted on trainee counselors. To examine participants' implicit bias, Pearce utilized semantic-differential instrument with 12 pairs of bipolar adjective adapted from the scale developed by Osgood and colleagues (1957). Participants were asked to respond to a case vignette with clients from different cultural backgrounds (i.e., White British, Asian British, Jewish British, and West Indian British) and rate the client on the semantic-differential scale. Pearce also included questions about attribution in the study: participants were asked to respond whether the client or the situation was more responsible for the presenting concerns. The result of this study showed that White clients were rated by the counselor trainees more favorably compared to clients from other cultural backgrounds. For example, White clients were rated more "friendly", "warm", and "helpful" while clients from other cultural backgrounds were rated more "hostile", "cold", and "obstructive". In addition, counselor trainees also perceive White clients as less responsible for their issues and clients from other cultural backgrounds as more responsible for their presenting concerns. These findings showcased counselor trainees' negative implicit bias towards clients from culturally minoritized groups.

In Fujitsubo's (1991) research study, therapists' implicit bias towards ethnic minority clients were also analyzed. The researcher developed case vignettes with identical information other than clients' ethnicity and assigned the cases randomly to participants. The researcher asked participants to provide a diagnosis for the client, rate the severity of the diagnosis, rate their ability to provide treatment to the client, and rate the potential treatment outcome. The results of this study revealed that therapists tended to assign more severe diagnoses to African and Asian American clients compared to White American clients. The researcher also found that

therapists tended to have poorer evaluation of the treatment outcome for African and Asian American clients than that for White American clients.

More recently, Boysen and Vogel (2008) put effort into examining therapists' implicit bias towards minoritized individuals. They utilized IAT to test counselor trainees' implicit bias towards African American clients as well as clients who identify as lesbian woman or gay man. The outcomes of this study revealed that counselor trainees harbored negative implicit bias towards ethnic minority and sexual orientation minority clients, despite their self-reported high-level multicultural competency. This finding is consistent with the result of Wisch and Mahalik's (1999) research study, which discovered that when therapists perceived anger in their clients, they reacted more negatively to sexual orientation minority clients than heterosexual clients. Furthermore, these researchers discovered that even though counselors exhibited more positive explicit bias than average population, their implicit bias was the same level as that of the general population. These findings further demonstrate how therapists are able to manage and present positive explicit bias; however, this positive front does not exempt them from negative implicit bias.

Boysen's (2009) review of previous research studies about implicit and explicit bias among mental health professionals also confirm that therapists are better able to manage their explicit bias than implicit bias. The review found that explicit bias towards minoritized American individuals was rarely reported by therapists, and even when it was reported the bias tended to be positive rather than negative. However, therapists' implicit bias tended diverge from their self-reported attitudes—in past research studies, therapists exhibited negative implicit bias towards minoritized American individuals even among those who reported high levels of multicultural

competency. As Boysen stated, "the expression of explicit bias should be atypical among counselors as long as they are given a chance to intentionally control their responses" (p. 241).

Therapists' implicit bias also targets client population other than the ethnic minority and sexual orientation minority groups. For instance, Adams (2008) randomly assigned case history with identical information other than client's body weight to participants and asked participants to respond to the case. The result of this study showed that therapists had negative implicit bias towards overweight women clients compared to average weight women clients. Specifically, therapists tended to view overweight clients as possessing lower self-esteem, more dependent, having a worse prognosis, more emotional, more impulsive, and more intolerant of change compared to how they perceive average weight clients. In addition, therapists assigned additional diagnoses (i.e., anti-social issues, hypochondrias, and addiction issues) to overweight clients. Regarding therapists' implicit bias based on gender, researchers have conflicting findings. Ackerman's (1993) study did not find therapists' implicit bias based on gender; however, the result indicated that therapists tended to have more favorable clinical evaluation towards those with women sex-role qualities. In Spielman's (2001) research study using case vignette, therapists with traditional sex-role orientation exhibited positive implicit bias towards women clients as evidenced by their differential outcome ratings and presenting concern attribution for women and men clients.

Effects of implicit bias in mental health treatment. Microaggression can present as a form of implicit bias. According to scholars and researchers, there are overlaps of concepts between implicit bias and aversive racism—unintentional, unconscious, and subtle (Dovidio, Gaertner, Kawakarni, & Hodson, 2002). As a manifestation of aversive racism, microaggressions also share similar characteristics with implicit bias: subtle insults that occur without one's

awareness (Constantine, Smith, Redington, & Owens, 2008; Sue et al., 2007). Boysen (2010) stated, "implicit bias is a possible explanation for the dissociation between intentional and unintentional discrimination manifested in aversive racism and microaggression" (p. 211). Given these close connections and similarities between implicit bias and microaggression, a review of therapists' microaggression towards minority clients is warranted.

In Owen and colleagues' (2014) research study about racial and ethnic microaggression in therapy, more than half of the participants (clients) reported experience of microaggression from their therapists. Furthermore, 76% of those who reported experience of microaggression noted that the incidents were not discussed in the treatment process. As a result of perceived microaggression from therapists, these clients tended to rate their working alliance with therapists as lower than those who did not have experience of microaggression and those who had discussions with the therapists about the incident. Similarly, Constantine's (2007) research study discovered that African American clients experienced microaggression from their therapists. After encountering the reported microaggressions, these clients had lower ratings of therapists' multicultural competency, therapeutic alliance, and their overall satisfaction in therapy. This client rating of therapist's multicultural competency was positively related to the working alliance, client satisfaction in therapy, session depth, and treatment outcome (Tao et al., 2015). Owen and colleagues (2011) also found that client-perceived microaggression from therapist in the treatment process was negatively associated with clients' psychological well-being.

This relationship between therapists' microaggression and therapy process and outcome is not limited to the experience of ethnic minority clients. The negative effect of microaggression also applies among gender minority clients. Clients who identified as minority based gender

reported experience of microaggression in therapy, which was negatively associated with their perception of the working alliance with the therapists and therapeutic outcome (Owen et al., 2010). Sexual orientation minority clients are not immune from microaggression in therapy either. A qualitative study conducted by Shelton and Delgado-Romero (2013) revealed that lesbian, gay, bisexual, and queer (LGBQ) clients had experiences of microaggressions and biases from therapists in sessions. These experiences had negative effects on both the clients and the therapy process: clients reported that as a result they felt powerless, invisible, and rejected. In addition, after encountering microaggressions from therapists, they tended to withhold information and take less initiative during therapy sessions. Clients noted that they became less confident in the effectiveness of therapy as well as in the therapists' abilities. Furthermore, research studies found that clients' perception of microaggression in therapy was not predicted by clients' ethnicity, therapists' ethnicity, or the ethnic match between the client and the therapist (Cabral & Smith, 2011; Owen et al, 2011). This means that microaggression can happen even with therapists who identify as ethnic minority.

In summary, as an outcome of therapists' multicultural training and their motivation to present in a socially desirable manner, therapists are often capable to manage their outward responses—explicit bias (Burkard & Knox, 2004). However, due to the nature of implicit bias (i.e., occurs without one's conscious intention, automatic, uncontrollable), this bias can sneak into therapy room and negatively affect the treatment process and outcome in a way that therapists are unaware of. Hansen and colleagues (2006) pointed out that therapists tended to overestimate their own multicultural competency and do not make extra effort in examining their own biases. This can be a dangerous practice given the negative effects of implicit bias. Hence, to be better able to provide appropriate and high quality treatment to minoritized individuals, it is

important for researchers and scholars to put more effort into examining therapists' implicit bias (Boysen, 2009).

However, there is a lack of effort in examining therapists' implicit bias towards non-American clients, including Chinese international students. The research studies conducted about therapists' bias so far have been focused on the bias towards minoritized American individuals. No known research study has examined therapists' bias towards international students. As discussed earlier in this chapter, Chinese international students face more challenges compared to their American counterparts and are in dire need of the assistance of mental health treatment. Despite this need, there is an underutilization of mental health services among Chinese international students. It is essential for scholars and practitioners to understand different factors, including therapist factors, that contribute to this underutilization. But research studies have exclusively focused on clients' internal factors and no known research studies have examined therapist factors on this issue. Several scholars have suggested that it is essential for therapists to reflect on and increase their self-awareness of values and biases when working with international students to provide more effective and culturally sensitive treatment (Arredondo, 1998; Arthur, 2008; Jacob & Greggo, 2001). Hence, an examination of therapists' implicit bias towards Chinese international students could potentially help scholars and practitioners better understand the underutilization of services in this population and improve the quality of treatment for these students.

Potential Therapist Implicit Bias Towards Chinese International Students

To better inform this research study about therapists' implicit bias towards Chinese international students, below is a literature review of factors that could evidence potential negative implicit bias from therapists.

Stereotypical impressions toward Chinese international students. Findings from previous research studies showed that therapists tended to have negative perceptions of clients who identify as ethnic minority, sexual orientation minority, and gender minority, compared to how they perceive clients who identify as majority (Abreu, 1999; Boysen & Vogel. 2008; Owen et al, 2014; Owen et al, 2010; Shelton & Delgado-Romero, 2013). The targets of these negative biases include Asians. According to Pearce (1994), counselors-in-training tended to perceive White clients as more helpful, friendlier, and warmer compared to how they perceived Asian clients—obstructive, hostile, and cold. In addition, Pearce also found that counselor-in-training tended to rate White clients more favorably on the semantic differential scale compared to how they rate Asian clients. In addition, counselor-in-training view Asian clients as more responsible for their presenting concerns while they perceive the situation as more responsible for White clients' presenting concerns. Similarly, Li-Repac (1980) found that White therapists tended to rate Chinese clients higher on passiveness and lower on social/interpersonal skills.

In general, individuals in American society harbor certain stereotypical impressions about Chinese international students. For instance, Bonazzo and Wong (2007) found that Asian international students were often perceived as academically conscious, over-achieving, and model students. Similarly, Findlay and Kohler's (2010) interview with students from dominate groups suggested that Chinese international students were perceived as "model minority" and "too smart." This "model minority" impression portrays Chinese individuals as hardworking, ambitious, intelligent, obedient, self-discipline, serious, and good at math and science (Lee & Joo, 2005). It also pictures Chinese individuals as lacking in social skills (Findlay & Kohler, 2010; Suzuki, 2002). Ruble and Zhang's (2013) qualitative study confirmed these stereotypical impressions toward Chinese international students. In the first part of their study, they found that

smart, quiet, good at math and science, shy, studious, and low on English language proficiency were traits about Chinese international students most frequently endorsed by American students. In the second part of the study, the researchers found five clusters stereotypical impressions geared toward Chinese international students. For example, American students perceived Chinese international students as smart/hardworking and kind/polite, which was rated as favorable traits. In addition, American students also perceived Chinese international students as socially awkward, quiet, not assimilated to American culture, oblivious, loud, intrusive on personal space, and as lacking in English language skills, which they rated as unfavorable traits. Although the smart/hardworking stereotype was one of the favorable traits, researchers noted that this can lead to American students' feelings of jealousy and being threatened due to the perceived competitiveness, which could lead to Chinese international students being perceived as low on the warmth scale (Fiske et al., 2002; Fiske et al., 1999). Furthermore, Chinese international students reported being treated as a "problem" and "inferior" due to their English language learner status (Constantine et al., 2005; Lee & Rice, 2007). For instance, Rubin and Smith (1990) found that students rated Asian international student teaching assistants as less favorable and lower on their teaching abilities compared to how they rated those who were native English speaker. It is possible that these stereotypical impressions about Chinese international students also exits among mental health therapists due to influence from general society.

Hence, when therapists harbor implicit bias towards Chinese international students, it is likely that they will endorse stereotypical impressions about this population and perceive them in unfavorable lights.

Degree of pathology seen in client's presenting concerns. Therapists' lack of consideration of or knowledge about a client's culture background can lead to diagnoses that over-pathologize or under-pathologize the clients (Lopez, 1989). According to Cheung (2009), given that mental health therapists are usually trained based on European American value systems, it is quite possible for them to misunderstand Asian clients' presenting concerns, which could lead to pathologize the population more or less than other groups.

No known research studies to date have focused on therapists' tendency to pathologize Chinese international students more or less than other groups, although there are some research studies about this issue among Asian American clients. In Chan's (2012) qualitative study, Chinese American students reported experience of minimization of racial/cultural issues, as well as pathologizing cultural values and communication styles from their therapists, which led to culturally insensitive treatment recommendations. Yeh (2000) also found that due to Asian Americans' tendency to somaticize their presenting concerns based on cultural values, they were likely to be pathologized more than other populations by mental health professionals, which led to underutilization of mental health services in this population. Some researchers expressed their concerns about same issue occurring among international students. For instance, Yoon and Portman (2004) noted that "an overemphasis on such problems (international students' adjustment problems) may create a tendency among counselors to stereotype international students as problematic and deficient. This may lead counselors to patronize the students" (p. 38).

