ABSTRACT

Title of thesis: COUNTERTRANSFERENCE REACTIONS IN A CROSS-RACIAL DYAD: THE ROLE OF THERAPIST UNIVERSAL-DIVERSE ORIENTATION AND PRESENTATION OF CLIENT STRENGTHS

James Michael Harbin, Master of Arts, 2004

Thesis directed by: Professor Charles Gelso
Department of Psychology

The purpose of this study was to examine the influence of universal-diverse orientation (UDO) and information on client strengths on European American therapists' countertransference to an angry African American client. Forty-five European American therapist trainees completed a measure of UDO and were randomly assigned to one of two conditions in which they were either given or not given information on client strengths. Therapists then watched and responded to a videotape of an angry African American client. Countertransference was measured in terms of therapist state anxiety, cognitive recall, and behavioral avoidance.

Results showed that therapist UDO was significantly and negatively related to their countertransference reactions in a cross-racial situation. Additionally, results were not significant for the main effect of information on client strengths and for the interaction of UDO and information on client strengths on countertransference reactions. Implications for counseling and future research were explored.

COUNTERTRANSFERENCE REACTIONS IN A CROSS-RACIAL DYAD: THE
ROLE OF THERAPIST UNIVERSAL-DIVERSE ORIENTATION AND
PRESENTATION OF CLIENT STRENGTHS

by

James Michael Harbin

Thesis submitted to the Faculty of the Graduate School of the
University of Maryland, College Park in partial fulfillment
of the requirements for the degree of
Master of Arts
2004

Advisory Committee:

      Professor Charles Gelso, Chair
      Professor Kathy Zamostny
      Professor Mary Ann Hoffman

TABLE OF CONTENTS

LIST OF TABLES

CHAPTER 1

INTRODUCTION

Over the next several decades, the United States is expected to undergo dramatic

shifts in its demographics as numbers of racial/ethic minorities increase. According to

the U.S. Census Bureau (2001), nearly half the United States population will be people of

color by the year 2050. As society becomes progressively more multicultural, therapists

are more likely to see clients from culturally diverse backgrounds (Fuertes & Brobst,

2002). Thus, it seems especially important to study potential problems that may arise in

cross-cultural therapy dyads (Sue & Sue, 2003). One such problem is that minority

clients are more likely to drop out of counseling than other clients (Sue, 1977). It is

necessary that we understand the therapist and client factors that lead to problems, such

as untimely withdrawal from therapy, in order to prepare therapists-in-training to

effectively treat clients of another race (Sue & Sue, 2003). One therapist factor that may

influence the therapy process in a cross-cultural dyad is the occurrence of

countertransference reactions.

<u>Countertransference</u>

Several negative outcomes may result when therapists exhibit countertransference

reactions. For instance, therapists who exhibit countertransference behavior are more

likely to have poorer therapy outcomes and weaker working alliances with their clients

(Hayes, Riker, & Ingram, 1997; Ligiero & Gelso, 2002). Even small amounts of

countertransference behavior are likely to lead to poorer outcomes (Friedman & Gelso,

2000; Hayes et al., 1997). In a case study on countertransference, when the client

discussed material that tapped into therapist's unresolved issues, the therapist was more

likely to keep the session shallow and feel less trustworthy, expert, and attractive (Rosenberger & Hayes, 2002). Researchers have also found that therapists who are more able to effectively manage their countertransference reactions are more likely to have better treatment outcomes with clients than therapists who are not as able to manage their countertransference (Gelso, Fassinger, Gomez, & Latts, 2002).

Several theorists have written about the role of countertransference reactions in cross-cultural situations (Comas-Diaz & Jacobsen, 1991; Gelso & Mohr, 2002; Gorkin, 1987; Jones, 1984, 1985; Vontress, 1995, 1996). Gorkin (1987) notes that several types of countertransference occur in cross-cultural dyads. For instance, therapists may become overly curious, or experience "hypercuriosity," about the clients' culture to the extent that the therapists' interest is not relevant to the therapy. Gorkin also notes that prejudice to some degree in cross-racial dyads is "probably unavoidable in the initial phase of treatment (p.71)" and issues of trust and empathy become more important as a result. Despite the theoretical and clinical interest in the effect of race on countertransference, next to no empirical research has been published on this topic. Hence, further investigation of countertransference reactions to clients of a different race seems especially important.

Multiculturalism

Research on multiculturalism has rapidly developed in the past several years. For instance, a vast amount of research has focused on counselors' multicultural competence (MCC; Constantine, 2000, 2002; Sodowsky, Huo-Jackson, Richardson, & Corey, 1998; Sue, Arredondo, & McDavis, 1992; Worthington, Mobley, Franks, & Tan, 2000). Theorists and clinicians have noted that the counseling process in a cross-racial dyad is

frequently more complex and difficult than in a same-racial dyad (Comas-Diaz & Jacobsen, 1991; Gelso & Mohr, 2002; Gorkin, 1987; Sue & Sue, 2003). Thus, it seems especially important for therapists to understand how race-related variables influence therapy process.

One such race-related variable is universal-diverse orientation (UDO; Miville, Gelso, Pannu, Liu, Touradji, Holloway, & Fuertes, 1999). The construct of UDO is largely based on the theoretical work of Vontress (1988, 1996), who theorized that in order for effective counseling of culturally diverse clients to occur, therapists need to simultaneously be aware of client commonalties and differences and be accepting of these similarities and differences. However, no research has examined how therapists' awareness of and acceptance of others' similarities and differences may influence their reactions to a client of another race. UDO involves an awareness of and appreciation of others' similarities and differences (Miville et al., 1999). There are three highly interrelated components to UDO: a) comfort with differences b) relativistic appreciation and c) diversity of contact (Fuertes, Miville, Mohr, Sedlacek, & Gretchen, 2000). Comfort with differences relates to one's affective comfort with people who are culturally different from them. Relativistic appreciation is the recognition and appreciation of other's similarities and differences and how they impact one's personal development. Diversity of Contact is the interest in and commitment to being involved in both culturally diverse activities and in interacting with others' who are different. UDO has been found to be related in theoretically predicted ways to several variables (Miville et al., 1999). For example, it was positively correlated with racial identity and feminism, while it was negatively correlated with homophobia and dogmatism. Client UDO has

also been found to be related to client perceptions of diverse counselors (Fuertes & Gelso, 1998) and therapy (Fuertes, 1999; Fuertes & Gelso, 2000). However, little or no research has investigated how therapists' UDO influences the counseling process with a client of another race.

According to Sue et al. (1992), appreciating and having an awareness of both people's similarities and differences is an important aspect of multicultural competence. Constantine et al. (2001) found school counselor's universal-diverse orientation to significantly predict self-perceived multicultural counseling awareness even after controlling for previous multicultural counseling education. Thus, it seems likely that therapists' UDO would influence their ability to manage their reactions toward clients in cross-cultural situations. For example, a Caucasian therapist with low UDO may have difficulty identifying with an African American client's anger. The therapist may not be able to appreciate the clients' cultural value of direct affective communication and may feel threatened by the client's anger. The therapist may psychologically withdraw from the client and exhibit greater avoidance behavior as a result. In contrast, a Caucasian therapist with high UDO would be likely to appreciate the cultural differences that exist between the therapist and the client. The therapist may be able to experience greater empathy toward the client and approach the clients' material as a result.

Positive Psychology

Though there has recently a call for an increase in research on "positive psychology" variables in the psychological sciences (Gelso & Fassinger, 1992; Seligman & Csikszentimihalyi, 2000), much of psychological research has previously focused on pathology. The explanation for the dearth of research in positive psychology seems to be

based in the field's history. Psychotherapy was formed out of the medical field and continues to be influenced by its origins. Consequently, the dominant model in psychotherapy is the medical model (Bohart & Talman, 1999). According to this model, therapists treat clients from the perspective of a physician who diagnoses and applies interventions appropriate to those diagnoses. The medical model is rooted in psychopathology, which stresses the importance of treating problems as disorders. As a result, therapists are often not taught to look at problems from the perspective of client strengths.

Therapists' focus on client strengths may influence how therapists conceptualize their clients (Gelso & Woodhouse, 2003). However, no empirical research has investigated how therapists' focus on client strengths relates to therapy process and outcome. It seems likely that therapists' focus on client strengths would also influence therapists' cognitive, affective, and behavioral reactions to clients. The process of focusing on client strengths may make a client from a culturally diverse background feel less threatening to the therapist and seem more real. The therapist would then be able to feel more connected to the client and experience less anxiety as a result. Further, focus on client strengths may enable the therapist to better conceptualize why the client is reacting the way he or she is are and be more able to approach the client's material.

African American Anger

Sue and Sue (2003) note that Whites are more likely to misinterpret Blacks' communication styles than the other way around. Blacks, especially men, are more likely to speak with affect, converse closer, and make direct eye contact than Whites. When an African American male exhibits these behaviors, unconscious racist stereotypes of the

"hostile, angry, prone-to-violence Black male" are often triggered (Sue & Sue, 2003, p.88). White therapists frequently experience countertransference as a result and react with nonverbal distancing (e.g., therapists may tip their chair back). Since angry African American males have been hypothesized to create sizable race-related countertransference in European American therapists, a White therapist and angry Black client dyad was chosen for the present investigation. Focusing on client strengths may be able to help therapists overcome such countertransference reactions to an angry Black client. For example, a therapist who focuses on the strengths of an angry African American client may be able to experience greater empathy and less anxiety than a therapist who does not focus on the client's strengths.

Additionally, the effects of therapists' UDO on countertransference reactions in a cross-cultural dyad may depend on whether or not they receive information on the client strengths. For example, when people are told something that goes against their beliefs, they often react against it (Brehm & Brehm, 1981). This research indicates that therapists with low UDO who are presented with a client's strengths may react against the strengths message by avoiding client material, experiencing cognitive distortions, and feeling anxious. These low UDO therapists may not be able to appreciate the cultural differences that exist between the therapist and the client and understand that a client who has salient cultural differences may also have positive qualities that are similar to the therapist. Thus, when these therapists are presented with client strengths, they may not be able to integrate these strengths into their client conceptualization. Instead of integrating the strengths into their conceptualization, they may experience conflict, since they may not be able to understand that someone who is very different may also be similar in many

ways. This conflict may be perceived as a threat by the therapist, who consequently withdraws psychologically from the client. These therapists would be expected to experience the greatest countertransference reactions.

In contrast, high UDO therapists who receive information on the client strengths would be expected to react very differently. They would understand that a culturally diverse client can be simultaneously similar and different from them, and they would be able to integrate the client strengths into their conceptualization. As a result of this integration, they would be expected to approach the client's material while experiencing very few cognitive distortions and little anxiety. These therapists would be expected to experience the least countertransference reactions. Both high UDO and low UDO therapists who do not receive information on client strengths would be expected to experience a moderate amount of countertransference reactions. Thus, the effects of the therapists UDO on countertransference reactions in a cross cultural situation were expected to depend on whether or not they receive information on client strengths. Hence, we predicted an interaction between the therapists' UDO and whether or not they receive information on client strengths.

No previous research has investigated how therapist variables such as UDO and focus on client strengths affect their reactions to a client of another race. Thus, the present study examined the effects of therapist UDO and whether or not they received information on client strengths on the three theorized components of countertransference reactions (i.e., behavior, cognition, and affect) in an audio-visual analogue with an angry Black client. By understanding how therapist factors influence the therapy process with culturally diverse clients, we can use the information to create better outcomes.

CHAPTER 2

REVIEW OF THE LITERATURE

The purpose of this study was to examine the effects of therapists' focus on client strengths and therapists' universality-diversity orientation (UDO) on countertransference reactions in a cross-racial situation with an angry client. Theorists have proposed that therapist countertransference can be a significant hindrance in cross-racial counseling (Gelso & Mohr, 2002; Gorkin, 1987), especially when the client is African American (Comas-Diaz & Jacobsen, 1991; Jones, 1984, 1985; Vontress, 1995). UDO and focus on client strengths have also been proposed to play a particularly important role when the client is a different race than the therapist (Davis, Clance, & Gailis, 1999; Lopez, Prosser, Edwards, Magyar-Moe, Neufeld, & Rasmussen, 2002; Vontress, 1988, 1996). However, no empirical research has investigated countertransference reactions in a cross-cultural dyad and the influence of either therapists' universal-diverse orientation or focus on client strengths. To explore these relationships, I will review the literature in three sections. Universality-diversity will be investigated in the first section, client strengths will be examined in the second section, and countertransference will be discussed in the third section.

Universal-Diverse Orientation

In this section, multiculturalism will be broadly discussed, and the construct of universal-diverse orientation will be explored.

<u>Multiculturalism</u>

As the population has grown more diverse, research on multiculturalism has also rapidly developed. For example, a vast amount of research in recent years has focused on

counselors' multicultural competence (MCC; Constantine, 2000, 2002; Sodowsky, Huo-Jackson, Richardson, & Corey, 1998; Sue, Arredondo, & McDavis, 1992; Worthington, Mobley, Franks, & Tan, 2000). Constantine (2002) found that counselors' multicultural competence was uniquely important in explaining minority clients' satisfaction with counseling, even after general counseling competence had been accounted for. This MCC study indicated that when counselors see minority clients they need to not only focus on the universal aspects that are similar to clients of all races, but they also need to develop counseling skills and awareness specific to dealing with minority clients.

Because the US is becoming increasingly diverse, therapists can expect to see more clients of races different from their own (Fuertes & Brobst, 2002). Unfortunately, many problems arise in cross-racial counseling, especially when the client is a minority. Minority clients, for instance, are more likely to drop out of therapy than other clients (Sue, 1977). Additionally, African Americans were found to have more positive views towards mental health services than Caucasians before using them but less positive views than Caucasians after using them (Diala, Muntanter, Walrath, Nickerson, LaVeist, & Leaf, 2000). In order to overcome such race-related problems, Griffith and Jones (1979) proposed that therapists need to establish an alliance especially quickly with minorities. However, cultural dissimilarity makes development of the working alliance in the beginning stages more difficult and complex (Gelso and Mohr, 2002). This complexity needs to be untangled to determine what factors may facilitate and damage such an alliance.

Theorists and clinicians have consistently pointed to race as a barrier to effective cross-racial counseling (Comas-Diaz & Jacobsen, 1991; Gelso & Mohr, 2002; Gorkin,

1987; Sue & Sue, 2003; Vontress, 1995, 1996). Researchers, however, have found

inconsistent and inconclusive results when examining the influence of race on cross-

cultural counseling process and outcome (Atkinson, 1983; Burkard & Ponterotto, 1999;

Fisher, Matthews, Kurpius, Burke, 2001). I will first discuss the theoretical pieces, and

then I will explore the empirical research. Finally, I will offer an explanation for this

ostensible conflict between theory and research on race in cross-cultural counseling.

Several theorists and clinicians have noted that counseling clients of another race

appears to be more complex and difficult than counseling clients of one's own race

(Comas-Diaz & Jacobsen, 1991; Gelso & Mohr, 2002; Gorkin, 1987; Sue & Sue, 2003).

Vontress (1996) wrote of "historical hostility" as a cultural barrier in cross-cultural

counseling. Historical hostility is related to Jung's (1968) concept of the collective

unconscious in that people are the product of not only their personal history but also their

cultural histories that influence all members of a culture. For example, African

Americans have historically been treated as inferior by Whites, which has left

psychological scars on African Americans as a group (Karon, 1975). As a result,

hostility toward Whites lies in the cultural unconscious of African Americans. Historical

hostility in minority groups tends to lie dormant unless activated by emotional content

(Vontress, 1996).

Although theory has consistently pointed to racial dissimilarity as a hindrance to

counseling process and outcome, research on the influence of race in therapy has

produced inconsistent results. Atkinson's (1983) review of studies investigating the

influence of race on therapy outcome found no systematic effects. For example, while

many studies found that Black clients were more satisfied in a racially similar dyad

(Banks, Berenson, Carkhuff, 1967; Burrell & Rayder, 1971; Grantham, 1973), other studies found no relationship between racial similarity and client satisfaction (Cimbolic, 1973; Jones, 1978, Proctor & Rosen, 1981). Studies examining the effect of race on therapy process also had conflicting findings (Cimbolic, 1972; Wright, 1975).

Studies done since Atkinson's (1983) review have generally examined the effects of race in combination with other variables rather than the effects of race separately. However, two recent studies singled out the effects of race on therapy process. Fisher et al. (2001) predicted that counselor trainee's expectations of client behaviors would vary depending on the client's race and ethnicity but found no such effects. Similarly, Burkard and Ponterotto (1999) found, among other things, that therapist ratings of the working alliance were not significantly affected by race in and of itself. However, the authors did find a race X racial identity interaction effect on counselors' perceptions of the working alliance in same-racial and cross racial dyads. Race-related variables, such as racial identity, may need to be examined along with race in order to understand the impact of race in therapy. Taken together, these two studies support Atkinson's (1983) finding that race by itself does not predictably affect therapy process.

Even though studies examining the effect of race alone have produced inconclusive results, problems still appear to exist (e.g., Diala et al., 2000). Perhaps there is some limitation to these studies that have looked at the effect of race alone on process and outcome. One way to explain the inconclusive results of these studies is the influence of a third variable (Heppner, Kivlighan, and Wampold, 1999). In other words, there may be factors other than race that are unaccounted for when researchers look at the

effect of race alone. Examples of race-related variables that have been investigated

include racial identity, acculturation, and cultural mistrust.

Cultural mistrust is one client variable that appears to moderate the relationship

between client satisfaction and therapist race in a cross-racial situation. Cultural mistrust

is the degree to which a minority person distrusts Whites (Terrell & Terrell, 1981).

Watkins and Terrell (1988) investigated Black undergraduates' perceptions of White and

Black counselors and found an interaction between counselor race and cultural mistrust.

Specifically, participants high in cultural distrust viewed White therapists as less expert,

trustworthy, and attractive, expected to disclose less in counseling, and had lower

expectations of counseling outcome than low mistrust participants. Watkins and Terrell's

study indicated that clients' cultural mistrust could to be a significant barrier to effective

cross-racial counseling. Variables associated with race, such as cultural mistrust, need to

be further studied to better understand the role of race in cross-cultural situations.

<u>History and Definition of UDO</u>

A recently developed construct, UDO, has also been shown to relate to

multicultural counseling competency and other race related variables (Constantine,

Arorash, Barakett, Blackmon, Donnelly, & Edles, 2001; Fuertes, Miville, Mohr,

Sedlacek, & Gretchen, 2000; Fuertes, Sedlacek, Roger, & Mohr, 2000). Miville et al.

(1999) were the first to introduce and study the construct of UDO. They defined UDO as

"An attitude toward all other persons that is inclusive yet differentiating in that

similarities and differences are both recognized and accepted; the shared experience of

being human results in a sense of connectedness with people and is associated with a plurality or diversity of interactions with others" (Miville et al., 1999, p.292).

In other words, those with high UDO appreciate and are aware of similarities and differences among people. UDO is based on Vontress' (1979, 1988, 1996) work that described how all people are at the same time alike and different. People are the product of five interacting cultures: universal culture, ecological culture, national culture, regional culture, and racioethnic community (Vontress 1986, 1988, 1996). Universal culture refers to the aspect that is similar to all human beings (e.g., sleeping) while the other cultures refer to aspects that make us different from each other (e.g., race and sex). Therapists need to see the universal aspects of clients first and then recognize the differences between them and their clients (Vontress, 1988). This process is especially important for effective cross-cultural counseling (Ford, Harris, & Schuerger, 1993; Vontress, 1996). Thus, therapist UDO appears to be a significant ingredient to overcoming cultural barriers in cross-racial counseling such as historical hostility.

