The Effects of a Multimedia Intervention on Help-Seeking Process with A Chinese College Student Sample

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This dissertation titled

The Effects of a Multimedia Intervention on Help-Seeking Process with A Chinese College Student Sample

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ABSTRACT

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Psychotherapy has been rapidly developing and is still a relatively new profession in Mainland China. The public has little knowledge of counseling and there is very little research that has examined the help-seeking process in the Chinese population. This study aims to examine the effects of a multimedia intervention on barriers, attitudes, and intentions to seek counseling with Chinese people. The multimedia is developed based on prior empirical research on help-seeking behaviors organized according to a cross-cultural help-seeking model (CCHS; Song et al. 2015). A total of 200 participants were randomly assigned to one of the two conditions: (1) the media-exposed intervention group, who watched the 30-minute video intervention, and (2) a control group, who watched a 5-minute hospital commercial. Results indicated that the intervention was effective at increasing both positive attitudes towards therapy and intentions to seek therapy. In addition, the psychoeducation on counseling process significantly enhanced positive attitudes towards counseling among participants who have little knowledge about counseling and who have low self-stigma about counseling. The intervention also improved participants’ perceptions about treatment accessibility. It was noteworthy that adherence to Asian value presented as a barrier to attitudes towards counseling through public-stigma and self-stigma. Furthermore, the knowledge about counseling and positive attitudes towards counseling predicted positive intentions to seek help.
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CHAPTER 1: REVIEW OF LITERATURE

The psychological training market in China has been drastically growing in the past two decades. The majority of the existing psychotherapies in China are western-derived (Fu, et al., 2010). The importation of Western-derived psychotherapy in China may reflect the increasing demand for mental health services. Indeed, according to the latest data, roughly 100 million Chinese people experience mental disorders in China (Fei, 2006). In addition, suicide is becoming a leading cause of death for Chinese individuals (Li, Kleinman & Becker, 2001) and 250,000 people commit suicide in China each year. The suicide rate of 20-30/10,000 people is greater than the worldwide average of 14/10,000 people (Hodges & Oei, 2007; see Zhao et al., 2012).

Despite the rapid development of the profession of psychotherapy and increasing demands for counseling in contemporary China, the utilization of counseling services is minimal. In a survey conducted by the World Health Organization among 15 countries on treatment seeking after first onset of mood disorder (Wang, et al., 2007). Estimated projections of the cumulative probability of treatment contact based on the year of disorder onset and by 50 years after onset were made. China was among the countries that had lowest treatment seeking rate. For instance, the rate of making treatment contact in year of onset of major depressive disorder was 6.0% (compared to 35.4% for U.S.); and the estimated rate of making treatment contact by 50 years was 7.9% (compared to 94.8% for U.S.). Therefore, it is imperative to conduct empirical studies on how to improve Chinese people’s treatment seeking behaviors.
Application of Psychotherapy in China

Due to the premature developmental stage of the profession of psychotherapy and/or the cultural contextual differences, some aspects of western-derived psychotherapy may need to adjust to Chinese culture or be educated to Chinese population. For instance, promoting autonomy, maintaining clear boundaries and avoiding dual relationships, and the crucial importance of confidentiality in therapy may encounter collisions in China. In fact, most clients are introduced to their therapists by friends or people who know the psychotherapist, and 34.2% of psychotherapists provided therapy for acquaintances in their practice (Deng, & Qian, 2011). Also, Chinese clients display a tendency to relate to their therapist with deference and compliance, and even to be “overly trusting” or “overestimating” the therapist’s professional competence (Qian, Smith, Chen, & Xia, 2002).

In a recent national survey with a large representative sample of Chinese clients (n=1,100) (Zhao et al., 2012), 90% of participants considered their therapists to be competent. Interestingly, in another survey (Zhao et al., 2012), 74.2% of psychological practitioners reported that they felt incompetent in their practices. In addition, more than 90% of clients believed their therapists would properly protect their privacy (Zhao et al., 2012). In contrast, half of the therapists reported that they had broken patient confidentiality by discussing their clients with family members or friends (Zhao et al., 2012). The striking discrepancies between therapist and client’s perceptions about therapeutic process and therapist’s clinical competence may suggest that Chinese clients or/and therapists have limited knowledge about the nature of psychotherapy or the proper treatment during sessions (Zhao et al., 2012).
Some Chinese scholars have addressed their concerns on Chinese clients’ lack of understanding of client’s role and psychotherapy process. For instance, Duan and colleagues (2012) suggested that, for Chinese clients, compliance to therapist is more about being a good client than about cooperating with therapists, which may not facilitate therapeutic changes. In fact, Chinese clients seem to be more interested in a focus on self rather than others in therapy. Duan et al.’s (2012) found that Chinese clients reported a high frequency of directives in the therapeutic concerns domain with a focus on personal growth and awareness. In this context, therapists’ push for self-exploration and self-reliance can be interpreted as a conscious or unconscious advocacy for a nonliberal model of the self. In addition to the misconceptions about therapeutic relationships, some other cultural aspects may also serve as barriers that keep Chinese people from seeking treatment. For instance, having mental health problems is treated as a disgrace to the family.

The gap between the drastic development of psychotherapy training and the lack of general knowledge of psychotherapy among the public may hinder the growth of this new profession in China. Therefore, effort towards effectively disseminating knowledge of psychotherapy in China is imperative, such as educating the general populations about the expected therapeutic relationship and the roles of therapist and client. In order to maximize the effectiveness of the intervention, it stands to reason that the intervention should be framed around the empirically supported factors that influence one’s help-seeking behaviors.
Help-Seeking Model

Contrast to the scarcity of empirical studies of help-seeking for treatment in contemporary China, the help-seeking literature in the West is ample. Most of the recent help-seeking models are based on Ajzen and Fishbein’s (1980) theory of reasoned action and planned behavior (TRA/PB). The theory of TRA/PB posits that belief-based factors affect attitudes, and attitudes in turn influence behavioral intentions of help-seeking that ultimately relate to behavior outcome. A rigorously studied pathway based on TRA/PB is the Vogel et al.’s (2005) model. This model suggested that psychological factors (stigma, treatment fears, previous counseling, perceived social support, expected outcome of therapeutic services, and social norm perceptions) predicted attitudes toward help seeking, which mediated help-seeking intentions (e.g., Kim & Omizo, 2003; Vogel, Wester, Wei, & Boysen, 2005; Liao, Rounds, & Klein, 2005).

Figure 1. Theory of Reasoned Action and Planned Behavior (TRA/PB) Model

Cross-Cultural Help-Seeking Process

Based on Vogel et al.’s (2005) model, my colleagues and I examined a cross-cultural help-seeking model with a Chinese sample and a U.S. sample. (CCHS; Song, Anderson, Himawan, McClintock, Jiang, & McCraick, 2016). This preliminary study extended the existing help-seeking models by adding an additional level pertaining to the
cultural contextual components. The cultural contextual variables included independent self, interdependent self, and gender, which we believe were antecedent factors to the existing help-seeking process. Therefore, in the cross-cultural help-seeking model (CCHS), we designated the cultural contextual factors existing on a first-order level that influence counseling-specific variables which are on the second level and include expectations about counseling, public-stigma, and previous therapy experience. These level two variables influence attitudes about counseling (level three), in turn influence intentions to seek help (level four). The study on CCHS model (Song et al., 2016) included a total of 296 Chinese college participants and 334 U.S. college participants, and a Structural Equation Modeling (SEM) was conducted separately for the U.S. and Chinese samples. The CCHS model (Figure 2) was validated across both the U.S. and Chinese samples.

![Figure 2. Cross-Cultural Help-Seeking Model](image)

Additional Variables Added to the CCHS Model

Given the Chinese cultural context, the current study attempts to refine the cross-cultural help-seeking model by adding factors that presumably are sensitive to Chinese cultural context, including perceived social support, adherence to Asian Values, perceived treatment accessibility, and self-stigma. Some aspects of Chinese values, such as viewing seeking psychotherapy as a disgrace to the family, could serve as barriers that
keep potential clients from seeking treatment. Thus, it would be of interest to examine the effect of the variable of how Asian values influence the behaviors in the help-seeking process, which is represented by the Asian Value Scale (AVS). The AVE assesses cultural values, including conformity to norms, family recognition through achievement, emotional self-control, collectivism, humility, and filial piety (Kim et al., 1999). In addition, the variable of perceived social support was identified as a variable that predicted help-seeking attitudes in a previous study (Vogel, et al., 2005). In a recent study conducted in Taiwan (Yeh, 2002), it was suggested that seeking help from family and close friends was more preferable than professional counseling services. It would be of interest to examine how other non-psychotherapy social resources, impact help-seeking process in people in Mainland China. The factors of adherence to Asian values and perceived social support, presumably, will serve as cultural contextual influence. Therefore, they are placed in the cultural contextual factors (level one).

Public-stigma attached to seeking counseling refers to simply seeking counseling appears to carry its own mark of disgrace (Vogel & Wade, 2009). Related to public-stigma, self-stigma attached to seeking mental health services means seeking help may potentially threaten one’s self-esteem (Fisher, Nadler, & Whitcher-Alagna, 1982). Perceptions of public-stigma impact help-seeking indirectly by contributing to the experience of self-stigma (Vogel, & Wade, 2009). In addition, research is starting to identify how self-stigma may be related to cultural norms (Vogel & Wade, 2009). Therefore, self-stigma is included as an additional variable in the present study. Moreover, as discussed above, most of the Chinese people has limited knowledge about the concept and accessibility of the counseling services. Therefore, it is highly likely that
participants’ perceived treatment accessibility serves as a barrier in their help-seeking process. The variables of self-stigma and perceived treatment accessibility are presumably are belief-based factors, therefore, there are placed in the counseling-counseling specific factors (level two). The revised cross-cultural help-seeking model is depicted as below (Figure 3)

![Figure 3. Revised Cross-Cultural Help-Seeking Model](image)

**Constructing a Therapy Educational Program in China**

Based on the revised cross-cultural help-seeking model, the factors included in the model were chosen as a theoretical blueprint for a multimedia intervention program. Given that that the cultural contextual factors (level one) presumably influence the help-seeking process in a more enduring way compared to other factors. It stands to reason that the counseling specific variables (level two) including expectations about counseling (EAC), public-stigma, self-stigma, and perceived perceived treatment accessibility are believe-based factors and are susceptible to psychoeducational intervention. Therefore, the educational program was developed with content framed around improving participants’ understanding of the expectations about counseling, reductions of public-
stigma and self-stigma, and improving perceived treatment accessibility. The program was enhanced with a multimedia presentational format.

The intervention incorporating components of expectations about counseling (EAC) has been assessed in some preparatory programs. For instance, in a preliminary study conducted by Guajardo and Anderson (2006), the data showed that the multimedia condition had resulted superior treatment effectiveness to the information-only intervention. The multimedia program effectively addressed the content of aspects of EAC, including client characteristics, counseling process and outcome. Specifically, they incorporated sections of the multimedia program with the Privacy, First Session, and Diagnosis and Labeling section, which also included an example of vicarious therapy. In these sections, general counseling process and procedures, such as confidentiality, establishing goals, and talking openly, are addressed, which has been included in some other preparatory programs (i.e., Douglas et al., 1999; Webster, 1992; Douglas et al., 1999; Katz, Brown, Schwartz, Weintraub, Barksdale & Robinson, 2004; Webster, 1992; and Zwick & Attkisson, 1985).

There have also been a number of programs designed for stigma-reduction on mental illness. For instance, the Anti-Stigma Project workshop (ASP), which was developed in 1993 by On Our Own of Maryland, Inc. (a statewide mental health consumer education and advocacy group) and the Maryland Mental Hygiene Administration. The ASP was designed to educate participants in a small group setting about mental illness stigma’s impact on people with mental illness.

For the intervention methods, there are two major strategies, education and contact. Education method refers to increasing knowledge about mental health by
replacing erroneous misconceptions with factors (Watson et al. 2004). Contact method refers to using people with personal mental health challenges in either video (Corrigan et al. 2007) or in vivo (Rusch et al. 2008). A recent meta-analysis included 79 studies of public stigma change revealed that both education and contact methods positively affected participants’ attitudes and behavioral intentions, but contact yield significantly stronger outcomes than education. This meta-analysis suggested that messages delivered via interpersonal contact from a person with mental illness are more effective than via educational strategies (see Michaels et al. 2014).

Thus, we adopted the format that has been effectively used in previous studies, which includes re-enacted vignettes from actual therapy sessions to emphasize important interactions between client and therapist and to provide vicarious learning experience for the client. Sections of video clips were designed to provide participants with realistic examples of good therapeutic interactions. The presenting problems addressed in the clips were closely relevant to Chinese populations, such as parents’ high expectations of children and clients’ expectation of having a “quick” fix in therapy. The therapist actor was a Chinese graduate student in clinical psychology and the client actor was a Chinese as well. The language spoken was Mandarin and the subtitles were in English. The length of viewing time was 33 minutes. The content of the multimedia video is described as in Table 1.

Current Study

A large number of Chinese people are unfamiliar with the concept of psychotherapy or hold misconceptions about therapy. This may place barriers for Chinese people to seeking professional mental health services. The current study primarily aims to
examine the effects of an intervention to increase professional mental health help-seeking behaviors with a Chinese college student population.

Second, gender has been widely studied in the help-seeking literature. The extant literature across various fields (Nadler, 1991) and various cultural groups (e.g., Yoo, Goh, Yoon, 2005) shows that men generally seek less help than women. Females, as compared to males, have a greater proclivity to seek professional psychological services (Deane & Chamberlain, 1994; Komiya, Good, & Sherrod, 2000; Tata & Leong, 1994) and are less likely to be influenced by stigma (Eisenberg, Downs, Golberstein, & Zivin, 2009; See Topkaya, 2014). Males who endorse traditionally masculine traits (Pederson & Vogel, 2007), such as restricted emotionality (Lane, & Addis, 2005; Vogel, Wester, Hammer, & Downing-Matibag, 2014), are more likely to experience stigma for seeking professional help. This study also aims to examine the effects of gender in reacting to the multimedia intervention.

In addition, there has been only one previous study on examining help-seeking processes with a Mainland Chinese population (Song et al., 2016). Given that in this previous study recruited participants had limited previous counseling experience, it could be assumed that the help-seeking process examined in the prior study might not be fully developed. The other aim of the current study is to examine the help-seeking process with participants who received psychoeducation on psychotherapy.

**Hypotheses**

1. **Effectiveness of Multimedia Intervention**

   1A. Compared to the control group, participants who view the multimedia presentation will report more accurate expectations about therapy as evidenced by higher
scores on the EAC-B, less public-stigma and self-stigma about seeking counseling as evidenced by lower scores on the self-stigma scale and public-stigma scales, and higher perceived treatment accessibility as evidenced by higher scores on the perceived treatment accessibility scale.

1B. For both groups, compared to males, female participants will report more accurate expectation about therapy, less public-stigma and self-stigma, and higher level of perceived treatment accessibility. There will be an interaction between intervention and gender.

2. Examination of the Help-Seeking Process for the Intervention Group

2A. According to the revised CCHS model, it was predicted that cultural contextual variables (independent self, interdependent self, adherence to Asian values, perceived social support) would predict counseling specific variables (expectation about counseling, perceived treatment accessibility, public-stigma and self-stigma).

2B. Based on the refined path assumptions of the CCHS-China model, for the intervention group, counseling specific variables (expectation about counseling, public-stigma, self-stigma, perceived treatment accessibility) will predict attitude. Specifically, it was predicted that expectation about counseling, perceived treatment accessibility would positively predict attitudes about counseling. Similarly, it was predicted that public-stigma and self-stigma would negatively predict attitudes about counseling.

2C. According to the refined CCHS-China model, it is predicted that for the intervention group, intention to seek help would be positively associated with attitudes toward seeking help.
CHAPTER 2: METHODS

Participants

Participants were recruited through offering extra research credits in one of or both of the two courses (a course in Critical Thinking and a course in Political Science) at an urban university in Shanghai, China. Students were all undergraduates who included students from all four years of different majors. The instructor of the above two courses verbally informed students of this study 2-3 weeks prior to the actual study and informed students that they could choose not to come to the study without affecting their academic performance.

The initial sample was 200 undergraduate students. Of the 200 participants, 5 participants from the intervention group and 8 from the control group were excluded due to the participants not having completed at least one of the measures. Thus, the final sample included 95 participants for the intervention group and 92 participants for the control group. The age range of the participants from the intervention group was 17-21 (Mean=19.0, SD=.78). The age range of the participants from the control group was 17-22 (Mean=19.0, SD=1.97). About one third of the total participants were male (33.57%). The male participants accounted for 37.7% in the intervention group and 29.6% in the control group. Four of the participants in the intervention group and six in the control group reported having previous counseling experiences.

Measures

The descriptions of the measures, including the constructs, items, and the range of the scores, can be found in Table 2. The measures were presented to participants from the control group and treatment group in the following order.
Expectations About Counseling-Brief Form (EAC-B) (see Appendix C)

The EAC-B (Tinsley, Workman, & Kass (1980) was designed to measure clients’ expectations about the therapy process, including the therapeutic conditions and the roles of the counselor and client. This measure consists of 66 items, which are rated on a 7-point scale ranging from 1 (not true) to 7 (definitely true). The EAC items were constructed primarily with three factors a) client involvement (e.g., “I expect to become better able to help myself in the future.”) b) counselor expertise, which include counselor subjective expertise (e.g., “I expect the counselor to discuss his or her own attitudes and relate them to my problem.”) and counselor directive helping (e.g., “I expect the counselor to know how to help me.”) c) counselor facilitative conditions (e.g., “I expect the counselor to like me.”) (Anderson, Patterson, McClintock & Song, 2013). In the present study, the three EAC-B factors have good internal consistency (Client Involvement, $\alpha = .94$; Counselor Expertise, $\alpha = .90$; Facilitative Condition, $\alpha = .93$).