However, literature suggested the possibility of pathologizing Chinese international students' presenting concerns less than those of other student populations. Research studies have provided evidence for Asian international students' experience of being minimized and being

invisible. Diangelo (2006) once conducted a qualitative study and observed a classroom experience with more than 50% of the students being Asian international students. The outcome of this study exemplified how Asian international students were ignored, invalidated of their perspectives, and treated as invisible in classrooms by both their American peers and instructors. Hsieh's (2007) case study also revealed similar themes. In this study, a Chinese woman international student was interviewed about her overall experience on an American campus. The student shared experience of being ignored and silenced by her American peers, as well as being treated as invisible in classrooms. In addition, this student reported incidents where her cultural background was treated as inferior and her silence was perceived as incompetence. Consistently, other research findings showed that Asian international students were often treated as invisible and unwanted, their struggles were minimized and denied, and their presence was unacknowledged (Constantine, Anderson, Berkel, Caldwell, & Utsey, 2005; Houshmand et al., 2014; Lee & Rice, 2007; Poyrazli & Grahame, 2007). Sue (2010) pointed out that this invisibility culture can lead Americans to ignore international students' existence and struggles systematically and automatically. Moreover, Asian international students presented a tendency to minimize their own struggles due to cultural values and needs to protect their self-esteem (Constantine et al., 2005; Owen, 2002; Yip, 2005). With the minimization of issues from both external and internal forces, it is reasonable to suspect that mental health professionals will tend to pathologize Chinese international students' presenting concerns less than those of Chinese American and White American students. This treatment of Chinese international students can present as microaggression and implicit bias.

Attribution of presenting concerns. According to Weiner (1985) and Heider (1958), individuals tend to attribute other people's success to external factors, such as the circumstances

and resources, and other people's struggles to internal causes, such as personality traits and personal effort. Different scholars and researchers confirm that when it comes to individuals from outgroups, people tend attribute these outgroup members' failures or struggles to their personal weakness (internal factors) while attributing their success and fortunes to chance and luck (external factors; Agroskin & Jonas, 2010; Fristche et al., 2008; Pettigrew, 1979). Other research study findings are also consistent with this theory. For instance, Hughes and Tuch (2000) found that individuals from different ethnic backgrounds (i.e., White, Black, Asian, and Latino Americans) all presented a tendency to attribute the misfortune of those from other groups to their own personal deficits and traits. In their research study about perceived cause of racial inequality, Sniderman and Hagan (1985) also discovered that their participants perceived individuals from minority groups as lacking effort in changing their circumstances—they did not try hard enough. Appelbaum (2001) and Winter (2008) had similar findings in their research studies. This attribution bias is also applicable when it comes to the cause of poverty. Some researchers found that individuals tend to blame the financial struggles of those from low SES to internal factors, such as laziness, lack of effort, and so on (Cozzarelli, Wilkinson, & Tagler, 2001; Hunt, 1996, 2007; Smith & Stone, 1989). Anderson (1992) also confirmed this victim blaming tendency when it comes to attitudes towards AIDS victims: people tend to blame the contraction of AIDS on these patients' personal habits and poor choices—they cause and deserve their own disease. The same finding is also applicable when it comes to attitudes towards others based on older versus younger age (Erber & Danker, 1995; Ferris et al., 1985). Masuoka and Junnm's (2013) study showed that given immigrants' outgroup status, including nationality and ethnicity, citizens tended to attribute negative characteristics to this population and positive ones to their fellow citizens. Chinese international students present as an outgroup in the United

46

States, including their nationality, language ability, cultural background, and ethnicity. Hence, it is possible that therapists will perceive Chinese international students' struggles as caused more by internal factors than by external factors.

There is a positive relationship between discrimination/prejudice/bias towards certain groups and internal attribution of failures. The research findings from Gill and Andreychik (2007)'s and Gill and colleagues' (2013) studies provided evidence of this relationship: those who displayed prejudice towards outgroup members were more likely to use internal explanations for the group members' struggles, whereas those who perceive external control of the outgroup members tended to present with compassion for their sufferings. Mulford and Lee (1996) as well as Johnson and colleagues (2002) have similar findings in their research studies about attitudes towards AIDS victims—prejudice towards this group is related to the internal attribution of the disease contraction and struggles. The same applies to anti-transgender prejudice—those who discriminate against transgender individuals tend to blame the victims for bringing the violence towards themselves (Dalbert, 2009; Furnham, 2003; Grant et al., 2011; Symonds, 2010; Thomas et al., 2016). Harell and colleagues (2017) also found that those who blamed immigrants' predispositions for their struggles tended to be more hostile towards this population. Supported by these research findings, it is likely that therapists' internal attribution of Chinese international students' struggles serves as evidence for their negative implicit bias towards this population.

Insufficient training to provide treatment for Chinese international students.
Although the field of psychology has put forth a great amount of effort in multicultural training to help therapists better understand their bias against minoritized groups in America, so far it has paid little attention to training in helping therapists encounter their biases toward international

students. As pointed out by Diangelo (2006), multicultural training in educational settings in America did not include international students' concerns and issues. Some scholars became aware of how little preparation counselors-in-training had through their education to provide mental health treatment to international students (Arthur, 2008; Fouad, 1991). Yoon and Portman (2004) also noted that most textbooks that address multicultural issues in therapy did not include issues about providing treatment to international students. Instead, the theories and skills about providing treatment to minoritized American clients are generalized to treating international students. However, there are major differences between these two populations in terms of experiences and struggles due to sociopolitical variables, such as nationality and language (Jacob & Greggo, 2001; Yoon & Portman, 2004). Hence, the multicultural training to provide appropriate treatment for minoritized American clients may not be directly applicable to treatment for international students.

Several scholars have proposed the need to increase preparation of mental health professionals to provide treatment to international students. Back in 1996, Lewthwaite noted that counselor training programs should provide training that could help students better understand and address international students' adjustment issues. Years later, Jacob and Greggo (2001) re-emphasized the needs to educate counselors about international students' unique experiences to provide culturally sensitive and effective treatment to this population. Yoon & Portman (2004) also raised their concerns about counseling centers have not yet developed strategies to target treatment for international students. With this continuous effort in raising awareness about providing treatment targeting international students' unique experiences, it is safe to assume that there has not been much progress in this aspect of training mental health professionals. Hence, it

is quite possible that therapists will report themselves as not well prepared and equipped to work with Chinese international students in mental health treatment.

In summary, when harboring negative implicit bias towards Chinese international students, therapists are likely to endorse stereotypical impressions about this population, which will present as unfavorable perceptions of this population. In addition, therapists' implicit bias may show up as their tendency to pathologize issues faced by Chinese international students less than those faced by Chinese American and White American students. Furthermore, therapists' potential internal attribution of Chinese international students' struggles can serve as another evidence for their implicit bias against this population. Lastly, given the lack of effort in providing multicultural training for therapists to better work with international students, it is likely that therapists will report that they are not well prepared to provide quality treatment to Chinese international students.

Chapter III

Method

This study aimed to collect data regarding therapists' implicit biases toward Chinese international students. Specifically, the investigator examined if therapists perceive Chinese international students differently compared to how they perceive domestic students. The population of interest, measurements used, as well as research design and procedures are discussed in the following sections.

Research Hypotheses

This study aimed to explore therapists' implicit biases toward Chinese international students. The hypotheses for this study is listed below:

- Therapists will rate the Chinese-international-student client in a less favorable manner compared to how they rate the Chinese-American-student and White-American-student clients.

- Therapists will pathologize the Chinese-international-student client less than they pathologize the Chinese-American-student client and the White-American-student client.

- Therapists will perceive the Chinese-international-student client as more responsible for their presenting concerns than how they perceive White-American-student and Asian-American-student clients. Therapists will perceive the circumstance as less responsible for Chinese-international-client's presenting concerns.

- Therapists will report that their training as less sufficient in preparing them to provide treatment to Chinese-international-student client than that to Chinese-American-student and White-American-student clients.

Participants

After obtaining the approval from the Institutional Review Board, the investigator sent out recruitment emails to the contact person listed for American Psychological Association (APA) accredited graduate programs, internship sites, and postdoctoral residency programs (list was retrieved from https://www.apa.org/ed/accreditation/programs). In the email, the investigator asked the contact person to distribute the study invitation to the students in the program, the staff members at the internship site, or staff members at the postdoctoral residency program. The email stated that the study examines therapists' conceptualization of a case. The email also informed potential participants that information regarding one's training background as well as demographics will be asked. The inclusion criteria were a minimum age of 18, currently working in or pursuing a career in the mental health profession, completion of minimum one semester of practicum, and have experience working with young adults.

A priori power analysis showed that to achieve a small effect size of 0.2 and an estimated power of 0.8 (Cohen, 1988), a minimum of 199 participants was required. A total of 396 participants started the online survey, among whom 233 participants completed the survey. A total of 163 participants did not complete the study and were not included in the analysis. Of the 233 participants who completed the survey study, 74.7% ($n = 174$) were graduate students and 25.3% ($n = 59$) were professionals who already obtained their degree. A majority (78.1% , $n = 182$) of the participants self-identified as women, 20.6% ($n = 48$) as men, and 1.3% ($n = 3$) as gender variant or gender non-conforming. Regarding ethnicity, 79.4% ($n = 185$) of the 233

participants self-identified as White/Caucasian American/European origin, 7.3% (n = 17) as Hispanic/Latino/a, 6.4% (n = 15) as Asian American/Asian origin/Pacifica Islander, 3.9% (n = 9) as African American/Black/African origin, 1.7% (n = 4) as other, 0.9% (n = 2) as biracial/multiracial, and 0.4% (n = 1) as Middle Eastern. Eighty-two percent of the participants (n = 192) fell within the 20-35 years age range with the youngest being 23-year-old and the oldest being 70-year-old. Majority (92.7% , n = 216) of these participants identified as Americans while 7.3% (n = 17) identified as non-Americans. Twenty-seven percent (n = 63) of the 233 participants reported having past experience working with Chinese international students.

For the 163 participants that were not included in the analysis, 20 did not meet all 4 inclusion criteria and hence were directed to the end of the survey. The remaining 143 participants dropped out of the study and did not complete the survey. A majority of these 143 participants (n = 134) dropped out of the study just before the Diagnostic Impression questionnaire. Among the remaining 9 participants, 2 were assigned to the Chinese-international-student client condition, 5 to the Chinese-American-student client condition, and 2 to the White-American-student client condition. Demographic information was gathered on 3 participants. Of these 3 participants, 2 were graduate students and 1 was professionals who already obtained their degree. Two of the participants self-identified as women and 1 as men. Regarding ethnicity, 1 of the 3 participants self-identified as White/Caucasian American/European origin, 1 as biracial/multiracial, and 1 as Middle Eastern and White/Caucasian American/European origin. In terms of age, these three participants were 24, 36, and 44 years of age. All three participants self-identified as Americans. Two participants reported having past experience working with Chinese international students.

Measures

        Inclusion Criteria Questionnaire (Appendix A). Those who were interested in participating in this research study were asked to provide information regarding their age, practicum experience, and current profession. Those who were at least 18 years of age, had at least one semester of practicum experience, had experience working with young adults, and were currently working in the mental health profession were directed to the rest of the study. Those who did not meet all four of the inclusion criteria were directed to the end of survey page.

        Demographic Questionnaire (Appendix B). There were two demographic questionnaires used in this study: one questionnaire for participants recruited from graduate programs and individuals on internship, and the other for those staff member at internship sites and postdoctoral residency programs. Both demographic questionnaires asked participants to provide the following information about themselves: age, gender, ethnicity, identity as American, area of expertise (clinical or counseling), numbers of international student clients they have worked with, numbers of Chinese-international-student clients they have worked with, and numbers of Chinese American students they have worked with. One of the questionnaires then asked graduate students and interns who are enrolled in graduate programs to provide information regarding the degree sought, numbers of practica completed, and numbers of college counseling center practica completed. The other questionnaire asked full time staff at internship sites and postdoctoral residency programs to provide information regarding licensure and years working as a licensed professional.

        Diagnostic Impression Questionnaire (Appendix C). The investigator created a questionnaire about diagnostic impressions of the client. This questionnaire consisted of four parts: the number of sessions needed by the client, severity of client's symptoms, attribution of

client's struggles, and sufficiency of therapist's training to provide treatment for this client. Participants were asked to respond to this questionnaire based on their impression of the client.

