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PREDICTORS OF TREATMENT ACCEPTABILITY, WILLINGNESS TO SEE A COUNSELOR, AND COUNSELOR PREFERENCES FOR ASIAN AMERICANS AND WHITES: ACCULTURATION, LOSS OF FACE, SELF-CONSTRUALS, AND COLLECTIVE SELF-ESTEEM

DISSERTATION

Presented in Partial Fulfillment of the Requirements for
the Degree Doctor of Philosophy in the Graduate School of
The Ohio State University

By

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* * * * *

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The purpose of this study was to increase knowledge regarding barriers to utilization of mental health services by Asian Americans through examination of the influence of cultural factors on counseling variables with Asian American college students. To that end, this study explored three previously unexamined or underexamined barriers to use of counseling services by Asian Americans.

It was hypothesized that between-groups comparisons on the three dependent variables of treatment acceptability, willingness to see a counselor, and counselor preferences would help answer the question of whether these were barriers to utilization for Asian Americans, as compared to Whites. In addition, within-group comparisons were designed to address the question of how these barriers manifested for Asian Americans. Four variables culturally-relevant for Asian Americans were examined in terms of their relationship to each of the barriers to counseling.

Specifically, the cultural variables in this study were: level of acculturation, sensitivity to loss of face, independent versus interdependent construals of the self, and collective self-esteem (how individuals feel about their membership in the racial/ethnic groups to which they belong). The counseling variables were treatment acceptability ratings for four types of treatments (individual cognitive-behavioral therapy, individual
client-centered therapy, group therapy, and family systems therapy), ratings of willingness to see a counselor for relationship, academic/career, and substance abuse problems, and preferences for a counselor similar on demographic characteristics or on cognitive characteristics.

Participants were 232 White university students and 215 Asian American university students. White participants were undergraduates enrolled in Introductory Psychology classes at The Ohio State University (OSU). Asian Americans were defined as individuals of Asian or Pacific Islander descent who were either U.S. citizens or U.S. Permanent Residents at the time of participation in the study. Of the total sample of Asian American participants, approximately half were undergraduate students in Introductory Psychology classes at OSU. The other half of the Asian American sample was drawn from classes with a high Asian American enrollment at two California universities.

Participants were administered questionnaire packets by the principal investigator of this study or an instructor in their class. Participants at OSU received partial credit toward their introductory psychology course for their participation. Participants from the California universities received extra credit in their psychology course for their participation.

Linear and multiple linear regression analyses were used to test hypotheses about the independent variables as predictors of each of the dependent variables. Support was provided for viewing treatment acceptability, willingness to see a counselor, and counselor preferences as barriers to utilization of mental health services for Asian Americans. However, there were mixed findings among the various cultural variables in terms of viewing them as predictors of each of the barriers to utilization. In general, no single
cultural variable consistently predicted variance in all dependent variables. The acculturation construct was, surprisingly, not a strong predictor. Similarly, loss of face was not a strong predictor of any counseling variables except counselor preferences. On the other hand, both self-construal and collective self-esteem were fairly strong predictors.

Results are discussed in light of the information they provide about barriers to utilization of mental health services by Asian Americans. Implications of this study's results for counselors and other providers of mental health services to Asian Americans are proposed. Directions for future research address both the limitations of the current study as well as ideas stemming from the findings in this study. Finally, limitations of the study are delineated.
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CHAPTER 1

INTRODUCTION

In this chapter, the conceptual framework for the present study is presented. Research on underutilization of mental health services by Asian Americans is first outlined. This is followed by an assessment of the need for research on three specific barriers to utilization, as well as an overview of several important cultural variables that explain within-group differences among Asian Americans. Last, the purpose of the present study is provided.

Cross-cultural and multicultural research has long been interested in the question of utilization of mental health services by members of racial/ethnic minority groups. This is evidenced by the large body of literature on Asian American patterns of service utilization and outcomes (see Cheung & Snowden, 1990; Hatanaka, Watanabe, & Ono, 1975; Leong, 1986; Sattler, 1977; D.W. Sue & Kirk, 1975; S. Sue, 1977; S. Sue & McKinney, 1975; S. Sue & D.W. Sue, 1974). In most of this research, “underutilization” is defined as a lower rate of mental health service use than expected when compared to a group’s prevalence in a population. Utilization of treatment, and relatedly, length of treatment, are
considered important because these factors are related to favorable treatment outcomes (Orlinsky, Grawe, & Parks, 1994).

A classic study on underutilization was conducted by S. Sue (1977), who examined community mental health centers in Seattle and found that Asian Americans had much higher premature termination rates than Whites. Underutilization has been documented in other settings as well, and is often found to be accompanied by differences in treatment length and outcomes. For example, Snowden and Cheung (1990) reviewed data from the National Institute of Mental Health and found that Asian Americans were not as likely to be hospitalized as Whites, but when hospitalized they remained longer than Whites.

Although there have been a few studies showing Asian Americans do not underutilize some types of mental health services (e.g., D.W. Sue & Kirk, 1975, found that Asian American students underused university psychiatric services, but overused university counseling center services), most studies show Asian Americans underutilize (S. Sue, Zane, & Young, 1994).

Researchers are confident that the problem of underutilization exists. For example, Uba (1994) states, "underutilization has been found in a variety of Asian American groups, with both students and adults, in both inpatient and outpatient facilities, at numerous mental health facilities . . . and over decades" (Uba, 1994, p. 196). S. Sue, Zane, and Young (1994) seem to agree with this assessment by stating that the most appropriate conclusion at this time is that ethnic differences exist in utilization patterns and not enough research has been conducted to explain the reasons.

Literature reviews have also addressed reasons for underutilization by Asian Americans. Leong (1986) found that underutilization seemed to result from the interactions
of both client and service provider variables. Examples of client variables would be: gender, acculturation, stage of ethnic identity, geographic location, and religious beliefs (Leong, Wagner, & Tata, 1995).

Another explanation advanced to explain underutilization by Asian Americans and other racial/ethnic minorities is that they have less need for mental health services than Whites. However, this explanation has been discredited. For example, in reviewing the research on the immigration experience, Leong (1986) found evidence that stresses associated with immigration contribute to mental health problems of Asian Americans. Some stresses may be related to war and violence in the native country, conflict between the culture immigrants are leaving and U.S. culture, racial/ethnic tension and discrimination in the new community, and economic disadvantages in terms of underemployment or unemployment (Atkinson, Morten, & Sue, 1993).

D.W. Sue and D. Sue (1990) also dispel the myth that Asian Americans are a "model minority" group who suffer from few mental health problems. They point out historic acts of discrimination whose legacies live on in race-based hate crimes perpetrated against Asian Americans today. In addition, they delineate the bimodal distribution of Asian Americans in terms of educational attainment and income such that some immigrants (especially Southeast Asians) live far below the poverty line. Third, Sue and Sue point out the existence of poverty-stricken ghettos such as Chinatowns and Manilatowns, where suicide rates can be three times as high as the national average (Jacobs, Landau, & Pell, 1971; cited in D.W. Sue & D. Sue, 1990).