Intentions to Seek Counseling Inventory (ISCI; Cash, Begley, McCown, & Welse, 1975) (see Appendix D)

The ISCI is a 17-item, self-report questionnaire that asks respondents to rate how likely they would be to seek counseling services if they were experiencing the problem listed (e.g., “weight control,” “depression,” “relationship difficulties”). Participants rated the likelihood of seeking counseling services on a Likert-type scale ranging from 1 (very unlikely) to 6 (very likely) with higher scores indicating a greater likelihood of seeking services. The ISCI consists of three subscales examining respondents’ likelihood of seeking the services of a therapist for (a) interpersonal, (b) academic, and (c) drug and alcohol problems. The ISCI variables have demonstrated adequate internal consistency.
In this study, the internal consistencies were good for the two subscales included, (a) interpersonal ($\alpha = .82$) and (b) academic problems ($\alpha = .76$).

*Attitudes Towards Seeking Professional Psychological Help Scale: A Shortened Form (ATSPPH; Fischer & Farina, 1995)* (see Appendix E)

The 10-item ATSPPH was used to assess respondents’ attitudes toward seeking professional counseling services. ATSPPH items are rated on a 4-point Likert-type scale ranging from 1 (agree) to 4 (disagree) with higher scores indicating more positive attitudes (e.g., “If I believed I was having a mental breakdown, my first inclination would be to get professional help.” “The idea of talking about problems with a therapist strikes me as a poor way to get rid of emotional conflicts.”). The ATSPPH has adequate construct validity, as it has been found to negatively correlate with help-seeking stigma ($r = -.40$; Komiya et al., 2000). In the present sample, the internal consistency was acceptable ($\alpha = .71$).

*Stigma Scale for Receiving Psychological Help (SSRPH; Komiya et al., 2000)* (see Appendix F)

The 5-item SSRPH assesses the level of public-stigma involved in seeking professional counseling services. The SSRPH is rated on a 4-point Likert-type scale from 0 (strongly disagree) to 3 (strongly agree), with higher scores indicating greater stigmatized help-seeking beliefs (e.g., “Seeing a therapist for emotional or interpersonal problems carries public-stigma.” “People will see a person in a less favorable way if they come to know that he/she has seen a therapist.”). Construct validity was supported by a negative correlation with positive attitudes toward help seeking for mental health services.
In the present sample, the internal consistency was poor ($\alpha = .50$).

**Self-Stigma of Seeking Help scale (SSOSH; Vogel et al., 2006) (see Appendix G)**

The SSOSH is a 10-item scale measuring the level of self-stigma involved in seeking counseling. Responses are on a 5-point scale ranging from 1 (Strongly Disagree) to 5 (Strongly Agree). For instance, “I would feel inadequate if I went to a therapist for psychological help.” Five items are reverse-scored so that higher scores indicate greater self-stigma. The internal consistency and validity of SSOSH was examined with a confirmatory factor analysis and compared across samples from six countries (English, Greece, Israel, Taiwan, Turkey, and the United States). The results suggested that the internal consistencies of the SSOSH across six country samples was .77-.89. It has a similar univariate structure across countries and is sufficiently invariant across countries. (Vogel, et al., 2013). In the present study, the internal consistency was relatively acceptable ($\alpha = .66$).

**The Self-Construal Scale (SCS; Singelis, 1994) (see Appendix H)**

The SCS is a 30-item measure of self construal styles. The scale has three subscales, two of which were used in the current study. In this scale, 15 items comprise the independent subscale (e.g., “I’d rather say “no” directly, than risk being misunderstood”), and the other 15 items comprise the interdependent subscale (e.g., “I would sacrifice my self-interest for the benefit of the group I am in”). Respondents indicate their agreement with each of the items on a 7-point Likert-type scale, ranging from 1 (strongly disagree) to 7 (strongly agree). The SCS was found to have adequate validity and reliability (Singelis, 1994; Singelis & Sharkey, 1995). It has also been
translated into multiple languages (e.g., Chinese, Japanese, Arabic and Hebrew) and has been researched in several countries (Hardin, Leong, Bhagwat, 2004). In the present study, the internal consistencies were acceptable (Cronbach $\alpha = .71$ for the independent-self and Cronbach $\alpha = .72$ for the interdependent-self scale).

**Asian Values Scale (AVS; Kim et al., 1999) (see Appendix I)**

The AVS contains 36 statements (18 of which are reverse worded) reflecting Asian cultural values and utilizes a 7-point Likert-type scale (1=strongly disagree, 7=strongly agree) to assess the respondent’s endorsement of each item (e.g., “One should not deviate from familial and social norms.” Kim et al. (1999) reported coefficient alphas of .81 and .82 based on two separate samples and a 2-week test-retest reliability coefficient alpha of .86. Support for AVS’s construct validity was obtained by identifying via a nationwide survey items that reflected cultural values commonly observed across various Asian American ethnic groups; items that were more highly endorsed by first-generation Asian American than by European Americans were retained. In addition, an exploratory factor analysis showed six factors representing related aspects of Asian cultural values: collectiveness conformity to norms, emotional self-control, family recognition through achievement, filial piety, and humility; As additional evidence of AVS’s construct validity, a follow-up study by Kim, Yang, Atkinson, Wolfe, and Hong (2001) showed that these six factors were closely interrelated and commonly observed among and similarly defined by Asian Americans of various ethnic origins. AVS’s convergent validity was obtained through a confirmatory factor analysis in which a factor structure representing the relationship between behavioral acculturation and values
enculturation yielded a good fit to the data (Kim et al., 1999). In the present study, the internal consistency was marginally acceptable ($\alpha = .61$).

**Perceived treatment accessibility (see Appendix J)**

This measure is created specifically for this study. It entails three items on a 1-2 scale (1=True, 2=False) including “Do you know where to seek professional psychological help?” “Is it easy for you to find a place that provides counseling services if you need?” “Do you think it is affordable for you to see a therapist?” The internal consistency was acceptable in this study ($\alpha = .74$).

**Interpersonal Support Evaluation List-12 (ISEL-12; Cohen et al., 1985) (see Appendix K)**

The ISEL-12 is derived from the long form of the ISEL and contains 12 items that assess the perceived availability of social support on a 4-point scale ranging from 0 (definitely false) to 3 (definitely true). All items are summed to yield a total score (scores range=0-36). It consists of three subscales: Appraisal (advice or guidance), Belonging (empathy, acceptance, concern), and Tangible (help or assistance, such as material or financial aid). It entails items such as “There is someone I can turn to for advice about handling problems with my family.” The internal consistency reliability and validity of this measure has been supported in a large-scale survey (Rayne, 2012) The internal consistency for this sample was acceptable ($\alpha = .81$).

**Quiz (see Appendix L)**

This measure is created specifically for this study. It entails seven items on a 1-2 scale (1=True, 2=False), such as “It is unethical if the counselor share my information with his/her spouse.” “Counselor is very similar to a medical doctor. He/she is expected
to offer me quick solutions to fix my problems in the first session.” The internal consistency was poor ($\alpha = .27$).

**Procedures**

Prior to the data collection, the procedure was approved by Ohio University Institutional Review Board (IRB). All participants were informed that the study would take place for about an hour and a half. They were also informed that the study was anonymous and that their decisions on whether or not to participate would not impact the evaluation of their academic performance.

Prior to the study, a list of randomly generated identification numbers were created and data was collected through paper-and-pencil questionnaires. At the beginning of the study, the consent was through usual practices in China, which involved verbally reading and explaining the informed consent form (Appendix A). The text of the informed consent was presented through power point. Those who consented were assigned with a study number, which indicated their random assignment to either group A or group B, then the two groups of subjects were immediately separated into two different rooms. Group A received the multimedia intervention developed for this study (see Appendix B for the script of the video). Subjects assigned to group B watched a 5-minute hospital commercial. After the interventions, subjects from both groups filled out several questionnaires and a quiz. Then participants were dismissed.
CHAPTER 3: RESULTS

Manipulation Check and Descriptive Statistics

Missing Data

Within the final sample, there were only 8 missing items among all participants and these appeared to be randomly distributed. Expectation maximization imputation technique was used to replace these missing items. The scores from the 7-item quiz related to the multimedia program were examined to assess participants’ attentiveness to the intervention. The results indicated both the intervention group and control group data were normally distributed. In the intervention group, fifty-six out of ninety-five participants missed one or no questions (60%), twenty-six missed two questions (27%), nine missed three questions (10%) and four missed four questions (4.2%). In the control group, only 17% of the participants missed one or no questions. It suggested that participants in the intervention group paid attention. The mean (the higher the better) for of the intervention group (\(M=5.56, \text{SD}=1\)) was significantly higher than the control group (\(M=4.78, \text{SD}=.98\)). \(p < .001\) (see Table 4).

Descriptive Statistics

Previous counseling was not examined, as only 10 (5%) of the participants received previous counseling. Means and Standard Deviations for measures of expectation about counseling, Public-stigma scale, self-stigma scale, perceived treatment accessibility, interdependent-self, independent self, perceived social support, Asian value, attitude, and intention can be found in Table 3. Many measured variables showed a significant correlation with other measured variables in the expected direction (see Table 5). The subscales of EAC-B were highly correlated ranging from .71-.83. Also, the
subscales of intention to seek help were also significantly correlated ranging from .15-.66. Therefore, the total score of EAC-B and Intention to seek help was used in the remaining analyses.

Independent-self was significantly correlated with perceived treatment accessibility (r=.25) and perceived social support (r=.29). Interdependent-self was significantly correlated with expectation about counseling (r=.26), perceived social support (r=.23) and Asian value (r=.43). Asian value was significantly correlated with both public-stigma (r=.36) and self-stigma (r=.32), and negatively correlated with attitude towards counseling (r=-.21). Perceived social support was correlated with perceived treatment accessibility (r=.38), and was negatively correlated with public-stigma (r=-.25). Expectation about counseling was positively correlated with intention to seek help (r=.27). Both public-stigma (r=-.38) and self-stigma (r=-.43) were negatively correlated with attitude about counseling. Public-stigma and self-stigma were moderately correlated (r=.61). Attitude was significantly correlated with intention (r=.48). These correlations will be further explored in subsequent analyses.

**Effects of the Multimedia Intervention**

The analyses initially excluded the thirteen participants in the intervention who missed more than three questions, but it did not change the results with all the participants included. Therefore, the following analyses included all the participants.

**Normality for Dependent Variables**

In order to assess the whether the data met the underlying assumption of normality in the maximum likelihood method, a multivariate normality test was conducted. The values of kurtosis and skewness of all the dependent variables did not
violate the normality assumption. The assumption of homogeneity was tested with Levene’s test and none of the dependent variables violate this assumption.

To test hypothesis 1A and 1B, a 2X2 MANOVA was used, which included groups (treatment vs. control) and gender (male vs. female). Interaction of group X gender was considered supportive of the hypotheses (see Table 6). The dependent variables included were expectation about counseling, self-stigma, public-stigma, perceived treatment accessibility, attitudes towards counseling, and intention to seek counseling. The main effect was found in both group (F(6, 178)=2.29, p<.05, η_p²=.07), and gender (F(6, 178)=2.54, p<.05, η_p²=.082) but not the interaction (F(6, 178)=1.42, p=ns, η_p²=.05, ns, see Table 5 for MANOVA results). As for the group main effect, three variables showed significant difference with intervention: intention to seek help (F(1, 183)=9.34, p<.01, η_p²=.43), attitudes towards counseling (F(1, 183)=4.77, p<.05, η_p²=.03) and perceived treatment accessibility (F(1, 183)=6.0, p<.05, η_p²=.03). A set of Post hoc contrast tests were conducted with these three variables as dependent variables and group as independent variable. It indicated that participants in the treatment group had more positive attitudes towards counseling (p<.05), higher level of intention to seek help (p<.05), and higher level of perceived treatment accessibility (p<.001).

For the gender main effect, three variables were found to be significantly contributing to this omnibus main effect: expectations about counseling (EAC-B (F(1, 183)=4.13, p<.05, η_p²=.02), intentions to seek counseling (INT: F(1, 183)=9.89, p<.01, η_p²=.05), and attitudes towards counseling(F(1, 183)=5.17, p<.05, η_p²=.03). A set of Post hoc contrast tests were conducted with these three variables as dependent variables and gender as independent variables. It indicated that female participants have more positive
attitudes towards counseling ($p<.05$) and higher level of intention to seek help ($p<.001$), especially for seeking help for interpersonal problems ($p<.001$) (see Table 6).

Predicting Help-Seeking Processes

For both groups, Homoscedasticity was checked via a scatterplot of standardized residuals and standardized predicted values and no violations were found. Normality and linearity were also checked with no violation found. The multicollinearity was checked with the correlations between independent variables and tolerance values. None of the correlations between independent variables was above .65 and none of the tolerance values of the independent variables was below .20. Therefore, we assumed that the multicollinearity assumption was not violated.

To test hypothesis 2A, 2B, and 2C, a series of multiple regressions were conducted to examine the help-seeking paths. The hypotheses were based on the proposed cross-cultural help-seeking model. Therefore, the analyses were conducted in three different steps to map onto this model.

First, to test hypothesis 2 A, a series of separate hierarchal multiple regressions were conducted. Each of the counseling specific variables (EAC, public-stigma, self-stigma, and perceived treatment accessibility) as the dependent variable was regressed onto cultural contextual variables (independent and interdependent self, Asian values, gender, and perceived social support; 1st step), treatment condition (2nd step), and the five interactions of treatment X the cultural contextual variables (3rd step). The findings indicated that there was no interaction effect on treatment condition X each of the cultural contextual factors. The overall model significantly predicted expectations about counseling $F(5, 180)=2.621, p<.005, R2=.142, Adj R2=.088$, self-stigma (F(5,
and perceived treatment accessibility 

\[ F(5, 180) = 4.653, p < .001, R^2 = .227, \text{Adj R}^2 = .178 \]. Specifically, based on interpretation of Beta weights and \( p \) values, female has significantly more accurate expectations about counseling (\( \beta = -2.083, p < .05 \)). For the intervention group, the more adherence to Asian value, the more public-stigma (\( \beta = 2.047, p < .05 \)). The more independent-self, the less self-stigma (\( \beta = -3.112, p < .005 \)). For the control group, the more adherence to Asian value, the more self-stigma (\( \beta = 2.467, p < .05 \)). In addition, treatment condition added significant effects of prediction from cultural contextual variables to public-stigma 

\[ \Delta F = 2.634, p < .05, \Delta R^2 = .068 \], self-stigma (\( \Delta F = 5.973, p < .001, \Delta R^2 = .143 \)), and perceived treatment accessibility (\( \Delta F = 4.798, p < .001, \Delta R^2 = .110 \)) (see Table 8).

Second, to test hypothesis 2B, after controlling cultural contextual variables (independent and interdependent self, Asian values, gender, and perceived social support; 1st step), attitude as the dependent variable was regressed onto treatment condition and each of the counseling specific variables (EAC, public-stigma, self-stigma, and perceived treatment accessibility), respectively (2nd step), and each of the interactions of the treatment X each of the counseling specific variables (condition X EAC, condition X public-stigma, condition X self-stigma, and condition X perceived treatment accessibility) were entered respectively (3rd step).

The findings (see Table 9) indicated that the overall the above four models significantly predicted attitude. Specifically, the interaction of treatment condition and EAC was marginally significant (\( \beta = -.187, p = .086 \)). Expectations about counseling and treatment condition explained additional 8.7% of variance of attitude (\( \Delta F = 8.87, p < .001 \)). Based on interpretation of Beta weights and \( p \) values, the more accurate expectations
about counseling (EAC), the more positive attitude ($\beta = .40, p < .001$). Treatment intervention improved positive attitude in the intervention group ($\beta = .163, p < .05$). We did further examinations on the treatment effect on low EAC and high EAC, respectively. We computed low EAC (1 standard deviation below mean) and high EAC (1 standard deviation above mean). The findings suggested that with treatment improve positive attitudes towards counseling only with participants who had low EAC (1 SD below mean) ($\beta = .287, p < .01$) but not with participants with high EAC (1 SD above mean), ($\beta = .040, p = .69$).

Public-stigma and treatment condition explained additional 8.9% of variance of attitude ($\Delta F = 9.07, p < .001$). Specially, the interaction of treatment condition and public-stigma marginally predicted attitude ($\beta = -.171, p = .050$). Public-stigma marginally negatively predicted positive attitude ($\beta = -.164, p = .054$). Treatment condition significantly improved positive attitude ($\beta = .17, p < .05$). We further examined the effect of high public-stigma (1 SD above mean) and low public-stigma (1 SD below mean). The results indicated that the treatment significantly predicted attitude only when public-stigma level was low ($\beta = -.321, p < .005$), but not with participants with high level of public-stigma ($\beta = .017, p = .875$).

Self stigma and treatment condition explained additional 13.2% of variance of attitude ($\Delta F = 14.20, p < .001$). Specifically, there was no interaction of treatment condition and self-stigma. The higher level of self-stigma, the less positive attitude about counseling in the treatment group ($\beta = -.225, p < .05$) and the control group ($\beta = -.444, p < .001$). The treatment intervention significantly improved positive attitude ($\beta = .176, p < .05$).
Perceived treatment accessibility and treatment condition explained additional 6.1% of variance of attitude ($\Delta F=6.07, p<.005$). Specifically, the interaction of treatment condition and perceived treatment accessibility has no effect on attitude ($\beta = -0.011, p = .91$). Perceived treatment accessibility significantly predicted positive attitude ($\beta = 0.203, p < .05$).

Third, to test hypothesis 2C, a hierarchical multiple regression was conducted. After controlling the counseling specific variables (1st step), intention was regressed onto attitude and treatment condition (2nd step), and interaction of treatment and attitude (3rd step). The overall model significantly predicted intention to seek help ($F(7, 179)=12.69, p<.001, R^2=.332, \text{Adj } R^2=.306$). The attitude explained additional 17.7% of variance of intention after control counseling specific variables ($\Delta F=23.69, p<.001$). There was no interaction between attitude and treatment intervention ($\beta = .1, p = .272$). The more positive attitude, ($\beta = .373, p < .001$), expectations about counseling ($\beta = .284, p < .001$), and public-stigma ($\beta = .182, p < .005$), the more intention to seek help (see Table 9).