   Degree of pathology seen in client's presenting concerns. The investigator created two items to measure the degree of pathology participants saw in a client's presenting concerns. One item asked about participants' perception of the total number of sessions needed by the client and four choices were provided ranging from 1 = *1-4 sessions* to 4 = *more than 12 sessions*. Higher scores indicated participants' perception of the client needing more therapy sessions for their struggles. The other item created by the investigator asked participants to report their perception of client's symptom severity. Ten symptoms were listed (i.e., excessive worry, sleep disturbance, irritability, difficulty concentrating, sadness, hopelessness, low self-esteem, social isolation/withdrawn, low energy/motivation, guilt/shame) and responses were rated on a 5-point Likert scale, ranging from 1 = *mild* to 5 = *severe*. Higher scores indicated that participants perceive client as experiencing higher symptom severity.

   Attribution. The investigator created items regarding the attribution of client's struggles based on research findings regarding the relationship between locus of control and biases—researchers found a positive relationship between individuals' perception of certain groups' responsibility for their struggles and their discrimination against the same groups (Harell et al., 2017; Johnson et al., 2002). The Attributes Used to Measure Victim Blaming and Society Blaming scale developed by Johnson and colleagues (2002) was used to inform the item selection and modification. There are 4 sets of items in the original scale with 10 items in each set. These 4 sets of items aim to measure stable victim attributes, unstable victim attributes, stable society attributes, and unstable society attributes. The investigator selected three items from this scale that appeared to be relevant and appropriate for the purpose of this research study

and modify them to a new item (i.e., "This client should take more initiatives and actions to change her current situation") to measure participants' perception of client's internal locus of control. The investigator also selected and modified another three items from the aforementioned scale to measure participants' perception of client's external locus of control—the investigator changed the wordings of the items in the original scale (i.e., "government" and "rich") to better fit the purpose of this study (i.e., "university", "faculty", and "students"). In addition, informed by Pearce's (1994) study, 2 items were designed to measure if participants perceive that clients' problem was caused by client or the situation), the investigator created two items measuring participants' perception of the extent to which the client or the external environment is responsible for presenting concerns.

Responses were rated on a 5-point Likert scale ranging from 1 = *strongly disagree* to 5 = *strongly agree*. Higher scores indicate stronger belief that the client/circumstance was responsible for the presenting concerns. In the Attributes Used to Measure Victim Blaming and Society Blaming scale, the Cronbach reliability coefficient for the .76 for the victim blaming items and .81 for society blaming items. Pearce did not provide information regarding other psychometrics of the attribution questions used. Since the items included in this part of the questionnaire were a selected few from an existing scale based on relevance to the concepts intended to be measured in this study, the psychometric properties of the original scale is not applicable to these selected items.

Training sufficiency. The investigator created one item to measure participants' report of whether their previous training was sufficient for them to provide treatment for the client. This item asked participants to respond to the statement "I have sufficient training that prepares me to provide appropriate and quality treatment to this client." Responses were rated on a 5-point

Likert scale ranging from 1 = *strongly disagree* to 5 = *strongly agree*. Higher scores indicated participants' stronger belief that their training was sufficient to provide treatment to the client.

Semantic Differential Scale (Appendix D). Osgood and colleagues (1957) developed the semantic differential scale as a measurement for individuals' attitudes. It is a general measurement format that can be adapted according to the concepts used (Aronson, 1979). Osgood and colleagues suggested that the semantic differential scale is "a highly generalizable technique of measurement which must be adapted to the requirement of each research problem to which it is applied (p. 76)." To use the semantic differential scale, one must select pairs of bipolar words that measure individual's attitude according to the concepts used. The original semantic differential scale developed by Osgoods and colleagues is highly correlated with the Thurstone attitude scales and has a relatively high reliability. In addition, Osgoods and colleagues (1957) conducted a factor analysis and found three factors: evaluation ('good-bad' axis), potency ('strong-weak' axis), and activity ('active-passive' axis). Other researchers adapted this scale in their study and found a slightly different factor loading, including functional-utilitarian, affective-emotional, and moral-ethical (Komorita & Bass, 1967).

This study used the semantic differential scale developed by Pearce (1994) in her research using the general measurement format. This scale consists of twelve sets of bipolar adjectives, such as warm and cold, strong and weak, hostile and friendly. Pearce's study asked the participants to rate their impressions of the client on a scale from 1 to 11 for each bipolar adjective set with the middle point representing a neutral attitude. In addition to the twelve items used in Pearce's study, fourteen sets of bipolar adjectives were added into the semantic differential scale. The investigator created these sets based on research findings of stereotypical impressions individuals harbored toward Chinese international students (Ruble & Zhang, 2013).

This created a twenty-six items instrument (see Appendix D for the items added by the investigator), among which fourteen were to be reverse coded. Responses were rated on an 11-point Likert scale ranging from 1 to 11. Higher total scores on this scale indicated less favorable perception toward target population, and lower total scores indicated more favorable perception towards the target population. Individuals' more favorable rating of one population than the other indicated their potential bias toward the other population.

Pearce's (1994) research study did not report the reliability and factor analysis of this scale. However, studies showed that the majority of the bipolar pairs used in this study was loaded on evaluative factors in previous research studies, which was the intended purpose of the measure (Aronson, 1979; Komorita & Bass, 1967; Osgood, Suci, & Tannenbaum, 1957; Salcuni, Riso, Mazzeschi, & Lis, 2007). Despite the lack of detailed psychometric information of the semantic differential scale, the explorative nature of this measure can be very informative in this research study. In addition, because the semantic differential scale has not been a popular measurement of choice in research studies about implicit bias, it was hoped that participants would be less likely to guess the purpose of this study and reduce confounds to the research design. An exploratory factor analysis was conducted on this scale (including items from Pearce's study and items added by the investigator) to provide more detailed psychometrics information (see Reliability section in Chapter IV for more details).

Procedure

After the investigator obtained approval from the Institutional Review Board, emails (see Appendix E for recruitment email) were sent out to the contact person of APA-accredited psychology graduate programs as well as APA-accredited internship sites and APA-accredited

postdoctoral residency programs. This email contained the recruitment letter for the contact person to distribute to qualified individuals.

Individuals who agreed to participate in this study proceeded to click on the survey link in the recruitment letter. This survey provided an information letter including necessary information for informed consent to participate in this study (see Appendix F for informational letter). The letter also informed participants that they would have an opportunity to enter a drawing for one of five $20 Amazon gift cards as a reward for completing the study. By clicking on the continue button, participants provided informed consent to participate in this study.

After providing consent, participants proceeded to complete the Inclusion Criteria Questionnaire where they were asked to provide information regarding their age, practicum experience, experience working with young adults, and current profession. Those who were not qualified for this study were directed to the end of survey page. For those who were qualified to participate in this study, they were randomly assigned to one of the three conditions (i.e., Chinese-international-student client, Chinese-American-student client, or White-American-student client). In their assigned condition, participants listened to three audio recordings of a client's responses to three intake questions (see Appendix G for client intake recording). The vignettes for these recordings were developed by the investigator and reviewed by the dissertation committee members. In these audio recordings, a voice presented as the client discussed her background, her presenting concerns, and her goals for therapy. Other than client's identity and cultural background (e.g. holidays celebrated), the rest of the audio recording content remained the same in these three conditions. There was also information regarding client's demographic background (i.e., name, age, gender, ethnicity, sexual orientation, major) in a text format with client's name and ethnicity differing according to the condition. To make the

audio recordings present as close to real clinical scenario as possible, the audio recording for the Chinese-international-student client condition was recorded by a Chinese international student, the one for the Chinese-American-student client condition was recorded by a Chinese American individual, and the one for the White-American-student client condition was recorded by a White American individual. The investigator obtained several voice records for each condition and edited the recordings to decrease differences in speech speed and pauses among the recordings. The dissertation committee members reviewed the recordings and selected the ones which appeared to be most natural for the usage of this research study. The voice recordings can be found at

https://drive.google.com/drive/folders/18qf8TBSb7UczsdESu4dnfADhuBqx4pra?usp=sharing.

After listening to the three audio recordings of the *client* responding to three intake questions, participants then completed the Diagnostic Impression Questionnaire and the semantic differential scale based on their perception of the client. As the last part of this study, participants first responded to the question to determine whether they were graduate students or working professionals at internship sites or in postdoctoral residency programs. Depending on their responses, the survey then directed them to complete the Demographic Questionnaire appropriate for their current status. After completing the study, participants were provided an opportunity to enter a drawing for one of five $20 Amazon gift cards. Those who wished to enter the drawing were directed to a separate link to provide contact information for gift card drawing. The actual duration of time needed to complete participation, as recorded by Qualtrics, ranged from 14 seconds to 6 days. When only those who completed the study were included, the range was 4 minutes to 3 days, with 86% of the participants completed the study within 30 minutes.

Analytic Strategy

After collecting data from the study, the investigator downloaded the raw data directly from Qualtrics into the Statistical Package for the Social Science (SPSS). The investigator ran descriptive analyses on the demographic information collected to clear the missing data and provided summarized information regarding participants' demographic backgrounds. The reliability coefficients of the Semantic Differential Scale were examined.

When analyzing the semantic differential scale, client's cultural background served as an independent variable with three levels (i.e., Chinese international, Chinese American, White American). The total score of participants' rating on the scale served as a dependent variable. The investigator conducted a one-way ANOVA to examine if participants rated the Chinese-international-student client differently compared to how they rate the other two clients. A post hoc comparison using Bonferroni was also conducted to examine the nature of differences when found. In the same regard and using the same procedure, one-way ANOVA and post hoc comparison suing Bonferroni were conducted on the data collected through the Diagnostic Impression Questionnaire.

Chapter IV

Results

This chapter describes participant demographics, preliminary analyses used to prepare the data, analyses used to test the experimental hypotheses, post-hoc findings, and a summary of the results.

Reliability

Cronbach's alpha was used to examine the internal consistency reliability of each of the measures administered. For the semantic differential scale, the computed Cronbach's alpha was 0.91. This showed that the scale reached acceptable reliability. In all cases, deletion of individual item resulted in a decrease in alpha, suggesting that all items were worthy of retention. Maximum likelihood Exploratory Factor Analysis (EFA) with Oblimin rotation was conducted on the 26 items from this questionnaire. A criterion of eigenvalues greater than 1 resulted in a 5-factor solution. The initial eigenvalues showed that the first factor explained 33% of the variance, the second factor 10% of the variance, the third factor 6% of the variance, the fourth factor 5% of the variance, and the fifth factor 4% of the variance. Majority of the items (12 out of 26) loaded on the first factor, 4 loaded on the second factor, 5 loaded on the third factor, 1 loaded on the forth factor, and 5 loaded on the fifth factor. Inspection of the scree plot revealed a substantial change in variance and an elbow shaped bend in the distribution, supporting consideration for a one-factor solution. The one-factor solution was examined explained 33% of the variance, was preferred because of the "leveling off" of eigenvalues on the scree plot, and the insufficient number of primary loadings on some subsequent factors.

The symptom severity scale, comprised of ten items, had a Cronbach's alpha of 0.79, which reached acceptable reliability. In all cases, deletion of individual item resulted in a

decrease in alpha, suggesting that all items were worthy of retention. Maximum likelihood EFA with Oblimin rotation was conducted on the 10 items from this questionnaire. A criterion of eigenvalues greater than 1 resulted in a 3-factor solution. The initial eigenvalues showed that the first factor explained 35% of the variance, the second factor 13% of the variance, and the third factor 10% of the variance. Majority of the items (5 out of 10) loaded on the first factor, 1 on the second factor, and 3 on the third factor. Again, inspection of the scree plot supported consideration of a one-factor solution. The one-factor solutions explained 35% of the variance, making it the preferred model because of the "leveling off" of eigenvalues on the scree plot, and the insufficient number of primary loadings on the second factor.

The attribution questionnaire (see first two questions in Appendix C) had a Cronbach's alpha of 0.46, which is lower than what is typically acceptable. Most items appeared to be worthy of retention, resulting in a decrease in the alpha when deleted, except two internal attribution items (i.e., "the client should take more initiatives and actions to change her current situation," "this client should take the responsibility for difficulties she experienced")—the removal of these two items would increase the alpha to 0.66. Hence, these two items were dropped for further analysis.