Thus, there is little evidence that low rates of utilization are due to a lack of mental health problems among Asian Americans. In fact, ethnic minorities may have more need
for mental health services than Whites (Atkinson, Morten, & Sue, 1993). In addition, other racial groups, such as African Americans, have been found to overutilize inpatient mental health services (Snowden & Cheung, 1990). The underutilization of services is not easily explained by the idea that racial groups have fewer mental health problems.

Another hypothesis about underutilization by Asian Americans is that Asian cultural values may work against acknowledgement of and/or help-seeking for mental health problems (Atkinson, Morten, & Sue, 1993). Some Asian cultural values of note in this case include tendencies to attribute mental illness to biological, not psychological, causes (S. Sue, Wagner, Margulis, & Lew, 1976), as well as a tendency to express psychological symptoms by somaticizing (Leong, 1986).

According to Atkinson, Morten, and Sue (1993), however, the most salient explanation of ethnic minority underutilization of mental health services is that psychology as a profession has failed to meet the mental health needs of racial/ethnic minorities due to a lack of culturally relevant counseling. Culturally relevant counseling could take the form of matches between client and counselor on language, ethnicity, and values. It could also be evidenced by confronting racism among White trainees and training professionals in cultural sensitivity. Finally, culturally relevant counseling would incorporate a recognition that the sole focus on intrapsychic etiology of mental health problems is not inclusive of peoples for whom extrapsychic causes of problems (e.g., racism, discrimination) may be more salient (Atkinson, Morten, & Sue, 1993).

It is important that the problem of underutilization and premature termination by Asian Americans be understood so that counseling services can best be targeted toward this population and its needs. Because the Asian American population is the fastest growing
An ethnic minority group in the United States (Kitano & Maki, 1996), it is especially important that the mental health needs of this population be met. Understanding the barriers to Asian American utilization of mental health services can be a large part of this effort.

As researchers have gathered evidence that patterns of mental health service utilization differ both between and within racial/ethnic groups, the focus has turned to studying variables that may explain why there are lower rates of utilization or higher rates of premature termination or dropout (see Hu, Snowden, Jerrell, & Kang, 1993; Hu, Snowden, Jerrell, & Nguyen, 1991; S. Sue, Fujino, Hu, Takeuchi, & Zane, 1991). Among Asian Americans, some of the barriers to use of mental health services include cultural inhibitions against seeking mental health services, client suspiciousness, consumer ignorance of available services, lack of financial resources, geographic inaccessibility of services, and shortages of culturally-sensitive personnel (Uba, 1994).

In terms of research on barriers to utilization by Asian Americans, some areas of focus are more distal to the problem, while other areas are more proximal. The distal-proximal model (S. Sue & Zane, 1987) was proposed to explain that some factors (e.g., credibility of counselor) may be more closely related to goals, such as eradicating underutilization of services, than other factors. In fact, counselor credibility has been shown to be a strong predictor of utilization intent (Akutsu, Lin, & Zane, 1990) for Asian Americans. Thus, fruitful areas of inquiry into barriers to utilization of counseling services would be variables that are more proximally related to counseling.

One proximal barrier to use of mental health services that has not been studied is treatment acceptability. Kazdin (1980a) has defined treatment acceptability as the consumer's "evaluation of whether treatment is appropriate for the problem, whether
treatment is fair, reasonable, and unintrusive, and whether treatment meets with conventional notions about what treatment should be" (Kazdin, 1980a, p. 259). In addition to determining the efficacy of psychotherapies, or studying the satisfaction consumers feel about the psychotherapies they receive, it is important to also ask whether the treatments were ever acceptable to the consumer. Especially for Asian Americans, Western-style intrapsychic- and individual-focused treatment for mental health problems may not be deemed acceptable. There have been no studies that examine the acceptability of psychotherapy treatments for Asian Americans.

A second potential barrier to utilization of mental health services by Asian Americans is willingness to see a counselor for a particular problem. That is, Asian Americans may have different standards than Whites in terms of whom they will seek therapy from and for what issues they will seek therapy. It may be that some types of problems are not viewed as appropriate for help from a counselor, or perhaps counselors are not the help sources that Asian Americans think of when they have certain types of problems. There has been very little research on this construct as it pertains to Asian Americans.

A third potential barrier to utilization is counselor preferences. Research with African American subjects is consistent in finding that they prefer racially-similar counselors (Atkinson, 1983). Asian Americans may also prefer to see ethnically-similar counselors; underutilization or premature termination from mental health services may be due to a lack of ethnically-similar counselors. It has been found that Asian Americans increase use of mental health services when there are more Asian American therapists (Atkinson & Matsushita, 1991; Atkinson, Poston, Furlong & Mercado, 1989; Wu &
but it is not ethnicity alone that accounts for the rise in utilization rates. More important than similarity in ethnicity are counselor characteristics such as being educated; being older than the client; having similar attitudes, personality, and socioeconomic class as the client; and being empathic (Uba, 1994).

S. Sue (1993, 1998) presents two competing hypotheses about matching clients and counselors. One states that simple demographic (e.g., ethnic or gender) matching is sufficient to increase utilization rates of mental health services by Asian Americans. The second hypothesis is that cognitive similarities are more important for explaining underutilization and premature termination. The cognitive match hypothesis suggests that even client matches with ethnically dissimilar counselors can increase utilization rates if the counselor thinks the same way as the client. According to S. Sue, cognitive matching refers to similarities in value orientation and personality style between client and counselor. Some examples of matches in values or personality style would be having the same goals for therapy or conceptualizing problems in the same way. A direct test of these two competing hypotheses has not been conducted with Asian Americans.

As a group, Asian Americans are not uniformly homogeneous; there are many within-group differences. For example, Asian Americans differ from one another in terms of acculturation to American society. Acculturation refers to the process of cultural change produced by contact with a culture different from the culture of origin; it is a complex process with multiple choices and outcomes (Leong & Chou, 1994). Because counseling and psychotherapy are grounded in Western cultural values such as individualism and self-actualization, it is possible that degree of acculturation to Western societies will influence
counseling variables. In fact, Atkinson and Thompson (1992) identified acculturation as one of three important areas for research with racial/ethnic minorities in the future.

Because counseling and psychotherapy are endeavors that strive to help individuals understand and/or change themselves, cultural differences in the view of the self are also important in counseling research. Cultures differ from one another on the individualism-collectivism continuum, with Asian cultures tending to fall toward the collectivistic end and American cultures tending toward the individualistic end of the continuum. On an individual level, measurement of the individualism-collectivism construct has been operationalized by measuring construals of the self, where individuals range on two separate continuums. These continuums reflect the independent self and the interdependent self (Singelis, 1994). Thus, while Asians as a group are more likely than Americans as a group to be rated as collectivistic, there may be individual within-group differences among Asian Americans, as well as among Whites, in terms of the balance of their ratings of themselves as independent and interdependent.