Empirical Research

In order to measure UDO, Miville et al. (1999) created the Miville-Guzman Universality-Diversity Scale (M-GUDS). They conceptualized UDO as a unidimentional construct that reflects an attitude of understanding that all people are simultaneously the same and different, as well as an appreciation of these similarities and differences. The M-GUDS contains three subscales that assess the behavioral, cognitive, and affective components of UDO: a) Diversity of Contact, b) Relativistic Appreciation, and c) Sense of Connection. Diversity of Contact assesses respondents' interest in and commitment to

being involved in multicultural activities and relates to the behavioral aspect of the measure. Relativistic Appreciation assesses both respondents' appreciation of similarities and differences, and how these similarities and differences influence their growth, by tapping into the cognitive component of the measure. Sense of Connection measures how comfortable people are with others that are different from them and relates to the affective component. UDO was found to positively relate to empathy, healthy narcissism, and attitudes toward feminism and the women's movement. The M-GUDS was also found to be negatively associated with homophobia and dogmatism while correlating with the White Racial Identity Attitude Scale and the Black Racial Identity Atitude Scale in theoretically predicted ways. Hence, the measure has proven to demonstrate a sound beginning to its validity.

Fuertes, Miville, Mohr, Sedlacek, and Gretchen (2000) examined the factor structure of the 45-item M-GUDS and created a 12 item short form (M-GUDS-S). They found that the original scale and the short form appear to measure UDO as a multidimensional construct consisting of three components. The names of the first two components, Diversity of Contact and Relativistic Appreciation, were found to accurately represent the subscales and thus were retained. However, the third component, Sense of Connection, was found to be more complicated than was originally conceptualized and was renamed Comfort with Differences.

Recent studies have used UDO to predict client preferences for particular counselors (Fuertes, 1999; Fuertes & Gelso, 1998, 2000). For example, Fuertes and Gelso (1998) looked at White, Black, and Asian undergraduate students' (n=309) UDO and their preferences for diverse counselors. They found an interaction between

participant race and UDO such that participants low on UDO more strongly preferred counselors with similar attitudes, and this effect was stronger for Asian Americans than African Americans and European Americans. Since high UDO participants were more likely to choose counselors with dissimilar attitudes, these results suggest that clients in cross-racial counseling who are high in UDO may do better in therapy with a counselor of a different race than clients low in UDO.

Using a similar methodology, two studies (Fuertes, 1999; Fuertes & Gelso, 2000) have examined undergraduate students' UDO and their perceptions of Hispanic counselors' ethnicity and accent. Participants in both studies watched a video showing a picture of a Hispanic counselor varying in ethnicity (i.e., White, Mestizo, Black) and heard a recorded message from the counselor either with or without a Spanish accent. Fuertes and Gelso (2000) sampled 212 European Americans using this method and found UDO to interact with counselor accent. Specifically, low UDO participants rated nonaccented counselors significantly more attractive, trustworthy, and expert than accented counselors participants while there were no differences for high UDO participants. Additionally, student's UDO interacted with counselor race such that high UDO clients were more willing to work with the Black Hispanic counselor than Mestizo or White, and there were no differences in counselor preference for low UDO students. These findings support other research showing that high UDO clients look for more diversity when help-seeking than low UDO clients (Fuertes, Sedlacek, Roger, & Mohr, 2000).

Fuertes (1999), using the same methodology as Fuertes and Gelso (2000), sampled Asian and African American undergraduate students (n=97) and found an

unexpected interaction between participants' UDO and counselor accent. In particular, high UDO participants gave higher ratings on outcome variables (e.g., willingness to engage in long term counseling) to both accented and nonaccented counselors than low UDO participants; however, low UDO participants gave accented counselors higher outcome ratings than the nonaccented counselors. This is in contrast to the results of Fuertes and Gelso's (2000) study using White participants where low UDO participants gave higher ratings to nonaccented counselors. Perhaps since the participants in the Fuertes' (1999) study were ethnic minorities, they identified more with the accented therapist and gave them higher ratings as a result. Fuertes (1999) also found that students' UDO was a stronger mediator of the anticipated working alliance for African Americans than Asians. In other words, the African Americans with high UDO rated the alliance higher than low UDO African Americans and this effect was stronger than for the Asian American participants. This result indicates that perhaps African American clients' UDO is more important in establishing a strong working alliance in cross-cultural counseling than in other races.

To test Sue, Arredondo, and McDavis' (1992) theory that having an awareness and appreciation of others' similarities and differences is an important aspect of multicultural competence, Constantine et al. (2001) examined the relationship between multicultural counseling competence and UDO by sampling school counselors (n=100). After accounting for previous multicultural education, UDO predicted counselors' perceived multicultural counseling knowledge and awareness. In particular, the Diversity of Contact and Relativistic Appreciation subscales uniquely predicted perceived multicultural counseling knowledge, and only the Diversity of Contact subscale uniquely

predicted perceived multicultural counseling awareness. Given that MCC has been found to uniquely predict minority client satisfaction (Constantine, 2002), supported Vontress' (1996) idea that therapist UDO is important to successful cross-cultural counseling. Nonetheless, no study has yet investigated how therapist UDO may directly affect counseling process and outcome in a cross-racial situation.

One way counselors' UDO may affect the counseling process in cross-cultural therapy is through countertransference reactions. Schwaber (1983), a White therapist, described her countertransference reactions to an African American client as having an element to them that goes beyond what is typical. She stated, "There seems to be another dimension - more critical – at issue. It was that I felt a particular resistance to being experienced in this way, as central to another person's experience, while so different from how I felt myself to be" (p.389). She seems to be describing having problems identifying with this client because of low UDO. In other words, she was unable to integrate the idea that she was simultaneously similar to and yet different from this African American client. Comments such as these further suggest that UDO should be examined as a potential influence on countertransference reactions in cross-racial situations.

Client Strengths

In this section, I will first give a brief overview of positive psychology, then I will examine literature on client strengths, and finally I will look at the role of client strengths in cross-cultural counseling.

<u>Positive Psychology</u>

Positive psychology has recently gained attention as entire issues have been devoted to the topic within the past few years (American Psychologist, Vol. 55, number 1, 2000; Journal of Social and Clinical Psychology, Vol. 19, number 1, 2000). Research has shown that positive psychology promises to improve quality of life and prevent illness (Seligman & Csikszentmihalyi, 2000). For example, fostering an attitude of optimism has been shown to prevent depression and protect people against physical illness (Seligman, Schulman, DeRubeis, & Hollon, 1999; Taylor, Kemeny, Reed, Bower, & Gruenewald, 2000). Positive psychology is a growing area of research that has shown great potential.

Although positive psychology has recently received attention, much of psychology has previously been dominated by a focus on pathology. For instance, more is known about negative affect's influence on illness than positive affect's influence on health (Salovey, Rothman, Detweiler, & Stewart, 2000). Thus, more research still needs to be done on aspects of positive psychology, such as healthy personalities and human strengths (Gelso & Fassinger, 1992; Gelso & Woodhouse, 2003; Seligman & Csikszentmihalyi, 2000).

Client Strengths

When applied to psychotherapy, the model of positive psychology can be translated into a model of client strengths. In particular, the field of counseling psychology has been interested in client strengths since its inception. Super (1955) notes that counseling psychology distinguishes itself from clinical psychology through its focus on "hygeiology," where as clinical psychology is more interested in psychopathology. Hygeiology encourages client strengths and resources, while psychopathology focuses on

weaknesses and maladjustment. Describing it another way, Super (1977) admittedly oversimplified counseling psychology's distinction from clinical psychology when he stated, "Clinical psychologists tend to look for what is wrong and how to treat it, while counseling psychologists look for what is right, and how to help use it." Gelso and Fretz (2001) have since supported this notion when they identified focusing on client strengths as one of counseling psychology's unifying themes, even with severely disturbed clients.

Despite the fact that viewing clients from a positive perspective is integral to counseling psychology, the field has done little to validate the usefulness of this approach (Gelso & Fassinger, 1992; Gelso & Woodhouse, 2003). Counseling psychology has provided little empirical research to guide clinicians on how to use client strengths in sessions with clients. Additionally, Gelso & Fassinger (1992) described research on healthy personalities as the field's "unfulfilled promise" and called for more research in this area. The paucity of empirical research in positive aspects of human functioning has become increasingly more salient to the field of psychology, and Seligman and Csikszentmihalyi (2000) have recently echoed the call for more positive research to the entire field.

As indicated, the psychopathology model has dominated clinical practice and research, including areas such as assessment and diagnosis (Sandron, 1970; Witryol & Boly, 1954; Chazin, Kaplan, & Terio, 2000; Gelso & Woodhouse, 2003). As a result, the majority of psychological tests assess weaknesses more than strengths. For example, Lambert's (1996) widely used Outcome Questionnaire measures therapy outcome based solely on symptom reduction. Many problems may arise when clients' diagnoses and treatment is based solely on the model of pathology. Sandron (1970) theorized that when

clients are diagnosed from the perspective of pathology, it becomes a self-fulfilling prophecy. He gave a case example of a psychiatric client diagnosed using the MMPI and other pathology based assessment measures for over a year. The client, in turn, internalized such assessments and defined himself in terms of his mental illness. The client sabotaged attempts of the hospital staff to find him employment, and he remained hospitalized. The therapist decided to change his approach and began testing the patient based on his strengths. Within two months, the patient terminated, left the hospital, and found work. A follow-up interview with the patient found that the patient perceived the strengths-based evaluation made the difference and enabled him to accept responsibility for himself. It is important to note that positive diagnosis usually integrates client strengths and weaknesses, while negative diagnosis tends to focus on pathology (Witryol & Boly, 1954). Psychologists need to realize desirable self-fulfilling prophecies through adherence to a strength model and move away from a focus on the illness model that may be seen as excessive (Sandron, 1970).

Client strengths have recently gained attention in clinical literature (Chazin, Kaplan, & Terio, 2000; Gelso & Woodhouse, 2003). In the past few years, various theoretical orientations have examined and reexamined how they incorporate client strengths into their conceptualizations and treatment. Examples include Adlerian therapy (Slavik, Sperry, & Carlson, 2000), Humanistic therapy (Resnick, Warmoth, & Selin, 2001; Sheldon & Kasser, 2001; Taylor, 2001), Behavioral therapy (Follette & Linnerooth, 2001), Ego Psychology (Miller, 1998), the Satir system (McLendon, 1999), and Hope therapy (Lopez, Floyd, Ulven, & Snyder, 2000). In addition, Wachtel (1993) wrote about how therapists can explicitly attend to clients' strengths and build on them.

He noted, for instance, that therapists might need to challenge ostensible strengths that may not be true strengths in order to determine what are the clients' actual strengths and weaknesses. Despite this interest, pathology continues to be emphasized in actual practice (Chazin, Kaplan, & Terio, 2000), and strengths are rarely incorporated in meaningful ways in client conceptualizations, even in university counseling centers (Gelso & Woodhouse, 2003). Additionally, few empirical studies have examined how focus on client strengths may influence therapy process and outcome (Gelso & Woodhouse, 2003). Focus on client strengths needs to be further validated to supply a solid empirical foundation for the strength model.

A few empirical studies have investigated the effectiveness of interventions based on client strengths (Conoley, Padula, Payton, & Daniels, 1994; Mitchell & Berenson, 1970). One study examined the effects of therapist confrontations based on either client strength or weakness (Mitchell & Berenson, 1970). Therapists (n=56) conducting intake interviews were divided ex-post facto into high and low facilitative, where facilitative was operationalized as the therapists conveying empathy, positive regard, and genuineness. High facilitative therapists were found to give significantly more confrontations based on the clients' strengths or resources than low facilitative therapists. Conversely, low facilitative therapists gave significantly more confrontations based on the clients' weaknesses or pathology. Thus, it appears that therapists who are perceived as more empathic by third-party raters are more likely to use confrontations based on client strengths. The authors noted that it is especially important for therapists to focus on strengths in an intake interview in order to prepare clients for the challenges of psychotherapy. Relatedly, researchers have found that a confrontational style tends to

make clients more resistant and defensive (Miller, Benefield, & Tonigan, 1993; Salerno, Farber, McCullough, Winston, & Trujillo, 1992). Perhaps if therapists explicitly focus more on client strengths, clients will feel less defensive and be more receptive to interventions such as challenges.

Another study looked at the importance of psychotherapy homework assignments based on client strengths (Conoley, Padula, Payton, & Daniels, 1994). The study found, among other things, that clients were significantly more likely to follow therapist recommendations when they were based on client strengths than when they were not. The authors gave an example of a client who said he enjoyed writing and that writing down he thoughts had helped him in the past. Based on this information, the therapist recommended that the client write down times during the week that he felt badly and document specifically what he was doing, thinking, and feeling in the moment. Hence, the homework was based on the client's strength (i.e., writing), and he implemented the recommendation during the week.

In addition to exploring therapist interventions based on client strengths, studies have also examined the role of strengths in terms of more specific constructs. Researchers have operationalized strengths as hope (Lopez, Ciarlelli, Coffman, Stone, & Wyatt, 2000), spirituality (Avants, Warburton, & Margolin, 2001), intrinsic motivation (Sheldon & Kasser, 2001), hardiness (Kobasa, 1982), self-efficacy (Bandura, 1986), and "virtues" such as forgiveness and humility (see the Journal of Social and Clinical Psychology, Vol. 19, number 1, 2000). For example, one study investigated the utility of spirituality in HIV-positive injection users (Avants, Warburton, & Margolin, 2001). Participants (n=43) in a methadone clinic were asked how much their religion or

spirituality acts as a source of support and comfort for them. Participants with high perceived religious support were abstinent significantly longer during the first 6-months of treatment than those with low perceived religious support. Religious support was also a unique predictor of abstinence even after other variables (e.g., optimism and social support) had been controlled for. Consequently, human strengths, such as spirituality, appear to benefit people in difficult circumstances.

It is important to recognize that therapists need to balance client strengths and weaknesses in their conceptualizations (Gelso & Woodhouse, 2003). Though the strength model appears to imply that only client strengths should be addressed, this is not true. Several theorists have emphasized that the strength model focuses on weakness as well as strengths, while the model of pathology typically focuses more on deficits (Gelso & Woodhouse, 2003; Sandron, 1970; Witryol & Boly, 1954). Hence, the strength model is a misnomer in that its name does not include the model's additional focus on client weaknesses.

Client strengths in cross-cultural counseling

Treatment approaches based on psychopathology can have particularly detrimental affects when applied to clients of another culture or race (Chazin, Kaplan, & Terio, 2000). Cowger (1994) stated that clinical practice that generally focuses on pathology "reinforces those social structures that generate and regulate unequal power relationships that victimize clients," (p.206) and that this effect is amplified with minority populations (Chazin et al., 2000). Thus, therapists who are of the majority race, such as European American counselors, may need to pay particular attention to client strengths when working with a minority client.

Multiculturalism movement believes that diversity should be celebrated and that the strengths associated with diversity need attention (Sue, 1999). As a result, clinicians have written at length on client strengths in cross-cultural counseling. This includes literature on client strengths of the deaf (Hoyt, Siegelman, & Schlesinger, 1981), poor gifted women (Koepping, 1996), the elderly (Marin, Newman, Onawola, Kollar, & Sucov, 1988), gay couples (Winkelpleck & Westfeld, 1982), HIV users and spirituality (Avants, Warburton, & Margolin, 2001), and even borderlines (Goldstein, 1995). The group that has received the most attention in the clinical literature on client strengths is African Americans. Clinicians have written about a wide range of African American groups, including mothers and daughters (Greene, 1990), women (Boyd-Franklin, 1991; Jefferies, 1976), obese and overweight women (Davis, Clance, & Gailis, 1999), women's spirituality (Frame, Williams, & Green, 1999), and families (Lyles & Carter, 1982; Stevenson & Renard, 1993). Strengths that may be more common in African Americans than in other races include: expressive individualism through the creation of unique solutions, preference for the spoken word over writings, and use of social support (Davis, Clance, & Gailis, 1999). Additionally, religiosity has been found to predict psychological well being of African Americans but not Whites (Blaine & Crocker, 1995). Lyles and Carter (1982) theorized that in order to develop an early alliance with African Americans, client strengths need to be identified quickly. Since cultural dissimilarity makes development of the alliance in the beginning stages more difficult and complex (Gelso and Mohr, 2002), perhaps it is especially important for therapists who are working with African American clients in cross-racial psychotherapy to focus on client strengths early on in treatment in order to overcome factors such as cultural mistrust.

Despite the large clinical literature emphasizing the importance of focusing on client strengths in cross-cultural counseling (especially when working with African Americans), an extensive literature search found no empirical research on the topic. Studies need to be done to explore the utility of focusing on client strengths with all clients. In particular, studies need to validate the effectiveness of therapists' focus on minority clients' strengths. The best possible multicultural model needs to account for strengths and weaknesses that are both unique to the culture and more universal (Lopez, Prosser, Edwards, Magyar-Moe, Neufeld, & Rasmussen, 2002). Thus, researchers can look at whether clients' strengths that are unique to their culture are more important to recognize than strengths that are universal to all cultures. In addition, studies can investigate how therapists' UDO may influence their ability to focus on to client strengths in a cross-racial situation.

Countertransference

In this section, I will first discuss the history and various definitions of countertransference and, then I will examine countertransference in the context of its structural theory.

History and Definitions

Freud first introduced countertransference (1910/1959) when he stated, "We have become aware of the 'countertransference,' which arises in the physician as a result of the patient's influence on his unconscious feelings, and we are almost inclined to insist that he shall recognize his countertransference and overcome it" (pp.144-145). Though Freud thought countertransference to be an essentially problematic construct, theorists have since thought that therapists can also use it beneficially and defined it as such. Gelso and

Carter (1985, 1994) organized countertransference definitions into three categories: (a) the classical definition (b) the totalistic definition, and (c) therapist reactions to client material that taps into therapists' unresolved issues.

Freud (1910/1959) explained that countertransference reactions arise from therapists' distortions because of the therapists own conflicts or needs. These distortions were unconscious reactions to the patient's transference. He conceived countertransference as an essentially pejorative construct in which there is no way for it to be used beneficially by the therapist. This definition has been termed the classical definition (Gelso & Carter, 1985, 1994). Therapists needed to work through their unresolved issues in order to reduce their anti-therapeutic countertransference reactions. The totalistic definition of countertransference terms the construct as all therapists' feelings and reactions to the client (Fromm-Reichman, 1950; Heiman, 1950; Kernberg, 1965). This definition is broader than the classical definition and includes realistic and well as distorted and conflict-based reactions to the client. In addition, the totalistic definition views countertransference as both beneficial and harmful, while the classical definition considers it essentially negative. Coming from the totalistic definition, Sullivan (1954) recognized that the key to using countertransference beneficially is to be aware of one's reactions and then use them judiciously.

A third definition, which will be used in the present study, defines countertransference as, "Internal and external reactions in which unresolved conflicts of the therapist, usually but not always unconscious, are implicated" and these reactions can be used beneficially "if the therapist successfully understands his or her reactions and uses them to help understand the patient" (Gelso & Hayes, 2002, p.269). This definition

is similar to the classical definition in that countertransference consists of therapist reactions that are irrational rather than reality based (Gelso & Carter, 1985, 1994; Gelso & Hayes, 1998). However, it differs from the classical definition and is similar to the totalistic definition in that countertransference reactions can be used beneficially as well as detrimentally in therapy. Countertransference reactions, when defined in the third way, appear to be extremely common. Hayes, McCracken, McClanahan, Hill, Harp, and Carozzoni (1998) reviewed transcripts of therapists describing their reactions to clients and found countertransference reactions were reported in 80% of therapists' sessions. It is important to recognize that since this study only included therapist's opinions on their reactions, only conscious conflicts could be examined. Though reactions that therapists were unaware of went unexplored, countertransference was still found to be present in the large majority of sessions.