Maximum likelihood EFA with Oblimin rotation was conducted on the 6 items from this questionnaire. A criterion of eigenvalues greater than 1 resulted in a 2-factor solution. The initial eigenvalues showed that the first factor explained 34% of the variance and the second factor 21% of the variance. One item (i.e., "the client should take more initiatives and actions to change her current situation") loaded on the first factor and 3 items (i.e., "the university does not do enough to help students like this client to succeed"; "the faculty and staff pay less attention to the needs of students like this client than to other groups of students"; "this client suffered because of the

environment she was in") on the second factor. Inspection of the scree plot supported

consideration of a two-factor solution. Using the $\pm$.45 cutoff criteria, 2 (i.e., "sometimes there is

too little publicity about programs to help students like this client"; "this client should take the

responsibility for difficulties she experienced") of the 6 items did not load on the 2-factor solution

and were dropped. With these two items dropped and the two internal attribution items that were

dropped due to Cronbach's alpha (one item overlapped), 3 items were remaining (i.e., "the

university does not do enough to help students like this client to succeed," "this client suffered

because of the environment she was in," "the faculty and staff pay less attention to the needs of

students like this client than to other groups of students"). Among these 3 items, dropping of the item

"this client suffered because of the environment she was in" will increase Cronbach's alpha from

0.66 to 0.70. Hence, only two items (i.e., "the university does not do enough to help students like

this client to succeed," "the faculty and staff pay less attention to the needs of students like this client

than to other groups of students") of the attribution questionnaire were used in the one-way

ANOVA analysis. Given that the only two items remained for the analysis both loaded on the

second factor, they reflected a 1-factor solution instead of the original 2-factor solution for this

questionnaire. Hence, the outcome of this two-item analysis cannot be used for testing the

attribution hypothesis that the 6-item questionnaire were designed for, making analysis at the

item level most appropriate.

Descriptive Statistics

Table 1 shows the descriptive statistics (i.e., means, standard deviations, intercorrelations

using Pearson's *r*) of the study variables. Participants' favorable rating of the client was

positively associated with their external attribution of client's presenting concerns. In addition,

higher perceived symptom severity of the client was positively associated with more perceived

sessions needed by the client. Furthermore, when participants reported themselves as sufficiently

trained to treat the client, they tended to report that the client needed fewer sessions and the client's concerns were more attributable to internal factors (i.e., client's personality, characteristics, laziness, etc.).

Table 2 shows the descriptive statistics, including means, standard deviations, and intercorrelations using Pearson's correlations, of the study variables within each conditions (i.e., Chinese-international-student client, Chinese-American-student client, White-American-student client). In the Chinese-international-student client condition, the client's perceived symptom severity was positively associated with the number of perceived sessions needed for the client. Similarly, participants' favorable ratings of the client was positively associated with the external attribution of client's presenting concerns. Moreover, when participants in this condition reported themselves as sufficiently trained to provide treatment to the client, they were less likely to report favorable ratings of the client or external attribution of the client's presenting concerns. In the Chinese-American-student client condition, no significant intercorrelation between variables were found. In the White-American-student client condition, participants' report of themselves as sufficiently trained to provide treatment to the client was negatively associated with their perception of the number of sessions needed by the client, client's symptom severity, and external attribution of client's presenting concerns.

Favorable/unfavorable Rating

To test the hypothesis that therapists rated the Chinese-international-student client in a less favorable manner compared to how they rated the White-American-student client and Chinese-American-student client, the investigator conducted a one-way Analysis of Variance (ANOVA) to compare the effect of client's cultural background on participants' total ratings on the semantic differential questionnaire in three conditions.

The test for normality and homogeneity of variance indicated that these assumptions underlying the application of ANOVA were met. The results of ANOVA indicated that there was a significant effect of client's cultural background on participants' total rating on the semantic differential questionnaire at the $p < .05$ level for all three conditions [$F(2, 230) = 8.136$, $p < .001$, $\eta2 = .07$]. An alpha level of .05 was used for all subsequent analyses. Post hoc comparisons using the Bonferroni correction were conducted to determine which pairs of the three condition means differed significantly. The results were presented in Table 3 and indicated that the mean score for the White-American-student client condition ($M = 183.42$, $SD = 21.16$) was significantly lower than the Chinese-international-student client condition ($M = 198.32$, $SD = 24.02$) and the Chinese-American-student client condition ($M = 192.73$, $SD = 24.43$). This indicates that participants rated the Chinese-international-student client and Chinese-American-student client more positively than how they rated the White-American-student client. The effect size of these two significant effects were 0.66 and 0.41, respectively. There was no statistically significant difference between the mean score for the Chinese-international-student client condition and that for the Chinese-American-student client condition.

Degree of Pathology Seen in Client's Presenting Concerns

To test the hypothesis that therapists will pathologize less the client who presented as a Chinese-international-student client when compared with the White-American-student client and Chinese-American-student client, another one-way Analysis of Variance (ANOVA) and a Kruskal-Wallis test were used. For each of these analyses, the independent variable had 3 conditions: Chinese-international-student client, Chinese-American-student client, and White-American-student client. The dependent variables were participants' diagnostic impression of the client—specifically, number of sessions needed by the client and severity of the symptoms.

65

The effect of client's cultural background on participants' estimated number of sessions needed by the client was tested. Participants were asked to choose among 1-4 sessions, 4-8 sessions, 8-12 sessions, and more than 12 sessions. Due to the ordinal nature of the dependent variable and the 3-level independent variable, a non-parametric test Kruskal-Wallis test was conducted. The test showed that there were no statistically significant differences in participants' perception of sessions needed by the client among three conditions [$H(2) = 5.28$, $p = .071$], with an adjusted mean sessions needed of 113.46 for Chinese-international-student client, 129.47 for Chinese-American-student client, and 108.03 for White-American-student client. The unadjusted means of sessions needed by the clients were 2.45 for the Chinese-international-student client, 2.60 for Chinese-American-student client, and 2.38 for White-American-student client. This indicates that participants did not perceive differences among these three groups in terms of sessions needed by the clients.

Another analysis was conducted regarding the effect of client's cultural background on participants' ratings of client's symptom severity. The test for normality indicated the data were statistically normal. However, the assumption of homogeneity of variance was violated; *Levene's* $F(2, 230) = 4.16$, $p = .017$, indicating that this assumption underlying the application of ANOVA was not met. Hence, *Welch's* adjusted F ratio (3.92) was obtained, which was significant at the p <.05 level [$F(2, 151.50) = 3.92$, $p = .022$, $\eta^2 = .03$]. Post hoc comparisons using the Bonferroni correction were conducted to determine which pairs of the three condition means differed significantly. The results are Table 4 and indicated that the mean score for the White-American-student client condition ($M = 26.74$, $SD = 4.77$) was significantly lower than the Chinese-international-student client condition ($M = 28.78$, $SD = 5.83$) and the Chinese-American-student client condition ($M = 28.54$, $SD = 4.52$). This indicates that participants perceived the White-

American-student client as experiencing less severe symptoms than the Chinese-international-student client and the Chinese-American-student client. The effect size of these two significant effects were 0.38 and 0.39, respectively. There was no significant difference between the Chinese American and the Chinese-international-student client conditions.

Attribution

Data analysis was conducted to examine the hypothesis that therapist will perceive the client who presents as Chinese-international-student client as more responsible for and the circumstances as less responsible for their presenting concerns than how they perceive the clients who presented as a White-American-student client or Chinese-American-student client. The independent variable had three conditions: Chinese-international-student client, Chinese-American-student client, and White-American-student client. The dependent variable was participants' ratings of attribution of client's presenting concerns. Participants were asked to provide ratings from 1 to 5 on internal and external attribution items.

As mentioned in the Reliability section, only 2 items (i.e., "the university does not do enough to help students like this client to succeed," "the faculty and staff pay less attention to the needs of students like this client than to other groups of students") of the 6 items in this questionnaire were included in this data analysis due to reliability issues. The test for normality and homogeneity of variance indicated that these assumptions underlying the application of ANOVA were met. A one-way ANOVA was conducted to examine the effect of client's cultural background on participants' perceived attribution of client's presenting concerns.

There was a significant effect of client's cultural background on participants' rating on the attribution of client's presenting concerns [$F(2, 230) = 11.11$, $p < .001$, $\eta^2 = .09$]. The results indicated that the mean score for the White-American-student client condition ($M = 5.37$, $SD =$

1.41) was significantly lower than the mean score for Chinese-international-student client condition ($M = 6.56$, $SD = 1.69$) and the mean score for the Chinese-American-student client condition ($M = 6.09$, $SD = 1.63$). The effect size of these two significant effects were 0.59 and 0.36, respectively. There was no significant difference between the Chinese-American-student client and the Chinese-international-student client conditions. This outcome indicated that participants perceived the external environment as less responsible for the presenting concerns of the White-American-student client compared to the Chinese-international-student client and Chinese-American-student client. However, due to the major modification of this questionnaire, the outcome cannot be used confidently for testing the hypothesis regarding therapists' perceived attribution of client's presenting concerns.

Additional one-way ANOVA analyses were conducted on one external attribution item (i.e. "This client suffered because of the environment she was in") and one internal attribution item (i.e. "This client should take the responsibility for difficulties she experienced"). The test for normality and homogeneity of variance indicated that these assumptions underlying the application of ANOVA were met. The results of ANOVA indicated that there was a significant effect of client's cultural background on participants' rating on the external attribution item at the $p < .025$ level for all three conditions [$F(2, 230) = 8.610$, $p < .001$]. Post hoc comparisons using the Bonferroni correction were conducted to determine which pairs of the three condition means differed significantly. The results indicated that the mean score for the Chinese-international-student client condition ($M = 3.78$, $SD = 0.82$) was significantly higher than the Chinese-American-student client condition ($M = 3.42$, $SD = 0.86$) and the White-American-student client condition ($M = 3.23$, $SD = 0.82$). This indicates that participants perceived Chinese-international-student client's presenting concerns as more attributable to external environment compared to

how they perceive those of Chinese American and White-American-student clients. The effect size of these two significant effects were 0.43 and 0.67, respectively. There was no statistically significant difference between the mean score for the White-American-student client and the Chinese-American-student client conditions. Regarding the data analysis outcome for the internal attribution item, the results of ANOVA indicated that there was no significant effects of client's cultural background on participants' rating on the internal attribution item at the $p < .025$ level for all three conditions [$F(2, 230) = .864$, $p = .423$]. The means that participants did not have different perceptions of internal attribution of presenting concerns among these three conditions.

Training Sufficiency

Data analysis was conducted to examine the hypothesis that therapists will report their training as less sufficient in preparing them to provide treatment to Chinese-international-student client than that to White-American-student client and Chinese-American-student client. The independent variable had three conditions: Chinese-international-student client, Chinese-American-student client, and White-American-student client. The dependent variable was participants' ratings from Strongly Disagree (1) to Strongly Agree (5) on the item "I have sufficient training that prepares me to provide appropriate and quality treatment to this client".

The test for homogeneity of variance indicated that this assumption underlying the application of ANOVA was met. However, the test for normality, examining standard skewness and the Shapiro-Wilks test, indicated the data were skewed. Hence, a non-parametric test using the Kruskal-Wallis test was conducted. The results were given in Table 5 and indicated that there was no statistically significant difference among the participants' reported sufficiency of training in three conditions [$H(2) = 3.62$, $p = .164$].

Analyses Based on Participants' Demographics

Additional data analyses were conducted to explore if participants responded to the questionnaires differently based on their demographic backgrounds.

Graduation students and professionals. One-way ANOVA analyses were conducted on the data from participants who self-identified as graduate students and those as professionals.

For the graduate-student subsample, the outcome of data analyses on the Semantic Differential Scale indicated that participants who self-identified as graduate students rated the Chinese-international-student client (M = 199.25, SD = 24.44) more favorably compared to their perception of the White-American-student client, (M = 183.28, SD = 19.26) at the p < .05 level [$F(2, 173)$ = 7.900, p = .001]. In addition, these participants did not rate the Chinese-international-student client (M = 199.25, SD = 24.44) and the Chinese-American-student clients (M = 192.12, SD = 21.79) differently on this scale. Based on the data analyses of the external attribution item, graduate-student participants perceived Chinese-international-student client's (M = 3.84, SD = 0.77) presenting concerns as more attributable to her environment compared how the perceive the concerns of the White-American-student (M = 3.38, SD = 0.80) and Chinese-American-student clients (M = 3.45, SD = 0.81) at the p < .05 level [$F(2, 173)$ = 5.784, p = .004]. There was no difference between their perception of external attribution of presenting concerns for the White-American-student and Chinese-American-student clients. No statistically significant differences were found among these three conditions on the other scales (i.e. number of sessions needed [$F(2, 173)$ = 2.892, p = .058], symptom severity [$F(2, 173)$ = 2.887, p = .058], internal attribution [$F(2, 173)$ = 0.058, p = .944], reported training sufficiency [$F(2, 173)$ = 2.048, p = .132]).

For the professionals sample, the analyses showed that participants perceived the Chinese-international-student client's ($M = 3.60$, $SD = 0.94$) presenting concerns as more attributable to the environment she was in compared to those of the White-American-student client ($M = 2.71$, $SD = 0.69$) at the p < .05 level [$F(2, 58) = 4.788$, $p = .012$]. There was no difference between their responses on the external attribution item for the Chinese-international-student client and the Chinese-American-student client ($M = 3.36$, $SD = 1.00$). No statistically significant differences were found among these three conditions on the other scales (i.e. favorable/unfavorable rating [$F(2, 58) = 0.991$, $p = .378$], number of sessions needed [$F(2, 58) = 1.602$, $p = .211$], symptom severity [$F(2, 58) = 1.225$, $p = .301$], internal attribution [$F(2, 58) = 3.115$, $p = .052$], reported training sufficiency [$F(2, 58) = 2.932$, $p = .061$]).