The presumption of more than one type of “self” (i.e., collective/interdependent, personal/independent) leads to the notion that there may be a distinction between personal and collective self-esteem. Luhtanen and Crocker (1992) created a measure of collective identity based on a distinction between personal and collective aspects of the self as hypothesized by Triandis (1989) and others (see Hui, 1988). Collective identity, according to the authors, refers to those aspects of identity that have to do with memberships in social groups. Collective self-esteem, then, is the value one places on one’s social groups. Collective self-esteem is hypothesized to be something individuals strive to maintain or enhance just as they do personal self-esteem (Luhtanen & Crocker,
However, psychological theories of self-esteem have focused mainly on the individual and personal aspects of esteem. Luhtanen and Crocker suggest that collective self-esteem may have implications for domains such as psychological adjustment. To this date, there has not been any examination of how within-group differences among Asian Americans on collective self-esteem may impact upon counseling variables.

A value related to the collectivistic orientation of traditional Asian culture is awareness of loss of face. Because of the importance of building connections among self, family, and community, members of collectivistic societies try not to bring shame or stigma to others (Ho, 1984). One way in which this is accomplished is to be aware of loss of face. Face, according to Bond (1991), refers to one's moral integrity as a civilized person. The concept of face may be universal (Ho, 1976), but what constitutes a desirable face is specific to the culture (Bond & Hwang, 1986). Maintaining face is accomplished in part by subtle communication which avoids direct confrontation, challenges, and assertiveness. This communication style runs counter to the ideal of "honest and direct" communication espoused by many counselors (Leong, Wagner, & Kim, 1995). Thus, individuals who are highly sensitive to loss of face may find the philosophy and many of the interventions of counseling and psychotherapy to be unacceptable.

In summary, the purpose of this study is to increase knowledge regarding barriers to utilization of mental health services by Asian Americans. Specifically, this study will examine the cultural variables of acculturation, construals of the self, loss of face, and collective self-esteem as predictor variables of three possible barriers to utilization of mental health services by Asian Americans: treatment acceptability, willingness to see a counselor, and counselor preferences.
CHAPTER 2

LITERATURE REVIEW

In this chapter, definition of the term *Asian American* will first be detailed. Next, the following topic areas will be addressed in discussion of the selected literature: 1) Asian American mental health service utilization and help-seeking, 2) treatment acceptability, 3) willingness to see a counselor, 4) counselor preferences, 5) acculturation, 6) individualism-collectivism, 7) construals of the self, 8) collective self-esteem, and 9) face. This chapter will end by summing up the literature review in a conclusion section and presenting the hypotheses for the current study.

**Definition of Asian Americans**

The term *Asian American* refers to people who have origins in Asian nationality groups that number more than 20 (Kitano & Maki, 1996). The largest Asian American groups in the United States are the Chinese, Filipino, and Japanese groups, respectively. Other groups with large numbers include Asian Indians, Koreans, Vietnamese, Cambodians, Hmong, Laotians, and Thais. In addition, for the purposes of this study, the
term *Asian Americans* also encompasses Pacific Islander groups such as native Hawaiians, Samoans, and Guamanians.

Not only is there diversity among Asian Americans in terms of nationality, but immigration history can also be vastly different. Kitano and Maki (1996) note that the Chinese and Japanese American groups can sometimes include individuals who have been in the United States for four or five generations (or higher) since some members of these groups came to the United States as early as the late 1800s and early 1900s. On the other hand, Southeast Asians such as the Vietnamese have often immigrated much more recently and are, therefore, likely to be less acculturated to United States culture.

Other areas of diversity resulting from the large numbers of nationality groups that make up Asian Americans include religion, language, and refugee history. Thus, the group known as Asian Americans is quite broad, speaking to the importance not only of examining between-group differences, but also within-group differences when studying Asian Americans.

**Asian American Mental Health Service Utilization and Help-Seeking**

The seminal research project in this area was conducted by S. Sue (1977), who analyzed a database of 14,000 clients in 17 community mental health centers in Seattle. Asian Americans who received treatment equal to that of Whites (in terms of diagnosis, type of personnel seen, and types of services rendered) had poorer outcomes as measured by premature termination rates. For example, dropout rates for Asian American (as well as African American and Native American) utilizers of the system after one session was 52 percent, controlling for all demographic variables other than ethnicity.
These findings were replicated in a three-year longitudinal study when S. Sue and McKinney (1975) looked at community mental health centers in Seattle. Underutilization, based on comparing the size of the Asian American population in the area to the population of patients using the mental health centers studied, was found in the study. Although Asian Americans constituted 2.4% of the total population, they made up only 0.7% of the patient population.

These findings were bolstered by similar results in other populations. For example, Lee and Mixson (1985; cited in Leong, 1986) surveyed 73 Asian American students at a counseling center in California. Asian Americans rated counseling as less effective for personal, social, and emotional concerns than Whites. In addition, Asian Americans rated counselors as less competent, were less favorable to returning to counselors, and used fewer sessions despite having the same number of concerns as Whites.

Over time, the literature on utilization of mental health services by Asian Americans has broadened to attempt to find explanations for the low utilization rates found in earlier studies. Two studies (Hu, Snowden, Jerrell, & Kang, 1993; Hu, Snowden, Jerrell, & Nguyen, 1991) focused on use of public mental health services in San Francisco and Santa Clara counties from July 1987 to June 1988. Results suggested that within-group differences among Asian American users of the mental health system were important to consider, as well as language ability. Non-English speakers were more likely to be medicated, suggesting a possible over-reliance on less language-mediated forms of treatment. On the other hand, they were less likely than English-speaking clients to be hospitalized and more likely to enter individual outpatient treatment, although they attended fewer sessions. This suggests a presence of culturally-sensitive response to special needs.
S. Sue, Fujino, Hu, Takeuchi, and Zane (1991) continued this line of research by examining data on Los Angeles County mental health system patients collected between 1984 and 1988. Asian Americans underutilized services, had a significantly lower proportion of dropouts than Whites, and had lower dropout rates if they were in the higher social classes. In addition, Asian Americans dropped out of therapy less when they were matched by ethnicity and/or gender with their therapist. However, ethnic match of therapist was important only for non-English speaking Asian Americans. Thus, within-group differences among Asian Americans are important to assess in research examining possible reasons for underutilization or premature termination of mental health services. Asian Americans were also found to have attended more sessions than any other ethnic group, including Whites. Based on GAS ratings, Asian Americans were less likely than Mexican Americans and Whites, but more likely than African Americans, to improve after treatment.

One construct that has been examined for its utility in understanding underutilization is help-seeking attitudes. These attitudes are greatly influenced by cultural values (Tata & Leong, 1994). For Asian Americans, some cultural values that may be important in help-seeking include emphasis on indirect communication, subordination of individual goals to the goals of the collective, non-disclosure of private problems to non-family members, and restraint in emotional expressiveness (Leong, Wagner, & Tata, 1995).