Structural Theory of Countertransference

Using the third definition mentioned above, Hayes (1995) developed a theoretical model of countertransference. He identified five components of countertransference: origins, triggers, manifestations, effects, and management factors. The present study will look at the influence of CT origins (i.e., UDO), triggers (i.e., angry Black client), manifestations (i.e., affective, cognitive, and behavioral reactions), and management factors (i.e., focus on client strengths).

Origins. Origins refer to therapists' unresolved conflicts. Being human, all therapists have issues in their lives that are unresolved to some degree. Therapists can use these unresolved conflicts, consciously or unconsciously, to facilitate the therapy process (e.g., help therapists identify with the client; Hayes et al, 1998; Reich, 1951,

1960) or to hinder the process (e.g., distort therapists perception of reality; Cutler, 1958). For example, research has shown that therapists with greater trait anxiety are more likely to avoid the client material (Hayes & Gelso, 1991), be less personally-involved with their clients (Yulis & Kiesler, 1968), and be less competent overall (Bandura, 1956) than less anxious therapists. Trait anxiety appears to indicate the presence of some underlying issues and thus may be considered an origin of countertransference. Other constructs that indicate the presence of unresolved conflicts related to race, such as UDO, need to be investigated to understand countertransference origins

Countertransference origins can stem from a number of issues. In a study utilizing consensual qualitative research method, Hayes et al. (1998) found countertransference reactions to originate from family issues in eight out of the eight studied therapists. Other origins included therapists' needs and values (e.g., grandiosity) and therapy-specific issues (e.g., termination). Of the three therapists in the study who saw a client of another race, one mentioned racial issues as an origin of countertransference. The therapist described racial related countertransference reactions upon discovering that her client was Asian. The fact that one third of therapists in a cross-racial dyad mentioned racial issues as a source of countertransference is significant and in consistent with a wide range of theory and clinical observations (Comas-Diaz & Jacobsen, 1991; Gelso & Mohr, 2002; Gorkin, 1987; Jones, 1984, 1985; Vontress, 1995, 1996). Gorkin (1987) gives the example of a Jewish therapist, a member of the dominant culture, who perceived his Arab minority client as unsophisticated and not psychologically minded. Gorkin suggested that such reactions are common when the therapist is of the majority culture and the client is a minority. Given that Hayes et al.'s

(1998) study examined only conscious countertransference, perhaps even more racial

origins of countertransference would have been observed if countertransference had been

measured in a more objective way and social desirability had been taken into account.

Constructs that indicate the presence of unresolved conflicts related to race, such as

UDO, need to be investigated in order to understand how countertransference origins

may influence therapy process in a cross-racial situation.

    <u>Triggers</u>. Events in therapy that touch on therapists' unresolved issues are known

as triggers. Examples include the content of the client's material, the client's expression

of emotion, and change in the therapy structure (Hayes et al., 1998). The vast majority

research (including the present study) has investigated triggers in terms of the clients'

role in eliciting countertransference reactions as opposed to events such as termination.

Specifically, two main categories of triggers have been most commonly studied: clients'

presenting style and clients' presenting problem. Three client presenting styles that have

frequently been investigated are hostile, seductive, and dependent (Hayes & Gelso, 1991;

Peabody & Gelso, 1982; Robbins & Jolkovski, 1987; Yulis & Keisler, 1968). Clients'

presenting problems that have been examined include rape (Latts & Gelso, 1995), HIV

infection (Hayes & Gelso, 1993), and same-sex relationship problems (Gelso et al.,

1995). The present investigation will explore triggers in terms of the client's presenting

style (i.e., anger) in addition to the client's race (i.e., African American).

    After reviewing research on triggers and origins, Rosenberger and Hayes (2002)

concluded, "client factors, in and of themselves, do not predictably cause

countertransference reactions" (p.221). For example, two studies found that therapists

were not more likely to experience countertransference with a lesbian or gay client than a

heterosexual client (Hayes & Gelso, 1993; Gelso, Fassinger, Gomez, & Latts, 1995).

These studies did find, however, that therapist homophobia interacted with the sexual

orientation of the client in the predicted manner. Specifically, homophobia was

positively related to avoidance behavior with the homosexual clients, but was

uncorrelated to avoidance behavior with the heterosexual clients. When only client

factors were taken into consideration, no systematic effects were uncovered. Yet, when

both origins (i.e., homophobia) and triggers (i.e., sexual orientation) were taken into

consideration, researchers were better able to predict countertransference reactions.

Sharkin and Gelso (1993) also found that when clients touched on therapists' unresolved

issues related to anger, they were more likely to be anxious and be angry at their clients.

These studies support the idea that countertransference reactions are more likely to be

elicited when client and therapist factors interact than when they occur separately.

One potential trigger of countertransference reactions for a White therapist is an

angry Black client. In cross-cultural dyads, race complicates the therapy relationship and

provides more chances for therapists to "screw up" (Comas-Diaz & Jacobsen, 1991;

Gelso & Mohr, 2002). Therapists may experience "ethnocultural disorientation" as a

result (Comas-Diaz & Jacobsen, 1991). Jones (1984, 1985) noted that Black clients are

likely to evoke more frequent and complicated countertransference reactions than other

races because society's image of Blacks affects therapists' projections. Additionally,

cultural factors that elicit countertransference reactions often serve as a catalyst for other

unresolved issues such as anger (Comas-Diaz & Jacobsen, 1991). Hence, an angry Black

client may touch on a White therapist's unresolved conflicts related to race and,

consequently, the therapist's latent issues related to anger may also surface.

Manifestations. Manifestations refer to therapist thoughts, feelings, and behaviors that are elicited when their unresolved issues are touched on. Internally, countertransference can manifest itself through affective reactions (e.g., anxiety; Bandura, 1956; Hayes & Gelso, 1991, 1993; Yulis & Keisler, 1968) and cognitive distortions (e.g., inaccurately recalling client material; Cutler, 1958; Gelso et al., 1995). External manifestations of countertransference have most often been studied through behavioral reactions (e.g., verbal avoidance; Bandura, Lipsher, & Miller, 1960; Hayes & Gelso, 1991, 1993; Latts & Gelso, 1995). The present study will be assessing countertransference manifestations in terms of therapists' cognitive, affective, and behavioral reactions. Hence, only studies using at least one of these dependent variables were reviewed.

An extensive literature review found that 11 published studies have investigated therapists' cognitive, behavioral and / or affective reactions to clients as dependent variables. Seven of these studies examined only behavioral reactions, one looked solely at affective reactions, one looked exclusively at cognitive distortions in reaction to clients, and two studies investigated all three reactions to clients. It needs to be noted, however, that several studies (e.g., Bandura, 1956) have examined anxiety as an independent variable. Manifestations of countertransference are dependent variables by definition, since manifestations are considered a result or an outcome. Thus, studies using anxiety as a predictor variable were not included in this section.

Cognitive countertransference reactions are commonly operationalized as therapists' inaccurate recall of client material when it touches on therapists' unresolved issues. Cutler (1958) pioneered this technique when he discovered that therapists either

under-report or over-report clients' behavior when clients talked about issues that therapists had not resolved. Gelso et al. (1995) supported this idea when they found, as predicted, that females were significantly more likely to inaccurately recall sexual content when they saw a lesbian client than when they saw a heterosexual client, whereas there was no such effect for male therapists. When female therapists saw lesbian clients, the sexual material brought up in the session appeared more likely to tap into therapists' unresolved issues around sexuality than when they saw heterosexual clients. Measuring countertransference in terms of asking therapists to recall the number of sexual words spoken in the session appeared to be unaffected by social desirability, since therapists could not know the actual number used. As a result, therapists may not be able to hide cognitive manifestations of countertransference when their presence is not socially desirable (e.g., in a cross-racial situation).

Affective countertransference reactions have typically been studied as therapist state anxiety elicited from client material. As hypothesized, Sharkin and Gelso (1993) found that therapists who were more anger prone and more uncomfortable with their own anger were more likely to experience anxiety when clients were angry with the therapist. Additionally, therapists have been shown to experience greater anxiety with clients who are HIV-positive than those who are HIV-negative (Hayes & Gelso, 1993). These studies together support countertransference theory in that when client material taps into therapists' unresolved issues, therapists are more likely to experience anxiety (Singer & Luborsky, 1977).

Behavioral countertransference reactions have generally been measured as therapists' verbal avoidance of client material. Bandura, Lipsher, and Mitchell (1960)

developed a coding system in which approval, exploration, instigation, reflection, and labeling are classified as approach reactions, while disapproval, topical transition, silence, ignoring, and mislabeling are categorized as avoidance reactions. Two studies used this system and found a positive correlation between therapist homophobia and behavioral avoidance (Gelso et al., 1995; Hayes and Gelso, 1993). In other words, homophobic therapists were more likely to avoid the clients' material than less homophobic therapists. Thus, therapists were more likely to verbally keep away from client material when it touches therapists' unresolved conflicts.

Effects. Effects are considered, "the way countertransference manifestations promote or hinder therapy process and outcome" (Hayes et al., 1998, p.469). Since the present investigation will only be examining therapist factors, no clients will be asked to evaluate therapy process and outcome. However, I will briefly summarize countertransference effects here.

Several negative outcomes may result when therapists exhibit countertransference reactions. Countertransference behavior has been found to be negatively related both to treatment success in cases with poor outcome (Hayes et al., 1995) and to the working alliance (Ligiero & Gelso, 2002). Several authors have indicated that even small amounts of countertransference behavior are likely to lead to poorer outcomes (Friedman & Gelso, 2001; Hayes et al., 1995). Gelso, Latts, Gomez, and Fassinger (2002) found that countertransference management abilities were positively related to treatment outcome. In particular, the authors found that when counselors possessed better conceptualization skills, self-integration, and anxiety management in their therapy relationships, counselors were more likely to experience better outcomes with their

clients. Research on effects generally seems to show that countertransference has a significant impact on therapy process and outcome.

Management Factors. Management factors are defined as "therapist behaviors and characteristics that help therapists regulate and productively use their countertransference reactions" (Hayes et al., 1998, p.469). Examples of behavioral management factors include seeking supervision, getting one's needs met, and listening to tapes of sessions (Hayes, 1995). Therapist characteristics have been more studied than behaviors. Specifically, five attributes have been shown to regulate countertransference reactions (Friedman & Gelso, 2000; Hayes, Gelso, VanWagoner, & Diemer, 1991; Van Wagoner, Gelso, Hayes, and Diemer; 1991) and be positively related to working alliance and therapy outcome (Rosenberger & Hayes, 2002; Gelso, Latts, Gomez, Fassinger, 2002). The first is *self-insight*, which refers to therapists' awareness of their feelings and what causes those feelings. Second, *self-integration* assesses therapists' understanding of the boundaries between themselves and their clients. *Anxiety management*, the third characteristic, determines how well therapists are able to control their level of anxiety. The fourth attribute, *empathy*, assesses therapists' ability to understand their clients on an emotional and intellectual level. *Conceptualizing skills*, the fifth characteristic, refers to therapists' ability to conceptualize their clients' dynamics within the therapeutic relationship. Together, these five attributes help therapists to control their countertransference reactions to clients.

One management factor related to conceptualizing skills is the therapist's focus on client strengths. When therapists focus on client strengths in a difficult session, they may cognitively utilize them to relieve their anxiety. Therapists aware of an angry

African American client's strengths, for example, may be able to use them to see beyond the client's anger and more deeply empathize with the meaning behind the client's words. However, client strengths are rarely integrated into conceptualizations in practice and little is known as to how focusing on them may affect therapy process (Gelso & Woodhouse, 2003).

A European American therapist who has subconsciously internalized subtle racist attitudes while growing up with a racist family may not feel completely comfortable with clients of another race. Thus, when the therapist sees an angry African American client, unconscious racial stereotypes may be stimulated, and he may experience a great deal of anxiety as a result. The therapist may avoid the client's very real anger by trying to change the topic. The therapist may also distort the client's material to fit his racial stereotypes. Additionally, this therapist may not be as able to focus on an African American client's strengths and reduce his or her countertransference reactions as a therapist without unconscious racist attitudes. Such a situation, though an exaggeration, could be detrimental to the outcome of therapy in a lesser form. Hence, the purpose of this study is to investigate the influence of White therapists' UDO and focus on client strengths on cognitive, affective, and behavioral countertransference reactions to an angry Black client.

CHAPTER 3

STATEMENT OF THE PROBLEM

Universal-diverse orientation (UDO) has been found to be related in theoretically

predicted ways to racial identity, healthy narcissism, empathy and androgyny (Miville et

al., 1999). Researchers have also examined how clients' UDO influences their

perceptions of counselors of another race (Fuertes & Gelso, 1998). However, little or no

research has looked at how counselors' UDO influences the counseling process with a

client of another race. One study found that school counselors' scores on the Miville-

Guzman Universality-Diversity Scale-Short Form (M-GUDS-S) significantly predicted

their self-perceived multicultural counseling knowledge (Constantine et al., 2001). Thus,

it seems likely that counselors' UDO would influence their ability to manage their

feelings toward clients in cross-cultural situations.

UDO is related to wellness variables such as positive thinking and empathy

(Miville et al., 1998) and contributes to research on healthy components of personality

that has been lacking in counseling psychology (Gelso & Fassinger, 1992). Additionally,

the multiculturalism movement suggests that diversity and client strengths related to

diversity need to be celebrated (Sue & Sue, 2003). Nonetheless, very few empirical

studies have addressed the utility of counselors' focus on client strengths (Gelso &

Woodhouse, 2003). Regarding this utility, counselors' ability to focus on client strengths

may better enable them to connect with a client and see beyond any resistance the client

may be presenting. By being aware of clients' more positive aspects, therapists who

focus on client strengths may be more understanding and empathic than therapists who

do not. Relatedly, focus on client strengths may influence therapists' ability to manage their thoughts and feelings toward a client of another race.

One way counselor's UDO and ability to focus on client strengths may influence therapy process in a cross-cultural situation is through countertransference reactions. Analogue studies have looked at countertransference reactions to lesbian clients (Gelso et al., 1995), a sexually abused client (Latts & Gelso, 1995), and clients with HIV (Hayes & Gelso, 1993). However, none of these studies have examined how counselors' focus on client strengths and counselors' universal-diverse orientation may influence their reactions to a client of another race.

Hence, the present study investigated how counselors' focus on client strengths and counselors' universal-diverse orientation predicted counselor countertransference reactions in a cross-cultural situation. White therapists watched a videotape of an African American actor portraying an angry client, and therapists were asked to respond to the client at specific stopping points. A White therapist-Black client situation was chosen as it was thought that this particular cross-cultural dyad would tend to be the most emotionally charged and thus perhaps elicit the greatest amount of countertransference reactions in therapists. In order to elicit further countertransference, the Black client was implicitly angry at White people. One study found when an African American client implicitly angry at European Americans to elicit more countertransference from European American therapists than an African American client explicitly angry at European Americans (Brittan, 1993). It seemed that the implicit anger toward Whites created greater ambiguity in the cross-racial situation, and therapists showed greater countertransference reactions as a result. Hence, a cross-racial dyad in which the Black

client is implicitly angry at Whites was expected to elicit substantial countertransference in the present study.

Therapist countertransference reactions to the client will be assessed in terms of three components. The first component, behavioral avoidance, will be determined by obtaining the ratio of avoidance responses to all responses (Bandura, 1960). The affective component will be measured by the State-Trait Anxiety Inventory (STAI-S; Spielberger, Gorsuch, Lushene, 1970), which was administered immediately after therapists have finished the session. Asking the therapist how many angry words were employed in the session will be used to assess the final component, cognitive distortion. These three components will be used as a combined measure of countertransference in the multivariate multiple regression.

Therapists' comfort with differences, relativistic appreciation, and diversity of contact has predicted counselors' perceived multicultural competence (Constantine et al, 2001). It seems likely then that therapists who have a low universal-diverse orientation are likely to feel less competent with a difficult client of another race than high UDO therapists. Therefore, they may feel more anxious when dealing with a client of another race than therapists with high UDO. Therapists with low UDO may also cognitively distort more client material than high UDO therapists. Additionally, low UDO therapists may respond to a client in a way that avoids more of their material than high UDO therapists. Note once again that the African American client is implicitly angry at European Americans, and this implicit anger toward Whites may prime therapist UDO attitudes to a greater extent.

Hypothesis 1a: Therapists' universal-diverse orientation will be negatively related to their state anxiety following a cross-racial situation.

Hypothesis 1b: Therapists' universal-diverse orientation will be negatively related to their cognitive distortions following a cross-racial situation.

Hypothesis 1c: Therapists' universal-diverse orientation will be negatively related to their behavioral avoidance in cross-racial situation.

Gelso & Woodhouse (2003) hypothesize that therapists' focus on client strengths influences the way therapists conceptualize their clients. It seems likely that therapists who are given information about a client's strengths in an intake evaluation would be able to experience greater empathy in a session than those who are not. Therefore, they may be able to address the client's difficult material more directly rather than ignore it (i.e., behavioral avoidance). They may also distort less of the client's material in a session than therapists who are not told about the client's strengths. In addition, therapists who are given information on a client's strengths may experience less anxiety in a session than those who are not.

Hypothesis 2a: Therapists who are given information on client strengths will experience less anxiety than therapists who are not given information on client strengths in a cross-racial situation.

Hypothesis 2b: Therapists who are given information on client strengths will experience fewer cognitive distortions than therapists who are not given information on client strengths in a cross-racial situation.

Hypothesis 2c: Therapists who are given information on client strengths will exhibit less behavioral avoidance than therapists who are not given information on client strengths in a cross-racial situation.

The social psychology literature on the boomerang effect posits that when people are told something that goes against their beliefs, they react against it (Brehm & Brehm, 1981). For example, if a binge-drinker were told to be abstinent, they would be expected to drink more. Such research would lead to the expectation that if low UDO therapists are told about a client's strengths before experiencing an angry Black client, they would react against the strengths message by avoiding the client material, experiencing cognitive distortions, and feeling anxious. The low UDO therapists who are given the client's strengths in advance may not be able to integrate the client's strengths into their conceptualization and thus would have the most countertransference reactions as a result. In contrast, high UDO therapists who receive information on an angry Black client's strengths may be more adept at integrating the strengths into their conceptualization and would therefore exhibit the least countertransference reactions. Additionally, since low UDO therapists in the neutral condition not have client strengths at their disposal to react against, they would be expected to experience less countertransference reactions than low UDO therapists in the strengths condition. High UDO therapists in the neutral condition may better handle their thoughts and feelings when dealing with an angry Black client than low UDO therapists in the neutral condition, and thus would be expected to experience fewer counter transference reactions.

Hypothesis 3a: The effect of therapists' universal-diverse orientation on their anxiety in a cross-racial situation depends on whether or not they receive information on the client strengths. Hence, there is an interaction such that high UDO therapists in the strengths condition would experience the least anxiety, low UDO therapists in the strengths condition would experience the most anxiety, and therapists in the neutral condition who have high UDO would experience less anxiety than low UDO therapists.

Hypothesis 3b: The effect of therapists' universal-diverse orientation on their cognitive distortions in a cross-racial situation depends on whether or not they receive information on the client strengths. Hence, there is an interaction such that high UDO therapists in the strengths condition would experience the least cognitive distortions, low UDO therapists in the strengths condition would experience the most cognitive distortions, and therapists in the neutral condition who have high UDO would experience fewer cognitive distortions than low UDO therapists.