*Bootstrapping*

As a result from the above linear regression analyses, six sets of paths were emerged (the path of independent-self $\rightarrow$ self-stigma $\rightarrow$ attitude $\rightarrow$ intention; independent-self $\rightarrow$ EAC $\rightarrow$ attitude $\rightarrow$ intention; Asian value $\rightarrow$ self-stigma $\rightarrow$ attitude $\rightarrow$ intention; Asian value $\rightarrow$ public-stigma $\rightarrow$ attitude $\rightarrow$ intention; perceived social support $\rightarrow$ perceived treatment accessibility $\rightarrow$ attitude $\rightarrow$ intention; and gender $\rightarrow$ EAC $\rightarrow$ attitude $\rightarrow$ intention). The regression analyses were conducted to assess each component of the proposed mediation on model. First, the indirect effect of each of cultural variables (independent self, gender, perceived social support, Asian value) on attitude through the mediators of
each of the counseling specific variable (EAC, public-stigma, self-stigma, and perceived treatment accessibility) was calculated with 5000 bootstrap resamples (Preacher & Hayes, 2008) (a) from each of the four cultural factors to each of the counseling specific factors, and (b) from each of the four counseling specific variables to attitude about counseling. In other words, a total of six indirect effects were estimated for their significant levels. In addition, the other three indirect effects were estimated with a) each of the significant counseling specific factors and b) from attitude to intention to seek help. If the 95% CI for these estimates of indirect effects does not include zero, then a conclusion can be made that the indirect effect is statistically significant at the .05 level (see Shrout & Bolger, 2002). The results indicated that the 95% CI for 7 out 8 indirect effects did not include zero, indicating that these indirect effects were statistically significant (See Figure 4).
CHAPTER 4: DISCUSSION

The video intervention developed for this study significantly improved affirming attitudes and increased participants’ intention to seek help for counseling. The findings are unique in that it is one of the only studies to have developed a media intervention to improve positive attitudes about counseling based on an empirically-supported model of help-seeking. Further, the findings are the only known empirical findings on the promotion of positive attitudes and help-seeking behavior in Mainland China.

Effects of the Help-Seeking Intervention

The enhancement of positive attitude towards counseling and intention to seek professional services in the present study was strikingly significant. First, in fact, both the positive attitudes toward counseling and the intentions to see help in the intervention group in the present study were significantly higher than those in the previous studies with Western participants (e.g., Vogel et al., 2005, Cantazro, 2009).  

Second, to further assess the significant effects of the multimedia intervention on help-seeking process in the present study, we also examined the mean differences of attitudes and intentions between the sample from the present study and the other Chinese college sample from our prior study (Song et al., 2016). The finding suggested that the intervention group from the present study had significantly higher affirming attitudes and intentions to seek counseling than the participants from our prior study. Interestingly, the significant differences in attitudes and intention to seek help between participants from

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1 The mean of attitude in the intervention group in the present study was 2.86 (SD=.64), which was significantly higher than those in the Vogel. et al (2005)’s study (M=2.56, SD=.53) and Cantazaro (2009)’s study (M=2.66, SD=.56). The mean of intention to seek help in the intervention group in the present study was 3.70 (SD=.83), which was significantly higher than those in the Vogel. et al. (2005)’s study (M=2.1, SD=.60) and Cantarzo (2009)’s study (M=1.32, SD=.39).
the control group from the current study and those from our prior study was also observed².

In addition, the means of the expectations about counseling of both the control group and intervention group from this study were significantly higher than that of the Chinese sample in the prior study (Song et al., 2016)³. The means of public-stigma for both groups in the study were significantly smaller than those for the Chinese sample and U.S. sample from the previous study. Thus, it appeared that participants in the current study have significantly higher levels of knowledge on counseling and have less stigma about seeking treatment than the sample from our prior study.⁴ Nonetheless, it was striking that in spite of the participants having already gained knowledge of counseling and having a high level of positive attitudes and intentions to seek help, the multimedia program still contributed to significant improvements in positive attitude and intention to seek help.

It is practically important to note that the video intervention significantly improved participants’ perceptions of perceived treatment accessibility. Song et al. (2016) speculated that the general public in China had limited knowledge about where psychotherapy was provided. The current study provides evidence to corroborate that

² In our prior study (Song et al., 2016), the mean of attitude for the Chinese sample=2.48, which was significantly smaller than that of the control group in the current study (2.71; p=.000). The mean of intention=2.76, which was significantly smaller than that of the control group in the current study (3.69; p=.000).

³ In our prior study (Song et al., 2015), the mean of EAC-B for Chinese sample=4.95, which was significantly lower than that of the control group in the current study (5.30; p=.006); the means of public-stigma for Chinese sample=2.13, which was significantly higher than that of the control group in the current study (2.01; p=.033).

⁴ We further explored what might have contributed to the significant differences between the Chinese college sample from the present study and the Chinese college sample from our prior study, regarding their attitudes towards counseling, intention to seek help, stigma, and expectations about counseling. For more information, please contact the author.
hunch and, furthermore, that the information provided to students about available counseling services seemed to help students quickly gain the knowledge of where to seek counseling services.

Furthermore, the video intervention significantly improve participants’ affirming attitudes, but only with participants have little knowledge of counseling. It may indicate the “ceiling effect” in the intervention, namely, if participants have already had significant knowledge about counseling, there is limited room for improvement in their attitudes towards counseling. Furthermore, Interestingly, the intervention was effective in affirming attitudes with participants who have low public-stigma, but was not effective among participants who have high public-stigma. These findings shed lights on how to target the particular populations who are more responsive to psychoeducational intervention.

The Help-Seeking Intervention and the CCHSM Model

The findings of the predictive pathways of the help-seeking will be discussed in their order within the model (i.e., from cultural contextual variables to intentions to seek counseling). It was noteworthy that Asian values significantly negatively predicted both public-stigma and self-stigma. Also, self-stigma mediated the prediction of Asian values on attitudes towards counseling. Some researchers (e.g., Shea, & Yeh, 2008) believe that Asian values would lead to internalized stigma to receive counseling, which, in turn, would lead to negative help-seeking attitudes. However, there has been a lack of empirical evidence to support this assumption. This study provided evidence on how Asian values likely influenced their help-seeking intentions through stigma. It was interesting to consider the possibility that psychotherapy may be perceived as a Western-
derived practice and as such may clash with Chinese traditional values and induce stigma (i.e., Sue & Sue, 1987; Tabora & Flaskerud, 1997). For instance, Asians may perceive receiving professional help as a sign of immaturity (Uba, 1994), weakness (Narikiyo & Kameoka, 1992), and shame or disgrace to family (Flaskerud & Liu, 1990; Yeh, 2000; Zane & Yeh, 2002). This may shed some light on how to adapt psychotherapy within the Chinese cultural context. For instance, therapists should be sensitive to Chinese values, traditions, family structure, and current social influences (Cheung and Chan, 2002; Deng et al., 2013) so to reduce stigma and enhance positive attitudes toward seeking counseling.

In Vogel and Wei (2005)’s study, it was found that perceived social support buffered psychological distress, which in turn decreased intentions to seek counseling. In this study, consistent with Vogel and Wei’s study, we found that the more perceived social support, the less public-stigma and more participants perceived that treatment was accessible. It is likely that individuals who have a good social support system may carry less stigma and are more open to various social resources. This finding is also congruent with literature that social support is a causal contributor to well-being (e.g., Cohen & Syme, 1985; House, 1981; Kessler & McLeod, 1985; Cohen & Wills, 1985).

Another interesting finding was that self-construal (independent-self and interdependent-self) were supported in our prior study (Song, et al., 2015) and Yeh’s (2002) study on Taiwanese college students as strong predictors of attitudes towards counseling or intention to seek help. However, in this study, among these variables, only independent self was a significant predictor on self-stigma. The more independent, the less social-stigma. On the other hand, Adherence to Asian values and perceived social
support emerged as variables that predicted stigma. It is intriguing to explore how the intervention may have diluted the strength of prediction of self-construal on counseling-specific variables, while it may have strengthened links from adherence to Asian values and perceived social support to counseling variables.

The findings on the gender effect on the help-seeking process were consistent with the existing literature on Asian populations suggesting that Asian women had more positive attitude about seeking help than Asian men (e.g., Ang et al., 2004; Gloria, Hird, & Navarro, 2001; Leong & Zachar, 1999; Tata & Leoung, 1994; Tracey, Leong, & Glidden, 1986; Yeh, 2002). They were also congruent with the literature on western populations (e.g., Rogler & Cortez, 1993; Smith, Tran, & Thompson, 2008). The present study suggested that females have more accurate understanding of expectations about counseling, which includes client roles, therapist roles, and the therapeutic relationship etc.

The gender effect on stigma, however, was inconsistent with literature on gender effect on stigma in western populations (e.g., Vogel, Wade, & Hackler, A. H., 2007; Vogel, Wester, Hammer, & Downing-Matibag, 2014), namely, we did not find gender differences in the perception of stigma. It might be explained by two reasons. One is that the male participants were much less than females both in the intervention group and control group, which could have been underpowered for the test. The other is that inconsistency on gender effect on stigma may be related to the different populations being examined (Shea & Yeh, 2008). The findings of this study were congruent with Shea and Yeh’s (2008) study on Asian American undergraduate and graduate students. It is likely that Chinese women perceived public-stigma attached to mental health services
just as much as their male counterparts. Consistent with this assumption, although gender effect on stigma were not significant in the intervention group nor with the total sample, it was significant in the control group. It may suggest that the intervention that endeavored to reduce stigma in males may dilute the general gender effect. As Doherty and Doherty (2010) suggested that acknowledgement of the factors that influenced help-seeking will aid the design of gender specific promotion and prevention. In the future, to examine male and female response to psychoeducation programs differently, interventions can use both male and female actors.

Finally, it is important to highlight that the increases in attitudes toward counseling and intentions to seek help were also accompanied findings in which attitudes predicted intentions. That is, the path finding of this study indicated that attitudes towards counseling significantly predicted intentions to seeking help. This finding was also consistent with the extant literature on help-seeking process with American samples (e.g., Vogel & Wester, 2005; Liao, Rounds, & Klein, 2005) and other cultural groups (i.e., Song, et al., 2015, Cantazaro, 2009). Thus, it is fair to conclude that the video intervention improved intentions to seek help by improving positive attitudes towards counseling. A summary of the indirect effects among the variables can be found in Figure 4.

Limitations and Future Directions

Despite the strengths of this study, several limitations should be mentioned. First, although the study demonstrated its strength in improving positive attitude and intention even with a population that has much knowledge about counseling prior to intervention, the fact that this sample had received additional knowledge about counseling is a
limitation. This might suggest to some that the findings of this study could be more narrowly limited to this particular sample. However, all participants had the same instructional background before the intervention. It also seems unlikely that this sample was any more informed about counseling (based on any information about therapy and counseling provided in class) than student registered for psychology classes in the United States. It also could be that the instructors who taught the classes that the participants were attending was speaking of therapy in such a positive way so that the students complied to the instructors.

Second, the gender effect was significant with the control group, but not with the intervention group. It was unclear whether the gender effect with the intervention group was diluted by the fact the video that used a male actor. In the future study, a more balanced design can be useful to detect stigma-reduction specifically on male stereotypes. For instance, a video that uses female actresses can be incorporated into the study design.

Third, although this study provided some rather interesting findings on the help-seeking process (e.g., how Asian value indirectly affected attitude), it is unclear why Asian values and perceived social support emerged as strong predictors to counseling variables in the intervention group, while self-construal variables did not have salient links to counseling variables. A more sophisticated research design, such as pre- and post-test, can be used to examine if intervention influences the help-seeking process. Also, a more sophisticated statistical method, such as SEM with a larger sample, can be used to examine the help-seeking process with participants who receive psychoeducation intervention.
Fourth, future research may need to examine the role of additional factors at different stages of the decision-making process. This type of longitudinal design may further elaborate on why and when people decide to seek help. Finally, it should be noted that although the procedures used allowed for more gathering of information about individuals’ help-seeking behavior, they did not allow for direct causal relationships to be identified.

This study not only paved the way to future research, but also provided empirical support for the effectiveness of psychoeducation with general population. Given the beginning stage of psychotherapy in the contemporary China and that the majority of the Chines people have little knowledge of counseling, this study gave a promising direction as to how to educate general population about counseling and improve their intention to seek counseling services.

Conclusions

Perhaps the most parsimonious explanation for the results of the current study may be that the multimedia intervention was apparently successful. It significantly improved participants’ positive attitudes towards counseling and increased their intention to seek help. Also, it seemed that a brief psychoeducation about counseling and recourses could quickly improve participants’ perceptions about perceived treatment accessibility. As for the mechanism of the intervention, the cross-cultural help-seeking model (CCHS) provided a map for us to examine the help-seeking process. It is noteworthy that Asian value presented as a barrier to attitudes towards counseling through self-stigma. The knowledge about counseling and positive attitudes towards counseling has been consistently predicted positive intention to seek help.
REFERENCES


Press.


model and acculturation effects with Asian and Asian American college students. *Journal of Counseling Psychology, 52*, 400-411.


### Table 1

*Description of the Multimedia Intervention Program*

<table>
<thead>
<tr>
<th>Factors</th>
<th>Content included</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stigma</strong></td>
<td>Who seek counseling?</td>
</tr>
<tr>
<td></td>
<td>Differences between counseling and talking to a friend</td>
</tr>
<tr>
<td></td>
<td>Is it rare for a man to seek counseling?</td>
</tr>
<tr>
<td></td>
<td>Is it a sign of a personal weakness or inadequacy to see a counseling?</td>
</tr>
<tr>
<td><strong>Expectations about</strong></td>
<td><strong>First session</strong></td>
</tr>
<tr>
<td>Counseling</td>
<td>Goal</td>
</tr>
<tr>
<td></td>
<td>Roles</td>
</tr>
<tr>
<td></td>
<td>Ethics</td>
</tr>
<tr>
<td></td>
<td>Expectations</td>
</tr>
<tr>
<td></td>
<td>Openness</td>
</tr>
<tr>
<td></td>
<td>Confidentiality</td>
</tr>
<tr>
<td><strong>Perceived treatment</strong></td>
<td>What services are available?</td>
</tr>
<tr>
<td>accessibility</td>
<td>Fee</td>
</tr>
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<td></td>
<td>How to make an appointment?</td>
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Table 2

Constructs, Items, and the Range of the Scores of Each Measure

<table>
<thead>
<tr>
<th>Scale</th>
<th>Construct</th>
<th>Items</th>
<th>Range</th>
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<tr>
<td></td>
<td>EAC</td>
<td>Items</td>
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<tr>
<td></td>
<td>CI</td>
<td>Items</td>
<td>1 - 11</td>
</tr>
<tr>
<td></td>
<td>CE</td>
<td>Items</td>
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<tr>
<td></td>
<td>FC</td>
<td>Items</td>
<td>1 - 11</td>
</tr>
<tr>
<td></td>
<td>Intention</td>
<td>Items</td>
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<tr>
<td></td>
<td>Intention</td>
<td>Items</td>
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<td>Items</td>
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<td>Self-Construal</td>
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<td></td>
<td>Asian Value</td>
<td>Items</td>
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<tr>
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<td>Treatment</td>
<td>Items</td>
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<tr>
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<td>Social Support</td>
<td>Items</td>
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<tr>
<td></td>
<td>Appraisal</td>
<td>Items</td>
<td>2 - 4</td>
</tr>
</tbody>
</table>

Note: EAC = Expectations about Counseling; Intention Brief Form; Intention=Intentions of Seeking Counseling Inventory; Attitudes=Attitudes Towards Seeking Professional Psychological Help: A shortened form; Public-Stigma=Stigma Scale for Receiving Public Evaluation; Self-Stigma=Self-Stigma of Seeking Help Scale Items; Self-Construal=Self-Construal Scale; Asian Value=Asian Value Scale; Treatment=Treatment Accessibility; Social Support=Interpersonal Support Evaluation List-12. CI=Client Involvement; EAC=Expectation about Counseling; FC=Facilitating Condition; Interpersonal=Interpersonal Problems; Academic=Academic Problems; Drug/alcohol=Drug/alcohol Problems; Independent=Independent Self; Interdependent=Interdependent Self. 

This study used the total scores of each measure, except the Self-Construal Scale.
### Table 3

**Demographics of Study Participants for the Multimedia Group and Control Group**

<table>
<thead>
<tr>
<th>Gender</th>
<th>Multimedia</th>
<th>%</th>
<th>Control</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
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<td>72.4</td>
<td>71</td>
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</tr>
<tr>
<td>Male</td>
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<td>27.4</td>
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<td>22.8</td>
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</table>

<table>
<thead>
<tr>
<th>Age (Years)</th>
<th>Multimedia</th>
<th>%</th>
<th>Control</th>
<th>%</th>
</tr>
</thead>
<tbody>
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<td>17</td>
<td>1</td>
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<td>1</td>
<td>1.1</td>
</tr>
<tr>
<td>18</td>
<td>14</td>
<td>14.7</td>
<td>10</td>
<td>10.9</td>
</tr>
<tr>
<td>19</td>
<td>19</td>
<td>52.6</td>
<td>46</td>
<td>50</td>
</tr>
<tr>
<td>20</td>
<td>26</td>
<td>27.4</td>
<td>30</td>
<td>32.6</td>
</tr>
<tr>
<td>21</td>
<td>21</td>
<td>4.2</td>
<td>3</td>
<td>3.3</td>
</tr>
<tr>
<td>22</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1.1</td>
</tr>
</tbody>
</table>

### Table 4.

**Means and Standard Deviations of Quiz for the multimedia group and control group**

<table>
<thead>
<tr>
<th>Score Frequency</th>
<th>Multimedia Group</th>
<th>Control Group</th>
<th>( d )</th>
</tr>
</thead>
<tbody>
<tr>
<td>M(SD)</td>
<td>5.56(.99)</td>
<td>4.78(.98)</td>
<td>.000***</td>
</tr>
</tbody>
</table>

Note: M=Mean; SD=Standard Deviation.