Three studies have examined help-seeking patterns of Asian American college students. Atkinson and Gim (1989) sampled Chinese American, Korean American, and Japanese American college students and found that acculturation was directly related to positive attitudes toward seeking professional psychological help. Tata and Leong (1994) found similar results in a study that used gender, individualism-collectivism, acculturation,
and social-network orientation to predict attitudes toward seeking professional psychological help among Chinese Americans. All variables were found to be significant predictors of help-seeking attitudes. Specifically, women, more acculturated students, more individualistic students, and those with a more positive outlook in connecting with and seeking support from others all had more positive attitudes toward seeking professional psychological help.

In a third study, Solberg, Ritsma, Davis, Tata, and Jolly (1994) sampled 596 undergraduate and graduate Asian American students and found previous counseling experience was related to willingness to seek help from a university counseling center. Together, these studies suggest that cultural and demographic variables are important to consider in terms of help-seeking and utilization of mental health services.

In summary, studies reviewed here have shed light upon the problem of low rates of utilization and high rates of premature termination and dropout among Asian Americans. However, there are many other possible explanations for low utilization and/or high premature termination rates that have yet to be examined. The concept of treatment acceptability is one of those possible areas for exploration.

**Treatment Acceptability**

One potential explanation for the grim statistics on underutilization of mental health services by Asian Americans is the concept of treatment acceptability. Western, individual-focused treatment for mental health problems may not be deemed acceptable to Asian Americans, thus accounting for low utilization rates, as well as high premature dropout and termination rates once services are utilized.
The question of effectiveness and efficacy of psychotherapies has been researched (Seligman, 1995; Smith & Glass, 1977; Smith, Glass, & Miller, 1980; Stiles, Shapiro, & Elliott, 1986) in the quest to find the best therapies for desired outcomes. However, often overlooked in these studies is the question of whether a treatment is important to the society for which it was designed. In fact, a few investigators have suggested a need for broader criteria of treatment evaluation (Garfield, 1978; Strupp & Hadley, 1977; Wolf, 1978).

Wolf (1978) feels that the importance of a treatment to the consumers of that treatment is as vital a concern as the efficacy of a treatment. Empirical support for a treatment is not enough to ensure compliance if the treatment is not also acceptable to the client (Kazdin & Krouse, 1983).

Although consumer/client satisfaction is important to evaluating treatment, ratings of satisfaction presuppose the availability of acceptable and effective treatments from which people may select (Kazdin, 1977). Acceptability of treatments is important, according to Kazdin (1980b), for three reasons: 1) for some clinical problems several effective techniques are available, but not all may be equally acceptable to clients, 2) ethical and legal concerns about some treatments may hinder their utility, and 3) examining acceptability can increase the likelihood that treatment is sought, initiated, and adhered to once it is initiated. These reasons are compelling, but yet another reason not mentioned is of equal importance in cross-cultural research. From a cultural standpoint, it is ethically imperative that therapists have knowledge about the acceptability of various treatments cross-culturally rather than indiscriminantly applying treatments to all groups.

Research on treatment acceptability began by focusing on behavioral interventions with children. Instruments used to assess treatment acceptability include the first scale
developed for this purpose, the Treatment Evaluation Inventory (TEI; Kazdin, 1980a), and the short form of the TEI, the TEI-SF (Kelley, Heffer, Gresham, & Elliott, 1989). The only other major instrument utilized in treatment acceptability research was developed for use primarily to evaluate school-based interventions for children. Most studies of treatment acceptability have employed an analogue design, where researchers present raters with a written case description of a problem and the treatment applied to that problem. After reading the treatment vignette, the rater completes an acceptability rating scale.

Miltenberger (1990) summarized the types of raters in research on treatment acceptability. Raters have included psychiatric staff, psychologists, college students, and consumers of treatment. College students were used as raters initially, but research on childhood behavioral treatments has moved toward use of potential or actual consumers of treatments to increase validity. However, for the purposes of this study, college students would be the potential consumers of counseling from university counseling centers.

The types of problems most frequently evaluated have been reinforcement-based or punishment-based behavioral procedures for behavioral problems (Miltenberger, 1990). Factors that have been found to be related to treatment acceptability include problem severity, treatment approach, side effects of treatment, time needed to implement treatment, and cost. Finally, Miltenberger states that acceptability ratings can be influenced by better understanding of a procedure in that it increases a procedure's acceptability. Therefore, this proposed study will take into consideration participants’ previous counseling experience in analyses.

More recently, the literature on treatment acceptability has broadened from research on childhood behavioral problem treatments to focus on acceptability of treatments in
psychotherapy or counseling with adults (Banken & Wilson, 1992; Betts & Remer, 1993; Bornstein et al., 1983; Bornstein et al., 1987; Flaming & Wilson, 1992; Hecker, Fink, & Fritzler, 1993; Hunsley, 1993; Lundervold, Lewin, & Bourland, 1990; Morin, Gaulier, Barry & Kowatch, 1992; Sturmey, 1992; Upton & Jensen, 1991; Wilson & Flaming, 1990; Wilson, Flaming, & Dehle, 1992; Wilson & Wilson, 1991). The majority of this literature samples White subjects; there are no treatment acceptability studies on psychotherapy with racial/ethnic minority adults, including Asian Americans.

Of the studies listed above, several examined treatment acceptability for marital problems (Bornstein et al., 1983; Bornstein et al., 1987; Flaming & Wilson, 1992; Upton & Jensen, 1991; Wilson & Flaming, 1990; Wilson, Flaming, & Dehle, 1992). For example, Bornstein et al. (1987) examined the acceptability of egalitarian versus traditional therapeutic interventions in behavioral marital therapy. Eighty introductory psychology students were presented with two videotapes of either an egalitarian or a traditional therapy session conducted by either a male or a female therapist. Subjects than rated the treatments using the Treatment Evaluation Inventory (TEI; Kazdin, 1980a). Subjects found the traditional behavioral marital therapy vignettes significantly more acceptable than the egalitarian treatments, leading the researchers to caution marital therapists to keep in mind clients’ values, as well as the values of the counselor, when choosing interventions.

Another group of treatment acceptability studies on psychotherapy with adults focuses on various types of interventions (Betts & Remer, 1993; Hunsley, 1993; Lundervold, Lewin, & Bourland, 1990). For instance, Betts and Remer were interested in the ethics of manipulative or deceptive treatments such as paradoxical interventions.
Ninety-seven undergraduates took part in a semester-long simulated experimental manipulation of a family attending family therapy sessions, then filled out treatment acceptability ratings for either paradoxical or nonparadoxical treatments presented in a vignette. Results indicated that paradoxical directives were judged as less acceptable than nonparadoxical interventions, but neither was deemed unacceptable.