Hypothesis 3c: The effect of therapists' universal-diverse orientation on their behavioral avoidance in a cross-racial situation depends on whether or not they receive information on the client strengths. Hence, there is an interaction such that high UDO therapists in the strengths condition would exhibit the least behavioral avoidance, low UDO therapists in the strengths condition would exhibit the most behavioral avoidance, and therapists in the neutral condition who have high UDO would exhibit less behavioral avoidance than low UDO therapists.

CHAPTER 4

METHOD

<u>Research Design</u>

The present audio-visual analogue study utilized one continuous and one

categorical predictor variable in a between subjects design. The continuous predictor

variable was universal-diverse orientation, while presentation of client strengths was the

categorical variable manipulated according to random assignment. The dependent

variables were the three theorized components of countertransference (i.e., cognitive,

affective, and behavioral).

<u>Participants</u>

To qualify for participation, trainees must have taken at least one pre-practicum

course or have been enrolled in a practicum course at the time of participation. Sixty-five

participants were recruited and participated in the present study from a large mid-Atlantic

university. Forty-five participants were European American, 11 were African American,

six were Asian American, and three were Latino/a. However, only European American

counselor trainees were used in the present study in order to assess White therapists'

countertransference reactions in a cross-racial situation with a Black client. Hence, all

non-European American participants were dropped from the analyses. Experimental

conditions were randomly assigned within gender blocks in order to obtain an equal

number of males and females in each condition. Thirty-five of the participants were

female, and 10 were male. Participants came from masters and doctoral programs in

counseling psychology ($n = 14$), clinical psychology ($n = 14$), college student personnel

($n = 5$), school psychology ($n = 4$), marriage and family therapy ($n = 3$), social work ($n =$

2), and other programs (n = 3). Additionally, 36% of participants were in their first year of graduate school, 20% were in their second year, 18% were in their third year, 13% were in their fourth year, and 10% were in their fifth year or greater. Participants averaged 28.9 years of age with the youngest participant being 22 years old and the oldest participant being 53 years old.

Stimulus Tapes

Participants saw two videotaped clients, one European American male and one African American male. For the warm-up client, a European American male was used to aid in preparing participants for the format of the analogue study and to establish a base-line level of therapist state anxiety. The White client spoke for approximately 2 minutes about his anxieties around asking out a particular female. He stated that he has "played it safe" with women in the past and wanted to change that by asking this girl on a date (for the script, see Appendix C). Participants were asked to verbally respond to the client at two stopping points in order to familiarize them with the analogue procedure.

For the stimulus client, an angry African American male was used in order to elicit race-related countertransference reactions. Sue and Sue (2003) note that a dominant stereotype in our society is of the hostile Black male, and this stereotype is often triggered in White therapists when Black male clients speak with intense affect and closer conversation distance. For this reason, it was believed that an angry Black male client would elicit the more race-related countertransference reactions than a Black female or a Black client who exhibited emotions other than anger. Hence, the stimulus clients were limited to angry Black males.

Two African American male actors were videotaped as they followed the same script in an identical manner (Appendix F). In the script, the client was a counselor working for a mental health agency who is angry about the way he was treated by his colleagues. The client expressed feelings of resentment, frustration, and persecution, and the intensity of these feelings increased through the analogue. The client was chosen to be a professional therapist in order to make the stimulus more ego-near for the counselors participating in the study. The justification for the client's feelings and the race of the client's colleagues were left unclear in order to leave the stimulus material ambiguous and more dependent on the therapists' subjective interpretation. Furthermore, while the client never overtly stated the race of these co-workers, he hinted that they were White. A previous study found the condition used in the present study in which Whites were implicitly implicated to elicit greater avoidance behavior from White therapists than a condition in which Whites were explicitly implicated (Brittan,1993). It seemed that the ambiguity of the situation in which anger was implicitly directed toward Whites led to greater behavioral avoidance than the situation in which anger was explicitly directed at Whites. In addition, participants in the current study were asked to respond to the stimulus client at four stopping points. The number four was chosen to control for an effect due to the specific content of the clients' material at any one point without making the analogue too long as to fatigue the counselors.

To control for potential actor effects, two separate professional Black male actors trained together in order to make the performances as physically and emotionally consistent as possible. Precise movements and expressions were planned out in detail in advance of videotaping. After many performances by both actors, the best sessions were

selected for use in the study. Two videotapes, one for each actor, were then developed.

These tapes were each approximately six minutes long. Three practicing psychologists

(one European American male, one African American male, one African American

female) judged to have substantial experience working with African American clients

rated these actors on their believability, emotionality, likeability, and attractiveness on a 5

point Likert scale (1 = very low, 5 = very high; Brittan, 1993). It was agreed in advance

that actors must have ratings of 4.0 or higher on believability for the tapes to be usable.

The actors were found to have a means of 4.00 ($\underline{SD}$ = .82) and 4.33 ($\underline{SD}$ = .47) on

believability (see Table 1). In addition, it was agreed in advance that actors must have

ratings of 3.0 or higher on emotionality, likeability, and attractiveness for the tapes to be

usable. Judges gave the actors' degree of emotionality means of 4.67 ($\underline{SD}$ = .47) and 4.33

($\underline{SD}$ = .47). Additionally, the actors were found to have a means of 4.00 ($\underline{SD}$ = .82) and

3.33 ($\underline{SD}$ = .47) on likeability. The actors' mean scores of attractiveness were 3.67 ($\underline{SD}$ =

.94) and 4.00 ($\underline{SD}$ = .82). Finally, the same three judges rated these actors on Negroid vs.

Caucasoid features on a slightly different 5 point Likert scale (1 = very Caucasoid, 5 =

very Negroid).   For the tapes to be usable, it was agreed that actors must have ratings of

3.0 or higher on Negroid vs. Caucasoid features. Judges gave actors' Negroid vs.

Caucasoid features means of 4.33 ($\underline{SD}$ = .47) and 3.33 ($\underline{SD}$ = .47). Thus, the actors met

the minimum requirements on all dimensions of performance and features. Actors were

henceforth judged to be suitably believable, emotional, attractive, likable, and Negroid

for the purpose of the present analogue study (see Table 1).

Table 1

Means and Standard Deviations of Actors' Performance Ratings and Features

Actor	1	2
Believability	4.00	4.33
	(.82)	(.47)
Likeability	4.00	3.33
	(.82)	(.47)
Emotionality	4.67	4.33
	(.47)	(.47)
Attractiveness	3.67	4.00
	(.94)	(.82)
Negroid vs.	4.33	3.33
Caucasoid	(.47)	(.47)

Note. Standard deviations are listed in parentheses.

Measures

Miville Guzman Universality Diversity Scale Short Form (M-GUDS-S: Fuertes et al., 2000). The M-GUDS-S was used to assess the construct of universal-diverse orientation (see Appendix I). This construct reflects both an attitude of understanding that all people are simultaneously the same and different and an appreciation of these similarities and differences. The original 45-item measure the short form is based on contains three subscales: a) Diversity of Contact, b) Relativistic Appreciation, and c) Comfort with Differences (Miville et al., 1999). Diversity of Contact assesses respondents' interest and commitment to being involved in multicultural activities and relates to the behavioral aspect of the measure. Relativistic Appreciation assesses both respondents' appreciation of similarities and differences and how these similarities and differences influence their growth. It taps into the cognitive component of the measure. Though originally named Sense of Connection, the third subscale was renamed Comfort with Differences after a factor analysis showed the scale to be more complicated than originally theorized (Fuertes et al., 2000). Comfort with Differences measures how comfortable people are with others that are different from them and relates to the affective component.

Miville et al. (1999) found the original 45-item measure to be highly reliable with ratings of internal consistency and test-retest reliability ranging from .89 to .95. The validity of the M-GUDS has been established through its association with theoretically similar constructs. For example, it was found to have positive correlations with empathy, healthy narcissism, and attitudes toward feminism and the women's movement. Additionally, the M-GUDS was found to have negative correlations with homophobia, and dogmatism. It has also been found to correlate with the White Racial Identity

Attitude Scale and the Black Racial Identity Attitude Scale in theoretically predicted ways, thus providing further validation for the measure.

The short form of the Miville Guzman Universality Diversity Scale used in the present study contains 15 items, and each item is rated on a 6 point Likert-type scale (1 = strongly disagree, 6 = strongly agree; Fuertes et al., 2000). The short form was found to be sufficiently reliable with an alpha of .77. The validity of the M-GUDS-S has also been further established through its significant positive relationships with religious tolerance and the likelihood of friendship with someone of another race or sexual orientation. Some of the items of the M-GUDS-S include, "Getting to know someone of another race is generally an uncomfortable experience for me," and "In getting to know someone, I like knowing both how he/she differs from me and is similar to me." The total score range from 15 to 90, while the subscale scores range from 5 to 30 with higher scores indicating higher universal-diverse orientation.

Presentation of Client Strengths. The second independent variable, presentation of client strengths, was manipulated. Before counselors watched the video of the stimulus client, they received a sheet of intake information on the client. In the strength condition, the intake information described the following client strengths: the client is "close with his remaining family and seeks their support when he needs it," "overall, he is rather psychologically minded and seeks to understand how his past influences his present," "he continues to effectively communicate and express his emotions openly with his wife," "he maintains a collaborative approach to the relationship in which they work together on improving the marriage," "part of his work currently involves the development of a new program that *he created*," and "he is quite passionate about his

work, as he is in many other areas of his life"(Appendix D). In the neutral condition, the information on the client's strengths was replaced by the following neutral sentences: the client "appears to have a fairly ordinary relationship with his remaining family and corresponds with them on occasion," "live in a single story house near Silver Spring, Maryland," "he manages to go about his daily activities and continue to do his work," "he commutes to work everyday," and "part of his work currently involves the development of a new program at his agency, which is based in Washington D.C. approximately five minutes from American University." (Appendix E). This additional background information was added in the neutral condition to control for an effect due to the difference in length of the intake information.

In addition, to assess whether or not the presentation of client strengths manipulation was successful, counselors were asked two questions after they watched the video of the stimulus client (Appendix Q). The first question asked respondents to rate a single question (i.e., "I was given information on the client's strengths prior to seeing him") on a 6-point Likert-type scale (1=not at all true, 6=very true). The second question was free response and asked "Approximately how many strengths were mentioned in the client's case summary?"

Anger Discomfort Scale (ADS; Sharkin & Gelso, 1991). Therapist level of anger discomfort was also measured in the current study. This measure was included as a potential covariate to partial out variance from therapist's specific issues around anger. The construct of anger discomfort reflects the idea that people who are uncomfortable with anger typically feel threatened by their own experience of anger as well as are worried about others' reactions to their own anger. The measure is composed of 15 items,

and each item is rated on a 4 point Likert type scale (1 = almost never, 4 = almost always; Sharkin & Gelso, 1991). Sharkin and Gelso (1991) found the measure to be sufficiently reliable with ratings of internal consistency of .81 and test-retest reliability of .87 (see Appendix J). The validity of the ADS has been established through its positive relationship with trait anxiety, anger suppression, and anger expression. Additionally, the measure has been used to show that therapists uncomfortable with their own anger are more likely to feel anxious with and feel angry toward a female client who is angry at the therapist (Sharkin & Gelso, 1993).

Marlowe-Crowne Social Desirability Scale Short Form (SDS-S; Crowne & Marlowe, 1960). In addition, therapist social desirability was measured. In order to partial out variance from therapist response bias to other measures used in the study, SDS was included as a potential covariate. The measure is composed of 13 items rated as being either true or false (Appendix K). Internal consistency and test-retest reliabilities for the measure have been found in the range of .75 - .88 (Crowne & Marlowe, 1960). Examples of items include "No matter who I'm talking to, I'm always a good listener," and "I have never deliberately said something that hurt someone's feelings."

Countertransference assessment. Countertransference was assessed in terms of cognitive, affective, and behavioral components. The cognitive component was assessed by the accuracy of the counselors' recall of the number of angry words used by the client. The behavioral component was assessed by determining the proportion of the counselors' avoidant responses compared to their total responses (Bandura, Lipsher, and Miller, 1960). The affective component was assessed by measuring the counselors' state anxiety (Spielberger, Gorsuch, Lushene, 1970).

Cognitive Assessment. Counselors were asked to remember the number of angry words used by the client (Appendix M). The procedure was similar to the method used in previous analogue studies in which counselors were asked to recall the number of sexual words and / or words related to death used by clients (Gelso et al, 1995; Hayes & Gelso, 1993). This method was based on research showing that therapists overrecall or underrecall conflicting material (Cutler, 1958). It was assumed that when therapists experience countertransference they would be more likely to over or underestimate the number of angry words than therapists who do not experience countertransference. Thus, recall scores were obtained as the absolute deviation from the actual number of angry words in order to determine the accuracy of the counselors' recall of threatening material. A team of two Ph.D. students and two upper level undergraduate research assistants determined the number of angry words used by the client to be 23. This number was agreed upon after the team read the transcript of the client's material and watched the videotape of the client several times. Using this technique, Gelso et al. (1995) found cognitive distortions to be significant in a hypothesized sexual orientation X therapist gender interaction, thus providing the assessment with construct validity.

Behavioral assessment. The behavioral component of countertransference was measured using the method developed by Bandura, Lipsher, and Miller (1960). Therapist responses at the four stopping points of the stimulus client were divided into sentence units and coded as either approach (e.g., reflection) or avoidance (e.g., changing the topic). Therapists who experience countertransference reactions were expected to exhibit more avoidance responses to the client's material than those who did not. Thus, a ratio of the avoidance responses to the sum of approach and avoidance responses was obtained to

determine the frequency to which therapists gave avoidant responses (Appendix N). This method has been used in similar analogue studies examining therapist countertransference reactions (Gelso et al., 1995; Hayes & Gelso, 1993; Latts & Gelso, 1995). Using this method, two studies found as expected that homophobic therapists were more likely to exhibit behavioral avoidance with the gay client (Gelso et al., 1995; Hayes & Gelso, 1993). Additionally, Latts and Gelso (1995) found a hypothesized interaction effect using behavioral avoidance as the dependent variable. Hence, this method shows good construct validity.

Affective assessment. In order to assess the affective component of the therapists' countertransference reactions, therapist state anxiety was measured. Therapists who experience countertransference reactions were expected to have greater anxiety in a session than therapists who do not. Thus, the State Anxiety Inventory (SAI-S; Appendix G; Spielberger, Gorsuch, Lushene, 1970) was used, and therapists were asked to rate the measure as though they were still in the session with the client (Appendix L). The measure has participants rate 20 items on a scale from 1 (*not at all*) to 4 (*very much so*). The measure has been found to have predictably low test-retest reliability (since state anxiety is situational) ranging from .16 to .54 (Dreger, 1978). Gelso et al (1995) found the measure to have a high internal consistency (alpha=.91) as have an abundance of other studies (e.g., Sharkin & Gelso, 1993). The validity of the measure has been demonstrated through a number of researchers finding hypothesized effects using state anxiety (Hayes & Gelso, 1991, 1993; Sharkin & Gelso, 1991).

State anxiety was measured as the difference between therapist state anxiety with the African American client and therapist state anxiety with the European American

client. Measuring state anxiety in this matter should allow therapists' baseline level of

anxiety to be taken into account. For example, if a therapist typically experiences high

anxiety with all their clients, this therapist would be expected to have higher state anxiety

with both the White client and the Black client. Hence, this therapist is more likely to be

correctly measured as not having specific countertransference issues around anxiety with

African American clients by using this method.

Procedures

Participant Recruitment. Participants were recruited through the following means:

announcements in graduate practicum classes, electronic mail announcements, and direct

contact via phone and face-to-face. Though only European American participants were

used in the study's analyses, participants of all races and ethnicities were recruited. This

recruitment method was utilized so that participants would not anticipate the current

study to investigate race in any manner. Additionally, participants were told that they

would be participating in an analogue study on the counseling process but were not aware

of the study's hypotheses. To maintain confidentiality, codes were placed on all the

forms instead of participant names.

Data Collection. Before data was collected, a pilot study was conducted with

several participants who may have been aware of the study's hypotheses (e.g., the first

author's advisor) in order to receive feedback on the procedure. The following represents

the procedure used during data collection after extensive feedback from this pilot study.

Participants first filled out an informed consent form. Next, participants were given a

packet which included the M-GUDS-S, ADS, SDS-S, as well as other measures unrelated

to the hypotheses (e.g., the Inventory of Learning Processes, the Interpersonal

Dependency Scale, and the Inventory of Interpersonal Problems) in order to mask the purpose of the study. The three trait measures (i.e., M-GUDS-S, ADS, and SDS-S) were given before any contact with the clients or any information on the clients was given in order to avoid possible response bias to these trait measures. All measures in this packet were counterbalanced, while the M-GUDS-S, ADS, and the SDS-S were never the first or last measure to avoid possible primacy and recency effects.

Therapists then were given background information on the first videotaped client (Appendix B). When they have read the background information, participants were told to underline key points for the purpose of keeping the warm-up client and stimulus client conditions symmetrical. Once the tape recorder is started, the experimenter starts the tape and leaves the room. This European American male client was performed by a one actor in all conditions and acted to warm-up participants to the procedure of responding to the videotape (Appendix C). Therapists were prompted on the television screen to respond to the warm-up client for 30 seconds at two designated points. After the participants have finished responding to the first client, they are given the SAI-S to obtain baseline state anxiety reactions. They are then given background information on the stimulus client. Depending on the randomly assigned condition, they either receive information on the client's strengths (Appendix D) or receive neutral information (Appendix E), and they will watch a video of either actor 1 or actor 2. Participants are given several minutes to read the background information and are told to underline key points in order to make the manipulation more salient. The experimenter starts the tape recorder and video and then leaves the room. Therapists were prompted on the television screen to respond to the stimulus client for 30 seconds at four designated

points. After participants have finished responding to the second client, they are given the SAI-S, manipulation check, cognitive recall measure, and demographic form. Finally, participants are given the debriefing form (Appendix P).

Coding of behavioral approach/avoidance. In order to record therapists' verbal reactions to the analogue client, therapists were asked to respond at four pause points in the stimulus client as though they are in a real session. Participants' responses were recorded by audiotape, and transcripts of the stimulus client were made of these responses (Appendix P). Next, the responses were divided into grammatical units according to procedures outlined by Hill and O'Brien (1999) by a team of two Ph.D. students and two upper level undergraduate research assistants trained to at least 80% agreement on the task using transcripts from sessions unrelated to the present study. Four third-year Ph.D. students in counseling psychology blind to the study's hypotheses were then trained to label the responses according to the procedure pioneered by Dollard and Mowrer (1947) and revised by Bandura, Lipsher, and Miller (1960). Each response was labeled as one of the following: approval, exploration, instigation, reflection, labeling, disapproval, topical transition, silence, ignoring, or mislabeling (Appendix N). Responses not fitting any of these categories were labeled "other" and were treated as neutral responses in the analyses.

Numerous practice transcripts were used as examples until an inter-rater reliability of at least .80 was achieved. Finally, raters coded the participants' responses at both the unit and the turn level. At the unit level, each individual sentence unit was rated as approach or avoidance. Behavioral avoidance at the unit level was thus measured as the ratio of sentence units coded as avoidance responses to the total number of

sentence units for each therapist. At the turn level, each entire speaking turn was rated as approach or avoidance. Specifically, raters were told to select the unit within each speaking turn that appeared to carry the most weight, or would likely have the greatest impact on the stimulus client, among all the sentence units in that speaking turn (Appendix O). Behavioral avoidance at the turn level was thus measured as the ratio of speaking turns coded as avoidance responses to the total number of speaking turns for each therapist. The turn level appeared to make the most conceptual sense in the present study. For example, therapists may have made a single dramatic avoidance response that minimizes other approach responses within a speaking turn (Brittan, 1993). Only the turn level would be able to take into account responses that carry such an impact.