\*\*\*p<.001
Table 5

Means, Standard Deviations for the Multimedia Group and Control Group, Males and Females.

<table>
<thead>
<tr>
<th>Measures</th>
<th>Multimedia</th>
<th>Control</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>1. Independent</td>
<td>4.87</td>
<td>.65</td>
<td>4.84</td>
<td>.61</td>
</tr>
<tr>
<td>2. Interdependent</td>
<td>4.94</td>
<td>.61</td>
<td>5.02</td>
<td>.57</td>
</tr>
<tr>
<td>3. Asian Value</td>
<td>4.44</td>
<td>.37</td>
<td>4.51</td>
<td>.57</td>
</tr>
<tr>
<td>4. Social Support</td>
<td>2.93</td>
<td>.43</td>
<td>3.02</td>
<td>.35</td>
</tr>
<tr>
<td>5. EAC</td>
<td>5.31</td>
<td>.99</td>
<td>5.29</td>
<td>.88</td>
</tr>
<tr>
<td>6. Public-stigma</td>
<td>1.99</td>
<td>.43</td>
<td>2.01</td>
<td>.64</td>
</tr>
<tr>
<td>7. Self Stigma</td>
<td>2.03</td>
<td>.36</td>
<td>2.04</td>
<td>.33</td>
</tr>
<tr>
<td>8. Treatment</td>
<td>2.33</td>
<td>.51</td>
<td>2.03</td>
<td>.61</td>
</tr>
<tr>
<td>9. Attitude</td>
<td>2.86</td>
<td>.44</td>
<td>2.71</td>
<td>.42</td>
</tr>
<tr>
<td>10. Intention</td>
<td>3.70</td>
<td>.83</td>
<td>3.39</td>
<td>.90</td>
</tr>
</tbody>
</table>

Note: M=Mean; SD=Standard Deviation; Independent=Independent-Self; Interdependent=Interdependent-Self; Asian Value=Adherence to Asian Value; Social Support=Perceived Social Support; EAC=Expectation about Counseling; Treatment=Perceived treatment accessibility; Attitude=Attitude towards Counseling; Intention=Intention to Seek Help.

***p<.001, **p<.01, *p<.05
Table 6

Multivariate Analysis of Variance for Group, Gender, and Group X Gender

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>F</th>
<th>(\eta_p^2)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Within Subjects Effects</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group</td>
<td>6</td>
<td>2.29</td>
<td>.07</td>
<td>.037*</td>
</tr>
<tr>
<td>Gender</td>
<td>6</td>
<td>2.54</td>
<td>.08</td>
<td>.022*</td>
</tr>
<tr>
<td>Group X Gender</td>
<td>6</td>
<td>1.42</td>
<td>.05</td>
<td>.21</td>
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</tbody>
</table>

**Between Subjects Contrasts**

<table>
<thead>
<tr>
<th>Group</th>
<th>df</th>
<th>F</th>
<th>(\eta_p^2)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>EAC</td>
<td>1</td>
<td>.88</td>
<td>.005</td>
<td>.35</td>
</tr>
<tr>
<td>Public-stigma</td>
<td>1</td>
<td>.22</td>
<td>.002</td>
<td>.64</td>
</tr>
<tr>
<td>Self Stigma</td>
<td>1</td>
<td>.76</td>
<td>.00</td>
<td>.38</td>
</tr>
<tr>
<td>Treatment</td>
<td>1</td>
<td>6.00</td>
<td>.03</td>
<td>.014*</td>
</tr>
<tr>
<td>Attitude</td>
<td>1</td>
<td>4.77</td>
<td>.03</td>
<td>.03*</td>
</tr>
<tr>
<td>Intention</td>
<td>1</td>
<td>9.34</td>
<td>.43</td>
<td>.003**</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender</th>
<th>df</th>
<th>F</th>
<th>(\eta_p^2)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>EAC</td>
<td>1</td>
<td>4.13</td>
<td>.02</td>
<td>.04*</td>
</tr>
<tr>
<td>Public-stigma</td>
<td>1</td>
<td>.39</td>
<td>.00</td>
<td>.54</td>
</tr>
<tr>
<td>Self Stigma</td>
<td>1</td>
<td>.15</td>
<td>.00</td>
<td>.70</td>
</tr>
<tr>
<td>Treatment</td>
<td>1</td>
<td>1.10</td>
<td>.00</td>
<td>.30</td>
</tr>
<tr>
<td>Attitude</td>
<td>1</td>
<td>5.17</td>
<td>.03</td>
<td>.02*</td>
</tr>
<tr>
<td>Intention</td>
<td>1</td>
<td>9.89</td>
<td>.05</td>
<td>.002**</td>
</tr>
</tbody>
</table>

Note: EAC=Expectation about Counseling; Treatment=Perceived treatment accessibility; Attitude=Attitude towards Counseling; Intention=Intention to Seek Help.

***p<.001, **p<.01, *p<.05
Table 7

Hierarchical Multiple Regression Analysis on Effects of Cultural Contextual Variables, Treatment Condition, and Interactions of Treatment Condition and Each of the Cultural Contextual Variable on Each of the Counseling Specific Variable.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Block 1</th>
<th>Block 2</th>
<th>Block 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Traitability</td>
<td>Public-Significance</td>
<td>Traitability</td>
</tr>
<tr>
<td>Treatment Accessibility</td>
<td>EAC</td>
<td>Self-Stigma</td>
<td>Treatment Accessibility</td>
</tr>
<tr>
<td>Asian Value</td>
<td></td>
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<td>Asian Value</td>
</tr>
<tr>
<td>Treatment Condition</td>
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<td></td>
<td>Treatment Condition</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td>Gender</td>
</tr>
</tbody>
</table>

Note: Independent=Independent-Self; Interdependent=Interdependent-Self; Asian Value=Adherence to Asian Value; Social Support=Perceived Social Support; EAC=Expectation about Counseling; Treatment Accessibility=Perceived treatment accessibility; Attitude=Attitude towards Counseling; Condition=Treatment Condition.

**p < 0.05, ***p < 0.001, **p < 0.01, *p < 0.05
Table 8

Hierarchical Multiple Regression Analysis on Effects of Cultural Contextual Variables, Treatment Condition and Each of the Counseling Specific Variable, and Interactions of Treatment Condition and the Cultural Contextual Variable on Attitude

<table>
<thead>
<tr>
<th>Variable</th>
<th>Block 1</th>
<th></th>
<th>Block 2</th>
<th></th>
<th>Block 3</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Variable</td>
<td></td>
<td></td>
<td></td>
<td>Variable</td>
</tr>
<tr>
<td></td>
<td></td>
<td>β</td>
<td>t</td>
<td>ΔR²</td>
<td>β</td>
<td>t</td>
</tr>
<tr>
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<td>.85</td>
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<td>Interdependent</td>
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<td>-.29</td>
</tr>
<tr>
<td>Gender</td>
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<td>-1.29</td>
<td></td>
<td>Gender</td>
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<td>-2.01*</td>
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<td>Asian Value</td>
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<td>-.71</td>
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<td>Asian Value</td>
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<td>.32</td>
</tr>
<tr>
<td>Social Support</td>
<td>.07</td>
<td>.96</td>
<td></td>
<td>Social Support</td>
<td>.03</td>
<td>.34</td>
</tr>
</tbody>
</table>

|                   | Block 2 |            | Block 2 |            | Block 3 |            |
|                   |         | Variable   |         |            |         | Variable   |
|                   |         | β          | t       | ΔR²        | β       | t          | ΔR²       |
| Condition         | .16     | 2.30*      | .09     | Condition  | -.17    | -2.39*     | .09       |
| EAC               | .40     | 3.58***    |         | Public-stigma | -.47    | -3.57***   |          |

|                   | Block 3 |            | Block 3 |            |
|                   |         | Variable   |         |            |
|                   |         | β          | t       | ΔR²        |
| Condition X       | -.19    | -1.73      | .01     | Condition X | .25     | 1.97       | .02       |
| EAC               |         |            |         | Public-Stigma |        |            |

<table>
<thead>
<tr>
<th>Variable</th>
<th>Block 1</th>
<th></th>
<th>Block 2</th>
<th></th>
<th>Block 3</th>
<th></th>
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<tbody>
<tr>
<td></td>
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<td></td>
<td></td>
<td>Variable</td>
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<td>β</td>
<td>t</td>
<td>ΔR²</td>
<td>β</td>
<td>t</td>
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<tr>
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<td>.73</td>
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<td>-.65</td>
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<tr>
<td>Gender</td>
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<td>-2.45*</td>
<td></td>
<td>Gender</td>
<td>-.16</td>
<td>-2.17*</td>
</tr>
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<td></td>
<td>Asian Value</td>
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<td>-.12</td>
</tr>
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<td>Social Support</td>
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</table>

|          | Block 2 |            | Block 2 |            | Block 3 |            |
|          |         | Variable   |         |            |         | Variable   |
|          |         | β          | t       | ΔR²        | β       | t          | ΔR²       |
| Condition | .18    | 2.55*      | .13     | Condition  | .12     | 1.59       | .06       |
| Self-stigma | -.23  | -2.12*    |         | Treatment  | .20     | 2.03       |          |

|          | Block 3 |            |
|          |         | Variable   |
|          |         | β          | t       | ΔR²        |
| Condition X | -.16  | -1.57      | .01     | Condition X | -.01    | -.11*      | .00       |
| EAC Self-stigma |        |            |         | Treatment  |        |            |          |

Note: Independent=Independent-Self; Interdependent=Interdependent-Self; Asian Value=Adherence to Asian Value; Social Support=Perceived Social Support; EAC=Expectation about Counseling; Treatment=Perceived treatment accessibility; Attitude=Attitude towards Counseling; Condition=Treatment Condition; Attitude=Attitudes towards seeking counseling.

***p<.001, **p<.01, *p<.05
Table 9

Hierarchical Multiple Regression Analysis on Effects of Counseling Specific Variables, Treatment Condition and Attitude, and Interactions of Treatment Condition and Attitude on Intention.

<table>
<thead>
<tr>
<th>Variable</th>
<th>β</th>
<th>t</th>
<th>ΔR²</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Block 1</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EAC</td>
<td>.28</td>
<td><strong>4.39</strong>*</td>
<td>.15</td>
</tr>
<tr>
<td>Public-Stigma</td>
<td>.18</td>
<td>.2.71*</td>
<td></td>
</tr>
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<td>Self-stigma</td>
<td>.12</td>
<td>1.75*</td>
<td></td>
</tr>
<tr>
<td>Treatment</td>
<td>.05</td>
<td>.83</td>
<td></td>
</tr>
<tr>
<td><strong>Block 2</strong></td>
<td></td>
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<td></td>
</tr>
<tr>
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<td>.17</td>
</tr>
<tr>
<td>Attitude</td>
<td>.51</td>
<td><strong>5.60</strong>*</td>
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<td><strong>Block 3</strong></td>
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<tr>
<td>Condition X Attitude</td>
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<td>1.10</td>
<td>.01</td>
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</table>

Note: EAC=Expectation about Counseling; Treatment=Perceived treatment accessibility; Attitude=Attitude towards Counseling; Condition=Treatment Condition; Attitude=Attitudes towards seeking counseling; Intention=Intention to seek counseling. ***p<.001, **p<.01, *p<.05
Figure 4. The Pathway of the Help-Seeking Process with Bootstrapping Analysis of Mean Indirect Effects. *p < .05, **p < .01, ***p < .001.

**Diagram:**
- **Intention**
  - Influence
  - Perceived Need
  - Public Stigma
  - Self-Stigma
  - Asian Values
  - Gender
  - Perceived Social Support
  - Expectations About Counseling
  - Independent Self
  - Interdependent Self

**Significance Levels:**
- 1.00 > d
- 0.05 > d
- 0.01 > d
- 0.001 > d

**Path Coefficients:**
- 1.15
- 0.48
- 0.15
- 0.30
- 0.26
- 0.30
- 0.15

**Note:** The diagram illustrates the pathways and relationships between various factors influencing the help-seeking process, with significance levels indicated for each path.
APPENDIX A: CONSENT FORM

Title of Research
The Effectiveness of a Multimedia Intervention on Help-Seeking Process with a Chinese College Sample

Researchers:
Xiaoxia Song, M.S.          Ohio University, USA
Timothy Anderson, PhD       Ohio University, USA
Yufang, Bi, M.A.            Lixin University of Commence, Shanghai, China

You are being asked to participate in research. For you to be able to decide whether you want to participate in this project, you should understand what the project is about, as well as the possible risks and benefits in order to make an informed decision. This process is known as informed consent. This form describes the purpose, procedures, possible benefits, and risks. It also explains how your personal information will be used and protected.

Explanation of Study
This study is being done because we want to develop a video intervention to improve the utility of mental health services among college populations. It has been widely recognized that Chinese people are less likely to seek psychological services when they are distressed, but there are little study devoted to examine how Chinese people make decision in seeking professional help. We collaborate with the counseling center at Lixin University of Commence in this study.

If you agree to participate, you will be asked to read this consent form. You will be directed to watch a video and finish up some questionnaire.

You should not participate in this study if you are under the age of eighteen.

Your participation in this study will last about 60 minutes.

Risks and Discomforts
No risks or discomforts are anticipated

Benefits
This study is important to mental health field in that it aims to improve the utility of mental health service and provide psychoeducation about counseling.

This study is also meaningful in developing a culturally sensitive intervention for a Chinese population.

Individually, you may gain some knowledge about counseling process and counseling services in general.
Confidentiality and Records
Your study information will be kept confidential by the researchers at Psychology Department in Ohio University, USA.

Additionally, while every effort will be made to keep your study-related information confidential, they may be circumstances where this information must be shared with:

* Federal agencies, for example the Office of Human Research Protections, whose responsibility is to protect human subjects in research;
* Representatives of Ohio University (OU), including the Institutional Review Board, a committee that oversees the research at OU;

Contact Information
If you have any questions regarding this study, please contact the investigators of this study, Xiaoxia Song, xs167310@ohio.edu, Tim Anderson, andersot@ohio.edu Ohio University, and Yu-fang, Bi, phoenixbi@163.com, Lixin University of Commerce, Shanghai, China.

If you have any questions regarding your rights as a research participant, please contact Jo Ellen Sherow, Director of Research Compliance, Ohio University, (740)593-0664.

By agreeing to participate in this study, you are agreeing that:

• you have read this consent form (or it has been read to you) and have been given the opportunity to ask questions and have them answered
• you have been informed of potential risks and they have been explained to your satisfaction.
• you understand Ohio University has no funds set aside for any injuries you might receive as a result of participating in this study
• you are 18 years of age or older
• your participation in this research is completely voluntary
• you may leave the study at any time. If you decide to stop participating in the study, there will be no penalty to you and you will not lose any benefits to which you are otherwise entitled.

(Version date: 2/15/2015)
知情同意书

研究题目
针对大学生人群的录像干预以提高寻求心理咨询动机

研究者
Xiaoxia Song M.S.        Ohio University, USA
Timothy Anderson, PhD, Ohio University, USA
Yufang Bi, M.A.           Lixin University of Commence, Shanghai, China

你被邀请参加此项研究。在决定是否要参加这个研究之前，有必要先让你了解这个项目的内容，可能的受益或风险。这个过程称为知情同意。这个表格是要解释研究的目的，过程，可能的受益或风险。这个表格也会解释你的个人信息会如何被使用和保存。如果你有什么问题，可以向研究者提出来，这以后，如果你觉得可以，请你在最后签名。这样你才可以参加这个研究。

对研究的解释
我们做这个研究是为了开发一个提高人们寻求心理咨询服务动机的录像干预。中国人群相对于其他人群更少寻求心理咨询帮助。目前对于中国人群寻求心理咨询帮助的决策过程的研究非常少。这个研究我们与上海立信会计大学心理咨询中心合作。

如果你同意参与，你会被邀请读这个知情同意书。研究者会引导你看一段录像并完成一些问卷。
如果你小于 18 岁，你不能参加这项研究。

这些问卷需要 60 分钟左右完成。

风险和不适
没有任何风险和不适。

益处
这个研究对心理治疗研究领域来说很重要，因为它会针对中国人特殊的文化背景发展一套干预录像，以此提高人们对心理咨询的了解和寻求咨询的动机。

对于个人来说，你可以增加对心理咨询的了解，并了解自己对心理咨询的期望。

保密和档案管理
你的信息会保存在美国俄亥俄大学心理系的研究人员那里。所有信息都保密。

另外，我们会尽我们所能保证你的信息是保密的，除了以下几种情况：
• 联邦代理，比如人类研究保护办公室，他们的职责是保护人类研究中参与者的权益。
• 俄亥俄大学的代表，包括项目审批委员会，这是个审查所有俄亥俄大学开展的研究。

联系方式
如果你对这个研究有任何问题，请联系俄亥俄大学研究人员 Xiaoqie Song: xs167310@ohio.edu.

如果你对自己的权益有任何问题，请联系 Ellen Sherow，美国俄亥俄大学研究审核主任。电话 001－740－593－0664
APPENDIX B: INTERVENTION SCRIPT

Clip One

0-6s: Title
The purpose of this video is to give you some general information about therapy or counseling and to dispel common misconceptions.

Ohio University Psychotherapy and Interpersonal Research Lab, U.S.A.
Shanghai University of Commence, Counseling Psychological Services

6s-60s: Narratives in Chinese
Many people are not familiar with the way that counseling works, and therefore can go into their first counseling session not knowing what to expect, from either the therapist or themselves. Other people have worries or concerns about what exactly will happen during the session, for example, worries about confidentiality, the therapist, or how to talk about their problem. Of course, not every therapy session will be the same, and not every therapist will use the same techniques. However, this program will provide general information that you may find useful.

We would also like to demonstrate some ways to make the most of your time should you ever seek counseling services. In the first part of the video, there will be two interviews from a college students with counselors. In the second part of the video, we will demonstrate some psychotherapy sessions and explain some important components in psychotherapy.

Interview One
Student: I usually just talk to my friends or family about my problems. I don’t know if it is necessary for me to talk to a stranger counselor.