Yet another group of studies focuses on acceptability of treatments for specific counseling problem areas (Banken & Wilson, 1992; Hecker, Fink, & Fritzler, 1993; Morin, Gaulier, Barry & Kowatch, 1992; Sturmey, 1992; Wilson & Wilson, 1991). Typical of this group of studies is that conducted by Banken and Wilson, which examined the treatment acceptability of therapies for depression. They presented 174 college students with vignettes of a college student suffering from either major depression or dysthymia and treated with behavioral, cognitive, interpersonal, or pharmacotherapy techniques. Interpersonal therapy was rated as most acceptable, followed by behavioral, cognitive, and pharmacotherapy treatments. In addition, subjects with depressive symptoms rated psychotherapies as more acceptable than pharmacotherapy.

In summary, a gap in the treatment acceptability literature exists such that there have been no studies on acceptability of counseling treatments with adults that examines racial/ethnic differences. This proposed study seeks to address that absence by examining the acceptability of four types of treatment for Asian American and White college students: cognitive-behavioral individual counseling, client-centered individual counseling, group counseling, and family systems counseling.

Because of the lack of examination of acceptability of counseling treatments for Asian Americans, it seems worthwhile to test both acceptability of these three broad
counseling modalities and to examine finer distinctions among counseling treatments (e.g., types of individual therapy). Cognitive-behavioral and client-centered individual counseling were chosen as the individual modalities to test a hypothesis that has often been made in the literature on counseling Asian Americans. It has been suggested that for many Asian Americans, directive and concrete cognitive-behavioral interventions are recommended over more insight-oriented or affect-oriented interventions because of the higher degree of credibility and gift-giving potential (Atkinson, Maruyama, & Matsui, 1978; D.W. Sue & D. Sue, 1990; S. Sue & Zane, 1987).

Landrine (1992) suggested that family-oriented approaches to treatment would be a good match for individuals who hold a collectivistic/indexical view of the self (e.g., many Asian Americans). Draguns (1996) cautioned, however, that the match might be tempered by cultural variables such as importance of maintaining status and hierarchical roles within collectivistic families. Draguns also expresses skepticism of group therapy in the following statement contrasting indexical/collectivistic self-concept individuals with referential/individualistic individuals,

Thus the exposure of traditional Asian parents to the freewheeling and confrontational patterns of parent-child interaction in many typical American family therapy procedures is strongly counterindicated. It also appears to be paradoxical that group psychotherapy has both originated and thrived in the highly individualistic American and West European cultures in which the referential self is strongly represented. Thus the thrust of the indexical versus referential self dichotomy is clear, but the specific implications remain to be spelled out, explored, and tested (Draguns, 1996, pp. 11-12).

Thus, theoretically it is not clear whether Asian Americans will find group or family therapy more acceptable than individual therapy. This study will provide one way in which to test these ideas about the affinity between modalities of therapy and views of the self.
Willingness to See A Counselor

There have been many studies examining willingness to see a counselor with groups other than Asian Americans. For example, Hispanics have also been found to underutilize counseling services, leading Pomales and Williams (1989) to study the effects of level of acculturation and counseling style on willingness to see a counselor with 94 Hispanic college students. Their measure of willingness to see a counselor was an item from the Counselor Effectiveness Rating Scale (CERS; Atkinson & Carskaddon, 1975). The authors found a significant effect such that male students who were shown a videotape of a directive counseling condition indicated greater willingness to see the counselor than female students in the same condition. This study suggests the importance of examining within-group differences when looking at willingness to see a counselor.

Another study aimed at understanding Hispanic underutilization of counseling services looked at the effects of counselor ethnicity, subject acculturation, and counseling style on the perceptions of counselor credibility with 169 Mexican-American college students. Willingness to see a counselor was operationalized using a modified version of the Personal Problems Inventory (PPI; Cash, Begley, McCown, & Weise, 1975) which presented counseling concerns relevant to college students in general and Hispanic college students in particular. A principal-components factor analysis was computed with each of the items from the PPI, yielding two factors that were then used as dependent variables in a MANOVA. The authors found that subjects were more willing to see an ethnically similar counselor for personal/social and academic/career problems than an ethnically dissimilar counselor. Furthermore, this preference held across all levels of acculturation.
African Americans have also been studied in terms of their perceived willingness to see a counselor. Watkins, Terrell, Miller, and Terrell (1989) examined the effects of cultural mistrust on subjects' perceived willingness to return for a follow-up visit to a counselor with 120 Black college students who were presented with written vignettes of either a Black or a White counselor. However, no significant main effects or interactions were found when they conducted a 2 X 2 X 2 ANOVA with subject sex, subject mistrust level, and counselor race.

Finally, Blier, Atkinson, and Geer (1987) examined the effects of client gender, counselor gender, and counselor sex roles on client willingness to see the counselor for specific areas of concern. They hypothesized that client willingness to see a masculine, feminine, or androgynous counselor would be a function of the type of problem for which they seek help. Subjects were 107 utilizers of a university counseling center; however, race/ethnicity of subjects was not specified in the study. Using a principal-components factor analysis with varimax orthogonal rotation on 23 counseling concerns, the authors identified a four-factor solution using loadings of .70 or above: 1) personal concerns, 2) assertiveness concerns, 3) vocational concerns, and 4) academic concerns. Mean scores for these four areas were then used as dependent variables. They found that counselor sex role plays an important role, while counselor gender and client gender play negligible roles, in determining client willingness to see a counselor. In addition, the effect of counselor sex role on willingness to see a counselor was not uniform across problem types in that subjects preferred to see feminine counselors for discussing personal concerns, masculine counselors for discussing assertiveness concerns, and androgynous or masculine counselors for discussing academic concerns.
In studies on willingness to see a counselor with Asian Americans, there has also been a tendency to examine this variable in relation to specific counseling concerns. For example, research has been conducted examining the preferences of Asian Americans in seeing a counselor for academic/vocational concerns versus personal/emotional concerns.

The pattern of underutilization of mental health services by Asian Americans is complicated by findings that at times Asian Americans overutilize services, such as campus counseling center services (D.W. Sue & Kirk, 1975). Sue and Kirk's suggestion that this may be due to the less stigmatizing services provided by counseling centers (e.g., academic and career counseling), as opposed to psychiatric clinic services, was supported by Tracey, Leong, and Glidden's (1986) finding that Asian American clients to a university counseling center were more likely to indicate educational or vocational concerns as presenting issues compared to the personal or emotional concerns more commonly cited by White clients.