Ethnicity. One-way ANOVA analyses were conducted on the data from participants who self-identified as White/European and those who did not self-identify as White/European.

For the White/European sample, the outcome of data analyses showed that participants perceived the Chinese-international-student client's ($M = 3.75$, $SD = 0.84$) presenting concerns as more attributable to her environment compared to those of the White-American-student client ($M = 3.24$, $SD = 0.80$) at the p < .05 level [$F(2, 185) = 5.992$, $p = .003$]. There was no difference between their responses on the external attribution item for the Chinese-international-student client and the Chinese-American-student client ($M = 3.41$, $SD = 0.85$). In addition, the participants perceived the Chinese-international-student client ($M = 28.70$, $SD = 5.15$) as experiencing higher symptom severity compared to their perception of the White-American-student client ($M = 26.46$, $SD = 5.00$) at the p < .05 level [$F(2, 185) = 3.719$, $p = .026$]. There was no difference between their ratings for the Chinese-international-student client and the Chinese-American-student client ($M = 28.41$, $SD = 4.57$) regarding symptom severity.

Furthermore, these participants rated the Chinese-international-student client (M = 198.02, SD = 23.75) more favorably compared to how they rated the White-American-student client (M = 182.92, SD = 20.50) at the p < .05 level [$F(2, 185)$ = 6.865, p = .001]. They did not rate the Chinese-international-student and Chinese-American-student clients (M = 190.77, SD = 22.97) differently on the favorable/unfavorable scale. No statistically significant differences were found among these three conditions on the other scales (i.e. number of sessions needed [$F(2, 185)$ = 1.457, p = .236], internal attribution [$F(2, 185)$ = 0.565, p = .570], reported training sufficiency [$F(2, 185)$ = 1.126, p = .327]).

For the non-White/European sample, no statistically significant differences were found among these three conditions on all scales (i.e. favorable/unfavorable rating, number of sessions needed, symptom severity, external attribution, internal attribution, reported training sufficiency). This indicates that for those participants who did not self-identify as White/European, there was no differences among favorability perceptions [$F(2, 46)$ = 2.056, p = .140] of the Chinese-international-student, Chinese-American-student, and White-American-student clients. Similarly, within this group of participants, their ratings of the three clients did not differ for the sessions needed by the client [$F(2, 46)$ = 1.228, p = .303], client's reported symptom severity [$F(2, 46)$ = 0.387, p = .681], and reported sufficiency of training for working with the client [$F(2, 46)$ = 0.600, p = .553]. There were also no differences in ratings of internal attribution [$F(2, 46)$ = 0.211, p = .810] and external attribution of presenting concerns [$F(2, 46)$ = 2.724, p = .077] among these students.

Clinical experience. One-way ANOVA analyses were conducted on the data from participants who reported having clinical experience working with Chinese international students and those reported no clinical experience working with Chinese international students.

For the sample that reported previous clinical experience working with Chinese international students, the outcome of data analyses showed that participants perceived the Chinese-international-student client ($M = 197.19$, $SD = 22.92$) and the Chinese-American-student client ($M = 196.40$, $SD = 28.00$) more favorably compared to how they perceive the White-American-student client ($M = 179.61$, $SD = 22.12$) at the $p < .05$ level [$F(2, 94) = 4.778$, $p = .011$]. Participants did not rate the Chinese-international-student and Chinese-American-student clients differently on the favorable/unfavorable scale. In addition, these participants perceived the Chinese-international-student client's ($M = 3.72$, $SD = 0.85$) presenting concerns as more attributable to her environment compared to how they perceive those of the White-American-student client ($M = 3.07$, $SD = 0.66$) at the $p < .05$ level [$F(2, 94) = 5.152$, $p = .008$]. There was no difference between their responses on the external attribution item for the Chinese-international-student client and the Chinese-American-student client ($M = 3.54$, $SD = 0.85$). No statistically significant differences were found among these three conditions on the other scales (i.e. number of sessions needed [$F(2, 94) = 2.954$, $p = .057$], internal attribution [$F(2, 94) = 2.165$, $p = .121$], symptom severity [$F(2, 94) = 0.173$, $p = .841$], reported training sufficiency [$F(2, 94) = 0.275$, $p = .760$]).

For the sample that reported no previous experience working with Chinese international students, the outcome of data analyses showed that participants perceived the Chinese-international-student client ($M = 199.133$, $SD = 25.00$) and the Chinese-American-student client ($M = 189.86$, $SD = 20.72$)more favorably compared to how they perceive the White-American-student client ($M = 184.51$, $SD = 19.34$) at the $p < .05$ level [$F(2, 137) = 5.384$, $p = .006$]. Participants did not rate the Chinese-international-student client and the Chinese-American-student client differently on the favorable/unfavorable scale. In addition, these participants

perceived the Chinese-international-student client's ($M = 3.82$, $SD = 0.81$) presenting concerns as more attributable to her environment compared to how they perceive those of the Chinese-American-student ($M = 3.30$, $SD = 0.88$) and White-American-student clients ($M = 3.35$, $SD = 0.88$) at the p < .05 level [$F(2, 137) = 5.212$, $p = .007$]. There was no difference between their responses on the external attribution item for the Chinese-American-student client and the White-American-student client. Furthermore, participants perceived the Chinese-international-student client ($M = 29.22$, $SD = 5.85$) and Chinese-American-student client ($M = 29.18$, $SD = 4.12$) as experiencing higher symptom severity compared to how they perceive the White-American-student client ($M = 26.70$, $SD = 4.64$) at the p < .05 level [$F(2, 137) = 4.104$, $p = .014$]. There was no difference between their ratings for the Chinese-international-student client and the Chinese-American-student client regarding symptom severity. No statistically significant differences were found among these three conditions on the other scales (i.e. number of sessions needed [$F(2, 137) = 0.788$, $p = .008$], internal attribution [$F(2, 137) = 0.142$, $p = .008$], reported training sufficiency [$F(2, 137) = 5.152$, $p = 1.053$]).

Table 1

Descriptive Statistics and Intercorrelations for Study Variables

Variables	1	2	3	4	5
1. Favorable/unfavorable ratings	__				
2. Sessions needed	-.06	__			
3. Symptom severity	-.08	.23**	__		
4. Attribution	.28**	.04	.04	__	
5. Training sufficiency	-.02	-.22**	-.07	-.18**	__
M	191.46	2.48	28.02	19.52	4.41
SD	23.95	.65	5.13	2.68	.64

Note. N = 233; **p* < .05, ***p* < .01; Sessions needed was measured by participants' perception of the total number of sessions needed by the client and four choices were provided (1 = *1-4 sessions,* 2 = *4-8 sessions*, 3 = *8-12 sessions*, 4 = *more than 12 sessions*).

Table 2

Descriptive Statistics and Intercorrelation for Study Variables in Specific Conditions

Variables	1	2	3	4	5
Chinse-International-Student Client (*n* = 77)					
Favorable/unfavorable ratings	—				
Sessions needed	.05	—			
Symptom severity	-.09	.29*	—		
Attribution	.35**	.08	.08	—	
Training sufficiency	-.08	-.25*	.04	-.27*	—
M	198.32	2.45	28.78	20.51	4.36
SD	24.02	0.74	5.83	2.63	0.69
Chinese-American-Student Client (*n* = 78)					
Favorable/unfavorable ratings	—				
Sessions needed	-.12	—			
Symptom severity	-.15	.20	—		
Attribution	.20	-.06	-.10	—	
Training sufficiency	-.11	-.11	.01	.01	—
M	192.73	2.60	28.54	19.63	4.36
SD	24.43	0.57	4.52	2.73	0.58

Table 2 (continued)

Descriptive Statistics and Intercorrelation for Study Variables in Specific Conditions

Variables	1	2	3	4	5
White-American-Student Client (*n* = 78)					
Favorable/unfavorable ratings	—				
Sessions needed	-.19	—			
Symptom severity	-.18	.12	—		
Attribution	.08	.06	-.04	—	
Training sufficiency	.21	-.25*	-.23*	-.22*	—
M	183.42	2.38	26.74	18.44	4.50
SD	21.16	0.63	5.13	2.28	0.66

Note. N = 233; *p* < .05, **p* < .01; Sessions needed was measured by participants' perception of the total number of sessions needed by the client and four choices were provided (1 = *1-4 sessions,* 2 = *4-8 sessions*, 3 = *8-12 sessions*, 4 = *more than 12 sessions*).

Table 3

Bonferroni Comparison for Semantic Differential Scale by Client's Cultural Background

Comparisons	*Mean Difference*	*Std. Error*	*p*	95% CI	
				LL	*UL*
CI vs. CA	5.59	3.73	.407	-3.41	14.60
CI vs. WA	14.90	3.73	<.001***	5.90	23.91
CA vs. WA	9.31	3.72	.039*	0.33	18.28

Note: Larger numbers indicate more favorable ratings of the client. CI = Chinese-international-student client condition, CA = to Chinese-American-student client condition, and WA = White-American-student client condition.

Table 4

Bonferroni Comparison for Symptom Severity by Client's Cultural Background

Comparisons	Mean Difference	Std. Error	p	95% CI	
				LL	UL
CI vs. CA	0.24	0.81	1.00	-1.72	2.20
CI vs. WA	2.04	0.81	.039	0.07	4.00
CA vs. WA	1.79	0.81	.084	-0.16	3.75

Note: Larger numbers indicate higher perceived overall symptom severity.
CI = Chinese-international-student client condition, CA = to Chinese-American-student client condition, and WA = White-American-student client condition.

Table 5

Kruskal-Wallis Test of Training Sufficiency Reported by Client's Cultural Background

Category	*N*	*Mean Rank*	*df*	*h*	*p*
Chinese International	77	113.76			
Chinese American	78	109.90			
White American	78	127.30			
Total	233		2	3.62	.164

Chapter V

Discussion

Summary of the Study

This dissertation study was designed to examine therapists' implicit bias towards Chinese international students. More specifically, the investigator intended to examine if therapists perceive Chinese international students, their presenting concerns, attribution of their issues, and therapists' own training preparation differently compared to how they perceive those of American students (i.e., Chinese American, White American). This section serves as a discussion of the research findings.

The hypothesis that therapists would perceive Chinese-international-student client unfavorably compared to Chinese-American-student and White-American-student clients was measured by the semantic differential scale. The results showed that overall therapists tended to perceive Chinese-international-student client more favorably than how they perceived the White-American-student client, and there was no difference between therapists' perception of the Chinese-international-student client and the Chinese-American-student client. This finding is contrary to the investigator's hypotheses and are in contrast to findings from previous studies (Pearce, 1994; Rubin & Smith; 1990; Ruble & Zhang, 2013).

To examine if therapists pathologized the Chinese-international-student client less than the Chinese-American-student and White-American-student clients, the investigator created and used a question asking participants' estimated number of sessions needed by the client as well as a questionnaire regarding participants' perception of client's symptom severity. No significant differences were found among the means of three conditions (i.e., Chinese-international-student client, Chinese-American-student client, White-American-student client) regarding participants'

estimated number of sessions needed by the client. This indicated that participants did not perceive the Chinese-international-student client as needing more or fewer sessions compared to the other clients. The outcome of the questionnaire regarding participants' perception of client's symptom severity revealed that therapists perceived the Chinese-international-student client as experiencing higher symptom severity compared to how they perceived the White-American-student client. In addition, the result showed that therapists did not perceive the Chinese-international-student and the Chinese-American-student clients differently when asked about symptom severity. These findings do not support investigator's hypotheses. Rather than being pathologized less, the Chinese-international-student client, when compared with the White-American-student client, was pathologized more, by therapists.

The investigator created and intended to use a six-item questionnaire to examine if therapists perceived the Chinese-international-student client's issues as more attributable to internal factors rather than external factors. The reliability of the questionnaire did not reach an acceptable level and four items were deleted as a result of factor analysis. The data analysis using two items showed that therapists perceived the Chinese-international-student client's struggles as more attributable to external factors compared to how they perceived those of the White-American-student client. There was no difference between therapists' perception of internal or external attribution when data for the Chinese-international-student client was compared with data for the Chinese-American-student client. For instance, the analysis of the item "this client suffered because of the environment she was in" showed that therapists perceived Chinese-international-student client's presenting concerns as more attributable to the environment compared to how they perceived White-American-student client. This is not consistent with findings from previous research studies—struggles of individuals from minority

groups tend to be attributed more to their own internal factors (e.g. personal deficits and traits, lacking effort, poor choices, etc.) than to external factors, such as the environment and the social systems (Anderson, 1992; Appelbaum, 2001; Cozzarelli et al., 2001; Hughes & Tuch, 2000; Hunt, 1996, 2007; Winter, 2008).