Therapist: That’s great that you have friends and family that you feel safe to talk to. They are definitely great resources and support, especially when we are distress. So I would encourage you to use these resources if you have. But sometimes there are situations that you may feel difficult talking to them.

Student: That’s right. Especially when coming to college, I feel it harder to communicate with my parents and they don’t understand me most of the time. Sometimes I do feel I have to keep things to myself.

Therapist: You’re not alone in feeling this way. There are some issues you may feel hard to talk to your family or close friends, and counselor might be a better option. There are some differences between counseling and talking to a friend. First off, you and counselor will collaboratively identify the treatment goals, task, and interventions. Secondly, professional counselor can offer an objective perspective, which may help you gain some insights in your problems that you may hard to get from your friends or family. Thirdly,
you and counselor can target specific problems and practice new skills in therapy.
Fourthly, you can express some feelings that you may feel hard to express to your family and close friends. By expressing and exploring those feelings, you may grow yourself.

Interview Two

Student: I feel like it is only those with severe mental illness will see counselor. I feel like it is a personal weakness or inadequacy to see a counselor. I am concerned how other people would look at me if they know I talk to a counselor.

Therapist: It’s normal that you feel that way. After all, counseling is still relatively new in China and a lot of people have many misconceptions about counseling. Actually, in countries, like in U.S., where counseling and psychotherapy have been well-developed, counseling center in university usually very busy and students feel comfortable to talk to their concerns or problems to counselor. Some students just want to grow themselves through counseling.

Student: Oh, that’s interesting. What kind of problems do they present to counselor?

Therapist: The presenting problems that students coming for counseling are primarily on interpersonal problems, academic problems, relationship problems, or other adjustment issues. It is rare we see those with severe mental illnesses such as schizophrenia.

Student: That’s good to know. It seems that many of the issues that you just mentioned are very common in normal students. I remember that I cried several days in the first month coming to college. It is just such a new environment. I easily got so nervous in meeting new people or when having an exam. Do you mean we can even just talk to a counselor for these kinds of problems?

Therapist: Absolutely. To see a counselor is not a sign that you have severe mental problems, instead, it is a sign of a positive attitude that you are proactively seeking help and solving problem. Maybe you can get some enlightenment in therapy and find that the problems that you have are treasure to your life. Maybe you gain new perspectives about yourself and other people by working with counselor on the “irrational thoughts” that you have. Counseling could be an intimate internal journey with yourself. You may find your inner wisdom through this journey.

Video Intervention

1-45s:
Title:
Psychotherapy Sessions
Note: The client in this video is an actor, not a real client.
Narratives:
Next, we have some clips that are a re-enactment of a real therapy session. Therapist and client will demonstrate psychotherapy process and we will explain some important components in psychotherapy.

In the first clip, the clip will show how therapist and client discuss issues in the first session. In the first session, it usually consists of a more structured interview so that the therapist can get some background information on the client. After that, the focus of the therapy sessions will be on the tasks and goals the client and therapist created together. Many clients may not be expecting to have an assessment interview during the first session.

45s

First Session

Therapist: How are you?

Client: How are you?

Therapist: How do you feel about coming here?

Client: Nervous. I was anxious if anyone that I know is going to recognize me when in the waiting room. I am concerned if anyone is going to know the problems that I am struggling with.

Therapist: I understand it maybe anxiety-provoking. It’s a sign of strength that you decide to step out and ask for help. Is it your first time coming to talk to a counselor?

Client: Yes

Therapist: I’d like to stress a few things before we start. First, what we talk here just stay here. Today’s session will be a bit different than the future sessions. It will be more structured, but in the future sessions, I will encourage you to take a lead. Today, I will ask you a bunch of questions trying to get to know you better. Also, I would like to explain a bit about confidentiality. How much do you know about confidentiality?

Client: None

Therapist: Well, what we talk here just stay here except for a few conditions. If we suspect that you are at risk of hurting yourself or killing yourself, or hurting others, Or if I receive a court order, I will have to break confidentiality. Any questions?

Client: Will you report to my teachers?
Therapist: Without your permission, we will not disclose any of your information that you talk to me. If anyone calls in to ask if you are our client, we will not say “no” or “yes.”

Client: Will you tell my parents?

Therapist: No. Since you are beyond 18, we will not disclose any of your counseling information to your parents. I will also not talk about you to my colleagues without your permission. It is very important that you feel safe in counseling.

Client: I don’t really care if you share my information with others

Therapist: But it’s important for me to respect your privacy. It’s important to ensure your sense of safety in our relationship.

Client: Got it

Therapist: If you feel ok, I would want you to sign this disclosure form.

2:57-3:20s Narratives
Confidentiality
One of the biggest issues can be confidentiality. Clients may be confused about the extent of privacy in the session. This confusion may lead clients to be more guarded during initial sessions. The relationship that exists between the client and therapist is a confidential one. The therapist cannot break that confidentiality unless it is clear that the client intends to hurt his or her self or someone else. That means that the therapist will not discuss whatever the client says later when they go home with their families, or while they are having lunch with their colleagues, or disclose to your teachers that you are in therapy, unless you sign a release consent form. It is recommended that you discuss with therapist about confidentiality in your first session.

3:20S-
Therapist: So today I am going to ask you some questions related to your presenting concerns and your background information. What brings you here today?

Client: I have been feeling down lately, couldn’t feel alseep, my grades have dropped a lot

(An Hour Later)

Therapist: From what we talked about so far, your symptoms seem fit with diagnoses of Major Depressive Disorder and Generalized Anxiety Disorder. Anything else important?

Client: These are the major problems
Therapist: Any treatment goals in your mind?
Client: To make me feel happier
Therapist: image that you made a good progress in therapy after 6 months, how would you image your life is going to be?
Client: It will take 6 months? I thought I just need to come here for once or twice
Therapist: so you think I will give you some quick “fix”
Client: Yes, that’s what I thought
Therapist: I want to clarify that we are different than a medical doctor who give you prescriptions and you might just need a quick visit with. In psychotherapy, we might take quite some time to work through some problems. Based on what we just talked about today, I suggest that we meet at least 10-15 times.
Client: Oh, I didn’t know this before coming here.

4:56-6:35s
Narratives
Treatment Expectations
Some clients may enter therapy with unrealistic expectations regarding the outcome of therapy. For example, some client may expect therapist offer quick solutions to “fix” their problems and some even expect that they don’t need to come back after one session. A client may wish to change the behavior of someone else. Some clients may wish to find methods to fix someone else’s problem without looking within. Other clients may worry that fundamental aspects of their personality will be changed. Clients need to be aware that the focus will be on themselves, and can be reassured that any changes will be mutually agreed-upon between client and therapist.

Many clients have different worries or concerns regarding therapy that are not addressed during the first session, either because they are not discussed by the therapist, or the client is too shy to voice these concerns. For instance, before coming to therapy, some clients may believe that only “crazy” people go to therapy. Such clients may wonder if they are also “crazy” or if something is seriously wrong with them for seeking therapy. However, as you can see from this video clips, a lot of psychological problems, such as anxiety and depression are closely related to our interpersonal relationships with people in our life, like our family and friends.

Clients may also wonder about possible causes of psychological problems. This could include how and why problems can develop. Clients may not realize that some disorders have organic causes, while other disorders are actually normal reactions to stress or trauma. It may relax the client to know they are not necessarily responsible for the development of their disorder, and they can feel reassured to know that it can be treated. Worries or concerns of this nature should be brought up and discussed with the therapist.

6:36s-
Therapist: Get back to my last question: how would you image your life is going to be like after a few months?
Client: I would feel happier, my relationship with my parents would get better, and I would have motivation to study.
Therapist: Is it accurate to say that your treatment goals include, your depression and anxiety can be alleviated, your relationship with your parents will be improved, and you will be more productive in study?
Client: That’s accurate
Therapist: Then we can set these as our treatment goals

7:22-8:06s Narratives
Treatment Goals
Establishing goals early in the session is a key aspect of successful therapy. Therapists can use their expertise to help you sort out problems and establish treatment goals. However, working collaboratively with the therapist to establish these goals can make it clear to the client that their involvement is a necessary component for good therapy outcomes. With this knowledge, the client may become a more active participant in therapy. This is related to better outcomes in therapy.

8:06S- Session Two
Therapist: Like I said in our first meeting, I would like to have you take initiatives in therapy. Where would you like to begin with today?
Client: I’m not sure-what do you think would be best? You’re the expert, you can tell me. I need more direction from you.
Therapist: I have a couple of ideas to share with you, but I think it would work best if I heard yours first.
Client (impatiently) If I knew what to do, I’d just do it and wouldn’t ask you or be coming here to see you! I also really want you to tell me what my problems are and tell me how to fix them.
Therapist: Sounds like you want me to give you a direct and quick fix.
Client: That’s right. Shouldn’t it be like going to see a medical doctor? The doctor listens to my concerns and prescribes me medication. I also think you are just like a teacher who can tell me what to do.
Therapist: I’m glad that you share that with me. I want to clarify a few things here. Unlike in your relationship with a medical doctor, our relationship can be more you-centered, which means that I will make effort in understanding you and you help me to understand you as well. It’s a collaborative teamwork.
Client: Oh (pauses, looks confused)
Therapist: In our first meeting, I took a lead and guided you, as there was a lot of information that I needed to provide for you. But in the future sessions, I will encourage you to take more initiatives in terms of the topics that you want for us to talk about in session. I would encourage you to tell me the things that matter most to you, and I will join you, so then we can figure things out together.

Client: Oh, that’s something new to me. I don’t really know what to do. It makes me nervous.

Therapist: All right, let’s swap ideas. You tell me what you think is going on; then I’ll tell you what I see occurring; and lets see what we can put together.

Client: Like I just said, I don’t know—I don’t really have any ideas.

Therapist: Let’s wait for just a minute and see if anything comes to you. If not, I’ll be happy to go first and start us off.

Client: (20s pause). Well, maybe I’m afraid of being alone or something like that.

Therapist: That’s interesting and fits with what I’m thinking about. Tell me more about what it means to be “alone.” It sounds important.

Client: I think I’ve always been worried about that.

Therapist: From other things you’ve said, it makes me wonder if your parents cut off from you emotionally whenever you disappointed them by doing what you wanted rather than what they expected. I wonder if that created the feeling of being all alone, even though others were physically present— which would have been very confusing to a child. I mean, it could be confusing that your parents provide you with money and everything, but you still feel very alone.

Client: Yeah, I think that’s right, and the worst thing about it was that it seemed like it was all my fault. They work so hard so they can provide me with enough money and take care of me. I am the only child in my family, and I know they really center around me. They always tell me that “don’t worry about money, just study hard, so that you could become a doctor and have a good career in the future. As long as you study hard, we will work hard for you.” I feel like they really have sacrificed so much for me. I am afraid that I have really disappointed them. You see my grades just go down in the past year and I do not have motivation to study much. I’m really afraid that I bring shame to my parents. I’m also afraid that they are going to leave me or punish me if I let them down.

Therapist: Wow, that sounds very difficult and confusing to you. I think you have very good ideas, but something seems to hold you back from expressing them in the strong way you have just been doing with me. I have noticed that happening in here with me sometimes, and I hear it in your relationships with others as well. I wonder if there is
some connection between holding yourself back in this way and being afraid of being left. What comes to mind as I suggest this?

Client: Yeah, it feels wrong to express my emotions to my parents, you know, they have really worked hard and scarified so much for me, and I should not complain about. But you know, it’s also hard to live with them, and I feel so bad about myself.

Therapist: It sounds like you’ve had a difficult time with your parents. What’s been the hardest thing for you?

12:45-14:25s Narratives
Roles and Therapeutic Relationship
One of the most important aspects of therapy is the relationship that develops between the client and the therapist. The relationship that develops has the potential to affect the outcome of therapy. Clients sometimes are not sure how they are supposed to act in their role as “client” or “patient” in therapy. Clients also may not understand the nature of the work that is done or the therapist’s role in the sessions. Clients sometimes do not know what to expect from the therapist, or what kind of treatment they will receive.

In a medical setting, patients present problems and it is medical doctor’s job to make diagnoses and prescribe medication. Therefore, in the relationship with a medical doctor, the patient’s role is relatively passive by describing problems and being compliant to medications.

However, unlike in a medical relationship, in a therapeutic relationship, clients are encouraged to actively involve in the process of therapy, including discussion of the diagnosis, treatment goals, and interventions. Discussing these issues with the therapist can help the clients evaluate whether therapy is right for them. In addition, unlike in a medical relationship, in a therapeutic relationship, you can get practice in relating openly and honestly to another person within the counseling relationship. You may expect counselor or therapist be a “real” person not just a person doing a job. You may expect counselor to respect you as a person, and be warm and friendly toward you. Therefore, therapist’s role could be as an expert in their field, but you can expect that your relationship with them is not hierarchical and you can expect to be able to express your feelings and thoughts freely.

Session Seven

Client: Do you know how hard it is to live with an angry, demanding mom who keeps trying to tell me what to do all the time?

Therapist: You’re very angry at her. And I can see why; it would be hard to have someone after you like that. Tell me, how do you respond to her when she is doing this?
Client: I don’t know; I just hate it. I guess I yell back sometimes or just try to get away from them. It’s not just her, you know; her whole family is like that.

Therapist: They really are very critical of you, and I can image how hard that would be to live with. But it seems like criticism, in particular, really gets under your skin. What’s it like for you to be criticized so much?

Client: I hate it. I just hate it. They make me feel like I can’t do anything right—that I’m doing it wrong and failing all the time.

Therapist: “Doing it wrong and failing”—Ouch! Sounds like her constant criticism taps into your own painful feelings about yourself of not measuring up or not being enough. And having those shameful feelings of inadequacy aroused all the time could be infuriating.

Client: Yeah, I hate them for making me feel this way. If I could just make her stop, everything would be OK.

Therapist: This is very important for you, and we need to work together on it. I would like to understand better what you do when they criticize, so that I can help you learn some more assertive, limit-setting responses. But your own feeling of not measuring up is also a part of this problem that we need to work on, too, so that you can stop charging at the red flag they are waving. If we can change the internal part of you that overreacts, as if you believe what they are saying is true, it would be much easier for you to handle this than it has been in the past.

Client: What do you mean, “overreacts?”

Therapist: Sounds like their criticism makes you feel you can never do anything right. Is that accurate?

Client: Yes, but that’s not true. They just expect too much, and I can’t do it all. I can never do it good enough for them.

Therapist: I believe you—no matter what you do, they will never be pleased. But I don’t think that’s the whole problem—their expectations still upset you so much. It’s the way you end up feeling inside, about yourself, that becomes the bigger problem.

Client: Yeah, maybe so.

Therapist: So being able to work on your feelings about yourself would be helpful?

Client: I see what you mean, but I am not sure what to do.

Therapist: Tell me more about your feeling of not measuring up.
Client: Well, I guess I’ve always sort of felt like I’m not really good enough.

Clip Two: Video Intervention

I-30s Narratives

Openness

In the clip you just watched, client demonstrated how to openly share his feelings and thoughts with therapist. It is essential for clients to give as much information as possible about the reason for their visit. This helps the therapist to understand what the client is worried about. It is helpful for clients to share everything they can about their problems, including details and background information. It is not necessary for clients to know exactly what is bothering them. Still, clients should share any information that they do have. Clarification of details is very helpful to the therapist. In that way, therapist can use their knowledge and expertise to help you understand yourself better. Therefore, the communication between you and therapist is a two-way street and you can help therapist to use their expertise to help you.

31s: Session Ten (This should be “Session eight.” I will correct this error later)

3:06-3:48s

Ethics

Client: So you are saying that we can be closer than I thought about the medical relationship? Do you mean we can go out to have a cup of tea after session?

Therapist: That’s a really good question. I am glad that you bring this up. Therapists are not allowed to form a personal friendship with clients. The main reason is that we want to protect clients’ best interest. We do not want to break confidentiality rule. Also, by maintaining professional boundaries is very necessary for us to maintain objectivity, which is cruxical in counseling.

Client: That makes sense.

Therapist: Related to this, we try to avoid dual relationships, which means that I try not to see someone you know. I would discourage you if you want to introduce me to see one of your friends.

Client: Oh, this is not expected. But I guess it actually is helpful, so that we won’t make things complicated.

Therapist: Right. It’s important to maintain this professional boundary, so we can ensure to grow a relationship with trust and safety.

Narratives

Ethics: This clip also showed that therapist's practice with professional ethics. There are guidelines that all psychologists must follow when treating clients. In order to behave in an ethical or appropriate manner, a therapist may not have a romantic or
any other kind of relationship with a client outside of therapy. This also means that therapists should not treat family members or close friends. Therapists should always behave in a professional manner with their clients. Their responsibility to the client is that of a listener and to serve as a guide for the client. Therapists who behave in an unethical manner should be reported to the proper authorities.

3:49s

Session Ten

Therapist: It seems like something going on for you right now. I wonder what’s happening?

Client: You know, this doesn’t sound very nice to say, but I don’t think my mother really wants me to change very much. I don’t think she’s a mean person or anything, but I do think I’m getting better in therapy, and she’s not completely happy about that.

Therapist: How so?

Client: Well, I haven’t been depressed for a while now, and I’ve actually been feeling pretty good the last month or so. Maybe it’s just coincidence, but it seems that, as I’ve gotten better, my mother has withdrawn and been harder to talk to. And I think this has gone on between us before.

Therapist: You know, I think you are right. You have been doing very good work in here and getting better, and that may be kind of hard for your mother sometimes.

Client (fidgets, begins picking at her nail, and then starts talking about another topic)

Therapist: Maybe something just made you feel a bit uncomfortable?

Client: I don’t know. How much time is left?

Therapist: I’m wondering if something we’re talking about, or something that might be going on between us, could be making you uncomfortable right now?

Client: (pauses) well, I don’t really know why I’m saying this, but maybe I’m afraid that you’re going to go away or something?

Therapist: That sure makes sense to me. We were just talking about how your mother seems to act hurt and withdraws when you are feeling stronger, and I just told you that I thought you were doing very good work in here.