Based on these findings, Gim, Atkinson, and Whiteley (1990) examined the relationship between ethnicity, gender, and acculturation with willingness to see a counselor for problems experienced by Asian American undergraduates. They administered questionnaires that included the SL-ASIA (Suinn, Rickard-Figueroa, Lew, & Vigil, 1987) and a modified version of the PPI (Cash, Begley, McCown, & Weise, 1975) to 816 Asian American students and found that acculturation and gender were related to willingness to see a counselor. Concerns were factor analyzed using a principal-components analysis with a varimax rotation. They selected a three-factor solution (Relationship, Academic/Career, Health/Substance Abuse) with a loading of .50 or above as the criterion for inclusion of an item in a factor. Five items that did not load over .50 on any factor were treated as separate dependent variables.
Gim, Atkinson, and Whitely (1990) found that Asian American subjects were most willing to see a counselor about academic/career and financial concerns and least willing to see a counselor about ethnic identity confusion, roommate, health/substance abuse, and insomnia concerns. Women were more willing to see a counselor than men. An inverse relationship was found for acculturation and willingness to see a counselor, which conflicted with Atkinson and Gim's (1989) findings that more acculturated Asian Americans were more likely than less acculturated Asian Americans to be open to discussing their problems with a psychologist. The authors suggested that the severity of concerns ratings may have affected willingness to see a counselor in this study.

Another study with Asian Americans operationalized willingness to see a counselor as *utilization intent*, which was similar to the operationalization used by Pomales and Williams (1989). The proximal-distal model proposes that credibility may be more important in work with culturally diverse populations than cultural knowledge or culture-specific techniques. In terms of treatment utilization or compliance, credibility is a more proximal process, whereas cultural knowledge and techniques are more distal to effective outcomes in therapy (S. Sue & Zane, 1987).

Akutsu, Lin, and Zane (1990) tested this model with 152 Chinese students in Taiwan and 160 White students in the United States by presenting subjects with written transcripts of counseling sessions conducted by Rogers, Perls, and Ellis, and then asking them to rate their utilization intent. Utilization intent was a composite measure of responses to two items that evaluated participants' perceived willingness to see the presented counselor. The items were from the Counselor Effectiveness Rating Scale used by Atkinson and Wampold (1982). They found support for the proximal-distal model in that
both Chinese and White subjects rated counselor credibility as directly related to utilization intent. In addition, directive counseling style (an example of a distal process) failed to be a significant predictor of either counselor credibility or utilization intent. Finally, for Chinese subjects, Ellis' approach to counseling (as opposed to the approaches of Perls and Rogers) was also rated as a significant predictor of utilization intent.

Atkinson, Lowe, and Matthews (1995) investigated the relationships between Asian American acculturation, gender, and willingness to seek counseling with 187 Asian American undergraduates. Their measure of willingness to see a counselor consisted of two questions asking participants to indicate willingness to see a counselor for a personal problem and willingness to see a counselor for an academic problem. Contrary to expected, the interaction of subject acculturation level and type of problem (academic versus personal) did not significantly influence willingness to see a counselor. Neither was there a main effect for acculturation on willingness to see a counselor. This finding was in direct contradiction to the findings of Atkinson and Gim (1989). In addition, there were no gender differences in willingness to see a counselor. However, those Asian Americans who had previous counseling experience were significantly more willing to see a counselor for both types of problems than those with no prior counseling experience.

In summary, studies on acculturation and its influence on willingness to see a counselor for Asian Americans have yielded mixed findings. One problem in these studies is the lack of uniformity in measuring willingness to see a counselor. This study addresses that problem by using the same measure that Gim, Atkinson, and Whiteley (1990) used. In addition, research in this area has focused only on acculturation as a potential cultural predictor of ratings on willingness to see a counselor for various problem concerns. This
study seeks to extend the literature in this area by examining other cultural variables as predictors of willingness to see a counselor.

Counselor Preferences

Social influence theory (Simons, Berkowitz, & Moyer, 1970) suggests that credibility, attractiveness, and influence are a function of similarity between source and receiver. Thus, it has been suggested that racial/ethnic minority clients will prefer a counselor who is ethnically similar over one who is dissimilar because ethnically similar counselors are hypothesized to be better able to understand their clients' problems, serve as role models for their clients, and resolve their clients' difficulties (Atkinson, 1983). On the other hand, social influence research also suggests that attitudinal similarity is more powerful than membership-group similarity in determining attraction toward the source (Simons, Berkowitz, & Moyer, 1970). Thus, another view is that culturally-sensitive counselors of any racial or ethnic group can transcend cultural differences between themselves and their clients.

This argument for or against racial/ethnic similarity between client and counselor is best described as a dispute between an etic versus an emic view of cross-cultural counseling. The etic/emic distinction refers to the question of whether attention should be directed toward understanding the universal aspects of culture -- those things people of all cultures have in common -- or whether it should be directed toward understanding the unique aspects of each culture separately. Fukuyama (1990) argued for the etic view by stating that training would be too difficult if psychologists were required to understand all the cultures of the world, especially if culture is broadly defined to include gender, race,
ethnicity, sexual orientation, and other forms of difference between groups. In addition, Fukuyama stated that the emic/culture-specific perspective risks stereotyping individuals from each culture without recognizing their individual differences.

The emic view was argued by Locke (1990), who stated that the universalist perspective risks blaming the victim. In the etic view, individuals who do not fit into the dominant culture are seen as individually defective, without recognizing the cultural differences at work. In addition, Locke suggests that the etic perspective, in its broad definition of "culture", equates cultural differences with individual differences instead of recognizing them as separate but interdependent levels of being (Kluckhohn & Murray, 1953). Locke also criticizes the etic perspective for not considering the realities of racism and discrimination in society. Finally, he argues that rather than being narrow, the emic perspective is focused.

A review of the ethnic matching literature by Coleman, Wampold, and Casali (1995) examined the research on ethnic similarity in counseling using a meta-analysis with 17 articles and 4 dissertations. In general, they found that ethnic minorities tend to prefer ethnic minority counselors over European American counselors. However, they also found that cultural affiliation moderated preferences for ethnically similar counselors. Cultural affiliation has been operationalized in many ways: as racial or ethnic identity (Helms & Carter, 1991; Parham & Helms, 1981), cultural commitment (Atkinson, Furlong, & Poston, 1986), acculturation (López, López, & Fong, 1991), and cultural identification (Bennett & Big Foot-Sipes, 1991; Sanchez & Atkinson, 1983).

Some problems Coleman, Wampold, and Casali (1995) found in the studies analyzed included: 1) when an option to have no preference was not provided to subjects,
the tendency to state a preference for an ethnically similar counselor increased, 2) competing hypotheses such as choosing an ethnically similar counselor because of social desirability of that response, 3) ethnic minority college students at predominately White institutions could be struggling with personal identity issues and coping with acculturative stress, thereby making their responses to preference questions in these studies driven more by concerns about cultural affiliation than by true assessments of what a counselor can provide them, and 4) when ethnicity was the only salient factor assessed, other variables that might be taken into consideration when judging preference for a counselor were not factored into the preferences.