The investigator created and used an item to test if therapists report their training as less sufficient in preparing them to provide treatment to the Chinese-international-student client than that to Chinese-American-student and White-American-student clients. No differences were found among therapists' report of their training in preparing them to work with the clients in the three conditions. This finding is inconsistent with previous literature and investigator's hypotheses. Several scholars pointed out the lack of effort in graduate programs to include training to prepare therapists in providing mental health treatment to international students (Arthur, 2008; Diangelo, 2006; Fouad, 1991). Instead, training about multicultural issues of American minority groups are typically generalized to those of international students in particular, and perhaps international populations in general, regardless of the large amount of differences that may exist between, for example, Chinese American students and Chinese international students (see Jacob & Greggo, 2001; Yoon & Portman, 2004). It is possible that this lack of training focus on international populations reflects a lack of understanding of the potential differences. At the same time, the reported training to treat the White-American-student client did not differ from the other two clients, which may mean other factors inform the failure to find significant differences (which are further discussed below).

Conclusion and Discussion

The findings of this research study indicate that overall therapists may perceive Chinese international student clients more favorably compared to how they perceive White American

83

student clients. Furthermore, the findings suggest that therapists may perceive Chinese international student clients as experiencing higher symptom severity compared to how they perceive White American student clients; however, therapists may not perceive Chinese international student clients as needing more or less sessions compared to White American and Chinese American student clients. In addition, after a major modification of the attribution questionnaire, the outcome suggests that therapists may perceive Chinese international student clients' struggles as more attributable to external factors compared to how they perceive those of White American student clients. Lastly, the results of this study indicate that therapists did not report their multicultural training as insufficient to work with Chinese international student clients relative to training to work with American student clients. It is worth noting that no differences were found on any of the outcome measures between perceptions of a Chinese international student and a Chinese American student client.

This study utilized similar methodology as Pearce's (1994) study; but produced contradictory findings. Even though the findings in this research study are inconsistent with literature and all hypotheses, they should not be taken as evidence that there is a lack of implicit bias towards Chinese international student clients among therapists. On the contrary, given these statistically significant differences between therapists' attitude towards Chinese international student clients and that towards American student clients, we must consider the existence of bias. Only with high powered studies that yield no differences in how therapists perceive clients from different cultural backgrounds can we conclude the absence of bias. Findings of differential attitudes raise the possibility that biases may operate differently than found previously. It is also important to note, though the pattern is beyond the scope of the current study, that perceptions about the Chinese-America-student client were found to differ from the White-American-student

client in similar ways to how the Chinese-international-student client differed from the White-American-student client. This further raises questions about potential assumptions based on racial group members. Potential contributing factors and explanations for these research findings are discussed in details below.

Regarding the research outcome that therapists perceived the Chinese-international-student client more favorably compared to how they perceived the White-American-student client, different factors could contribute to this inconsistent finding with literature. It is possible that as a result of multicultural training, therapists have more acute awareness of the privileges enjoyed by White American student clients, which could lead to potential annoyance and frustration with White American students and favorable perceptions of minoritized students. This can be a contributing factor to the finding for the first hypothesis of this study. Another potential explanation is that therapists harbor genuine positive feelings towards Chinese international student clients given their courage and challenges of living in a foreign country. It is also possible that therapists rated the Chinese-international-student client more positively due to the potential model minority stereotypical impressions (i.e. hardworking, submissive, and complicit; Liou, 2018). Other potential contributing factors for this finding, such as benevolent bias, social desirability, and political correctness, are discussed in details in the subsections below.

In the findings for the second hypothesis (i.e. therapists would pathologize the Chinese-international-student client more than they would pathologize the other clients), it is worth nothing that therapists did not perceive the Chinese-international-student client as needing more sessions based on the presenting concerns compared to the other two clients. This could indicate that therapists do not perceive Chinese international student clients as struggling more or in need of additional treatment compared to the American students. In terms of the finding about

symptom severity, it is possible that due to the increased amount of Chinese international students living in the United States, therapists have more exposure to the struggles these students encounter in their daily life. This could lead to therapists perceive Chinese international student clients as facing more difficult challenges and experiencing more severe symptoms.

The finding for the last hypothesis (i.e., therapists did not report themselves as uniquely lacking training in providing quality and appropriate treatment to the Chinese-international-student client relative to the Chinese-American-student client and the White-American-student client) is inconsistent with existing literature (Arthur, 2008; Diangelo, 2006; Fouad, 1991; Yoon & Portman, 2004). However, there are different possible explanations for this outcome. It is possible that due to the increased number of Chinese international students studying in the U.S. in recent years, training for therapists has improved and therapists have received sufficient training for providing treatment to Chinese international student clients. It is also possible that with Chinese international students being the largest international student group in the U.S., therapists have obtained more clinical experience working with this population than with international students from other countries. Hence, it is possible that therapists would perceive themselves as well prepared to work with Chinese international students. Another possibility is that therapists are not aware that they are in need of training to work with Chinese international student clients. Given how multicultural training for therapists often assumes similarities between working with international population and working with American minoritized groups, therapists can perceive themselves as having received sufficient training for providing appropriate treatment to Chinese international students when they assume that the same training that helps build competence in working with Chinese American students directly translates to their work with Chinese international students. This possibility is also supported by the finding

in this study that therapists' perception of the Chinese-international-student client and Chinese-American-student client did not differ. Also, without education about international populations, therapists might not be aware of the unique challenges faced by Chinese international students and that they need more training to better work with this population. If there is such a lack of awareness, therapists are likely to perceive themselves as well-prepared to work with Chinese international student clients as to work with White American student clients.

Below are discussions of other potential contributing factors to the research findings.

Benevolent prejudice. One potential explanation for the findings that are not consistent with literature is benevolent prejudice. Benevolent prejudice was first proposed by Glick and Fiske in 1996 regarding attitudes towards women. According to the authors, benevolent sexism contains positive stereotypical impressions of women that imply women need care from men as they are perceived as inferior to and less competent than men. Benevolent sexism (e.g., women should be placed on pedestals) might appear to be positive on the surface, but it serves to restrict women to traditional gender roles and to continue the oppression of their rights. This theory is also applicable in biases and prejudice toward other minoritized groups. In general, benevolent prejudice is a bias containing positive feelings (i.e., sympathy, pity, sadness, and guilt) toward outgroup members based on their perception of these outgroup members as inferior, incompetent, and passive (Eckes, 2002; Fiske et al., 2002; Fiske et al., 1999; Ramasubramanian & Oliver, 2007). Benevolent prejudice thus grows out of an assumption of superiority of the dominant groups/ingroup members over minoritized groups/outgroup members. Examples of benevolent prejudice including assuming women as needing protection from men and assuming ethnic minority individuals as in need of more help than majority group members. Although benevolent prejudice might feel to those who hold and are exposed to such prejudice as

stemming from a good intention, it has the same underlying value as hostile prejudice and can be as hurtful and offensive as hostile prejudice (Ramasubramanian & Oliver, 2007; Ramos, Barreto, Ellemers, Moya, & Ferreira, 2018). Esposito and Romano (2016) did an excellent job summarizing benevolent prejudice using the example of benevolent racism towards black community—"those who carry out benevolent racism typically recognize and condemn racism; however, they do so by supporting attitudes, policies, and practices that ultimately uphold the prevailing racial status quo in the name of uplifting or empowering the black community" (p. 165).

If therapists hold benevolent prejudice towards Chinese international students, it is likely that they hold positive feelings toward this population, such as sympathy, pity, sadness, and guilt (Ramasubramanian & Oliver, 2007). This can look like a perception that this group needs and deserves extra help and needs to be "saved" because they are lacking in some way (as opposed to a recognition that some environments systematically privilege individuals differentially). These seemingly positive feelings that are part of benevolent prejudice may have contributed to their perception of Chinese international students as more favorable compared to how they perceived White American students. Another potential outcome of these seemingly positive feelings towards Chinese international students is negative perceptions of White American students. It is possible that due to benevolent prejudice, therapists perceive Chinese international students as more exotic and interesting while finding White American students as boring and privileged. This can also potentially contribute to the finding in this study that therapists rated the Chinese-international-student client more favorably compared to how they rated the White-American-student client.

According to the literature, the underlying assumption of these positive feelings is that Chinese international students are inferior to, less competent, more helpless, and more passive than White American students (Eckes, 2002; Fiske et al., 2002; Fiske et al., 1999). If this assumption exists in their perception of Chinese international students, therapists would be likely to perceive Chinese international students as less competent to deal with life obstacles, less capable of handling struggles, more passive in resolving issues, and hence experiencing more severe symptoms than White American students. This is supported by Werhun and Penner's (2010) finding in their study—those who hold benevolent prejudice are more likely to assume minoritized individuals experience difficulties in completing their work tasks and need more guidance and assistance from the majority group, which resulted in expressed higher desire to help. Thus, although assumptions/beliefs that associate international study with great stress an difficulty may seem to originate from a positive and supportive places, those assumptions may also limit the extent to which those who hold the assumptions/beliefs attribute autonomy and capacity for mastery to international students. Therefore, it is likely that benevolent prejudice can affect therapists' perception of Chinese international students as experiencing higher symptom severity compared to White American students.

Social desirability. Another potential explanation for these research findings is social desirability. It is possible that participants became aware of (i.e., guessed) the purpose of this research study, and hence these research findings reflect on their explicit bias instead of implicit bias. This means that participants' responses to the questionnaires are conscious, intentional, and edited (Boysen, 2009). According to the Boysen, therapists rarely present themselves with explicit bias; even when explicit bias is reported, they are usually all positive ones. This is consistent with the findings in this research study: therapists rated the Chinese-international-

student client more favorably compared to how they rated the White-American-student client and they perceived the Chinese-international- student client's struggles as more attributable to external factors. It is possible that participants' responses in this research study, reflective of their explicit bias, were confounded by social desirability. According to Krosnick (1999), social desirability is participants' tendency to report attitudes and behaviors that are socially accepted or respected in research studies. It can also be understood as participants' need for social approval (Holtgrave, 2004; Marlow & Crowne, 1961). Multiple research studies have provided evidence for the positive relationship between therapists' self-reported multicultural awareness (i.e., explicit bias) and their proneness to display social desirability bias in their responding—those who present with higher need for social approval self-report higher multicultural competence (Constantine & Ladany, 2000; Larson & Bradshaw, 2017; Sodowsky, Kuo-Jackson, Richardson, & Corey, 1998; Worthington, Mobley, Franks, & Tan, 2000). In conclusion, it is possible that this research study examined participants' explicit bias towards Chinese international student clients, and their responses were influenced by social desirability, which contributed to the overall more positive perception of the Chinese-international-student client than of the White-American-student client.

Political correctness. The other factor that may have potential effect on the findings of this research study is political correctness. The definition and the connotation of this term have changed over time. In 1994, Barker defined political correctness as a behavior of putting on a public front that is different from one's real opinions. In 1996, Kelly and Rubal-Lopez defined it as a social movement that addresses tolerance and equality. Strauts and Blanton (2015) also define political correctness as the use of inclusive language. At times, this term is used by those who are on the political right to dismiss the values and proposals of those who are on the

political left (Hughes, 2010). Similarly, Reinelt (2011) defines political correctness as a performance put on by those who want to present as thoughtful and considerate of others. Recently, Dickson (2017) raised a question about how we understand political correctness—is political correctness a behavior individuals use to manage their social appearance or does it reflect one's true internal attitudes towards minoritized groups? Political correctness carries different kinds of connotations, positive or negative, when used in different contexts. Hope, Milewski-Hertlein, and Rodriguez's (2001) understanding of this term appears to be fitting for the purpose of discussing the findings of this research study—political correctness is used to correct bias towards minoritized groups and to change the "normal" defined by majority groups; however, when it reaches a pathological level (i.e., when it introduces "silence, discomfort, and whitewashing", p. 36), negative effects cannot be avoided.

With the amount of effort devoted into multicultural awareness in the field of psychology, therapists are trained to respond and behave in culturally sensitive ways. This helps therapists to provide appropriate treatment and increase positive therapy outcome. It also encourages therapists to make contributions to larger scale sociocultural change. However, when the emphasis of multiculturalism is carried to a pathological level of political correctness, it can generate harsh judgements of one's characteristics when a person is presented with culturally insensitive/ignorant behavior or attitudes. When this kind of negative social judgement occurs, individuals often feel silenced and oppressed because their opinions are not accepted or allowed if not fitting the politically correct way (Deresiewicz, 2017). In this kind of atmosphere, therapists can feel that they are under constant surveillance and can tend to over-correct their public behavior and attitudes, which result in expressing overly positive attitudes toward minoritized groups and even negative attitudes toward majority groups. Although overly positive

views of out-groups can seem like a divergence from bias, it actually reflects a relatively less developed stage in the Developmental Model of Intercultural Sensitivity (Bennett, 2013). That is, the rejection of one's culture and elevation of another without a critical consideration of the potential positive and negative attributes of both cultures is less advanced with regard to intercultural sensitivity. It is possible that participants in this research study experienced this pressure of politically correctness and over-corrected their responses, which led to the finding that therapists rated the Chinese-international-student client more favorably than how they rated White-American-student client.