Additionally, Brittan (1993) found White therapists to exhibit significantly greater avoidance responses at the turn level with a Black client implicitly angry at Whites than a Black client explicitly angry at Whites. Such a finding provides some validity to using the turn level of behavioral avoidance in the current study. Upon completion of the ratings, it was found that one of the raters coded nearly all responses as avoidance, inconsistent with the ratings of other raters. Additionally, this rater's ratings were not correlated with the other raters. Hence, this rater was dropped from the analyses.

Inter-rater agreement was calculated to reflect agreement between raters as to whether a therapist response was approach, avoidance, or neither. Additionally, inter-rater agreement was calculated at both the unit level and the turn level. Each rater coded all 45 transcripts of European American therapist responses. At the unit level, the proportion of agreement between the three raters (1 with 2, 1 with 3, and 2 with 3) was .82, .79, and .75. The average proportion of inter-rater agreement at the unit level was

.79. At the turn level, the proportion of agreement between the three raters (1 with 2, 1 with 3, and 2 with 3) was .82, .78, and .73. The average proportion of inter-rater agreement at the unit level was .78. Inter-rater agreement was consistent with proportions found in similar studies (e.g., Gelso et al., 1995; Hayes & Gelso, 1993). Since there was little discernable difference between the mean proportion of inter-rater agreement at the unit level and turn level (.79 and .78, respectively), the turn level was chosen for the study's analyses since it was judged to make more theoretical sense. Hence, in the following results and discussion sections, behavioral avoidance will refer to therapist avoidance responses at the turn level.

CHAPTER 5

RESULTS

This study tested 3 sets of hypothesis. The first set of hypotheses proposed that therapists' universal-diverse orientation will be negatively related to their (a) state anxiety, (b) cognitive recall, and (c) behavioral avoidance following a cross-racial situation. The second set of hypotheses posited that therapists who are given information on client strengths will have (a) less anxiety, (b) more accurate cognitive recall, and (c) less behavioral avoidance than therapists who are not given information on client strengths in a cross-racial situation.

For the third set of hypotheses, an interaction was expected such that the effect of therapists' universal-diverse orientation on their (a) anxiety, (b) cognitive recall, and (c) behavioral avoidance in a cross-racial situation depends on whether or not they receive information on the client strengths. Specifically, the interaction predicted that high UDO therapists in the strengths condition would experience the (a) least anxiety, (b) most accurate cognitive recall, and (c) least behavioral avoidance. Low UDO therapists in the strengths condition would experience the (a) most anxiety, (b) least accurate cognitive recall, and (c) most behavioral avoidance. Additionally, therapists in the neutral condition who have high UDO would experience (a) less anxiety, (b) more accurate cognitive recall, and (c) less behavioral avoidance than low UDO therapists.

An alpha level of .05 was used for all hypothesized statistical analyses. This alpha level was chosen in order to decrease the possibility of Type I and Type II errors. Before the above hypotheses were tested, the manipulation check of the presentation of client strengths was examined. This manipulation check showed counselors in the strength

condition ($\underline{M}$ = 5.44, $\underline{SD}$ = .64) felt significantly stronger that they were given

information on the client's strengths than the neutral condition ($\underline{M}$ = 4.11, $\underline{SD}$ = 1.32), $\underline{t}$

(43) = 4.52, $\underline{p}$ = .000. Furthermore, counselors in the strength condition ($\underline{M}$ = 6.04, $\underline{SD}$ =

2.19) reported receiving significantly more strengths in the client's case summary than

did clients in the neutral condition ($\underline{M}$ = 4.50, $\underline{SD}$ = 2.21), $\underline{t}$ (43) = 2.30, $\underline{p}$ = .026. Hence,

the results suggested that manipulation of presentation of client strengths was

accomplished. Additionally, three possible covariates (i.e., discomfort with anger, social

desirability, and actor conditions) were correlated with the dependent variables. Since

discomfort with anger, social desirability, and actor conditions were not significantly

correlated with any of the dependent variables, these covariates were not included in any

of the analyses (see Table 2).

To test the three sets of hypotheses, a simultaneous multivariate multiple

regression was performed with UDO and strength conditions (dummy coded as 0 and 1)

as the predictor variables and state anxiety, cognitive recall, and behavioral avoidance as

the criterion variables. The first set of hypotheses, testing for a main effect of therapist

universal diverse orientation, was supported by the data. The multivariate multiple

regression found a significant effect of therapist universal diverse orientation on the three

dependent variables combined (i.e., state anxiety, cognitive recall, and behavioral

avoidance) with a value $\underline{F}$ (3, 44) = 3.90, $\underline{p}$ = .016. Post hoc univariate$\underline{F}$ tests showed

UDO significantly contributed to only one of the dependent variables, state anxiety, $\underline{F}$ (1,

44) = 7.13, $\underline{p}$ = .01. UDO did not contribute significantly to cognitive recall, $\underline{F}$ (1, 44) =

1.80, $\underline{p}$ =.187. Additionally, UDO did not contribute significantly to behavioral

Table 2

Intercorrelations between Social Desirability, Discomfort with Anger, Actor Conditions and Criterion Variables

Variables	SD	DA	Actor	State Anx.	Cog. Recall	Turn Avoid.
SD	1	-.05	-.19	-.24	.02	.21
DA		1	.11	.07	-.21	.14
Actor			1	.10	.09	-.01
State Anx.				1	.09	.11
Cog. Recall					1	.15
Turn Avoid.						1

SD = Marlow-Crown Social Desirability Scale; DA = Discomfort with Anger Scale; Actor = Actor Conditions; State Anx. = State Anxiety; Cog. Recall = Cognitive Recall; Turn Avoid. = Turn Avoidance

avoidance, $\underline{F}$ (1, 44) = 1.13, $\underline{p}$ = .295. Measures of central tendency and variance are presented in Table 3.

The second set of hypotheses, testing for the main effect of information on client strengths, was not statistically supported. Results were not significant for the effect of the strength conditions on the dependent variables in the multivariate multiple regression, $\underline{F}$ (3, 44) = 1.17, $\underline{p}$ = .334. The multivariate multiple regression thus indicated that the condition in which therapists received information on client strengths was not significantly different from the condition in which therapists did not receive such information on any of the dependent variables (i.e., state anxiety, cognitive recall, and behavioral avoidance). Hence, no follow-up tests were performed.

In the third set of hypotheses, an interaction between therapists' universal-diverse orientation and whether or not they receive information on the client strengths on the dependent variables was predicted. The multivariate multiple regression of this interaction effect was found to not be significant, $\underline{F}$ (3, 44) = 1.05, $\underline{p}$ = .382. Thus, no follow-up tests were performed.

Additional Analyses

Measures of central tendency and variance. Table 3 presents means, medians, standard deviations, actual ranges, and possible ranges for therapists' universal diverse orientation and the three dependent variables (i.e., state anxiety, cognitive recall, and behavioral avoidance). An examination of the table reveals the variability for these variables and the relatively low mean for turn avoidance, (M = 33.5; compared to 59.0, in the other study using the current video scene, Brittan, 1993). Hence, the present sample

Table 3

Measures of Central Tendency and Variance for Predictor and Criterion Variables

Variable	Central Tendency		Variance		
	Mean	Median	SD	Range	Possible Range
UDO	70.9	71	8.9	46-89	15-90
State Anxiety	4.0	3.0	10.7	-13-48	-60-60
Cognitive Recall	9.9	11	4.9	4-25	N/A
Turn Avoidance	33.5	25	36.7	0-100	0-100

of graduate student participants exhibited a substantially lower amount of turn avoidance with the angry Black client than Brittan's (1993) sample of both graduate students and practicing therapists.

Exploratory analyses. For all exploratory analyses, an adjusted alpha of .01 was used. This more stringent level of alpha was chosen for post-hoc analyses in order to decrease the likelihood of potential Type I and Type II errors and to reduce alpha inflation.   Though the multivariate interaction effect was not significant, possible interactions may exist between the two predictor variables and each separate criterion variable. To investigate this possibility, the continuous predictor variable UDO was divided into high and low according to a median split at 71. An inspection of the cell means presented in Table 4 revealed that patterns may in fact exist between the predictor variables and each criterion variable separately. Thus, three separate simultaneous multiple regressions were performed to investigate these potential interactions.

The first multiple regression examining the interaction of UDO and strength conditions on state anxiety was found to not to be significant, $\underline{F}$ (1, 41) = 2.28, $\underline{p}$ = .139. Despite this lack of a significant interaction effect, a pattern of means emerged revealing that this interaction may be significant with a larger sample size. Specifically, low UDO therapists in the neutral condition showed greater state anxiety ($\underline{M}$ = 13.6, $\underline{SD}$ = 15.1) than those in the client strength condition ($\underline{M}$ = 5.6, $\underline{SD}$ = 10.5), while high UDO therapists in both neutral and client strength conditions exhibited less state anxiety than low UDO therapists ($\underline{M}$ = -.4, $\underline{SD}$ = 7.5 and $\underline{M}$ = .9, $\underline{SD}$ = 7.3 respectively). Note that negative state anxiety means indicate that therapists had greater anxiety with the European American client than the African American client. This only marginally

Table 4

Cell Means and Standard Deviations for Dependent Variables

Dependent Variable	UDO*	Condition	
		Neutral	Client Strength
State Anxiety	High	-.4[a]	.9[b]
		(7.5)	(7.3)
	Low	13.6[c]	5.6[d]
		(15.1)	(10.5)
Cognitive Recall	High	10.8	11.1
		(4.3)	(4.5)
	Low	9.1	9.5
		(5.9)	(5.0)
Turn Avoidance	High	21.9	37.5
		(33.9)	(37.7)
	Low	53.6	38.5
		(46.6)	(33.3)

Note. Standard deviations are listed in parentheses.

Note. a: $\underline{n} = 8$; b:$\underline{n}$ = 14; c: $\underline{n} = 7$; d: $\underline{n} = 13$.

*based on a median split, where median = 71.

occurred with high UDO therapists in the neutral condition ($\underline{M}$ = -.4). Additionally, take notice that the nature of this non-significant interaction is different than that predicted by the third set of hypotheses above.

A second simultaneous multiple regression of UDO and strength conditions on cognitive recall was also performed. The interaction component of this regression was found to be non-significant, $\underline{F}$ (1, 41) = .82, $\underline{p}$ = .37. Additionally, a third simultaneous multiple regression of UDO and strength conditions on behavioral avoidance was conducted. This regression also showed a non-significant interaction, $\underline{F}$ (1, 41) = .02, $\underline{p}$ = .88.

In the cognitive recall measure, it appeared that participants were more likely to under-recall than over-recall the number of angry words verbalized by the African American client. Thus, a one-way chi-square test was performed in which participants' recall of the number of angry words was dichotomized into being either higher or lower than the actual number of angry words. This chi-square was found to be significant, X^2 = 30.4, $\underline{p}$ = .000. An examination of the frequencies revealed that indeed participants more frequently under-recalled the number of angry words ($\underline{n}$ = 41) than over-recalled ($\underline{n}$ = 4).

An additional post hoc analysis examined mean differences for males and females on turn avoidance. An independent samples T-test conducted on gender differences in turn avoidance was found to be non-significant, $\underline{t}$ (43) = -1.96, $\underline{p}$ = .057. Nonetheless, it appears that men in this sample exhibited more turn avoidance ($\underline{M}$ = 55.0, $\underline{SD}$ = 36.9) than women ($\underline{M}$ = 30.0, $\underline{SD}$ = 35.3) in the cross-racial situation with an angry male client.

Correlations among predictor and criterion variables. In table 5, Pearson correlation coefficients between predictor and criterion variables are presented. The table

Table 5

Intercorrelations between Predictor and Criterion Variables

Variables	Client Strength	State Anxiety	Cognitive Recall	Turn Avoidance
UDO	.172	-.29*	.21	-.11
Client Strength	1	.10	-.10	-.08
State Anxiety		1	.09	.11
Cognitive Recall			1	.15
Turn Avoidance				1

*p = .05, two-tailed

shows that only one correlation was significant at .05. Therapist UDO was shown to

negatively correlate with state anxiety ($\underline{r}$ = -.29, $\underline{p}$ = .05).

CHAPTER 6

DISCUSSION

This study aimed to investigate the effect of certain variables on cross-cultural counseling. Specifically, this study intended to look at the influence of universal-diverse orientation and information on client strengths on European American therapists' countertransference to an angry African American client. In this section, findings relevant to hypotheses will be discussed as well as other exploratory findings. Additionally, limitations of this research will be presented as well as directions for future research.

The Role of Therapist Universal-Diverse Orientation

Previous literature has shown UDO to predict counselors' perceived multicultural counseling knowledge and awareness (Constantine et al, 2001). Additionally, UDO has been shown to highly correlate with a newly developed measure of ethnocultural empathy (r = .70; Wang, Davidson, Yakushko, Savoy, Tan, & Bleier, 2003). However, this is the first study to investigate how therapist UDO may directly affect counseling process in a cross-racial situation. UDO was predicted to influence the counseling process in cross-racial therapy through countertransference reactions. Results showed that therapist UDO was significantly and negatively related to their countertransference reactions in a cross-racial situation. In particular, therapists with lower UDO were significantly more likely to experience greater anxiety with the angry Black client than the White client. Hence, it seems that therapists who have an awareness and acceptance of people's similarities and differences tend to have less countertransference, and specifically less anxiety, with an African American client than therapists who lack such an understanding. These findings

are consistent with hypotheses predicting therapists' UDO would be negatively related to their countertransference reactions following a cross-racial situation.

It is important to note that anxiety was the only dependent variable to compare therapist countertransference reactions with the Black client to the White client. In contrast, cognitive recall and behavioral avoidance were only measured with the African American client and so comparisons to the European American client were unavailable. Since low UDO therapists showed greater state anxiety with the Black client compared to the White client, it appears that the increase in anxiety with the Black client may be due to the client's race rather than due to other factors.

The negative relationship between therapist UDO and countertransference in a cross-racial dyad is consistent with the clinical literature. One White therapist described her countertransference reactions to an African American client when she stated, "There seems to be another dimension - more critical – at issue. It was that I felt a particular resistance to being experienced in this way, as central to another person's experience, while so different from how I felt myself to be" (Schwaber, 1983, p.389). Schwaber appeared to be unable to integrate the idea that she was simultaneously similar to and yet different from this African American client. Hence, she may have had problems identifying with this client as a result of low UDO. Additionally, her low UDO seemed increase her countertransference in such a cross-racial dyad. Perhaps low UDO therapists in the present study had reactions to an angry Black client that were similar in nature to those described by Schwaber. These low UDO therapists may have also felt resistant to the complexity of the cross-racial situation and felt greater anxiety as a consequence.

It is important to note the content of the angry Black client's material when trying to understand the influence of therapist UDO on countertransference in the present study. The client is a mental health worker who is frustrated by his colleagues and feels that they are holding his program back. Though he never explicitly states the race of these colleagues, he implies that these colleagues are White. For example, the client states that his colleagues "will always be jerks, it's part of their nature." Brittan (1993) found the condition used in the present study in which Whites are implicitly implicated (e.g., "I shouldn't expect much more from my colleagues") to elicit greater avoidance behavior from White therapists than a condition in which Whites are explicitly implicated (e.g., "I shouldn't expect much more from these White people"). Apparently, therapists had less of a cognitive frame to base their responses on in the more ambiguous condition in which anger was implicitly directed at White people than the condition in which explicit anger was aimed at White people. Since the present study used the condition in which anger was implicitly directed at White people, the content may have primed UDO attitudes to a greater extent. White therapists who better understood that this Black client is both similar and simultaneously different from them may have been more comfortable and less anxious in the ambiguity of the cross-racial situation.

In addition, the present study provides support for researching the influence of therapist UDO on counseling process in situations in which UDO is salient (e.g., cross-racial dyads). Prior research on therapist UDO has investigated its relationship with stable traits such as Openness to Experience in the Big Five (Thompson, Brossart, Carlozzi, Miville, 2002) and more fluid traits such as multicultural competence (Constantine et al., 2001). Nonetheless, this is the first study to look at the effect of UDO

on counseling process and found UDO to be negatively related to state anxiety in a cross-racial situation. It would be interesting to discover whether the countertransference reactions of low UDO counselors would negatively impact therapy outcome in actual cross-racial therapy. Hence, future research may investigate the influence of therapist UDO on counseling outcome.

The Role of Perceived Client Strengths

The present study expected that White therapists who were given information on the Black clients' strengths would exhibit less countertransference reactions than those not given such information. Despite the fact that therapists in the client strengths' condition noticed significantly more strengths than the neutral condition, these therapists did not exhibit less countertransference. Such a finding runs counter to clinical literature on using strengths when working with African Americans. Lyles and Carter (1982) theorized that client strengths need to be identified early on in order to develop an alliance with African Americans in the beginning of therapy. In addition, other theoreticians have argued that cultural dissimilarity makes development of the alliance in the beginning stages more difficult and complex (Gelso and Mohr, 2002). Since countertransference has been found to negatively impact the working alliance (Ligiero & Gelso, 2002), it was believed that therapists who perceived more psychological strengths in their clients may exhibit less countertransference in cross-racial psychotherapy. However, information on client strengths did not reduce therapist countertransference prior to an initial meeting with an angry Black client in the present study. Thus, perhaps perceived client strengths do not directly affect therapist countertransference reactions in actual cross-cultural therapy.

      Before attempting to understand of the lack of influence information on client strengths had on therapist countertransference, it is critical to examine key differences between experimental conditions. For example, therapists in the strengths condition were told in regards to the clients' relationship with his family that he is "close with his remaining family and seeks their support when he needs it. Overall, (the client) is rather psychologically minded and seeks to understand how his past influences his present." In contrast, therapists in the neutral condition were told relevant to the clients' relationship with his family that he "appears to have a fairly ordinary relationship with his remaining family and corresponds with them on occasion." In regards to his relationship with his wife, therapists in both conditions are told about some difficulties in his marriage. Therapists in the strengths condition are also told that "in spite of this, he continues to effectively communicate and express his emotions openly with his wife about these issues. He also maintains a collaborative approach to the relationship in which they work together on improving the marriage." Conversely, therapists in the neutral condition are told that "although (the client) is experiencing such marital issues, he manages to go about his daily activities and continue to do his work." It is also essential to note that though therapists in these conditions learned different information on the client, therapists in both conditions saw the same client. In other words, one participant may have been told of more client strengths than another participant, but both participants still saw the same angry Black client. Hence, the client's material was the same in both conditions, which may help to explain the lack of a relationship between perceived client strengths and countertransference.

There may be several reasons why information on client strengths did not decrease White therapists' countertransference with the angry Black client. One explanation may be that therapists in the strength condition may have viewed the information on the client's strengths as inconsistent with their experience of the analogue client. For instance, therapists in the strength condition were told the client is insightful and "psychologically minded." The client in the video, however, may have come across as blaming others rather than looking at himself or an interaction of himself and others as creating his problems at work (e.g., "They can preach and preach all they want about being open minded, but the proof is in the pudding. When it comes down to it, they're all alike. These arrogant fools are screwing up the whole program"). Additionally, in the strengths condition, therapists are told that the client upholds a "collaborative approach" with his wife. The analogue client, however, is extremely frustrated with his colleagues and is at the end of his rope. He feels that he has tried everything with them and it has not worked. Thus, there is little concrete evidence of a collaborative approach with the colleagues at work. Therefore, therapists in the strength condition may have viewed the information on the client's strengths as inconsistent and thus irrelevant. They may have simply ignored the strengths information as a consequence, nullifying any potential positive effects the strengths may have had of mitigating their countertransference.