In terms of the effect of ethnic matching on utilization of services, Coleman, Wampold, and Casali (1995) concluded that the perspective that ethnic minorities underutilize or prematurely drop out of services because of non-match with an ethnically similar counselor has not been confirmed through research. One explanation for the inconclusive evidence is provided by Helms (1984), who states that within-group differences such as level of acculturation or ethnic identity development among ethnic minority members influences preferences for a counselor and this cultural affiliation conceptualization explains the variance within minority groups about preferences for ethnically-similar counselors. This view suggests that those racial/ethnic minorities who are strongly affiliated with their cultural group will underutilize or prematurely drop out of counseling if not matched with a culturally-similar counselor (Coleman, Wampold, & Casali, 1995).

Research has addressed this hypothesis for African Americans. Carter (1993) described the difference between the race perspective and the racial identity perspective as
they influence the counseling process with Black and White client-counselor dyads. The race perspective suggests that either the client’s or the counselor’s race influences their manner of interacting with one another, the expression of racial stereotypes and cultural biases in therapy relationships, or potential conflict between the client and counselor. The racial identity perspective suggests that one’s stage of racial identity, regardless of one’s race, will have a stronger impact on therapy process than race. Cognitions or other results of one’s racial worldview influence how counseling participants perceive and interact with each other; hence, different combinations of stages result in different styles of interactions.

Carter (1993) examined these competing perspectives in a study with 31 simulated counselor-client dyads (19 White counselor/White client dyads, 8 White counselor/Black client dyads, 4 Black counselor/White client dyads). Results suggested that the racial identity perspective was most strongly supported by the White counselor/White client dyads in that counselor intentions were significantly influenced by racial attitudes. In White counselor/Black client dyads, the clients’ reactions were more related to the racial identity attitudes of counselors and clients than were counselor intentions. However, in every racial dyad combination, racial identity attitudes led to more significant relationships than race alone.

Two other studies that were not included in Coleman, Wampold, and Casali’s (1995) meta analysis looked at counselor preferences for Asians. Atkinson, Poston, Furlong, and Mercado (1989) conducted a counselor preference study that included ethnicity as an independent, as well as a dependent, variable. Subjects for the study were 339 African American, Asian American, Mexican-Americans, and Caucasian American undergraduate university students. The authors found that all subjects preferred an
ethnically-similar counselor to an ethnically dissimilar counselor, but even stronger preference was expressed for a counselor who was more educated, had similar attitudes, was older, and had a similar personality as the subject. In addition, ethnic minority subjects expressed greater preference for a counselor of the same sex and Asian Americans stated greater preference for a counselor with a similar socioeconomic background than for an ethnically similar counselor.

Mau and Jepsen (1988) studied 327 international Chinese and 350 American graduate students' preferences for counselors' characteristics. They found that the Chinese students differed significantly from the American students in their preferences on four of seven counselor characteristics. Specifically, Chinese graduate students were more concerned than American graduate students about counselors' age and racial background, whereas American graduate students were more concerned than Chinese students about counselors' religious beliefs and socioeconomic background. Female students from both cultures preferred a female counselor over a male counselor when it came to personal problems. An additional interesting finding in this study were the similarities and differences between the participants in terms of their images of a counselor. American students tended to perceive a counselor as a listener and a friend, while Chinese students perceived a counselor as a friend and an expert.

In his program of research on the question of effectiveness of ethnic-specific mental health services, S. Sue (1998) states that although ethnic-specific services were found to be associated with lower dropout rates, the processes accounting for these results remain unknown due to inability to randomly assign clients to therapists or services. Thus, S. Sue and his colleagues have moved toward a more micro-level analysis than ethnic-match by
examining therapist-client similarity in thinking (i.e., cognitive match) in relation to treatment outcomes.

S. Sue (1998) and colleagues collected data on therapists' and clients' beliefs regarding goals for treatment, preferred means for resolving problems, and acculturation. Degree of match between therapist and client was used as a predictor of post-treatment symptoms, adjustment, and clients' ratings of the treatment sessions. Preliminary findings suggest that cognitive match is significantly related to treatment outcome and clients' perceptions of sessions. In no cases were cognitive mismatches predictors of better outcomes. They also found that within-group differences were associated with acculturation levels of clients and therapists. Thus, it has been shown that not only is ethnic match important, but cognitive match within ethnic match is also favorable.

In summary, it seems that counselor preferences are an important consideration in terms of utilization of mental health services by Asian Americans. However, research on ethnic similarity has not been conclusive. Methodological concerns are a major problem with much previous research in this area. Thus, the present study seeks to address some of the problems Coleman, Wampold, and Casali (1995) noted by including a social desirability scale in the study, giving participants the opportunity to not have a preference at all, and by having participants assess factors other than ethnicity in determining preferences for a counselor.

In addition, the scale to measure counselor preferences created for this study seeks to address the hypotheses expressed by Atkinson and Thompson (1992) and S. Sue (1993, 1998) about demographic matching versus cognitive matching of client and counselor. As such, four questions in the scale assess preferences for a counselor based on demographic
similarity match (i.e., of the same ethnicity, gender, sexual orientation, and socioeconomic class), while two questions address preferences for a counselor based on cognitive similarity match (i.e., with the same personality style or value orientation).

**Acculturation**

Initial models of acculturation accepted by social scientists were better labeled *assimilation models*, rather than acculturation models, in that they implied that the United States was a melting pot of various cultures in which complete assimilation usually occurred three generations after immigration. Critics pointed out, however, that total assimilation was limited to European immigrants and people of color were never allowed to completely assimilate (Atkinson, Morten, & Sue, 1993).

More recent theorizing on acculturation has focused on the controversy between viewing acculturation as a unidimensional versus a bidimensional process (Atkinson, Morten, & Sue, 1993). That is, is acculturation a single continuum anchored by the indigenous culture on one end and the U.S. culture on the other end, or is there a simultaneous enculturation process within one's racial/ethnic group along with exposure to socialization forces within the dominant U.S. culture? In the realm of cross-cultural and multicultural counseling research, one of the most robust theories to be developed about multilinear acculturation is Berry's (1980) acculturation model.

Berry, Trimble, and Olmedo (1986) describe this alternative view of acculturation as a set of alternatives, rather than a single dimension ending in absorption into a society. This two-dimensional model conceptualizes an individual's acculturation status using two questions: 1) Is it of value to you to maintain cultural identity and characteristics?, and 2)
Is it considered to be of value to you to maintain relationships with other groups?

Responses of "yes" to both questions result in characterization as being an Integrationist; responses of "no" to both questions indicate a Marginalist; "yes" to question 1 and "no" to question 2 results in characterization as a Separationist; and "yes" to question 2, but "no" to question 1 yields characterization as an Assimilationist (Berry, Trimble, & Olmedo, 1986).

Using Berry's (1980) model as a foundation, Leong and Chou (1994) integrated Asian American ethnic identity and acculturation models, showing that Berry's Integrationist group was similar to S. Sue and Sue's (1973) Asian American, Suinn, Lew, & Vigil's (1987) Medium Acculturated person, and Cross' (1971) Internalization group in the racial identity model. Assimilationists in Berry's model were categorized as similar to Sue and Sue's Marginal Man, Suinn-Lew's High Acculturated group, and Cross' Pre-Encounter individual. Separationists were like Sue and Sue's Traditionalists, Suinn-Lew's Low Acculturated group, and Cross' Encounter and Immersion/Emersion groups. However, Berry's Marginalist group was not recognized by the other models, according to Leong and Chou. The authors pointed out that this model of acculturation reveals a great deal of convergence in the racial/ethnic identity literature.