Client: Well, I guess so, but that just makes things worse. You’re not going to stay with me either if I get better—isn’t that the point of this whole therapy thing anyway?

Therapist: That sounded important, but I didn’t understand it as well as I wanted to. Can you say that again or say it differently?
Client: If I get better, then we stop—just like with my mother. Then I won’t have my mother, or you, or anybody. Don’t you see? It’s helpless.

Therapist: You’re saying this so clearly. I didn’t understand at first, but you’re right—the issue we are struggling with right now is like what’s gone wrong before. To feel better and act stronger has meant that you had to be alone. In the past, you have had to be sad and depressed and needy in order to be close or connected to others. I think you’ve been struggling with this dilemma most of your life, and right now, it feels like it has to be the same old strong again for you and me.

Client: Yeah, it does.

Therapist: But I wonder if you and I can do this differently for once. Can we work together and try to find a way to make it come out better this time?

Client: It’s not working very well so far.

Therapist: Well, one difference I’m thinking about is that we’re talking about it—naming it and sharing it— and that hasn’t happened before.

Client: What difference does that make?

Therapist: Maybe it’s different because I can see what’s happening for you and get how discouraging it’s been for you to be undermined in this way so many times. And right now, I’m still feeling connected to you—still for you—as you are changing this and acting stronger in here with me.

Client: Well, that’s probably true, but these doesn’t really seem like huge differences to me.

Therapist: OK. I see these differences as more significant than you do right now, but let’s keep talking about this.

Client: Why? What’s the point?

Therapist: If you can stop holding yourself back in here with me, and find that everybody doesn’t have to respond the same way your mother does, it will help you act stronger with others in your life. Like your girlfriend, and your professor, and others we’ve been talking about.

Client: Do you really think that could happen?

Therapist: Yes, I do. How do you think your girlfriend will respond to you if you let yourself be as smart with her as you are in here with me? Would she be threatened, like
your mother has been and some others in your life will be, or would he enjoy that nice part of you, as I do and some others would?

9:32-10:05s Narratives
Safe Environment
In this video you saw a client who had concerns about abandonment. These kinds of feelings are common in therapy. In fact, one purpose of therapy is for clients to have a safe place to disclose such personal feelings. Clients need to know that they can share personal aspects of their lives without fear of being judged by the therapist. The therapist may make suggestions, but those comments are not absolutes. If the client can trust the therapist to not judge them, then they can be more relaxed in therapy, and perhaps more open to suggestions that the therapist might make. This would hopefully facilitate better communication between the client and therapist.

10:13S
Slide One and Two
If you have the following symptoms, you can seek counseling:

Feeling lonely, feeling down
Headache, be irritable, sleep problems
Academic problems, difficulty concentrating
Interpersonal distress
Relationship problems
Addict to internet
Panic attack
Loss of your loved one
Suicidal ideation
Feeling lost

Slide Two
How do you seek counseling?

Slide Three
Shanghai University of Commerce, Counseling Psychological Services
2nd Floor Room 211, 213
T: 67705045/67705455

Slide Four
Fee: Free to students

Slide Five
How to make an appointment?
-Phone: 67705045/67705455
-Walk-In (8:30-4:30, M-F)
If you need crisis intervention, please dial 4001619955

录像
Section One

这个录像带主要用于普及心理治疗和心理咨询知识，澄清我们对心理治疗的一些常见误解。

每个人在一生中都可能经历一些困难。如果你长期感到很孤独，想找个人分享你的感受和想法，但又觉得很难找到可以谈心的人，你可以考虑找心理咨询师谈谈。

如果你刚入学不久，觉得很难适应学校的新环境，或与室友处不好，或感到没有以前那样快乐了，或感到总想哭，易怒，孤单，或想退学，你可以考虑找心理咨询师谈谈。

如果你的成绩一直下降，无法专心看书，或者在某些科目上遇到难题，除了找你的老师或导师，你可以考虑找心理咨询师谈谈。

如果你在处理人际关系上遇到难处，心情低落，不知如何处理与男朋友或女朋友的关系，或刚分手情绪低落，你可以考虑与心理咨询师谈谈。

如果你和父母经常有冲突，以致你周末都不想回家；如果你和你的男朋友／女朋友，室友，同学，导师，或其他重要的人物有冲突；如果这种情况已经严重影响你的日常生活，或导致你无法集中注意力学习，你可以考虑与心理咨询师谈谈。

如果你由于学业，个人生活中的难处，人际关系问题而导致压力过大，你可能会有以下症状：头痛，易怒，睡眠障碍，过度焦虑，考试焦虑。你可以考虑跟心理咨询师谈谈。

如果你对未来职业该选择什么方向感到迷茫，或对于是否要申请出国犹豫不决，或不知去哪里找合适的实习单位或工作单位，除了可以跟职业咨询师谈谈之外，你也可以考虑跟心理咨询师谈谈。

无论你为什么样的事情而困扰，如果你感到内心痛苦矛盾，这些负面情绪若超过两周以上，你可以考虑跟心理咨询师谈谈。

如果你沉迷于网络，花了很长时间打游戏，花越来越少的时间跟家人朋友在一起，这种情况如果超过几周的花，建议你跟心理咨询师谈谈。

如果你有恐惧障碍，比如说，在人群中或商场会惊恐发作，出现以下症状：呼吸困难，冒汗，心跳加速。这种情况的话，建议你跟心理咨询师谈谈。

如果你沉迷于烟酒，网络，或暴饮暴食，建议你跟心理咨询师谈谈。
如果你为一些与性有关的问题而困扰，或者你被人强迫发生性行为，跟心理咨询师谈谈可能会对你有帮助。如果你刚刚失去亲人，跟心理咨询师谈谈也许会有帮助。如果你经历过创伤，经常有噩梦，担心那些可怕的事情会再次发生，或常常觉得想哭，建议你跟心理咨询师谈谈。

如果你在吃精神科的药物，你也可以同时跟心理咨询师谈。研究表明，精神科方面的药物和心理咨询结合，可以有效提高疗效。

如果你觉得你跟周围大多数人的关系都有问题，或你觉得你的个性不适合任何一个团体或组织，或你觉得其他人总在你背后说你坏话；或者你尽量避免与其他人交往，因为你怕别人会挑你的刺；如果你跟那些跟你亲近的人总是关系紧张；或者你经常用刀或其他的方式伤害自己；如果你经常莫名其妙感到极度痛苦，以上这些情况，长期的心理咨询会帮助你自我成长。

如果你发现自己对活动失去了兴趣，经常难过哭泣，或听到一些奇怪的声音，或有一些奇怪的想法，甚至想自杀，建议你立即联系心理咨询中心。

如果你发现你周围的人，比如说你的同学，朋友，有以上症状，你可以建议他们去找心理咨询师。

Section Two
Session 1

治疗师：你好
来访者：你好
治疗师：这是你第一次来心理咨询吗?
来访者：是的
治疗师：感觉怎么样呢?
来访者：很紧张。在等候室时都很怕碰到熟人
治疗师：你愿意跨出第一步寻求帮助，是一种勇气的表现。今天的会面与以后的治疗会面会相对不同。今天主要是结构化的面谈。我会问你一些问题，收集你的信息。然后，我们会讨论治疗的目标和方案。在以后的咨询面谈中，我会主要让你来主导。
来访者：好的
治疗师：首先，我会先介绍保密原则。我们今天所谈的内容会保密。除非以下几种情况：1）如果你有自杀或要伤害其他人的意向 2）如果我们收到法院传票，需要我们出庭作证或提供书面材料。
来访者：那你会告诉我的老师和父母吗?
治疗师：你已经是 18 岁以上成人。你若没有跟我们签订一份知情同意书，同意我们泄露你的信息给某个特定的人，我们不会打破保密原则。
来访者：哦，这样。其实我真的不介意的你向别人泄露我的信息。
治疗师：但我还是要尊重你的隐私权。在我们的关系中，你能否觉得安全很重要。
还有别的问题吗？
来访者：没有了。
治疗师：我需要你在这份保密协议上签名。
（来访者签名）

治疗师：你为什么今天决定来这里？
来访者：最近总也睡不着觉，情绪很低落，做什么都提不起劲
。。。。。

the end

治疗师：你今天所陈述的症状看起来象是抑郁症和焦虑症。你谈到的你与父母的关系也很紧张，让你很烦躁。你也谈到学业也很不顺。还有其他的吗？
来访者：主要就是这些。
治疗师：那你决定你来这里主要达到的目的是什么呢？
来访者：让我心情好起来。
治疗师：你可以想象治疗结束后，比如 6 个月之后，你的状况会是怎么样？
来访者：啊，你是说要 6 个月才行吗？我还以为一两次就好了。
治疗师：你希望我给你简洁快速地治疗？
来访者：是啊。
治疗师：这里我想解释一下：心理治疗通常是个缓慢地改变过程。如果你能找到那些简洁快速的办法，估计你早已经找到了，也不需要来这里了。有些问题，需要我们一次又一次地讨论，通过一些技巧的训练，才能慢慢得到改善。我想，根据你的状况，如果我们可以持续会面大概 10—15 次或以上，疗效会更好。
来访者：哦，这个还真是没想到。
治疗师：回到刚才的问题：如果几个月后，你的问题有了很大的改善，你想象自己的生活会是什么样子？
来访者：我的心情不会抑郁或焦虑了。我的学业也会有些改善。跟父母能更好地相处。
治疗师：所以，你的治疗目标是改善你的抑郁和焦虑症状。另外，你希望你的学业有进步；改善与父母的关系。
来访者：你说的很对。

Session 2:
治疗师：就象我在第一次会面时提到的，今后的治疗会面，我会让你来主导。让你决定会面的内容。你今天希望我们怎么样开始呢？

来访者：我不知道。你认为我们该怎么样开始呢？你是专家，你来告诉我。我需要你的引导。

治疗师：怎么样开始，我有一些想法，但我想先听听你的想法。

来访者：（很不耐烦的）如果我知道该怎么做，我也就不需要来这里了。我很想让你来告诉我，我的问题出在哪里，告诉我解决方案。(停顿 10s)。你让我主导，这让我很紧张。

治疗师：好，这样吧：你可以告诉我你在想什么，然后我会给你反馈，然后我们一起讨论该怎么开始。

来访者：就象我刚刚说的，我真的不知道该怎么开始。

治疗师：这样吧，你可以花一分钟的时间想想看，有哪些事情你想让我们一起谈。如果一分钟以后你还是想不出来，我会跟你分享我的想法。

来访者（沉默 20 分钟）。恩，也许可以谈谈，我总是害怕孤单。

治疗师：哈，这跟我想的差不多。孤单对你意味着什么呢？这个看起来毕竟重要。

来访者：我想，我总是担心自己会变得孤独，孤单。

治疗师：你上次提到说，但你做了自己想做的事，而不是父母想让你做的事，或者做了其他让他们失望的事，你父母总是不跟你说话。我不知道那样会不会也让你产生一种很孤单的感觉。就像有一群人在身边，但你觉得本质上还是孤身一人的。

来访者：是的。是这么回事。最糟糕的是，那种情况下，我总觉得是我自己的错。我父母工作那么辛苦，赚很多钱来供养我。我是家里唯一的孩子，全家人都很关心我，包括我爷爷奶奶外公外婆。他们总是告诉我：“你只要用功读书，其他事就不用管了，只要你将来读好书，变成医生或博士，我们再怎么努力辛苦都值的。”我觉得，他们真的为我牺牲了很多。

治疗师：听起来，你好笑感到很内疚。

来访者：是的。我现在学习没什么动力，成绩一直下降，又睡不好觉，觉得对不起父母。我都怕让父母丢脸。如果我再这样下去，我父母可能就更不高兴了。
治疗师：哇，听起来你感到非常内疚，也很困惑。你现在能跟我这样直白地表达，但你好像很难向你父母表达这些情感。我不知道这跟你说的害怕孤独是否有什么联系。你有什么想法吗？

来访者：是的。我觉得如果我这么直白地向父母表达，总觉得哪不对劲，好像大逆不道的样子。我爸妈真的已经很辛苦了，我真觉得不好意思这样说抱怨。但另一方面，我又觉得与他们在一起也很累。我真觉得这样挺糟糕的。

治疗师：好像与父母的相处有些困难。什么是其中最让你觉得最难对付的？

Session 3
来访者：跟我妈相处真的觉得很累。她总是指手画脚的，告诉我该做这做那的。

治疗师：你对她感到很愤怒，这完全可以理解。当她那么做的时候，你都怎么回应？

来访者：不知道，我真的很痛恨她这么做。有时候，我就骂回去，或离她远点。她不是唯一一个这样的，我的整个家庭都差不多这样。

治疗师：他们对你总是批评不满，我可以想象，这样真的很难与他们相处。但听起来，好像他们的批评指责，让你真正觉得无法忍受。当他们批评指责的时候，你是怎么感受？

来访者：我痛恨死了，觉得很痛恨他们这么做。他们那么做的时候，让我觉得我只是做错事，总是失败。

治疗师：‘总是做错事，总是失败。’天，他们那样的指责好像让你感到自己不够好，总觉得不到他们的期望，这样会感到非常痛苦。这样成天感到很羞愧自责，真的让人很难忍受。

来访者：是的。我很痛恨他们让我感到这样。如果我可以让他们停止这么做，事情就会好很多。

治疗师：这个好像是一个很重要的问题。我们需要一起来搞清楚。我想了解，当他们指责你的时候，你一般如何回应，那样的话，我们可以学一些设立人际边界的技巧。但是，你感到自己不够好，总觉得不到你父母的期望，这部分也是我们需要在继续探讨的。这样就可以帮助你识别，自己是否反应过激。我的意思是说，他们指责你的时候，你就把他们说的那些当真了。
来访者：你说的“过激反应”是什么意思？

治疗师：好像他们的指责批评让你觉得你总是做错事，做得不够好。是这样吗？

来访者：是的。但也不完全是那样。他们总是对我期望太高，我做不到。我永远也达不到他们的标准。

治疗师：好像无论你如何努力，也无法完全取悦他们。这确实令人很郁闷的。但我想当他们那么做的时候，会让你产生对自己的怀疑和指责，那才是个更重要的问题。

来访者：是的，也许真是这样

治疗师：因此，我们继续探讨这些你内在对自己的感觉和想法也许会很有帮助

来访者：我明白了，但我不知道该怎么做。

治疗师：觉得无法满足你父母的标准，这是怎样的一种感受

来访者：恩，好像觉得自己总也不够好。

Session 6

治疗师：你表情比较凝重，发生什么事了吗？

来访者：哎，（叹气），这个说起来也很难为情，我觉得我妈并不希望我有任何改变，包括来看心理治疗。我不认为她是个刻薄的人，但我觉得，通过心理治疗，我心情慢慢变好了，但我妈反而不开心了。

治疗师：怎么说呢？

来访者：我最近一段时间心情不错，没有那么抑郁了。这个也许只是个巧合，但我觉得，当我好起来的时候，我妈反而对我越来越冷淡了。这样的事情以前也发生过。

治疗师：恩，我想你也许是对的。你在最近好像变得好很多了。这个改变也许对你妈来说比较难以面对。

来访者：（很不安，抓头皮，苦笑）男生来这里看心理咨询的多吗？
治疗师：你现在看起来很不安，刚才我们谈的内容让你觉得有些不舒服？

来访者：我不知道。还有多少分钟？

治疗师：我不知道是否是我们刚刚谈到内容让你觉得很不安，或者有些别的事情让你觉得很不安？

来访者（沉默 20s）：我真不知道我为什么要说这个，也许是，我担心你也会象我妈那样，当我好起来后，你就离开我了。

治疗师：我明白了。我们刚刚谈到，当你好起来之后，你妈好像觉得很受伤，并对你越来越冷淡了。而我刚刚正跟你说，你现在好像看起来很不错。

来访者：我猜是这样的。但我们之间更糟了。如果我变好了，我们的关系也就结束了。心理治疗不正是如此吗？

治疗师：你刚刚说的好像非常重要。我很想更清楚地理解你，你能再解释得更清楚一点吗？

来访者：如果我变好了，心理治疗就结束了。就像跟我妈的关系一样。那样的话，我就失去了你，还有我妈，还有其他人。你明白了吗？这让人很无助。

治疗师：哦，你这样说就很清楚了。我刚开始没有明白，但你说得对。我们现在在探讨的问题是，你在过去的关系模式中，那个地方出问题了。对你来说，如果你变好了，变得坚强了，这也意味着，别人就离开你了，剩下你孤单一人。在过去你的家庭关系中，你不得不变得很抑郁，很依赖，这样你才能与他们变得亲近。你已经在这样的关系模式中非常长的时间了。现在在你我之间，你的模式也影响我们的关系了。

来访者：是的。

治疗师：我在想，我们可以一起来面对这个问题，也许这次可以有些改善。

来访者：目前为止，我看不到有什么不同。

治疗师：有件事我们可以做的是，我们去识辨这个模式，并坦诚分享，相互分担。这是在你以前的关系模式中没有发生过的。

来访者：这会有什么改变呢？
治疗师：我想说的是，我现在可以理解是怎么回事了。我看到你是多么地沮丧，因为你过去这么长时间，你不得不陷入那种关系模式中。我现在觉得你可以感受到你的感受。你在做改变，你也变得更坚强。

来访者：也许确实那样，但这真的没让我觉得有什么很大的改变。

治疗师：好，我觉得你的改变比你所认为的更显著。

来访者：为什么？什么意思呢？

治疗师：如果在我们之间，你不再象在跟你父母那样掩饰你的情绪，然后你看到并非所有人都会象你父母那样回应你，这样会帮助你跟别人在一起的时候变得更坚强些，就像跟你的女朋友，跟你的老师，和所有那些我们谈到的人。

来访者：你真是认为那是可能的吗？

治疗师：是的。你觉得，如果你跟你女朋友之间，也像现在你对我做的那样，她会怎么反应？她也会象你妈那样因此对你而冷淡吗？其他人可能非常喜欢你这样做，就像我一样。

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**session 8**

来访者：我感到非常空虚。

治疗师：空虚？那对你来说是怎样的一种感受？

来访者：我不知道。我只是觉得内心空空的。

治疗师：你能找到一种办法来描述这种空虚的感觉吗？

来访者：（沉默 1 分钟）

治疗师：好像很难表达？也许你可以用形容词，或做一个动作来表达这种空虚感。当你有这种感受的时，你通常都与谁在一起？都发生了什么？

来访者：我只是觉得内心有个空洞，总也填不满。
治疗师：你觉得内心很空虚，没有任何东西可以填满那个空洞，包括与朋友聚会，喝酒，狂欢，那个洞一直在那里

来访者：（点头，流泪）

治疗师：我可以感受到这是一种很受伤的感觉。我感到很难过，那些事情发生，让你觉得这样孤独空虚。谢谢你愿意跟我分享这些

来访者：（哭）我只是觉得我有些问题。我一直这么认为

治疗师：哪些部分有问题？你能告诉我更多吗？

Session 13

来访者：谢谢你的帮助。我觉得治疗很有帮助。我有个朋友也是抑郁，经常跟父母吵架。我跟她提起你，推荐她也来找你咨询

治疗师：我也很享受与你一起治疗的时间。谢谢你的坦诚分享和信任。你提到朋友的事，我想解释一下的是：我们尽量避免发生双重关系。也就是说，我会尽量避免给你和你的朋友家人做咨询。这样做的主要目的是保护你的利益，同时，避免双重关系可以保护我在咨询中的客观性

来访者：哦，我还没想过这些问题

治疗师：我并不是要回拒你的好意。我们需要遵守咨询师伦理规范。这也包括，我们之间除了咨询关系，不能发展别的私人关系，比如说朋友关系

来访者：这样可以理解。我本来想说请你吃饭，想好好谢谢你。你这样一说，我也明白了

治疗师：对的，如果我跟你出去吃饭喝茶，像朋友一样，那样是不符合伦理规范的。
Directions

Pretend that you are about to see a counseling psychologist for your first interview. We would like to know just what you think counseling will be like. On the following pages are statements about counseling. In each instance you are to indicate what you expect counseling to be like. The rating scale we would like you to use is printed at the top of each page. Your ratings of the statements are to be recorded on the answer sheets provided. For each statement, darken the space corresponding to the number which most accurately reflects your expectations. Do not make any marks in the questionnaire booklet.