Furthermore, according to Henley (2011), the pathological level of political correctness in the therapy room can lead to therapists' tendency to victimize clients and to associate minoritized clients with psychopathology. This negative influence of political correctness can be another potential contributing factor to part of the findings of this research study—therapists perceived the Chinese-international-student client as experiencing higher symptom severity compared to how they perceived the White-American-student client. In addition, this victimization of clients in therapy can result in an assumption of clients as lacking free will and as easily influenced by the external environment, which presents as perception of clients lacking individual/internal responsibility for presenting concerns (Henley, 2011). This connection serves as another potential explanation for the finding that therapists perceived the Chinese-international- student client's struggles as more attributable to external factors compared to how they perceived the White-American-student client's struggles.

Limitations and Future Research

There are several limitations of this study. These limitations include threat to construct validity, external validity, and internal validity. Each limitation is discussed in detail below.

First, the nature of vignette-based study posed a limitation to the generalizability of the study results. Given that participants provided their responses to the audio recordings of a client's answers to questions, this study did not fully capture all different factors that could potentially contribute to one's perception of client presentations. For instance, without being able to see the client's body language, visual minority status, facial expression, and in-person interaction in the therapy room, it is difficult for participants to perceive the client from a holistic stand point. In a word, the nature of this vignette-based study limits our ability to make assumptions about the extent to which we can apply the findings of this research study to real life scenarios in clinical settings.

There is another generalizability limitation of this research study. With mental health therapists being the targeted population for participants in this research study, the findings about bias cannot be applied to other professionals working with Chinese international students, such as professors, academic advisors, and administrative staff, etc. In addition, this research study focused on measuring and exploring bias towards Chinese international students, the findings cannot be applied to attitudes towards international students from other countries. Furthermore, given that this research study only recruited therapists from APA-accredited doctoral programs, internship sites, and post-doctoral sites, the research findings are not applicable to mental health professions who are not in a doctoral psychology training program or those who are not within the APA-accredited training environments.

As discussed earlier, it is possible that participants became aware of the purpose of this study and hence the findings were reflective of explicit bias versus implicit bias. This is one of the limitations of this study. Even though the investigator put effort into avoiding participants' awareness regarding the purpose of this research study in design and advertisement, it is possible

that due to the amount of culturally-relevant research and training participants became aware of the general purpose of this study. In future research about implicit bias, it would be helpful to build in a mechanism to test participants' awareness of the research design and purpose.

In addition, the measurements used in this research study reflect a substantial limitation. The investigator created different scales based on literature and past research studies to measure participants' implicit bias towards Chinese international students. The investigator avoided using well-established measures of implicit bias due to issues that could be introduced by participants' familiarity with those measures. Although this attempt may help decrease participants' awareness of the research purpose, it introduces reliability and validity issues to this study. Given that the scales used in this study were not well-researched regarding their measurements of implicit bias, it is possible that they failed to assess participants' implicit bias towards Chinese international students. In addition, one of the measures used in this study (i.e., the attribution questionnaire) demonstrated poor reliability for assessing participants' perception of attribution for client's presenting concerns and required such substantial modifications that it is extremely different from the original measure (only 33% of the items were retained) and resulting in analyses using prototypical items. This limits the ability to use this measure meaningfully to test the hypothesis. In future research, it can be helpful to have experts review the scale items, conduct pilot studies on these scales, and include well-established measurements to avoid issues introduced by non-well-established scales. With this, the development of valid measurement tools themselves is an area for future research.

Furthermore, the difference in the voices of the vignette recordings is another limitation of this research study. For the purpose of making the voice recording as close to real-life scenario as possible, the investigator did not use one person to record all three recordings;

instead, individuals from the same cultural background as the clients in the vignettes were used for the recordings. Although this is a benefit for the external validity of the study, it can be a threat to the internal validity. This method resulted in differences among the three recordings in terms of voice quality, recording quality, background sounds, speed and pacing of speech, vocal tones, volume of voice, and pitch of the sound. These seemingly nuance differences can result in a person's different perception of the intended client, which introduces possible confounds into this research study. Hence, in future similar studies, it is recommended that effort to be made to control for these factors to avoid introducing unintended variables in the research design. In future studies, it will be beneficial to hire professionals to record the vignette to ensure the consistencies of the voice quality (i.e. vocal tones, pacing, volume). It will also be helpful if the vignettes can be recorded using the same recording device and same controlled space to ensure consistencies of recording quality and background noise.

Lastly, in the text where client's background information was provided to the participants, both the Chinese international condition and Chinese American condition described client's ethnicity as "Asian." This could cause confusions for the participants and potentially contribute to the lack of significant differences found between the Chinese-international-student client condition and Chinese-American-student client condition in the measurements. In future research studies, to avoid this confusion and potential confound, it will be beneficial to further distinguish the backgrounds of clients when studying the intersecting effects of nationality and race on therapists' biases (e.g., stating in the text the background as Chinese international student or Chinese American student for conditions like those used in this study).

Implications and Recommendations

The findings of this research study potentially indicate the presence of positive feelings toward Chinese international student clients compared to White American student clients among therapists. Also, benevolent bias, social desirability, and the pressure to be politically correct may be potential factors that contribute to the findings of this study. Although this research study did not support the expectation that therapists would hold negative implicit bias towards Chinese international students, it raised the possibility that there might be some type of bias, albeit one that seems (at a superficial level) to be positive (but which may function similarly to negative bias). It is important for researchers and educators to continue examining this potential positive bias and to provide the training and education needed by therapists to reduce the potential for bias against Chinese international students to influence therapy.

Given the lack of differences between therapists' perceptions of the Chinese-international-student client and the Chinese-American-student client in this study, it is possible therapists make assumptions about the similarities of groups of individuals who share some similarities, such as these two clients, and are not aware of the unique experiences of either group. Hence, it will be helpful for future research studies to focus on therapists' perceptions of and potential differentiations between these two groups of individuals. It could also be helpful for researchers to explore therapists' assumptions about similarities across these two groups to evaluate whether racism operates similarly for these two groups to better inform multicultural training for mental health providers.

According to Hansen and colleagues (2006), experiential learning activities are more effective in increasing therapists' multicultural awareness than supervision or education. Therapists' ability to conduct self-evaluation and reflection is another critical component in the

process of reducing bias. Given that it takes more to change implicit bias than to change explicit

bias, it is essential that therapists can identify and examine their own values and bias (Boysen &

Vogel, 2008). This process not only asks for therapists' courage for self-criticism, it also requires

feedback from others to make this process possible and relatively easier. Fehr and Sassenberg's

(2009) research study showed that when individuals have the motivation to behave non-

prejudicially but did not have feedback from others regarding their behavior, it is highly likely

for them endorse benevolent prejudice. Practitioners, educators, and researchers should work

with each other on creating a safe environment in which this kind of feedback can be provided

nonjudgmentally. When individuals feel that they are accepted and their opinions are discussed

instead of judged, they will be less defensive or hurt, and more open and willing conduct self-

examination. In addition, this kind of accepting atmosphere can help therapists to *gather courage*

to say the unsayables in therapy sessions instead of silencing themselves and clients due to the

pressure of political correctness (Hope et al., 2001). It is also important for therapists to

differentiate between being politically incorrect from being their genuine selves—the former

indicates offensiveness and latter creates a space that promotes open exploration with self and

clients.

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Appendix A

Inclusion Criteria Questionnaire

What is your age?
    a. Under 18 years old
    b. 18 years or older

Are you currently working in or pursuing a career in mental health profession?
    a. Yes
    b. No

How many years/semesters of practicums have you completed?
    a. Less than a semester
    b. One semester
    c. One year
    d. Two years
    e. Three years
    f. Four years
    g. Five years and more

Do you have experience working with young adults in therapy?
    a. Yes
    b. No

Appendix B

Demographic Questionnaires

Are you a graduate student currently enrolled in a doctoral program (including those who are on internship)?
   a. Yes (will be directed to the Demographic Questionnaire for graduate students)
   b. No (will be directed to the Demographic Questionnaire for professionals at internship sites and postdoctoral residency programs)

Demographic questionnaire for graduate students

1. Please indicate your age ___. (drop down starts with 18)

2. What is your gender?
      a. Gender variant/gender non-conforming
      b. Man
      c. Transgender man
      d. Transgender woman
      e. Woman
      f. Other

3. Please indicate your race/ethnicity. Choose all that apply.
      a. African American/Black/African origin
      b. American Indian/Alaska Native/Aboriginal Canadian
      c. Asian American/Asian origin/Pacific Islander
      d. Biracial/Multiracial
      e. Hispanic/Latino/a
      f. Middle Eastern
      g. White/Caucasian American/European Origin
      h. Other. Please specify_____

4. Do you identify as American?
      a. Yes
      b. No

5. How many semesters of practicum have you completed? _____

6. How many semesters of practicum have you completed at a college counseling center? _____

7. How many clients who identify as international students have you worked with? _____

8. How many clients who identify as Chinese international students have you worked with? _____

9. How many clients who identify as Chinese Americans have you worked with? _____

Demographic questionnaire for professionals at internship sites and postdoctoral residency programs

1. Please indicate your age ___. (drop down starts with 18)

2. What is your gender?
   a. Gender variant/gender non-conforming
   b. Man
   c. Transgender man
   d. Transgender woman
   e. Woman
   f. Other

3. Please indicate your race/ethnicity. Choose all that apply.
   a. African American/Black/African origin
   b. American Indian/Alaska Native/Aboriginal Canadian
   c. Asian American/Asian origin/Pacific Islander
   d. Biracial/Multiracial
   e. Hispanic/Latino/a
   f. Middle Eastern
   g. White/Caucasian American/European Origin
   h. Other. Please specify_____

4. Do you identify as American?
   a. Yes
   b. No

5. Are you a licensed psychologist?
   a. Yes
   b. No
   c. I am a licensed professional in another discipline

6. How many years have you been conducting therapy as a licensed professional? ___.

7. How many clients who identify as international students have you worked with? _____

8. How many clients who identify as Chinese international students have you worked with? _____

9. How many clients who identify as Chinese Americans have you worked with? _____

Appendix C

Diagnostic Impression Questionnaire

According to your past experience working with clients in therapy, how many sessions do you think are needed by this client?
   a. 1-4 sessions
   b. 4-8 sessions
   c. 8-12 sessions
   d. More than 12 sessions

Below is a list of clinical symptoms. Based on your clinical impression of this client, please indicate your estimation of the severity of her symptoms.

Symptoms	Mild		Moderate		Severe
Excessive worry	1	2	3	4	5
Sleep disturbance	1	2	3	4	5
Irritability	1	2	3	4	5
Difficulty concentrating	1	2	3	4	5
Sadness	1	2	3	4	5
Hopelessness	1	2	3	4	5
Low self-esteem	1	2	3	4	5
Social isolation/withdrawn	1	2	3	4	5
Low energy/motivation	1	2	3	4	5
Guilt/shame	1	2	3	4	5

To what extent do you agree or disagree with the following statements?
This client should take more initiatives and actions to change her current situation. (I)
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

The university does not do enough to help students like this client to succeed. (E)
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

This client suffered because of the environment she was in. (I)
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

The faculty and staff pay less attention to the needs of students like this client than to the other groups of students. (E)

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

Sometimes there is too little publicity about programs to help students like this client. (E)

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

This client should take the responsibility for difficulties she experienced. (I)

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

To what extent do you agree or disagree with the following statement?
I have sufficient training that prepares me to provide appropriate and quality treatment to this client.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

Appendix D

Semantic Differential Scale

Please respond to the following scales based on your conceptualization of the client.

Inconsiderate   Considerate (R)
1____2____3____4____5____6____7____8____9____10____11

Interesting   Boring
1____2____3____4____5____6____7____8____9____10____11

Close   Distance
1____2____3____4____5____6____7____8____9____10____11

Passive   Active (R)
1____2____3____4____5____6____7____8____9____10____11

Narrow-minded   Open-minded (R)
1____2____3____4____5____6____7____8____9____10____11

Intelligent   Unintelligent
1____2____3____4____5____6____7____8____9____10____11

Awkward   Skillful (R)
1____2____3____4____5____6____7____8____9____10____11

Dependable   Undependable
1____2____3____4____5____6____7____8____9____10____11

Conceited   Modest (R)
1____2____3____4____5____6____7____8____9____10____11

Studious   Lazy
1____2____3____4____5____6____7____8____9____10____11

Motivated   Unmotivated
1____2____3____4____5____6____7____8____9____10____11

Creative   Uncreative (R)
1____2____3____4____5____6____7____8____9____10____11

Rude   Polite (R)
1____2____3____4____5____6____7____8____9____10____11

Dislikable   Likable (R)
1____2____3____4____5____6____7____8____9____10____11

Recruitment email for APA-accredited graduate programs
Email title: Participation Solicitation for Dissertation Study (chance to win a $20 Amazon gift card)

Dear __(name of training director)___,

My name is Yuxin Sun and I am a student in the Counseling Psychology doctoral program at Auburn University. I am contacting you to request your assistance in recruiting students enrolled in APA-accredited psychology graduate programs to participate in my doctoral dissertation study.