In addition, perhaps the information on the client's strengths did not adequately prepare therapists for the clients' level of anger. Both conditions include information that the client is having frustrations at work and that he has "become increasingly discouraged by what he sees as his colleagues' criticism of what he believes in." The strength condition additionally notes that the client is able to "effectively communicate

and express his emotions openly" with his wife. However, the analogue client comes

across as extremely angry at his colleagues at work (e.g., "I hate having to work with all

these jerks") and is apparently ready to give up on them (e.g., "To hell with all of them").

Hence, the specific strengths therapists were given in the strengths condition may not

have prepared therapists for the level of anger they experienced in their session with the

client. Perhaps if the client had been presenting different material, information on client

strengths might have decreased therapist countertransference. Future research can

examine whether information on client strengths can decrease therapist

countertransference when clients express other types of material (e.g., intense anxiety).

Furthermore, future research may investigate the influence of perceived client strengths

on counseling process variables, such as countertransference, within same race dyads and

other cross-racial dyads (e.g., African American therapists and Asian American clients).

The Interaction between UDO and Client Strengths

Results found that therapist UDO and client strength conditions did not

significantly interact with the three countertransference variables combined (i.e., state

anxiety, cognitive recall, and behavioral avoidance). This finding was inconsistent with

the study's hypotheses. Additionally, exploratory analyses found interactions between

client strength conditions and UDO on state anxiety, cognitive recall, and behavioral

avoidance separately to be non-significant.   Nonetheless, a pattern of means indicated a

possible interaction within the present sample for client strength conditions and UDO

specifically on state anxiety. Again, note that state anxiety was measured as the

difference in therapist state anxiety between the African American client and the

European American client. Hence, greater state anxiety with the Black client than the

White client implies the increase in anxiety is likely to be affected by the clients' race rather than other factors.

Within the sample, the results of the potential interaction of therapist UDO and client strengths on state anxiety pose interesting implications. It appears that high UDO therapists had scarcely any more state anxiety with the Black client than the White client if at all. Specifically, high UDO therapists in the neutral condition had slightly less state anxiety with the Black client than the White client ($\underline{M}$ = -.4), while high UDO therapists in the strength condition had slightly more state anxiety with the Black client than the White client, ($\underline{M}$ = .9). Compared to high UDO therapists, low UDO therapists had a substantially greater amount of state anxiety with the African American client than the European American client. In particular, low UDO therapists in the neutral condition had the greatest state anxiety ($\underline{M}$ = 13.6), while low UDO therapists in the strength condition had substantially less state anxiety ($\underline{M}$ = 5.6). It appears that White low UDO therapists' state anxiety may have been mitigated by learning about the Black client's strengths. Hence, European American therapists with less awareness and acceptance of people's similarities and differences may benefit most from learning about client strengths prior to seeing an African American client. Perhaps significance was not achieved for this possible interaction due to a small sample size of White therapists. Future research may investigate whether this potential interaction may be found in larger sample sizes of European American therapists. However, though a pattern appeared to emerge in the present sample, the result should not be generalized to actual cross-racial dyads.

The Role of Countertransference Reactions

Though no specific hypotheses on countertransference alone were made, several exploratory findings surfaced in the present study. For example, results showed that people were significantly more likely to under-recall than over recall the number of angry words with the African American client. Therapists may have attempted to be politically correct and thus were afraid of overestimating the number of angry words said by the Black client. Political correctness may be defined as "the degree a person is hypervigilant in preventing oneself from being aware of the degree of one's socialized oppressive attitudes, beliefs, or behaviors" and is also characterized by being "extremely rigid in monitoring one's attitudes, beliefs, and behaviors in order to satisfy the dictate of being absolutely certain that these are entirely non-oppressive in character" (Brittan-Powell, in press, p. 2). In the present study, people underestimated the number of angry words said by the African American client by an average of nearly 13 words, and only four of 45 participants overestimated the number of angry words. Hence, therapists seemed to be monitoring their responses in this situation in which race was salient. They may have been afraid of coming across as racist if they reported a high number of angry words and underestimated the number in order to avoid such perception from others. Furthermore, therapists may have been afraid to acknowledge to themselves that they may hold oppressive attitudes and so underestimated the number to avoid such self-perception. Such political correctness may explain why cognitive recall was not significant in any of the hypothesized analyses.

Results also showed therapists had a substantially lower amount of behavioral avoidance than was found in Brittan's (1993) study using the same analogue clients. There are many possible reasons for this disparity. First, several methodological

differences between the present study and Brittan's study must be pointed out. Research assistants were not in the room at any point while participants verbally responded to the African American client in the current study. In contrast, research assistants were present in the room for the entire duration while participants responded to the client in Brittan's study. Therapists may have felt uncomfortable with someone else in the room while they responded to such intense emotional affect. The presence of a third party may have reduced therapists' ability to treat the analogue session as though it was a real psychotherapy session and increased their behavioral avoidance as a consequence.

A second difference between the present study and Brittan's (1993) study is the amount of time therapists were allotted to respond to the client at each speaking turn. Before conducting research for the present study, a pilot study was conducted to determine the amount of time to allow therapists to respond the Black client. This pilot study concluded that therapists with the least avoidance tended to need less than 10 seconds to respond to the client. Therapists with low turn avoidance seemed to be bored and become less involved in the analogue session when they were permitted to speak for longer than 30 seconds. Additionally, few if any therapists needed longer than 30 seconds to respond. As a result, therapists in the current study were allowed to respond to the African American client for up to 30 seconds at each of the four speaking turns. Conversely, Brittan's study allowed therapists to respond to the client for up to several minutes for each of the four speaking turns. Hence, perhaps the longer therapists responded, the greater the chance of behavioral avoidance. Because therapists were allowed to respond for a longer period of time in Brittan's study, they may have also had a greater opportunity for avoidance behavior.

A third possible reason for greater therapist avoidance behavior in the current study than Brittan's (1993) study may be different samples. The present study used a sample composed of entirely graduate students compared to Brittan's sample composed of half graduate students and half mental healthcare workers in the community. No analyses on differences between graduate students and mental health workers were performed in Brittan's study. A third possible reason for the difference in means between Brittan's study and the current study may be the different times in which data was collected. The present study examined countertransference reactions to an angry African American client over a decade after Brittan investigated similar countertransference reactions. Graduate programs and society in general have had a greater focus on issues of diversity in more recent years (see Yang et al, 2003). Perhaps this increased focus has led current therapists-in-training to have less countertransference reactions, specifically less behavioral avoidance, than graduate students a decade ago.

Another interesting finding on countertransference was that men ($\underline{M}$ = 55.0, $\underline{SD}$ = 36.9) appeared to have greater avoidance behavior than women ($\underline{M}$ = 30.0, $\underline{SD}$ = 35.3) with the angry African American client, although this finding was not significant due to extreme variability and low numbers of men ($\underline{n}$ = 10). Perhaps male therapists may have been more likely to exhibit behavioral avoidance with the male African American client than female therapists due to the client's gender, race, anger aimed at White people, or more likely, some combination of these factors. The non-significant finding that men had greater behavioral avoidance than women is interesting since one could just as easily suggest women would have greater countertransference reactions to the client than men. For example, one could have hypothesized that White women in the study would be

intimidated by the angry Black client and experience greater avoidance behavior than men as a result. However, it appears that the same gender and cross-racial dyad combination may have produced the greatest behavioral avoidance within the present sample. Future investigations may endeavor to confirm this finding in other samples. Furthermore, future research can attempt to further explicate the specific factors that may be attributed to this potential finding. Finally, future research may examine other same and different gender and race combinations and their impact on countertransference reactions.

Implications for Counseling

The results of this study hold several implications for counseling and the training of future therapists. Results showed therapists with lower UDO were more likely to experience greater countertransference reactions, specifically state anxiety, with the African American client. These findings imply therapists who are less aware and accepting of the fact that people are simultaneously similar and different may experience even more problems in therapy situations with a client of another race in the near future. In 2000, nearly 30% of the US population was composed of racial and ethnic minorities, and that number is expected to be at nearly half the population by 2050 (U.S. Census Bureau, 2000, 2001). Given that therapists can expect to experience more cross-racial therapy dyads as they progress through their career, low UDO therapists' greater countertransference in such situations may need to be addressed in the training of future therapists.

An additional implication for the negative relationship between therapist UDO and state anxiety in a cross-racial situation is that the therapists with low UDO may not

be receiving adequate training to deal with such situations. A recent study, using the

Consensual Qualitative Research Method, compared African American and European

American therapist experiences in cross-racial dyads (Knox, Burkard, Johnson, Suzuki, &

Ponterotto, 2003). Knox et al. (2003) found only White therapists reported receiving little

or no didactic training addressing race. Additionally, European American therapists were

more likely to report have little or no supervision experiences addressing race. White

therapists were also more likely to feel more discomfort addressing race in a cross-racial

dyad than Black therapists. The authors concluded that the lack of training and clinical

experience of the White therapists in dealing with race may have increased their

discomfort in such situations. Such training experiences may be preventing White

therapists with already low UDO from growing in their attitudes of accepting and being

aware of clients' similarities and differences, which thus may lead to an increase in

countertransference in cross-cultural therapy situation.

In a similar vein, perhaps low UDO therapists may be attending very few or no

multicultural workshops or conferences which may help to increase their UDO and thus,

decrease their countertransference. Yeh and Arora (2003) found attendance to

multicultural workshops to predict higher levels of UDO. Additionally, all of the African

American therapists and none of the European American therapists in Knox et al's (2003)

study reported attended multicultural workshops and conferences postgraduate school.

Attendance to such workshops and conferences may enable European American

therapists to have a greater awareness and acceptance of similarities and differences of

clients in cross-racial dyads and hence, decrease their anxiety in these situations.

Attendance at multicultural workshops and conferences was not measured in the present

study. Future research may investigate whether attendance at multicultural workshops and conferences may help to decrease the countertransference of low UDO therapists by facilitating their acceptance and awareness of clients' similarities and differences.

<u>Limitations</u>

The findings of the present study must be understood in the context of its limitations. One limitation of the current study, as with all laboratory studies, is its generalizability to actual cross-racial therapy dyads. Nonetheless, several steps were taken to increase the study's external validity. For example, unlike previous analogue studies investigating countertransference that used a similar method (e.g., Brittan, 1993; Gelso et al., 1995; Hayes & Gelso, 1993; Latts & Gelso, 1995), therapists in this study responded to the client with no one in the room with them or even watching them. Hence, therapists may have been able to feel more comfortable in the lab situation and feel as though it is more like an actual counseling session as a result.

In order to create a situation in which no one was present in the room or watching while therapists responded to the client, therapist responses for the predetermined stopping points were limited to 30 seconds each. Previous studies allowed someone to be in the room or watch therapists in order to give therapists as much time to respond as they wished at each stopping point (Brittan, 1993; Gelso et al., 1995; Hayes & Gelso, 1993). Though a pilot study found most therapists did not need more than 30 seconds at each stopping point, some therapists may have used more time if allowed. This time limit may have resulted in a decrease in the amount of behavioral avoidance in the present sample.

The use of videotaped clients (e.g., Hayes & Gelso, 1993) seems to better approximate actual therapy than the use of audiotaped clients (e.g., Robbins and

Jolkovski, 1987). Additionally, having therapists respond to the client verbally (e.g., Latts & Gelso, 1995) appears to generalize more to actual counseling than the use of written responses or asking therapists to chose from prepared responses (e.g., Yulis & Keisler, 1968). Hence, having therapists respond verbally to a videotaped client may increase the study's generalizability. The present study also used predetermined stopping points, as is common to all studies employing this analogue methodology. Future studies may attempt to allow therapists to stop the video themselves when they wish, thus closer approximating actual counseling.

In addition, it is interesting to note that the use of videotaped actors may better approximate video teleconference counseling than face-to-face counseling. Video teleconference counseling is a newer form of therapy using distance technology allowing real-time interactions between therapist and client while they watch each other on a television screen or computer monitor. Although therapists in general seem to believe face-to-face counseling to be ideal, a recent study brings this assumption into question (Day & Schneider, 2002). Day and Schneider (2002) found more similarities than differences related to outcome between video counseling and face-to-face counseling. Additionally, clients reported significantly more participation in video counseling than face-to-face counseling. It seemed that clients may have felt safer in video counseling and/or made a greater effort to participate due to the increased distance. We are currently in an age when technology is increasing dramatically, and the Internet is becoming more and more widespread. As a consequence, the possibility exists that therapies done over the Internet may become increasingly popular. While online forms of therapy lack the subtleties of human interaction that face-to-face counseling offers (Coleman, Paternite, &

Sherman, 1999), online therapies may be more convenient. This convenience may be especially important to rural clients where there may be no therapist available for miles. Hence, as technology becomes more advanced, video analogue studies such as the present one may help to not only understand face-to-face counseling but also video teleconference counseling. A final limitation is the study's use of graduate student therapist trainees. Although understanding the counseling process of therapists-in-training is critical to improving training, caution needs to be exercised before generalizing the present sample to the population of actual clinicians.

Future Research

The current study's findings on the influence of UDO and information on client strengths on countertransference warrants further research in this area. This study may have lacked sufficient numbers of male therapists ($\underline{n}$ =10) to gain enough power for a significant gender difference on behavioral avoidance. Hence, future studies may wish to find more male therapists to further investigate whether there are any gender differences in countertransference reactions to angry male African American client in a cross-racial dyad. In addition, future studies may wish to look at other process variables that may be affected by therapist UDO in counseling. Ligiero and Gelso (2002) found countertransference to adversely affect the working alliance. Since UDO is negatively related to countertransference, perhaps therapists with a higher UDO are likely to form a stronger alliance than therapists with lower UDO. Additionally, one wonders whether the UDO of the therapist impacts outcome in cross-cultural counseling. Other studies may aim to investigate the impact of client UDO in addition to therapist UDO in cross-racial

dyads. For instance, clients with higher UDO may be more likely to experience positive outcomes in such dyads.

Another variable that may merit further study is client strengths. Little empirical research has been on conducted on the impact of client strengths on counseling. While client strengths were not found to directly influence countertransference, a pattern of means within the sample revealed a possible interaction of therapist UDO and client strengths on state anxiety in the present cross-racial dyad. Future researchers may want to see if information on client strengths directly affects counseling process in same-race dyads or other combinations of cross-racial dyads. Additionally, while the current study looked at the influence of information on client strengths prior to a first session of counseling, future studies may operationalize client strengths differently.   For example, future research may investigate strengths in terms of therapist interventions based on specific client strengths. Perhaps therapists who work more with strengths specific to a client's culture in a first session of cross-racial psychotherapy may be more likely to form a strong alliance. Finally, the present study found an interaction of UDO and strengths on state anxiety that may have lacked significance due to a small sample size. Future research may investigate whether such an interaction appears in other samples with larger numbers of European American therapists.

Appendix A:

Instructions for Participants

(Each part is read by a trained research assistant at the designated points in the procedure)

PART 1

Before you hand out the "PRE" measures:

These are some questionnaires for you to fill out. It should take a little while to get through these. All the rest of the questionnaires are much shorter. Let me know when you're finished.

PART 2

After they are done with the "PRE" measures:

The following portion of the study involves your interaction with two videotape clients in two separate sessions of counseling. Please try to assume that these simulated clients are real, as is your relationship with them. So you should interact in these two therapy sessions as you would with actual clients. To help make your interaction with these clients as realistic as possible, you will be given a brief case summary before seeing each client that includes background information. Also, assume you and the respective client have already established a good therapeutic relationship and that you've had four previous sessions. So basically, I'm going to give you the case summary for the first client, you'll watch the video of that client, then you'll fill out some very short forms, and then do it again for the second client. Once I've started the videotape I will not be able to answer any questions about the experiment.

PART 3

After handing the case summary:

Here is a case summary for the first client. When you're done reading it over, it will ask

you to circle some phrases to get you more acquainted with the case. When you're

completely finished, let me know and I'll start the video.

PART 4

<u>After they give you back the case summary</u>:

The video has a number of pauses that will last approximately 30 seconds. At each

pause, you'll be asked to respond to the client as though you were in a normal counseling

session. There will be instructions on the screen letting you know when you should start

responding. When you are finished with this first client, you will be given a case

summary for a second client and the procedure will be repeated. Remember that there are

no correct responses to the clients. You may want to respond to the clients other than

when the videotape is paused, but we are only interested in your verbal responses to the

clients at the pre-established pause points. Your identity is in no way going to be

associated with your responses. If you have any questions, please ask them now.

PART 5

<u>After they've finished the questionnaires for Bob, the first client:</u>

*I'm now going to give you the Case Summary for the second client. You're going
to again underline phrases on the case summary. Let me know when you're done
and I'll start the second video.*

Appendix B:

<u>Warm-up Client Case Summary</u>

Client Name: Bob Prinkert
Age: 26
Gender: Male
Occupation: Computer Salesman

Presenting Problem: Developing intimate relationships with women

<u>Background Information:</u>

Bob is a 26-year-old White single male salesman for a computer software firm. He is the oldest of three children. Bob has a sister (24) and a brother (22). Both parents are still living. His parents divorced when Bob was 13. Bob describes the divorce as being amicable and mutually desired by both parents. Bob states he remains close to both parents.

Bob sought your counseling services to address his concerns around dating. He stated that he has gotten tired of being nicknamed "Don Juan." Bob has dated a great deal but has not had a relationship last past a few months in duration. He states he would typically become bored and lose desire for the relationship.

Bob has been working on allowing himself to feel "more vulnerable" in relationships. He recently has been frustrated by his fear of asking out Paula, a woman he has started to care for. Bob has expressed that it is very threatening for him to not be in control of his feelings with women. However, he desires to address his inability to have intimate relationships with women.

Now that you have read the summary, please take a few minutes to go back and underline at least *5 words or phrases* that seem important or relevant in order to help you to be more acquainted with the case.

<u>When you are finished:</u>

Assume you have seen Bob for four sessions prior to this one.

Assume you are alone with Bob.

Once you are ready to begin the session with Bob,

please inform the Research Assistant so he/she can begin the tape.

Appendix C:

<u>Warm-up Client Script</u>

Well, believe it or not, I asked Paula out. God I was so scared. Hell I still am. But I did it. Jeez, this is so ridiculous. It's silly of me to be so uptight about this. I've dated a lot. But I always have sorta played it safe. I never asked out somebody who I was really like…

PAUSE

I don't know. Maybe I should call it off with Paula. I mean, yah I really do like her, but I don't want to get hurt. But I'm tired of playing it safe. I want to go through with this. Do you think I can do it?

PAUSE

(End of Script)

Appendix D:

Stimulus Client Case Summary for Strength Condition

Client Name: Ed Marcel
Age: 33
Gender: Male
Occupation: Mental Health Counselor

Presenting Problem: Job Dissatisfaction

Background Information:

Ed is a 33 year old married Black male counselor for a mental health agency. He is the youngest of two children with an older sister (36). His father died when Ed was 25. Ed describes their relationship as being "generally good," except for when his father's work would require him to be away at work for long periods of time. Ed is close with his remaining family and seeks their support when he needs it. Overall, Ed is rather psychologically minded and seeks to understand how his past influences his present.

Ed's wife, Janis, is 27 years of age. She works full-time as a nurse. They have been married two years. They have no children. Ed describes his relationship with his wife as good but going through a transitional phase. He states that he still loves her but that the "honeymoon is over," and they are having to work more than before in order to maintain their relationship. Ed believes that this is made more difficult due to his frustrations about work. In spite of this, he continues to effectively communicate and express his emotions openly with his wife about these issues. He also maintains a collaborative approach to the relationship in which they work together on improving the marriage.