Your responses will be kept in strictest confidence. DO NOT fill in the NAME GRID or STUDENT NUMBER GRID on the answer sheet. Your answers will be combined with the answers of others like yourself and reported only in the form of group averages. Your participation, however, is voluntary. If you do not wish to participate in this research, just hand the questionnaire and unmark answer sheets back to the person in charge.

To complete the questionnaire properly, you need one answer sheet and a #2 pencil. Tell the person in charge if you do not have the necessary materials. When you are ready to begin, answer each question as quickly and as accurately as possible. Finish each page before going to the next.

NOW TURN THE PAGE AND BEGIN

ANSWER THE FOLLOWING QUESTIONS ON THE ANSWER SHEET

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<td>Very True</td>
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I EXPECT TO...

1. Take psychological test.
2. Like the counselor
3. See a counselor in training
4. Gain some experience in new ways of solving problems within the counseling process
5. Openly express my emotions regarding myself and my problem

I EXPECT TO...

6. Understand the purpose of what happens in the interview.
7. Do assignments outside the counseling interviews.
8. Take responsibility for making my own decisions
9. Talk about my present concerns.
10. Get practice in relating openly and honestly to another person within the counseling relationship.

I EXPECT TO...
11. Enjoy my interviews with the counselor.
12. Practice some of the things I need to learn in the counseling relationship.
13. Get a better understanding of myself and others.
14. Stay in counseling for at least a few weeks, even if at first I am not sure it will help.
15. See the counselor for more than three interviews.

I EXPECT TO...
16. Never need counseling again.
17. Enjoy being with the counselor.
18. Stay in counseling even though it may be painful or unpleasant at times.
19. Contribute as much as I can in terms of expressing my feelings and discussing them.
20. See the counselor for only one interview.

I EXPECT TO...
21. Go to counseling only if I have a very serious problem.
22. Find that the counseling relationship will help the counselor and me to identify problems on which I need to work.
23. Become better able to help myself in the future.
24. Find that my problem will be solved once and for all in counseling.
25. Feel safe enough with the counselor to really say how I feel.

I EXPECT TO...
26. See an experienced counselor.
27. Find that all I need to do is to answer the counselor’s questions
28. Improve my relationships with others.
29. Ask the counselor to explain what he or she means whenever I do not understand something that is said
30. Work on my concerns outside the counseling interviews.
31. Find that the interview is not the place to bring up personal problems

THE FOLLOWING QUESTIONS CONCERN YOUR EXPECTATIONS ABOUT THE COUNSELOR

I EXPECT THE COUNSELOR TO...
32. Explain what’s wrong.
33. Help me identify and label my feelings so I can better understand them.
34. Tell me what to do.
35. Know how I feel even when I cannot say quite what I mean.
I EXPECT THE COUNSELOR TO…
36. Know how to help me.
37. Help me identify particular situations where I have problems
38. Give encouragement and reassurance.
39. Help me to know how I am feeling by putting my feelings into words for me
40. Be a “real” person not just a person doing a job.

I EXPECT THE COUNSELOR TO…
41. Help me discover what particular aspects of my behavior are relevant to my problems.
42. Inspire confidence and trust.
43. Frequently offer me advice.
44. Be honest with me.
45. Be someone who can be counted on.

I EXPECT THE COUNSELOR TO…
46. Be friendly and warm towards me.
47. Help me solve my problems
48. Discuss his or her own attitudes and relate them to my problem.
49. Give me support.
50. Decide what treatment plan is best.

I EXPECT THE COUNSELOR TO…
51. Know how I feel at times, without my having to speak.
52. Do most of the talking.
53. Respect me as a person.
54. Discuss his or her experiences and relate them to my problems.
55. Praise me when I show improvement.

I EXPECT THE COUNSELOR TO…
56. Make me face up to the differences between what I say and how I behave.
57. Talk freely about himself or herself.
58. Have no trouble getting along with people
59. Like me
60. Be someone I can really trust

I EXPECT THE COUNSELOR TO…
61. Like me in spite of the bad things that he or she knows about me.
62. Make me face up to the differences between how I see myself and how I am seen by others.
63. Be someone who is calm and easygoing.
64. Point out to me the differences between what I am and what I want to be
65. Just give me information
66. Get along well in the world
Please answer the following questions about yourself. This information will be used in combining your responses with those of other people like you.

67. How old are you?
68. What is your gender?
   1. Male
   2. Female
69. Have you ever been to see a professional counselor?
   1. YES
   2. NO.

指导语
设想一下，你将第一次与咨询师见面。我们想了解你认为你的咨询会是什么样的？下面的题目都是关于心理咨询的描述，请根据你认为咨询应该是什么样的情况，为每个题目选择你的评分，并在相应的数字打“✓”，评分标准印在每页顶端。

您的回答将被完全保密，只用来和其他答卷一起进行统计处理。您的参与完全是自愿的，如果您不愿意参与此项研究，只要将问卷和答题纸还给老师就可以了。

开始答题时，请尽可能精确快速地回答每个问题，确保每页题目完全答完后，再进入下一页的答题。
现在答题开始：

1 —— 2 —— 3 —— 4 —— 5 —— 6 —— 7
不符合 轻微符合 有些符合 恰好符合 很符合 非常符合 完全符合

我期待

<table>
<thead>
<tr>
<th>我期待</th>
<th>不符合</th>
<th>轻微符合</th>
<th>有些符合</th>
<th>恰好符合</th>
<th>很符合</th>
<th>非常符合</th>
<th>完全符合</th>
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</thead>
<tbody>
<tr>
<td>1. 做心理测验。</td>
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<tr>
<td>2. 喜欢我的咨询师。</td>
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<tr>
<td>3. 去见一位正在接受专业培训的咨询师。</td>
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<tr>
<td>4. 在咨询中获得解决问题的新办法</td>
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<td>7</td>
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<tr>
<td>5. 对我自己和我的问题，能够敞开地表达我的情绪。</td>
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<tr>
<td>6.</td>
<td>能理解会谈过程和内容的目的。</td>
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<tr>
<td>7.</td>
<td>咨询之外，可以做咨询师布置的作业。</td>
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<tr>
<td>8.</td>
<td>对自己的决定负责。</td>
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<td>9.</td>
<td>谈论我现在的烦恼。</td>
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<tr>
<td>10.</td>
<td>在与咨询师互动，建立关系的过程中，体验敞开心扉，与他人坦诚相处的关系。</td>
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<td>2</td>
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<tr>
<td>11.</td>
<td>享受与咨询师的谈话。</td>
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<tr>
<td>12.</td>
<td>在与咨询师的互动过程中，练习一些我需要去学习的东西。</td>
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<tr>
<td>13.</td>
<td>更好理解自己和他人。</td>
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<tr>
<td>14.</td>
<td>在咨询初期，即使不确定咨询对我是否有帮助，我也愿意维持至少几个星期的咨询。</td>
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<tr>
<td>15.</td>
<td>见咨询师至少三次以上。</td>
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<td>16.</td>
<td>这次之后，再也不要心理咨询</td>
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<td>2</td>
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<tr>
<td>17.</td>
<td>享受和咨询师在一起的时间。</td>
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<td>3</td>
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<tr>
<td>18.</td>
<td>即使我感到痛苦和不愉快，我也愿意继续咨询。</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>19.</td>
<td>尽我所能表达和讨论我的感觉和情绪。</td>
<td>1</td>
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<tr>
<td>20.</td>
<td>只见咨询师一次就好。</td>
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<td>2</td>
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### 我期待

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<th></th>
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<th>有些符合</th>
<th>恰好符合</th>
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<th>完全符合</th>
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<tbody>
<tr>
<td>21.</td>
<td>只有当我出现严重的问题时才会寻求心理帮助。</td>
<td>1</td>
<td>2</td>
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<tr>
<td>22.</td>
<td>通过与咨询师的互动过程中，我和咨询师一起去发现我需要解决的问题。</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>23.</td>
<td>将来，我能更有能力处理自己的问题。</td>
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<tr>
<td>24.</td>
<td>通过这次咨询，能够一劳永逸地解决我的问题。</td>
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</tr>
<tr>
<td>25.</td>
<td>咨询师能够让我有足够的安全感，以至于我能告诉咨询师我的真实感受。</td>
<td>1</td>
<td>2</td>
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</tr>
</tbody>
</table>
26. 遇到经验丰富的咨询师。
27. 我唯一需要做的就是回答咨询师的问题。
28. 改善我与他人的关系。
29. 当我不理解咨询师所要表达的意思时，我可以随时要求咨询师解释。
30. 在咨询过程之外，我能继续思考如何改善我的问题。
31. 越心理咨询并不是一个适合讨论私人问题的地方。

<table>
<thead>
<tr>
<th>我期待咨询师</th>
<th>不符合</th>
<th>轻微符合</th>
<th>有些符合</th>
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<th>很符合</th>
<th>非常符合</th>
<th>完全符合</th>
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</thead>
<tbody>
<tr>
<td>32. 解释哪里出问题了。</td>
<td>1 2</td>
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<tr>
<td>33. 帮助我了解和定义我的感受，以便我更好地理解它们。</td>
<td>1 2</td>
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<td>4</td>
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<tr>
<td>34. 告诉我该怎么做。</td>
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<tr>
<td>35. 在我不能清楚表达自己的时候，咨询师也能够理解我的感受。</td>
<td>1 2</td>
<td>3</td>
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<tr>
<td>36. 知道如何帮助我。</td>
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<tr>
<td>37. 帮助我认识我的问题所在。</td>
<td>1 2</td>
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<tr>
<td>38. 给我鼓励和安慰。</td>
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<tr>
<td>39. 把我的情绪用文字表达出来，以便我理解我的感受。</td>
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<tr>
<td>40. 是一个真诚的人，而不是仅把咨询当作一份工作的人。</td>
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<tr>
<td>41. 帮助我发现行为举止中所表现出来的问题所在。</td>
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<tr>
<td>42. 激发我的信心和对他人的信任感。</td>
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<td>43. 经常给我建议。</td>
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<tr>
<td>44. 与我以诚相待。</td>
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<tr>
<td>45. 是一位我可以信赖的人。</td>
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<table>
<thead>
<tr>
<th>我期待咨询师</th>
<th>不符合</th>
<th>轻微符合</th>
<th>有些符合</th>
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<th>非常符合</th>
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<tbody>
<tr>
<td>46. 对我的态度友好而温和。</td>
<td>1 2 3 4 5 6 7</td>
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<tr>
<td>47. 帮我解决我的问题。</td>
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<tr>
<td>48. 表达他/她对我的问题所持的态度和立场。</td>
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<td>49. 给我支持。</td>
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<tr>
<td>50. 决定哪个治疗计划是最好的。</td>
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<tr>
<td>51. 即使我没有告诉他/她，他/她也经常能知道我的感受。</td>
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<tr>
<td>52. 多数话由他/她来讲。</td>
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<tr>
<td>53. 将我当作“人”来尊重。</td>
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<tr>
<td>54. 讨论他/她自己的经验，并将他/她的经验和我的问题联系起来。</td>
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<td>55. 当我有进步的时候表扬我。</td>
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<td>56. 让我面对我言行不一致的地方。</td>
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<td>57. 轻松地谈论他/她自己。</td>
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<td>58. 没有与人相处的麻烦。</td>
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<td>59. 喜欢我。</td>
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<tr>
<td>60. 是一位能够让我非常信任的人。</td>
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<tr>
<td>61. 他/她尽管知道了一些不好的事情，仍然喜欢我。</td>
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<tr>
<td>62. 让我看到我对自身的看法和别人对我的看法不一致的地方。</td>
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<tr>
<td>63. 是一位沉静随和的人。</td>
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<tr>
<td>64. 指出我现在的状态和我的目标状态之间的差别。</td>
<td>1 2 3 4 5 6 7</td>
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<tr>
<td>65. 仅仅给我提供信息。</td>
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<tr>
<td>66. 在生活中，与他人相处融洽。</td>
<td>1 2 3 4 5 6 7</td>
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</tbody>
</table>

下面是关于你的个人信息的一些问题，请放心，你的回答将会和其他人的回答一起集中进行数据处理。

67. 你的年龄____

68. 你的性别：
   1. 男性
   2. 女性

69. 你以前有过看心理咨询师的经历吗？
   1. 是  2. 否
Please rate the likeliness that you would see a therapist if you were experiencing one of the following problems.

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<th></th>
<th>Very Unlikely</th>
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<th>Unlikely</th>
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<th>Somewhat Unlikely</th>
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<th>Somewhat Likely</th>
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<td>2</td>
<td>Excessive alcohol use</td>
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<td>Relationship difficulties</td>
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<td>Concerns about sexuality</td>
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<td>Depression</td>
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<td>17</td>
<td>Loneliness</td>
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假设你正在经历以下困难时，请评估你去看心理咨询师的可能性有多大。

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<tr>
<td>1. 体重控制。</td>
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<td>2. 过度饮酒</td>
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<td>3. 人际关系困难</td>
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<td>4. 和性有关的烦恼</td>
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<td>5. 抑郁</td>
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<td>6. 和父母的冲突</td>
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<td>7. 演讲焦虑</td>
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<td>8. 约会困难</td>
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<td>9. 专业选择</td>
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<td>10. 睡眠问题</td>
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<td>11. 毒品问题</td>
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<td>12. 自卑感</td>
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<td>13. 考试焦虑</td>
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<td>15. 学术拖延症</td>
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<td>16. 对自我的理解</td>
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<td>17. 孤独</td>
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APPENDIX E: ATTITUDES TOWARDS SEEKING PROFESSIONAL PSYCHOLOGICAL HELP: A SHORTENED FORM

Please circle the number corresponding to your level of agreement with the following statements.

1. If I believed I was having a mental breakdown, my first inclination would be to get professional help.
   
   Agree  Partly Agree  Partly Disagree  Disagree
   0  1  2  3

2. The idea of talking about problems with a therapist strikes me as a poor way to get rid of emotional conflicts.
   
   Agree  Partly Agree  Partly Disagree  Disagree
   0  1  2  3

3. If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in therapy.
   
   Agree  Partly Agree  Partly Disagree  Disagree
   0  1  2  3

4. There is something admirable in the attitude of a person willing to cope with his or her conflicts and fears without resorting to therapy.
   
   Agree  Partly Agree  Partly Disagree  Disagree
   0  1  2  3

5. I would want to go to a therapist if I were worried or upset for a long period of time.
   
   Agree  Partly Agree  Partly Disagree  Disagree
   0  1  2  3

6. I might want to see a therapist in the future.
   
   Agree  Partly Agree  Partly Disagree  Disagree
   0  1  2  3

7. A person with an emotional problem is not likely to solve it alone; he or she is likely to solve the problem with the help of a therapist.
   