Please forward the following message to all possible eligible students in your program. Eligible participants for this study are graduate students (including those who are on internship) in APA-accredited graduate programs and professionals working in an APA-accredited internship site and postdoctoral residency programs.

Dear Colleagues,

My name is Yuxin Sun and I am a student at the APA-accredited Counseling Psychology doctoral program at Auburn University. I would like to invite you to participate in my dissertation study to investigate therapist's conceptualization of clients.

Eligible participants for this study are 18 years of age or older, have completed at least one semester of practicum, currently working in or pursuing a career in the mental health profession, have experience working with young adults in therapy, and are graduate students enrolled in an APA-accredited graduate programs or professionals working at APA-accredited internship sites and postdoctoral residency programs.

Participation in this study involves reading about a case and providing one's diagnostic impression and conceptualization of the client. In addition, you will provide information about your background. After completing the survey, you may choose to enter a drawing for **one of five $20 Amazon gift cards** through a separate Qualtrics link.

This study will take approximately **15 minutes** to complete. A link to the survey is available in the student recruitment letter below. Participation of this study is **anonymous**.

This study has been approved by the Auburn University IRB (IRB Approval #18-102 EX 1803). If you have any questions about this project, you may contact me at yzs0034@auburn.edu or my dissertation chair, Dr. Annette Kluck at ask0002@auburn.edu. You may also contact the Auburn University Office of Research Compliance or the Institute Review Board by phone (334) 844-5966 or email at IRBadmin@auburn.edu or IRBChair@auburn.edu.

In you are interested in participating in this study, please follow the link below for information letter and access for participation in this study:

Survey link: https://auburn.qualtrics.com/jfe/form/SV_b3jyBZ4XQEd5M7b

Thank you for your time and consideration.

Sincerely,

Yuxin Sun, M.A.
Doctoral Candidate
Counseling Psychology doctoral program
Auburn University
Yzs0034@auburn.edu

Annette Kluck, Ph.D.
Training Director
Counseling Psychology doctoral program
Auburn University
Ask0002@auburn.edu

Recruitment email for APA-accredited internship sites and postdoctoral residency programs
Email title: Participation Solicitation for Dissertation Study (chance to win a $20 Amazon gift card)

Dear __(name of contact person)___,

My name is Yuxin Sun and I am a student in the Counseling Psychology doctoral program at Auburn University. I am contacting you to request your assistance in recruiting professionals working at APA-accredited internship sites and postdoctoral residency programs to participate in my doctoral dissertation study.

Please forward the following message to all possible eligible staff members at your site. Eligible participants for this study are graduate students (including those who are on internship) in APA-accredited graduate programs and professionals working in an APA-accredited internship site and postdoctoral residency programs.

Dear Colleagues,

My name is Yuxin Sun and I am a student at the APA-accredited Counseling Psychology doctoral program at Auburn University. I would like to invite you to participate in my dissertation study to investigate therapist's conceptualization of clients.

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Participation in this study involves reading about a case and providing one's diagnostic impression and conceptualization of the client. In addition, you will provide information about your background. After completing the survey, you may choose to enter a drawing for **one of five $20 Amazon gift cards** through a separate Qualtrics link.

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In you are interested in participating in this study, please follow the link below for information letter and access for participation in this study:

Survey link: https://auburn.qualtrics.com/jfe/form/SV_b3jyBZ4XQEd5M7b

Thank you for your time and consideration.

Sincerely,

Yuxin Sun, M.A.
Doctoral Candidate
Counseling Psychology doctoral program
Auburn University
Yzs0034@auburn.edu

Annette Kluck, Ph.D.
Training Director
Counseling Psychology doctoral program
Auburn University
Ask0002@auburn.edu

Information Letter

(NOTE: DO NOT AGREE TO PARTICIPTAE UNLESS IRB APPROVAL INFORMATION WITH CURRENT DATES HAS BEEN ADDED TO THIS DOCUMENT.)

INFORMATION LETTER
for a Research Study entitled
"Therapist's Conceptualization of Case"

You are invited to participate in a research study to investigate therapist's conceptualization of clients based on different factors. You are eligible to participate because you are 18 years of age or older, have completed at least one semester of practicum, have experience working with young adults in therapy, and are working in or pursuing a career in the mental health profession. The study is conducted by Yuxin Sun, M.A. under the direction of Professor Annette Kluck, Ph.D. in the Auburn University Department of Special Education, Rehabilitation, and Counseling.

What will be involved if you participate? Your participation is completely voluntary. If you decide to participate in this research study, you will be asked to answer questions regarding your demographic information, such as gender, age, ethnicity, etc. In addition, you will be asked to read a client intake summary and provide your impression and conceptualization of the client. After this, you will be asked to complete questionnaires regarding your perception of ways we work with clients. Your total time commitment will be 15 minutes. After your participation is complete, you will be linked to a separate study where you will enter your email address if you wish to enter a drawing for one of five $20 Amazon gift cards.

Are there any risks or discomforts? Even though it is very unlikely, you might experience minimal psychological discomfort while answering some of the questions. However, if you do experience any discomfort in the process, you may skip an item or discontinue your participation without penalty. Although we have designed the study so that we cannot link your responses to you, there is some chance that others around you may view your responses if you do not complete this study in a private place. We therefore encourage you to complete the study in a place where others cannot observe your responses.

Are there any benefits to yourself or others? If you participate in this study, there will not be direct benefits. However, your participation will contribute to an understanding of how therapists conceptualize clients.

Will you receive compensation for participating? To thank you for your time, you will have an opportunity to enter a drawing of one of five $20 Amazon gift cards.

Are there any costs? If you decide to participate, you will not have any costs other than your time.

If you change your mind about participating, you can withdraw at any time by closing your browser window of the survey link. Once you've submitted anonymous data, it cannot be withdrawn since it will be unidentifiable. Your decision about whether or not to participate or to stop participating will not jeopardize your future relations with Auburn University, the Department of Special Education, Rehabilitation, and Counseling or the investigators involved in this study.

Any data obtained in connection with this study will remain anonymous. Your privacy is protected because the data are anonymous. Data collected through your participation will be used as part of a dissertation study. It may be also used as part of a presentation at a professional meeting and/or published in a professional journal.

If you have questions about this study, please contact Yuxin Sun at yzs0034@auburn.edu

If you have questions about your rights as a research participant, you may contact the Auburn University Office of Research Compliance or the Institute Review Board by phone (334) 844-5966 or email at IRBadmin@auburn.edu or IRBChair@auburn.edu.

HAVING READ THE INFORMATION PROVIDED, YOU MUST DECIDE IF YOU WANT TO PARTICIPATE IN THIS RESEARCH PROJECT. IF YOU DECIDE TO PARTICIPATE, THE DATA YOU PROVIDE WILL SERVE AS YOUR AGREEMENT TO DO SO. TAKE A SCREEN SHOT OF THIS LETTER FOR YOUR RECORDS.

Yuxin Sun, M.A.
Investigator   Date

Annette Kluck, Ph.D.
Faculty Advisor   Date

The Auburn University Institutional Review Board has approved this document for use from 3/4/2018. Protocol #18-102 EX 1803.

https://auburn.qualtrics.com/jfe/form/SV_b3jyBZ4XQEd5M7b

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Appendix G

Client Intake Recording

</div>

In this section, you will listen to 3 short audio recordings of a client's response to 3 intake questions. Client's demographic information is provided in the text below. Please listen carefully. After listening to the audio recordings, you will be asked to provide your diagnostic impressions about this client.

Question 1
Can you tell me a little bit more about yourself, things that could be helpful for me to know?

Condition 1
Client background information:

Name: Lin Chen	Ethnicity: Asian
Age: 20	Sexual orientation: Heterosexual
Gender: Female	Major: Biochemistry

Audio recording 1a
Sure. I was born and raised in a small town outside of Beijing. I moved to the U.S. about three years ago for my undergrad. I am very close with my mom and dad, and they are very supportive to me both emotionally and financially, which makes things easier at times. But it can also be difficult cause I miss them a lot. I try to talk to them every other day, but I just get busier and busier with homework and exams.
What else…I live with three girls in a house off-campus, we hang out every now and then on weekends. I don't have other close friends here. All my closest friends are back home in China. I feel lonely at times because of that, and I tried to join some student clubs, but I just don't feel like I fit in anywhere. I am not saying that people are not nice to me, they are all very friendly. But I just feel like it is very hard to get close to other students here. I mean I get along with some students in my major, but there are only so many of them. Like we try to get together for Chinese New Year and other Chinese holidays, but it is still very different from being back in China. I know I am kind of rambling here, but Chinese New Year is the hardest time of a year for me. I just feel so alone with all my friends and family being so far away.

Condition 2
Client background information:
Name: Lindsey Chen
Age: 20
Gender: Female
Ethnicity: Asian
Sexual orientation: Heterosexual
Major: Biochemistry

Audio recording 1b
Sure. My family is originally from China but I was born and raised in a small town outside of Los Angeles. I moved here about three years ago for my undergrad. I am very close with my mom and dad, and they are very supportive to me both emotionally and financially, which makes things easier at times. But it can also be difficult cause I miss them a lot. I try to talk to them every other day, but I just get busier and busier with homework and exams.
What else…I live with three girls in a house off-campus, we hang out every now and then on weekends. I don't have other close friends here. All my closest friends are back home in California. I feel lonely at times because of that, and I tried to join some student clubs, but I just don't feel like I fit in anywhere. I am not saying that people are not nice to me, they are all very friendly. But I just feel like it is very hard to get close to other students here. I mean I get along with some students in my major, but there are only so many of them. Like we try to get together for Thanksgiving and other holidays, but it is still very different from being back in California. I know I am kind of rambling here, but Thanksgiving is the hardest time of a year for me. I just feel so alone with all my friends and family being so far away.

Condition 3
Client background information:
Name: Lindsey Johnson
Age: 20
Gender: Female
Ethnicity: Caucasian
Sexual orientation: Heterosexual
Major: Biochemistry

Audio recording 1c
Sure. I was born and raised in a small town outside of Los Angeles. I moved here about three years ago for my undergrad. I am very close with my mom and dad, and they are very supportive to me both emotionally and financially, which makes things easier at times. But it can also be difficult cause I miss them a lot. I try to talk to them every other day, but I just get busier and busier with homework and exams.
What else…I live with three girls in a house off-campus, we hang out every now and then on weekends. I don't have other close friends here. All my closest friends are back home in California. I feel lonely at times because of that, and I tried to join some student clubs, but I just don't feel like I fit in anywhere. I am not saying that people are not nice to me, they are all very friendly. But I just feel like it is very hard to get close to other students here. I mean I get along with some students in my major, but there are only so many of them. Like we try to get together for Thanksgiving and other holidays, but it is still very different from being back in California. I know I am kind of rambling here, but Thanksgiving is the hardest time of a year for me. I just feel so alone with all my friends and family being so far away.

Question 2
Can you tell me what you come in to therapy for?

Audio recording 2 (same in all three conditions)
My grades dropped from 3.9 to 3.0 and my professor told me it would be helpful for me to come use the services here. I get very anxious about exams but I also procrastinate a lot when I study, I don't understand why. I feel so tired and exhausted all the time. Like when I come home after class, I just take a nap. Almost every day. When I wake up, it's already late night. I don't feel like I have as much energy to study like before. Sometimes I feel so tired I don't even have any motivation to go to classes, which is not a good thing. I know that I have to go to classes and study for my exams, but I just don't have the energy or motivation. It's not like I am not trying. I tried to go to professors' office hours but I get so anxious talking to them. Sometimes I would be standing outside of their door and decide not to go in last minute cause I freak out. Things just become harder and harder. When did this start? Hmmm maybe 3 months…a little less than 3 months ago.

Question 3
What are you hoping to accomplish by the end of therapy?

Audio recording 3 (same in all three conditions)
I want to learn if there are strategies for me to get motivated to study and go to classes. I also want to learn how to lower my anxiety, especially before exams and when I try to talk to professors. Maybe also some social skills, too. Cause I am pretty shy and I can be awkward at times when I try to talk to people.