Ed sought your counseling services due to his increasing frustrations about his current job. Ed has worked for several years with this particular mental health agency. Part of Ed's work currently involves the development of a new program that he created, which aims to make early preventative interventions within the client population. Ed has repeatedly spoken about how his opinions are not respected by his agency. Ed is quite passionate about his work, as he is in many other areas of his life.

Ed has hoped that his involvement in the development of his program might change his feelings about his agency and much of its staff. However, Ed states that he has become increasingly discouraged by what he sees as his colleagues' criticism of what he believes in.

Now that you have read the summary, please take a few minutes to go back and underline at least *5 words or phrases* that seem important or relevant in order to help you to be more acquainted with the case.

<u>When you are finished:</u>

Assume you have seen Ed for four sessions prior to this one.
Assume you are alone with Ed.
Once you are ready to begin the session with Ed,
please inform the Research Assistant so he can begin the tape.

Appendix E:

<u>Stimulus Client Case Summary for Neutral</u>

Client Name: Ed Marcel
Age: 33
Gender: Male
Occupation: Mental Health Counselor

Presenting Problem: Job Dissatisfaction

<u>Background Information</u>:

Ed is a 33 year old married Black male counselor for a mental health agency. He graduated from Fordham University and enjoys tennis, which he plays about once a week or so. He is the youngest of two children with an older sister (36). His father died when Ed was 25. Ed describes their relationship as being "generally good," except for when his father's work would require him to be away at work for long periods of time. Ed appears to have a fairly ordinary relationship with his remaining family and corresponds with them on occasion.

Ed's wife, Janis, is 27 years of age. She works full-time as a nurse. They have been married two years and live in a single story house near Silver Spring, Maryland. They have no children. Ed describes his relationship with his wife as good but going through a transitional phase. He states that he still loves her but that the "honeymoon is over," and they are having to work more than before in order to maintain their relationship. Ed believes that this is made more difficult due to his frustrations about work. Although Ed is experiencing such marital issues, he manages to go about his daily activities and continue to do his work.

Ed sought your counseling services due to his increasing frustrations about his current job. Ed has worked for several years with this particular mental health agency,

where he commutes to work everyday. Part of Ed's work currently involves the development of a new program which aims to make early preventative interventions within the client population. Ed has repeatedly spoken about how his opinions are not respected by his agency, which is based in Washington D.C. approximately five minutes from American University.

Ed has hoped that his involvement in the development of this program might change his feelings about his agency and much of its staff. However, Ed states that he has become increasingly discouraged by what he sees as his colleagues' criticism of what he believes in.

Now that you have read the summary, please take a few minutes to go back and underline at least *5 words or phrases* that seem important or relevant in order to help you to be more acquainted with the case.

When you are finished:

Assume you have seen Ed for four sessions prior to this one.
Assume you are alone with Ed.
Once you are ready to begin the session with Ed,
please inform the Research Assistant so he/she can begin the tape.

Appendix F:

<u>Stimulus Client Script</u>

I'm still frustrated about work. It's really irritating to have to deal with these people who are just so damn clueless and don't know what's going on. Yet they push ahead and just keep screwing up the project. Damn, and I really believe in this project! I think that here's a real chance to do something to really help these clients turn things around. And now I just see it getting pissed away! Just because these people are stupid and arrogant.

Pause

You know, I've worked for a bunch of agencies and seen too many projects that, you know, really had the potential to help clients change their lives. It always seems like the 'system' takes over, leaving the clients short changed. So it's not like I haven't seen this type of thing before. Damn, but this time it's really bad. You know we're trying to really help these clients become effective in changing their lives. Hell, the program's a great idea! But I get so angry when I see what these incompetent fools have done with it! You know, I shouldn't expect much more from my colleagues! It's part of their nature.

Pause

These people so stupid! You know I think they're more than just stupid, I think they're malicious. They can preach and preach all they want about being open minded, but the proof is in the pudding. When it comes down to it, they're all alike. And who gets screwed over – who else but people like our clients. These arrogant fools are screwing up the whole program. It's just another set-up. Our clients are just being set up for a fall.

Hell that's why they're doing all this. They enjoy it. It makes them feel good to see people like our clients fall on their faces.

<div align="center">Pause</div>

I hate having to work with all these jerks. At first I thought they just didn't know what was going on. Hell, just like with this program. I've let them know good and well what it takes to help these clients. But their damn ears can't hear what I've been saying.

Oh yeah, they give their condescending nods and then 'politely' tell me to shut up. Damn, I'm sick of going in there every day and giving my all. They will always be jerks, it's their nature. I'm not going to try and teach them anymore. Hell, I can't stand them. They're not worth it. The hell with all of them.

<div align="center">Pause</div>

<div align="center">(End of Script)</div>

Appendix G:

Demographic Form

Age: _____

Sex: _____

Race/Ethnicity (please circle):

African-American   Latina/Latino

Asian-American   Native American

European American (White)   Other (please identify): _____

Highest degree held (e.g., BS, LCSW, MA in Counseling, Ph.D., etc.)
_____

Year in current graduate program: _____

Type of current graduate program (e.g., Masters in Counseling, Ph.D. in Clinical Psychology, etc.):

_____

Using a 5-point scale, where 5 = very high belief, rate how much you believe in and adhere to the techniques of:

_____ Psychoanalytic/Psychodynamic Therapy

_____ Experiential/Humanistic/Existential Therapy

_____ Behavioral/Cognitive Behavioral Therapy

Please write in your theoretical orientation:

_____

Appendix I:

Miville-Guzman Universality Diversity Scale – Short Form

The following items are made up of statements using several terms which are defined below for you. Please refer to them throughout the rest of the questionnaire.

Culture refers to the beliefs, values, traditions, ways of behaving, language of any social group. A social group may be racial, ethnic, religious, etc.

Race or racial background refers to a sub-group of people possessing common physical or genetic characteristics. Examples include White, Black, American Indian.

Ethnicity or ethnic group refers to specific social group sharing a unique cultural heritage (i.e., customs, beliefs, language, etc.). Two people can be of the same race (e.g., White), but be from different ethnic groups (e.g., Irish-American, Italian American).

Country refers to groups that have been politically defined; people from these groups belong to the same government (e.g., France, Ethiopia, United States). People of different races (White, Black, Asian) or ethnicities (Italian, Japanese) can be from the same country (United States).

Instructions: Please indicate how descriptive each statement is of you by filling in the number corresponding to your response. This is not a test, so there are no right or wrong, good or bad answers. All responses are anonymous and confidential.

1	2	3	4	5	6
Strongly Disagree	Disagree	Disagree a little bit	Agree a Little bit	Agree	Strongly Agree

1._____ I would like to join an organization that emphasizes getting to know people from different countries.

2._____ Persons with disabilities can teach me things I could not learn elsewhere.

3._____ Getting to know someone of another race is generally an uncomfortable experience for me.

4._____ I would like to go to dances that feature music from other countries.

5._____ I can best understand someone after I get to know how he/she is both similar and different from me.

6._____ I am only at ease with people of my race.

1	2	3	4	5	6
Strongly Disagree	Disagree	Disagree a little bit	Agree a Little bit	Agree	Strongly Agree

7._____ I often listen to music of other cultures.

8._____ Knowing how a person differs from me greatly enhances our friendship.

9._____ It's really hard for me to feel close to a person from another race.

10.____ I am interested in learning about the many cultures that have existed in this world.

11.____ In getting to know someone, I like knowing both how he/she differs from me and is similar to me.

12.____ It is very important that a friend agrees with me on most issues.

13.____ I attend events where I might get to know people from different racial backgrounds.

14.____ Knowing about the different experiences of other people helps me understand my own problems better.

15.____ I often feel irritated by persons of a different race.

Appendix J:

Anger Discomfort Scale

Use the scale below to respond to each statement. There are no right and wrong answers.

Write in the number that corresponds to your answer for each item.

1	2	3	4
Almost Never Sometimes		Frequently	Almost Always

_____ 1) I do not like it when I get angry.

_____ 2) I feel guilty about being angry with others.

_____ 3) I fear that my anger will hurt other people.

_____ 4) I would prefer that people not see me when I am angry.

_____ 5) I believe it is natural and healthy to feel angry.

_____ 6) I am troubled by my anger.

_____ 7) People do not seem to like me when I am angry.

_____ 8) I create more problems for myself when I am angry.

_____ 9) I should not be as angry as I often am.

_____ 10) I believe it is acceptable for people to feel angry.

_____ 11) I feel comfortable with my angry feelings.

_____ 12) When I get angry, I also get nervous.

_____ 13) My anger scares me.

_____ 14) I am embarrassed when I get angry.

_____ 15) I fear losing control because of my anger.

Appendix K:

<u>Marlowe-Crowne Social Desirability Scale Short Form</u>

Please respond to the following items as being either True (T) or False (F).

1.___   I sometimes feel resentful when I don't get my way.

2.___   On a few occasions, I have given up doing something because I thought too little of   my ability.

3.___   There have been times when I felt like rebelling against people in authority even though I knew they were right.

4.___   No matter who I'm talking to, I'm always a good listener.

5.___   I can remember "playing sick" to get out of something.

6.___   There have been occasions when I took advantage of someone.

7.___   I'm always willing to admit it when I make a mistake.

8.___   I sometimes try to get even, rather than forgive and forget

9.___   I am always courteous, even to people who are disagreeable.

10.__   There have been times when I was quite jealous of the good fortune of others.

11.__   I am sometimes irritated by people who ask favors of me.

12.__   I have never deliberately said something that hurt someone's feelings.

13.__   I have never been irked when people expressed ideas very different from my own.

Appendix L:

State Anxiety Inventory

A number of statements which people have used to describe themselves are given below. Read each statement and then circle the appropriate letter to the right of the statement to indicate how you felt overall during your session with Ed (the second client). There are no right or wrong answers. Do not spend too much time on any one statement but give the answer which seems to describe your feelings during the session best.

N = not at all   S = somewhat   M = moderately so   V = very much

		N	S	M	V
1.	I felt calm………………………………………	N	S	M	V
2.	I felt secure……………………………………	N	S	M	V
3.	I was tense……………………………………	N	S	M	V
4.	I felt strained………………………………...	N	S	M	V
5.	I felt at ease…………………………………	N	S	M	V
6.	I felt upset……………………………………	N	S	M	V
7.	I was worrying over possible misfortunes………..	N	S	M	V
8.	I felt satisfied………………………………..	N	S	M	V
9.	I felt frightened…………………………….…	N	S	M	V
10.	I felt comfortable……………………………..	N	S	M	V
11.	I felt self-confident…………………………....	N	S	M	V
12.	I felt nervous…………………………………	N	S	M	V
13.	I was jittery…………………………………....	N	S	M	V
14.	I felt indecisive…………………………….…	N	S	M	V
15.	I was relaxed…………………………………	N	S	M	V
16.	I felt content………………………………..	N	S	M	V
17.	I was worried……………………………….…	N	S	M	V
18.	I felt confused………………………………….	N	S	M	V
19.	I felt steady…………………………………….	N	S	M	V
20.	I felt pleasant………………………………….	N	S	M	V

Appendix M:

<u>Cognitive Recall Measure</u>

Approximately how many words conveying specific anger (e.g., words such as infuriate, stupid, or hell) did Ed use in your session?

_____

Appendix N:

Response Mode Categories for Units and Whole Turns

1) **Approval**: Therapist sanctions, accepts, or supports (including minimal encourages) the client's feelings or behaviors and/or expresses explicit agreement with the client's feelings or behaviors.

2) **Exploration**: Therapist asks for further clarification, elaboration, and detailing of the client's feelings or behaviors.

3) **Reflection**: Therapist repeats or restates the client's feelings. Therapist accurately relabels the client's feelings, attitudes, or behaviors. Also, counselor reflects content when only content is given.

4) **Labeling**: Therapist points out patterns in the client's feelings or behaviors; counselor suggests relationships between present feelings or behavior and past experiences.

5) **Disapproval**: Therapist is critical of the client's feelings or behaviors. Even if the statement is phrased supportively, anything that negates or opposed the client's feelings is disapproval.

6) **Silence**: Therapist says nothing for a whole speaking turn.

7) **Ignoring**: Therapist responds to the content of the client's material but ignores the affect.

8) **Mislabeling**: Therapist inaccurately identifies the client's feelings, attitudes, or behaviors. Mislabeling can also occur if the counselor inaccurately identifies the degree of feelings.

9) **Topic Transition**: Therapist changes the focus of discussion to an irrelevant topic or simply to a different topic.

10) **Other**: Therapist's response does not fit any of the other categories. Try to absolutely rule out the other possibilities before choosing this category.

Appendix O:

Directions to Raters

Our work will entail categorizing the verbal responses of therapists via a system developed in the 60s by Bandura et al. This has been used in several subsequent studies which are investigating phenomena similar to the variables of interest in this project. The attached categorical system will be used to classify therapists' responses. Therapists' responses have been unitized ahead of time for this phase of our work. Each unit has been established using a system developed by Auld and White and further refined by Hill. If you disagree with how the transcript has been unitized, please bear with us and rate it as it is.

Each transcript of the stimulus client (the client we are interested in rating) contains four speaking turns, each of which occurs after a pause in the client's speech. Each speaking turn contains one or more units. For each speaking turn, you are asked to perform two tasks. First, you are asked to rate each unit within the speaking turn. Please evaluate each therapist's response unit using the attached categories. After you have made a decision as to which category the therapist's response unit belongs to, please write the number of that category inside the brackets which separates and identifies the unit. Select only one category for each unit.

Secondly, you are asked to use your judgment to evaluate which verbal category used in the speaking turn carries the most weight as to its impact. In other words, given

the choice of only selecting one of the categories, which unit influences the character of the turn most? Do not make this selection based upon the quantity of the categorical material, but rather base this selection on a qualitative clinical judgment. Therefore, you may have only one unit of a speaking turn in a specific category, but feel the impact of this category's verbal material is so strong that it is what most characterizes the turn overall. You wll find a bracketed area at the bottom of every speaking turn. Please put this global rating for the speaking turn inside this bracket.

Appendix P:

<u>Sample Stimulus Client Transcript Rating</u>

It sounds like you're feeling really frustrated./ [3] This is a project that's really important to you,/ [3] and you feel like the other people involved aren't doing what they should be doing to help out./ [3]

Turn rating [3]

PAUSE ONE

R-2: You sound like your kind of at a loss as to whatto do./ [3] This sounds like it makes you really angry,/ [3] but you just don't feel like you have any control over the situation./ [3]

Turn rating [3]

PAUSE TWO

R-3: It sounds like you have a really hard time trusting the intentions of your colleagues./ [3]

Turn rating [3]

PAUSE THREE

R-4: You've talked a lot about how you don't think these people are listening to you or understanding you./ [3] I wonder how that might play out in here?/ [4] Do you feel like I'm understanding what you're saying, respecting what you say?/ [4]

Turn rating [4]

PAUSE FOUR

Appendix Q:

Client Strength Manipulation Check

Approximately how many strengths were mentioned in Ed's case summary?

_____

Please circle your answers to the following question:

I was given information on Ed's strengths prior to seeing him.

1	2	3	4	5	6
not at all true					very true

Appendix R:

<u>Debriefing Form</u>

Thank you for participating in this study. The purpose of the study is to investigate

therapists' reactions to Black male clients. You have participated in one of two

conditions. One condition includes information on client strengths in the second

clients' background information, whereas the other one includes neutral information.

After seeing the second client, you completed a questionnaire which attempted to

measure an attitude of understanding that all people are simultaneously the same and

different. This questionnaire along with your verbal responses and the affective

measure will be used to see if therapists' attitudes are related to their reactions toward

Black clients.

Please be certain that your verbal responses to the videos and written responses to

the questionnaires will be held in strict confidentiality. Under no circumstances will this

be violated. Rather, your responses will only be seen as anonymous.

Due to the fact that many therapists have not yet participated in this study, we

must ask you not to discuss this study in detail with anyone. This is crucial to

maintaining the study's validity. If you wish to speak to the study's primary investigator,

please feel free to contact James Harbin at (301) 220-3033. Again, our deepest

appreciation for your participation.

REFERENCES

Atkinson, D. R. (1983). Ethnic similarity in counseling psychology: A review of research. <u>The Counseling Psychologist, 11</u>, 79-92.

Avants, S. K., Warburton, L. A., & Margolin, A. (2001). Spiritual and religious support in recovery from addiction among HIV-positive injection drug users. <u>Journal of Psychoactive Drugs, 33</u>, 39-45.

Bandura, A. (1956). Psychotherapists' anxiety level, self insight, and psychotherapeutic competence. <u>Journal of Abnormal and Social Psychology, 52</u>, 333-337.

Bandura, A., Lipsher, D. H., & Miller, P. E. (1960). Psychotherapists' approach-avoidance reactions to patients' expressions of hostility. <u>Journal of Consulting Psychology, 21</u>(1-8).

Bandura, A. (1986). <u>Social foundations of thoughts and action</u>. Englewood Cliffs, NJ: Prentice-Hall.

Banks, G., Berenson, G. G., & Carkhuff, R. R. (1967). The effects of counselor race and training upon counseling and process with Negro clients in initial interviews. <u>Journal of Clinical Psychology, 23</u>, 70-72.

Blaine, B. & Crocker, J. (1995). Religiousness, race, and psychological well-being: Exploring social psychological mediators. <u>Personality & Social Psychology Bulletin, 21,</u> 1031-1041.

Boyd-Franklin, N. (1991). Recurrent themes in the treatment of African American women in group psychotherapy. <u>Women & Therapy, 11</u>, 25-40.

Brehm, S. S., & Brehm, J. W. (1981). <u>Psychological reactance: A theory of</u>

freedom and control. San Diego, CA: Academic Press.

Brittan, C. (1993). White therapists racial identity and countertransference reactions to Black male clients. Unpublished master's thesis.

Brittan-Powell, C. (In press). The development of a measure of political correctness ideology for racial issues. Cultural Diversity & Ethnic Minority Psychology.

Burkard, A. W., & Ponterotto, J. G. (1999). White counselor trainee' racial identity and working alliance perceptions. Journal of Counseling & Development, 77, 324-333.

Burrell, L., & Rayder, N. F. (1971). Black and White students attitudes toward White counselors. Journal of Negro Education, 20, 48-62.

Chazin, R., Kaplan, S., & Terio, S. (2000). The strengths perspective in brief treatment with culturally diverse clients. Crisis Intervention, 6, 41-50.

Cimbolic, P. T. (1972). Counselor race and experience effects on Black clients. Journal of Consulting and Clinical Psychology, 39, 328-332.

Cimbolic, P. T. (1973). Group effects on Black clients' perceptions of counselors. Journal of College Student Personnel, 14, 296-302.

Coleman, L. H., Paternite, C. E. & Sherman, R. C. (1999). A reexamination of deindividuation in synchronous computer-mediated communication. Computers in Human Behavior, 15, 51-65.

Comas-Diaz, L., & Jacobsen, F. M. (1991). Ethnocultural transference and countertransference in the therapeutic dyad. American Journal of Orthopsychiatry, 61, 392-402.

Conoley, C. W., Padula, M. A., Payton, D. S., & Daniels, J. A. (1994). Predictors

of client implementation of counselor recommendations: Match with problem, difficulty level, and building on client strengths. Journal of Counseling Psychology, 41, 3-7.

Constantine, M. G., Arorash, T. J., Barakett, M. D., Blackmon, S. M., Donnolly, P. C., & Edles, P. A. (2001). School counselors' universal diverse orientation and aspects of their multicultural counseling competence. Professional School Counseling, 5, 6-15.

Constantine, M. G. (2002). Predictors of satisfaction with counseling: Racial and ethnic minority clients' attitudes toward counseling and ratings of their counselors' general and multicultural counseling competence. Journal of Counseling Psychology, 49, 255-263.