   Agree  Partly Agree  Partly Disagree  Disagree
   0  1  2  3

8. Considering the time and expense involved in therapy, it would have doubtful value for a person like me.
   
   Agree  Partly Agree  Partly Disagree  Disagree
   0  1  2  3

9. A person should work out his or her own problems; seeing a therapist would be a last resort.
   
   Agree  Partly Agree  Partly Disagree  Disagree
   0  1  2  3

10. Personal and emotional troubles, like many things, tend to work out by themselves.
    
    Agree  Partly Agree  Partly Disagree  Disagree
    0  1  2  3
关于寻求专业心理帮助的态度，请在符合你情况的数字上划圈。

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<thead>
<tr>
<th></th>
<th>同意</th>
<th>基本同意</th>
<th>基本不同意</th>
<th>不同意</th>
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<tbody>
<tr>
<td>1. 如果我认为我正经历心理上的崩溃，我的首要选择是寻求专业帮助。</td>
<td>1</td>
<td>2</td>
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<tr>
<td>2. 通过与心理治疗师讨论，来摆脱情绪困扰，对我来说是一个糟糕的处理方式。</td>
<td>1</td>
<td>2</td>
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<tr>
<td>3. 如果在我现在的生活中，经历严重的情绪危机，我相信通过心理治疗获得缓解。</td>
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<td>2</td>
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<tr>
<td>4. 如果一个人<strong>不需要</strong>求助治疗也能处理他／她的内心冲突和恐惧，这样的状态是令人钦佩的。</td>
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<tr>
<td>5. 如果我经历长期的焦虑或抑郁，我会找一个心理治疗师。</td>
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<tr>
<td>6. 在将来，我觉得我可能会去见心理治疗师。</td>
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<tr>
<td>7. 一个人的情绪问题，是不太可能独自解决的，他或她很可能需要在专业治疗师的帮助下解决这个问题。</td>
<td>1</td>
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<tr>
<td>8. 考虑到心理治疗所投入的时间和费用，对我来说，心理治疗是否值得，是令我怀疑的。</td>
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<tr>
<td>9. 一个人应当自己解决困扰，见治疗师是万不得已的办法。</td>
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<tr>
<td>10. 像许多其他事情一样，个人的情绪困扰随着时间推移，会自然而然地解决了。</td>
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APPENDIX F: STIGMA SCALE FOR RECEIVING PSYCHOLOGICAL HELP

(SSRPH)

1. Seeing a therapist for emotional or interpersonal problems carries public-stigma.
   - Strongly Disagree
   - Disagree
   - Agree
   - Strongly Agree
   - 0
   - 1
   - 2
   - 3

2. It is a sign of a personal weakness or inadequacy to see a therapist for emotional or interpersonal problems.
   - Strongly Disagree
   - Disagree
   - Agree
   - Strongly Agree
   - 0
   - 1
   - 2
   - 3

3. People will see a person in a less favorable way if they come to know that he/she has seen a therapist.
   - Strongly Disagree
   - Disagree
   - Agree
   - Strongly Agree
   - 0
   - 1
   - 2
   - 3

4. It is advisable for a person to hide from people that he/she is in therapy.
   - Strongly Disagree
   - Disagree
   - Agree
   - Strongly Agree
   - 0
   - 1
   - 2
   - 3

5. People tend to like those who are in therapy.
   - Strongly Disagree
   - Disagree
   - Agree
   - Strongly Agree
   - 0
   - 1
   - 2
   - 3

接受心理帮助的污名量表，请在符合你的情况上划圈

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<tr>
<th></th>
<th>十分不同意</th>
<th>不同意</th>
<th>同意</th>
<th>十分同意</th>
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<tbody>
<tr>
<td>1. 因情绪或者个人问题寻求专业帮助会带来他人耻笑。</td>
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<tr>
<td>2. 因情绪和个人方面的问题去见心理咨询师，这是个人软弱无能的标志。</td>
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<tr>
<td>3. 一个人如果去过心理咨询师，人们会因此这个人气将降低喜爱程度。</td>
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<tr>
<td>4. 对于个人来说，最好不要对告诉别人，他/她正在接受心理治疗。</td>
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<tr>
<td>5. 人们可能会喜欢正在寻求心理治疗的人。</td>
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APPENDIX G: SELF-STIGMA OF SEEKING HELP SCALE ITEMS

INSTRUCTIONS: People at times find that they face problems that they consider seeking help for. This can bring up reactions about what seeking help would mean. Please use the 5-point scale to rate the degree to which each item describes how you might react in this situation.
1=Strongly Disagree
2=Disagree
3=Agree & Disagree Equally
4=Agree

1. I would feel inadequate if I went to a therapist for psychological help.
2. My self-confidence would NOT be threatened if I sought professional help.
3. Seeking psychological help would make me feel less intelligent.
4. My self-esteem would increase if I talked to a therapist.
5. My view of myself would not change just because I made the choice to see a therapist.
6. It would make me feel inferior to ask a therapist for help.
7. I would feel okay about myself if I made the choice to seek professional help.
8. If I went to a therapist, I would be less satisfied with myself.
9. My self-confidence would remain the same if I sought professional help for a problem I could not solve.
10. I would feel worse about myself if I could not solve my own problems.

接受心理帮助自我污名量表，请在符合你的情况上划圈

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<tr>
<th></th>
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<th>十分同意</th>
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<tbody>
<tr>
<td>1. 去看心理咨询师会让我会觉得自己无能。</td>
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<tr>
<td>2. 去看心理咨询师并不会影响我的自信心</td>
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<td>3</td>
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<tr>
<td>3. 去看心理咨询师会让我觉得自己不够聪明</td>
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<td>4. 去看心理咨询师会提高我的自尊心。</td>
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<tr>
<td>5. 因为我自己选择去看心理咨询师，因此，去看心理咨询师并不会改变我对自己的看法</td>
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<td>6. 去看心理咨询师会让我觉得自己低人一等</td>
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<tr>
<td>7. 如果是我自己决定去看心理咨询师，我会自我感觉良好</td>
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<td>3</td>
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<tr>
<td>8. 去看心理咨询师会让我对自己满意度降低</td>
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<tr>
<td>9. 对于自己不能解决的问题，去寻求专业帮助并不会影响我的自信心</td>
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<tr>
<td>10. 如果我不能自己解决问题，我会自我感觉更糟糕</td>
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APPENDIX H: SELF-CONSTRUAL SCALE (SCS)

Each statement write the number that best matches your agreement or disagreement, using the scale below.

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<th>6</th>
<th>7</th>
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<tbody>
<tr>
<td></td>
<td>Strongly Disagree</td>
<td>Somewhat Don’t Agree</td>
<td>Somewhat Agree</td>
<td>Strongly Agree</td>
<td>and/or Disagree</td>
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<tr>
<td>1</td>
<td>I enjoy being unique and different from others in many respects</td>
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<td>2</td>
<td>I feel comfortable using someone’s first name soon after I meet them</td>
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<td>3</td>
<td>Even when I strongly disagree with group members, I avoid an argument</td>
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<td>4</td>
<td>I have respect for the authority figures with whom I interact</td>
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<td>5</td>
<td>I do my own thing, regardless of what others think</td>
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<td>6</td>
<td>I respect people who are modest about themselves</td>
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<td>7</td>
<td>I feel it is important for me to act as an independent person</td>
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<td>8</td>
<td>I will sacrifice my self-interest for the benefit of the group I am in</td>
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<td>9</td>
<td>I’d rather say “no” directly than risk being misunderstood</td>
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<td>10</td>
<td>Having a lively imagination is important to me</td>
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<td>I should consider my parents’ advice when making education/career plans</td>
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<td>12</td>
<td>I feel my fate is interwined with the fate of those around me</td>
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<td>I prefer to be direct and forthright when dealing with people I’ve just met</td>
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<td>14</td>
<td>I feel good when I cooperate with others</td>
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<td>15</td>
<td>I am comfortable with being singled out for praise or rewards</td>
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<td>16</td>
<td>If my brother or sister fails, I feel responsible</td>
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<tr>
<td>17</td>
<td>My relationships…are more important than my own accomplishments</td>
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<td>18</td>
<td>Speaking up during a class (or a meeting) is not a problem for me</td>
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<td>19</td>
<td>I would offer my seat in a bus to my professor (or my boss)</td>
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<td>20</td>
<td>I act the same way no matter who I am with</td>
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<tr>
<td>21</td>
<td>My happiness depends on the happiness of those around me</td>
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<tr>
<td>22</td>
<td>I value being good health above everything</td>
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<td>23</td>
<td>I will stay in a group if they need me, even when I am not happy with the group</td>
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<td>24</td>
<td>I try to do what is best for me, regardless of how that might affect others</td>
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<td>25</td>
<td>Being able to take care of myself is a primary concern for me</td>
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<tr>
<td>26</td>
<td>It is important to me to respect decisions made by the group</td>
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<tr>
<td>27</td>
<td>My personal identity, independent of others, is very important to me</td>
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<tr>
<td>28</td>
<td>It is important for me to maintain harmony within my group</td>
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<tr>
<td>29</td>
<td>I act the same way at home that I do at school</td>
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<tr>
<td>30</td>
<td>I go along with what others want…even when I would rather do something different</td>
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自我建构量表（SCS），请在符合你的情况的数字划圈

请使用以下的评分标准，在每一题的前面写上符合你判断的数字。

1——>2——>3——>4——>5——>6——>7

强烈不同意 不同意 有些不同意 不表达同意或不同意 有些同意 比较同意 强烈同意

1. 我喜欢自己的独特性和在很多方面与他人的不同。
2. 在第一次遇到某人后就对其直呼其名，对此我感到很自然。
3. 即使我很不同意组员的观点，我也会避免争论。
4. 我对所接触到的权威人物充满敬重。
5. 我做我自己想做的事，不管别人是怎么想的。
6. 我尊敬谦虚的人。
7. 为人处世中，作为一个独立的个体，对我来说是很重要的。
8. 我愿意为我所在的集体的利益，牺牲我个人的兴趣。
9. 我宁愿直接说“不”，也不愿意被人误解。
10. 拥有广泛的想象力对我来说很重要。
11. 当我制定教育/职业规划时，我应考虑父母的建议。
12. 我感到我的命运是和身边人的命运息息相关的。
13. 与初次见面的人打交道，我偏向于直接坦率的表达方式。
14. 当我与他人合作时，我感到愉快。
15. 当被点名表扬或奖励时，我感到很自在。
16. 假如我的兄弟姐妹失败了，我会感到对此负有责任。
17. 我的人际关系比我自己的成就更重要。
18. 在课堂（会议上）站起来讲话对我来说不是问题。
19. 在公交车上，我会将我的座位让给我的老师（或老板）。
20. 不论和谁在一起，我表现如一。
21. 我的快乐取决于我身边人是否快乐。
22. 我认为健康是最重要的事情。
23. 即使我在一个团体中并不开心，但只要团体成员需要我，我便会呆在那里。
24. 我会做对我自己有利的事情，无论那样会对别人有什么影响。
25. 照顾好自己是最重要的。
26. 对我来说，尊重团体的决定很重要。
27. 我个人的身份认同，我独立于他人的那部分，对我来说是很重要的。
28. 团队的和谐，对我来说是重要的。
29. 我在学校和在家里表现如一。
30. 即使我其实想要做其它的事情，我也会附和别人的需要。
APPENDIX I: ASIAN VALUES SCALE (AVS)


Instructions: Use the scale below to indicate the extent to which you agree with the value expressed in each statement.

1=Strongly disagree
2=Moderately disagree
3=Mildly disagree
4=Neither Agree nor disagree
5=Mildly agree
6=Moderately agree
7=Strongly agree

----1. Educational failure does not bring shame to the family
----2. One should not deviate from familial and social norms
----3. Children should not place their parents in retirement homes
----4. One need not focus all energies on one’s studies
----5. One should be discouraged from talking about one’s accomplishments.
----6. One should not be boastful.
----7. Younger persons should be able to confront their elders.
----8. When one receives a gift, one should reciprocate with a gift of equal or greater value.
----9. One need not follow one’s family’s and the society’s norms.
----10. One need not achieve academically in order to make one’s parents proud.
----11. One need not minimize or depreciate one’s own achievements.
----12. One should consider the needs of others before considering one’s own needs.
----13. Educational and career achievements need not be one’s top priority.
----14. One should think about one’s group before oneself.
----15. One should be able to question a person in an authority position.
----16. Modesty is an important quality for a person.
----17. One’s achievements should be viewed as family’s achievements.
----18. Elders may not have more wisdom than younger persons.
----19. One should avoid bringing displeasure to one’s ancestors.
----20. One need not conform to one’s family’s and the society’s expectations.
----21. One should have sufficient inner resources to resolve emotional problems
----22. Parental love should be implicitly understood and not openly expressed.
----23. The worst thing one can do is to bring disgrace to one’s family reputation.
----24. One need not remain reserved and tranquil.
----25. The ability to control one’s emotions is a sign of strength.
----26. One should be humble and modest.
----27. Family’s reputation is not the primary social concern.
----28. One need not be able to resolve psychological problems on one’s own.
----29. Following familial and social expectations are important.
----30. One should not inconvenience others.
----31. Occupational failure does not bring shame to the family.
32. One need not follow the role expectations (gender, family hierarchy) of one’s family.
33. One should not make waves.
34. Children need not take care of their parents when the parents become unable to take care of themselves.
35. One need to control one’s expression of emotions.
36. One’s family need not be the main source of trust and dependence.

Note. Permission to use the Asian Values Scale must be obtained from Bryan K. Kim.

19. 你应该尽量不要亵渎你的祖先
20. 你不需要一定得遵从家庭和社会的期望
21. 你应该有足够的内在力量来解决情绪问题
22. 父母的爱应该含蓄表达，不要太外露
23. 让家人丢面子是件很糟糕的事
24. 你不需要含蓄保守
25. 能够控制情绪是一种能力
26. 你应该谦虚谨慎
27. 家庭的声望并不是社会最关注的焦点
28. 你不需要自己解决自己的心理问题
29. 顺从家庭和社会的标准很重要
30. 你不应该麻烦别人
31. 事业的失败不会让家庭蒙羞
32. 你不需要遵从家庭所定义你的角色，比如，你的性别，家庭等级
33. 你不应该三心二意
34. 当父母无法照顾他们自己的时候，儿女并没有义务要照顾他们的父母
35. 你应该控制你的情绪表达
36. 家庭并不一定是你可以信任和依靠的最主要的资源
APPENDIX J: PERCEIVED TREATMENT ACCESSIBILITY

Instruction: Use the scale below to indicate the extent to which you agree with the value expressed in each statement.
1=Yes
2=Not sure
3=No

1. Do you know where to seek professional psychological help?
2. Is it easy for you to find a place that provides counseling services if you need?
3. Do you think it is affordable for you to see a therapist?

治疗途径量表。请在符合你情况的数字划圈

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<thead>
<tr>
<th></th>
<th>是的</th>
<th>不确定</th>
<th>不是</th>
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<tbody>
<tr>
<td>1. 如果需要的话，我知道哪里可以寻求心理咨询</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>2. 如果需要的话，我很容易就可以找到可以提供心理咨询 的地方去寻求帮助</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>3. 费用上，我觉得心理咨询是我承担得起的。</td>
<td>1</td>
<td>2</td>
<td>3</td>
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APPENDIX K: INTERPERSONAL SUPPORT EVALUATION LIST-12

Instructions: Use the scale below to indicate the extent to which you agree with the value expressed in each statement.
1=Definitely false
2=False
3=True
4=Definitely true

1. If I wanted to go on a trip for a day (for example to the beach, the country or mountains), I would have a hard time finding someone to go with me.
2. I feel that there is no one I can share my most private worries and fears with.
3. If I were sick, I could easily find someone to help me with my daily chores.
4. There is someone I can turn to for advice about handling problems with my family.
5. If I decide one afternoon that I would like to go to a movie that evening, I could easily find someone to go with me.
6. When I need suggestions on how to deal with a personal problem, I know someone I can turn to.
7. I don’t often get invited to do things with others.
8. If I had to go out of town for a few weeks, it would be difficult to find someone who would look after my house or apartment (the plants, pets, garden, etc.)
9. If I wanted to have lunch with someone, I could easily find someone to join me.
10. If I was stranded 10 miles from home, there is someone I could call who could come and get me.
11. If a family crisis arose, it would be difficult to find someone who could give me good advice about how to handle it.
12. If I needed some help in moving to a new house or apartment, I would have a hard time finding someone to help me.

人际帮助量表：在符合你情况的数字上划圈
指导语：用以下量表表达你对下列陈述的同意程度

1=绝对不是的
2=不是的
3=是的
4=绝对是的

1. 如果我想出门旅行一天（比如去海边，乡村，或爬山），我很难找到人与我同行
2. 我觉得没有人可以分享我最私密的担忧和恐惧
3. 如果我生病了，我很容易找到人帮助我料理日常事务
4. 如果我跟家人有矛盾，我可以找到人寻求意见和帮助
5. 如果我某天下午，我决定晚上要去看电影，我很容易找到人陪我去
6. 如果我有人际关系的问题，我知道找谁去寻求建议和帮助
7. 我不是经常被别人邀请
8. 如果我必须得离家几个星期，我很难找到人照看我的房子和家务（比如植物，宠物，花园等）
9. 如果我想找人共进午餐，我很容易找到人
10. 如果在离家 10 公里外抛锚，我可以打电话叫人来带我回家
11. 如果有家庭危机，我很难找到人给我好的建议和意见来帮助我处理家庭危机
12. 如果我要搬到新家，我很难找到人来帮助我。
APPENDIX L: QUIZ

Please identify whether the following statements are true or false

1. It is unethical if the counselor share my information with his spouse.
2. Counselor is very similar to a medical doctor. He/she is expected to offer me quick solutions to fix my problems in the first session.
3. It is not appropriate to correct counselor when you think his/her statements are not accurate.
4. Only those who get serious problems go to see counselor
5. I can make a friend with the counselor outside of therapy, like inviting him/her to have a cup of coffee.
6. It’s primarily counselor’s job to tell me what treatment goals and treatment plans that I need to follow through.
7. It is free to seek counseling services at the counseling center on campus.

如果你认为以下陈述正确，请“T”上划圈。如果你认为以下陈述错误，请在”F”上划圈

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<tbody>
<tr>
<td>1.</td>
<td>咨询师如果把我的个人信息与他／她的伴侣分享，那是违反咨询伦理守则的</td>
<td>T</td>
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<td>2.</td>
<td>咨询师就像医生一样，在第一次咨询的时候，他们通常会给予一些快速有效的建议来处理我的问题</td>
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<tr>
<td>3.</td>
<td>当你觉得咨询师说的或做得不对时，你可以直接指出他／她</td>
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<td>4.</td>
<td>只有那些有严重精神问题的人才去看心理咨询师</td>
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<tr>
<td>5.</td>
<td>我可以跟咨询师做朋友，比如邀请他／她去喝咖啡</td>
<td>T</td>
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<tr>
<td>6.</td>
<td>关于咨询的目标和咨询计划，这些主要由咨询师来决定</td>
<td>T</td>
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<tr>
<td>7.</td>
<td>学校里的心理咨询中心对本校学生是免费的</td>
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