Cowger, C. D. (1994). Assessing client strengths: Clinical assessment for client empowerment. Social Work, 39, 262-268.

Crowne, D. P., & Marlowe, D. (1960). A new scale of social desirability independent of psychopathology. Journal of Consulting Psychology, 24, 349-354.

Cutler, R. L. (1958). Countertransference effects in psychotherapy. Journal of Consulting Psychology, 22, 349-356.

Davis, N. L., Clance, P. R., & Gailia, A. T. (1999). Treatment approaches for obese and overweight African American women: A consideration of cultural dimensions. Psychotherapy, 36, 27-35.

Day, S., & Schneider, P. L. (2002). Psychotherapy using distance technology: A comparison of face-to-face, video, and audio treatment. Journal of Counseling Psychology, 49, 499-503.

Diala, C., Muntaner, C., Walrath, C., Nickerson, K. J., LaVeist, T. A., & Leaf, P. J. (2000). Racial differences in attitudes toward professional mental health care and in the

use of services. American Journal of Orthopsychiatry, 70, 455-464.

Fisher, T. A., Matthews, L. G., Kurpius, S. E., & Burke, K. I. (2001). Effects of client race-ethnicity on perceptions of counselor trainees: Study 1 and Study 2. Counselor Education & Supervision, 41, 3-17.

Follette, W. C. & Linnerooth, P. J. (2001). Positive psychology: A clinical behavior analytic perspective. Journal of Humanistic Psychology, 41, 102-134.

Ford, D. Y., Harris, J., & Schuerger, J. M. (1993). Racial identity development among gifted black students: Counseling issues and concerns. Journal of Counseling & Development, 71, 409-417.

Frame, M. W., Williams, C. B., & Green, E. L. (1999). Balm in Gilead: Spiritual dimensions in counseling African American women. Journal of Multicultural Counseling and Development, 27, 182-192.

Freud, S. (Ed.). (1910/1957). Future prospects of psychoanalytic therapy (Vol. 11). London: Hogarth Press.

Friedman, S. C., & Gelso, C. J. (2000). The development of the Inventory of Countertransference Behavior. Journal of Clinical Psychology, 56, 1221-1235.

Fromm-Reichmann, F. (1950). Principles of intensive psychotherapy. Chicago: University of Chicago Press.

Fuertes, J. N., & Gelso, C. J. (1998). Asian American, European American, and African American students' universal-diverse orientation and preferences for characteristics of psychologists. Psychological Reports, 83, 280-282.

Fuertes, J. N. (1999). Asian Americans' and African Americans' initial perceptions of Hispanic counselors. Journal of Multicultural Counseling and

Development, 27, 122-135.

Fuertes, J. N., & Gelso, C. J. (2000). Hispanic counselors' race and accent, and European Americans' universal-diverse orientation: A study of initial perceptions. Cultural Diversity and Ethnic Minority Psychology, 6, 211-219.

Fuertes, J. N., Sedlacek, W. E., Roger, P., & Mohr, J. (2000). Correlates of universal-diverse orientation among first-year university students. Journal of First Year Experience and Students in Transition, 12, 45-59.

Fuertes, J. N., Miville, M. L., Mohr, J. J., Sedlacek, W. E., & Gretchen, D. (2000). Factor structure and short form of the Miville-Guzman Universality-Diversity Scale. Measurement and Evaluation in Counseling and Development, 33, 157-169.

Fuertes, J. N., & Brobst, K. (2002). Client's ratings of counselor multicultural competency. Cultural Diversity and Ethnic Minority Psychology, 8, 214 - 223.

Gelso, C. J., & Carter, J. A. (1985). The relationship in counseling and psychotherapy: Components, consequences, and theoretical antecedents. The Counseling Psychologist, 13, 155-244.

Gelso, C. J., & Fassinger, R. E. (1992). Personality, development, and counseling psychology: Depth, ambivalence, and actualization. Journal of Counseling Psychology, 39, 275-298.

Gelso, C. J., & Carter, J. A. (1994). Components of Psychotherapy Relationship: Their interaction and unfolding during treatment. Journal of Counseling Psychology, 41, 296-306.

Gelso, C. J., Fassinger, R. E., Gomez, M. J., & Latts, M. G. (1995). Countertransference reactions to lesbian clients: The role of homophobia, counselor

gender, and countertransference management. <u>Journal of Counseling Psychology, 42,</u> 356-364.

Gelso, C. J., & Hayes, J. A. (1998). <u>The psychotherapy relationship: Theory, research, and practice</u>. New York: Wiley.

Gelso, C. J., & Mohr, J. J. (2001). The working alliance and the transference / countertransference relationship: Their manifestation with racial / ethnic and sexual orientation minority clients and therapists. <u>Applied & Preventive Psychology, 10</u>, 51-68.

Gelso, C. J., & Fretz, B. (2001). <u>Counseling Psychology</u> (2nd ed.). Fort Worth, Texas: Harcourt.

Gelso, C. J., Latts, M. G., Gomez, M. J., & Fassinger, R. E. (2002). Countertransference management and therapy outcome: An initial evaluation. <u>Journal of Clinical Psychology, 58,</u> 861-867.

Gelso, C. J., & Hayes, J. A. (2002). The management of countertransference. In J. C. Norcross (Ed.), <u>Psychotherapy relationships that work: Therapist contributions and responsiveness to patients</u>. Chapter 14, pp. 267-285.

Gelso, C. J., & Woodhouse, S. (2002). Toward a Positive Psychotherapy: Focus on Human Strength. In W. B. Walsh (Ed.), <u>Counseling psychology and optimal human functioning</u>. Mahwah, NJ: Erlbaum. Chapter 9, pp. 171-197.

Goldstein, W. N. (1995). The borderline patient: Update on diagnosis, theory, and treatment from a psychodynamic perspective. <u>American Journal of Psychotherapy, 49</u>, 317-337.

Gorkin, M. (1987). Countertransference in cross-cultural psychotherapy: The example of Jewish therapist and Arab patient. <u>Psychiatry, 49</u>, 69-79.

Grantham, R. J. (1973). Effects of counselor sex, race, and language style on Black students in initial interviews. Journal of Counseling Psychology, 20(553-559).

Greene, B. A. (Ed.). (1990). What has gone before: The legacy of racism and sexism in the lives of Black mothers and daughters. New York: Academic Press

Griffith, M. S., & Jones, E. E. (Eds.). (1979). Race and psychotherapy: changing perspectives (Vol. 18). NY: Grune & Stratton.

Hayes, J. A., & Gelso, C. J. (1991). Effects of therapist trainees' anxiety and empathy on countertransference behavior. Journal of Clinical Psychology, 47, 284-290.

Hayes, J. A., Gelso, C. J., VanWagoner, S. L., & Dietmer, R. (1991). Managing countertransference: What the experts think. Psychological Reports, 69, 139-148.

Hayes, J. A., & Gelso, C. J. (1993). Counselors' discomfort with gay and HIV-infected clients. Journal of Counseling Psychology, 40, 86-93.

Hayes, J. A. (1995). Countertransference in group psychotherapy: Waking a sleeping dog. International Journal of Group Psychotherapy, 454, 521-535.

Hayes, J. A., Riker, J. B., & Ingram, K. M. (1997). Countertransferencee behavior and management in brief counseling: A field study. Psychotherapy Research, 7, 145-154.

Hayes, J. A., McCracken, J. E., McClanahan, M. K., Hill, C. E., Harp, J. S., & Carozzoni, P. (1998). Therapist perspectives on countertransference: Qualitative data in search of a theory. Journal of Counseling Psychology, 454, 468-482.

Heiman, P. (1950). Countertransference. British Journal of Medical Psychology, 33, 9-15.

Heppner, P. P., Kivlighan, D. M., & Wampold, B. E. (1999). Research design in counseling. Belmont, CA: Wadsworth.

Hoyt, M. F., Siegelman, E. Y., & Schlesinger, H. E. (1981). Special issues regarding psychotherapy with the deaf. American Journal of Psychiatry, 138, 807-810.

Jefferies, D. (1976). Counseling for Strengths of the Black woman. The Counseling Psychologist, 6, 20-22.

Jones, E. E. (1978). Effects of race on psychotherapy process and outcome: An exploratory investigation. Psychotherapy, 15, 226-236.

Jones, E. E. (1984). Some reflections of Black patient and psychotherapy. Clinical Psychologist, 37, 62-65.

Jones, E. E. (Ed.). (1985). Psychotherapy and counseling with black clients. Westport, CT: Greenwood Press.

Jung, C. G. (1968). The archetypes and the collective unconscious (R. F. C. Hull, Trans. 2nd ed.). Princeton, NJ: Princeton University.

Karon, B. P. (1975). Black scars: A rigorous invetigation of the effects of discrimination. New York: Springer.

Kernberg, O. (1965). Notes on countertransference. Journal of American Psychoanalytic Association, 13, 38-56.

Knox, S., Burkard, A. W., Johnson, A. J., Suzuki, & L. A. Ponterotto, J. G. (2003)African American and European American therapists' experiences of addressing race in cross-racial psychotherapy dyads. Journal of Counseling Psychology, 50, 466-481.

Kobasa, S. C. (Ed.). (1982). The hardy personality: Toward a social psychology of stress and illness. Hillsdale, NJ: Erlbaum.

Koepping, G. R. (Ed.). (1996). The impact of economic disadvantage on gifted

women's educational development (Vol. 18). NY: Hawthorn Press.

Lambert, M. J., Burlingame, G. M., Umphress, V., Hansen, N. B., Vermeersch, D. A., Clouse, G. C. & Yanchar, S. C. (1996). The reliability and validity of the Outcome Questionnaire. Clinical Psychology and Psychotherapy, 3, 249-258.

Latts, M. G., & Gelso, C. J. (1995). Countertransference behavior and management with survivors of sexual assault. Psychotherapy, 32, 405-415.

Ligiero, D., & Gelso, C. J. (2002). The therapists' contribution: Countertransference, attachment, and the working alliance. Psychotherapy, 39, 3-11.

Lopez, S. J., Floyd, R. K., Ulven, J. C., & Snyder, C. R. (Eds.). (2000). Hope therapy: Helping clients build a house of hope. NY: Academic Press.

Lopez, S. J., Prosser, E. C., Edwards, L. M., Magyar-Moe, J. L., Neufeld, J. E., & Rasmussen, H. N. (2002). Putting positive psychology in a multicultural context. In C. R. Snyder and S. J. Lopez (Eds.), Handbook of positive psychology. London: Oxford University Press. Chapter 51, pp. 700-714.

Lyles, M. R., & Carter, J. H. (1982). Myths and strengths of the black family: A historical and sociological contribution to family therapy. Journal of the National Medical Association, 74, 1119-1123.

Marin, R., Newman, S., Onawola, R., Kollar, M., & Sucov, M. (1989). A geropsychiatric strengths-oriented treatment program. Clinical Gerontologist, 8, 19-30.

Marlowe, D., & Crowne, D. P. (1961). Social desirability and response to perceived situational demands. Journal of Consulting Psychology, 25, 109-115.

McLendon, J. A. (Ed.). (1999). The Satir system: Brief therapy strategies. New York: Academic Press

Miller, W. R., Benefield, R. G., & Tonigan, J. S. (1993). Enhancing motivation for change in problem drinking: A controlled comparison of two therapist styles. <u>Journal of Consulting and Clinical Psychology, 61</u>, 455-461.

Miller, L. (1998). Ego autonomy and the healthy personality: Psychodynamics, cognitive style, and clinical applications. <u>Psychoanalytic Review, 85</u>, 423-448.

Mitchell, K. M., & Berenson, B. G. (1970). Differential use of confrontation by high and low facilitative therapists. <u>Journal of Nervous and Mental Disease, 151</u>, 303-309.

Miville, M. L., Gelso, C. J., Pannu, R., Liu, W., Touradji, P., Holloway, P., & Fuertes, J. N. (1999). Appreciating similarities and valuing differences: The Miville-Guzman Universality-Diversity Scale. <u>Journal of Counseling Psychology, 46</u>, 291-307.

Peabody, S. A., & Gelso, C. J. (1982). Countertransference and empathy: The complex relationship between two divergent concepts in counseling. <u>Journal of Counseling Psychology, 29</u>, 240-245.

Proctor, E. K., & Rosen, A. (1981). Expectations and preferences for counselor rafcee and their relation to intermediate treatment outcomes. <u>Journal of Counseling Psychology, 28</u>, 40-46.

Reich, A. (1951). On countertransference. <u>International Journal of Psychoanalysis, 32</u>, 25-31.

Reich, A. (1960). Further remarks on countertransference. <u>International Journal of Psychoanalysis, 41</u>, 389-395.

Resnick, S., Warmoth, A., & Selin, I. A. (2001). The humanistic psychology and positive psychology connection: Implications fro psychotherapy. <u>Journal of Humanistic</u>

Psychology, 41, 73-101.

Robbins, S. B. & Jolkovski, M. P. (1987). Managing countertransference feelings: An interactional model using awareness of feeling and theoretical framework. Journal of Counseling Psychology, 34, 276-282.

Rosenberger, E. W., & Hayes, J. A. (2002). Origins, consequences, and management of countertransference: A case study. Journal of Counseling Psychology, 49, 221-232.

Rubin, S. S. (1986). Ego-focused psychotherapy: A psychodynamic framework for a technical eclecticism. Psychotherapy, 23, 385-389.

Salerno, M., Farber, B. A., McCullough, L., Winston, A., & Trujillo, M. (1992). The effects of confrontation and clarification on patient affective and defensive responding. Psychotherapy Research, 2, 181-192.

Salvoy, P., Rothman, A. J., Detweiler, J. B., & Steward, W. T. (2000). Emotional states and physical health. American Psychologist, 55, 110-121.

Sandron, L. (1970). Two opposing models for a self-fulfilling prophecy. The Counseling Psychologist, 6, 82-87.

Schwaber, E. (1983). Psychoanalytic listening and psychic reality. International Review of Psychanalysis, 10, 379-392.

Seligman, M. E., Schulman, P., DeRubeis, R., & Hollon, S. (1999). The prevention of depression and anxiety. Prevention and Treatment, 2, 8-16.

Seligman, M. E., & Csikszentmihalyi, M. (2000). Positive psychology: An introduction. American Psychologist, 19, 5-14.

Sharkin, B., & Gelso, C. J. (1993). The influence of counselor trainee anger

proness on reactions to an angry client. Journal of Counseling Psychology, 71, 483-487.

Sheldon, K. M., & Kasser, T. (2001). Goals, congruence, and positive well-being: New empirical support for humanistic theories. Journal of Humanistic Psychology, 41, 30-50.

Singer, B. A., & Luborsky, L. (Eds.). (1977). Countertransference: The status of clinical versus quantitative research. NY: Pergamon.

Slavik, S., Sperry, L., & Carlson, J. (Eds.). (1999). Efficient Adlerian therapy with individuals and couples.

Sodowsky, G. R., Kuo-Jackson, P. Y., Richarson, M. F., & Corey, A. T. (1998). Correlates of self-reported multicultural competencies: Counseling multicultural social desirability, race, social inadequacy, locus of control racial ideology, and multicultural training. Journal of Counseling Psychology, 45, 256-264.

Stevenson, H. C. R., G. (1993). Trusting ole' wise owls: Therapeutic use of cultural strengths in African American families. Professional Psychology, 24, 433-442.

Sue, S. (1977). Community mental health services to minority groups: some optimism, some pessimism. American Psychologist, 32, (616-624).

Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. Journal of Multicultural Counseling and Development, 20, 64-68.

Sue, D. W., & Sue, D. (2003). Counseling the culturally diverse: Theory and practice (4th ed.). New York: Wiley.

Sullivan, H. S. (1954). The psychiatric interview. New York: Norton.

Super, D. E. (1955). Transition from vocational guidance to counseling

psychology. Journal of Counseling Psychology, 2, 3-9.

Super, D. E. (1977). The identity crisis of counseling psychologists. The Counseling Psychologist, 7, 13-15.

Taylor, S. E., Kemeny, M. E., Reed, G. M., Bower, J. E., & Gruenewald, T. L. (2000). Psychological resources, positive illusions, and health. American Psychologist, 19, 99-109.

Taylor, E. (2001). Positive psychology and humanistic psychology: A reply to Seligman. Journal of Humanistic Psychology, 41, 13-29.

Terrell, F., & Terrell, S. L. (1981). An inventory to measure cultural mistrust among Blacks. Western Journal of Black Studies, 5, 180-184.

Thompson, R. L., Brossart, D. F., Carlozzi, A. F., & Miville, M. L. (2002). Five-factor model (Big Five) personality traits and universal-diverse orientation in counselor trainees. Journal of Psychology, 136, 561-572.

U. S. Census Bureau. (2000, January). National population projections by race, Hispanic origin, and nativity. Retrieved January 1, 2004, from http://www.census.gov/population/www/projections/natsum-T5.html

U. S. Census Bureau. (2001, January). Resident population estimates of the United States by sex, race, and Hispanic origin: April 1, 1990 to July 1, 1999, with short-term projection to November 1, 2000. Retrieved January 1, 2004, from http://www.census.gov/population/estimates/nation/intfile3-1.txt

VanWagoner, S. L., Gelso, C. J., Hayes, J. A., & Diemer, R. (1991). Countertransference and the reputedly excellent therapist. Psychotherapy, 28, 411-421.

Vontress, C. E. (1979). Cross-cultural counseling: An existential approach.

Personnel and Guidance Journal, 58, 117-122.

Vontress, C. E. (Ed.). (1986). Social and cultural foundations. Itasca, Il: Peacock.

Vontress, C. E. (1988). An existential approach to cross-cultural counseling. Journal of Multicultural Counseling and Development, 16, 78-83.

Vontress, C. E. (Ed.). (1995). The breakdown of authority: Implications for counseling young African American males. Thousand Oaks, CA: Sage.

Vontress, C. E. (1996). A personal retrospective on cross-cultural counseling. Journal of Multicultural Counseling and Development, 24, 156-166.

Wachtel, P. L. (1993). Therapeutic communication: Principles and effective practice. NY: Guilford.

Wang, Y., Davidson, M. M., & Yakushko, O. F., Savoy, H. B., Tan, J. A., & Bleier, J. K. (2003). The Scale of Ethnocultural Empathy: Development, validation, and reliability. Journal of Counseling Psychology, 50, 221-234.

Watkins, C. E., & Terrell, F. (1988). Mistrust level and its effect on counseling expectations in Black client-White counselor relationships: An analogue study. Journal of Counseling Psychology, 35, 194-197.

Winkelpleck, J. M., & Westfeld, J. S. (1982). Counseling considerations with gay couples. The Personnel and Guidance Journal, 7, 294-296.

Witryol, S. L., & Boly, L. F. (1954). Positive diagnosis in personality counseling of college students. Journal of Counseling Psychology, 1, 63-69.

Worthington, R. L., Mobley, M., Franks, R. P., & Tan, J. A. (2000). Multicultural counseling competences: Verbal content, counselor attributions, and social desirability. Journal of Counseling Psychology, 47, 460-468.

Wright, W. (1975). Relationships of trust and racial perceptions toward therapist-client conditions during counseling. Journal of Negro Education, 44, 151-169.

Yeh, C. J., & Arora, A. K. (2003) Multicultural training and interdependent and independent self-construal as predictors of universal-diverse orientation among school counselors. Journal of Counseling & Development, 81, 78-83.

Yulis, S., & Kiesler, D. J. (1968). Countertransference response as a function of therapist anxiety and content of patient talk. Journal of Consulting and Clinical Psychology, 32, 414-419.