There is a dearth of literature on acculturation as it relates to utilization of mental health services. A search of the PsychLit database yielded only seven articles, one of which one (Damron-Rodriguez, Wallace, & Kington, 1994) was non-empirical, on Asian American acculturation and utilization of services (Atkinson & Gim, 1989; Atkinson, Whiteley, & Gim, 1990; Gim, Atkinson, & Whiteley, 1990; Leong, Wagner, & Kim, 1995; Tata & Leong, 1994; Ying & Miller, 1992). Each of these studies will briefly be reviewed here for their findings in regard to acculturation and mental health services.
utilization, although some of these studies have been reviewed elsewhere in this literature review.

Atkinson and Gim (1989) designed a study examining the relation between Asian American acculturation and use of mental health services in which they hypothesized that acculturated Asian Americans would have more favorable views of mental health services than traditional Asian Americans. The authors reported that data gathered from a sample of 557 Chinese, Japanese, and Korean American undergraduates was consistent with their hypothesis; more acculturated Asian American students were more likely than less acculturated Asian American students to recognize personal need for professional psychological help, to be tolerant of the stigma associated with psychological help, and to be open to discussing their problems with a psychologist.

Tata and Leong (1994) found similar results in a study that used gender, individualism-collectivism, acculturation, and social-network orientation to predict attitudes toward seeking professional psychological help among 219 Chinese American college students. They found that more acculturated students had more positive attitudes toward seeking professional psychological help.

Gim, Atkinson, and Whitely (1990) examined the relationship of acculturation, severity of concerns, and willingness to see a counselor for problems experienced by 816 Asian American undergraduates. They hypothesized that less acculturated respondents would indicate more severe problems than would more acculturated respondents. Results indicated that low-medium acculturated Asian Americans rated financial concerns as a greater problem than academic/career concerns, but high acculturated Asian Americans reversed these ratings. Both groups gave their lowest severity ratings to health/substance
abuse problems. Acculturation was also found to be related to willingness to see a
counselor about concerns in that low-medium acculturated Asian Americans expressed
greater willingness to see a counselor than less acculturated Asian Americans. This inverse
relationship conflicted with Atkinson and Gim's (1989) findings.

Atkinson, Whiteley, and Gim (1990) surveyed 816 Asian American students in a
study that hypothesized there would be a direct relationship between level of acculturation
and ratings of counselors as a help source. In addition, it was hypothesized that there
would be an inverse relationship between level of acculturation and ratings given older
relatives or older members of the community as sources of help. Their first hypothesis was
not supported in the direction hypothesized. Participants who were low acculturated
(“Asian-identified”) gave their highest ratings to counselors as help providers, whereas
“Western-identified”/high acculturated participants rated counselors lowest, and
“Bicultural”/medium acculturated respondents fell in between the other groups.

The second hypothesis also was not supported in that the highest acculturated
respondents rated highest their mother as a source of help, while low acculturated
respondents rated mother as lowest in source of help (Atkinson, Whiteley, & Gim, 1990).
The authors suggested that this may be due to geographic distance between low
acculturated/first-generation respondents and their families, or it may be due to language
barriers. In addition, oldest member of the community was rated significantly higher by
Asian-identified students, compared to Western-identified students, but overall, this was
not among the top choices of help sources for participants in the study.

Ying and Miller (1992) examined the help-seeking behavior and attitude of 143
Chinese Americans as predicted by acculturation level. Participants were solicited through
random selection using Chinese surnames found in the San Francisco public telephone directory. Acculturation was operationalized as generational level and fluency in English. They found that being born in the United States (i.e., being more acculturated) was a significant predictor of help-seeking behavior. In addition, higher English-speaking ability was a significant predictor of positive psychological help-seeking attitudes.

Leong, Wagner, and Kim (1995) examined the relation between expectations about group counseling, acculturation, and loss of face with 134 Asian American undergraduates. They found that acculturation status (primarily Integrationist status) was a significant predictor of positive orientations toward group counseling. This was consistent with literature (e.g., Atkinson & Gim, 1989) suggesting more highly acculturated Asian Americans have more positive attitudes toward seeking psychological help, as well as with theoretical literature (Berry, 1980) on acculturation statuses.

In summary, findings from empirical research on acculturation with Asian Americans has been contradictory. In some studies, Asian Americans who are more acculturated are found to be more open to psychological help. For example, they are better able to tolerate the stigma of seeking help for psychological problems (Atkinson & Gim, 1989) and have more positive attitudes toward seeking psychological help (Tata & Leong, 1994; Ying & Miller, 1992). On the other hand, other studies have found that Asian Americans with higher levels of acculturation are not as open to psychological help. For instance, higher acculturated Asian Americans were found to be less willing to see a counselor (Gim, Atkinson, & Whiteley, 1990) and rated mother as a help source over counselors (Atkinson, Whiteley, & Gim, 1990). The second set of findings run counter to predictions based on the theoretical literature. It may be that acculturation is a complex
variable and that third variables may often need to be taken into consideration when examining the relationship between acculturation and counseling variables.

**Individualism-Collectivism**

Eastern and Western cultures differ in many ways. One important way in which they differ is in terms of the orientation of the cultures on the individualism-collectivism continuum. Triandis, Brislin, and Hui (1988) presented the defining features of collectivistic cultures as those in which: the self is defined as part of the group; a person's behavior is influenced by group-defined norms and roles; one is what one's group does; people tend to have positive attitudes toward their extended families and ingroups; and individuals are more comfortable with vertical relationships (e.g., father-son).

On the other hand, individualistic cultures are those in which the self is autonomous and separate from groups; no single group defines one's identity or determines behavior; one is what one does; attitudes towards ingroups and extended families vary and may even be negative; and people are more comfortable with horizontal relationships (e.g., friend-friend or spouse-spouse) (Triandis, Brislin, & Hui, 1988).

The two types of cultural orientations differ also in terms of which values are considered most important. Collectivists value harmony, face-saving, filial piety (duty toward parents), modesty, thrift, equality in distribution of rewards among peers, and fulfillment of others' needs. Individualists value freedom, honesty, social recognition, comfort, equity (to each according to his/her contributions to group performance), and hedonism. Even when there are similarities between the two orientations, these are based on different foundations. For example, collectivists view self-reliance positively because it
means not burdening the ingroup, whereas individualists view it positively because it is associated with independence and doing one's own thing (Triandis, Brislin, & Hui, 1988).

Singelis and Sharkey (1995) explain that individualism and collectivism are terms used in reference to cultures, not individuals. On the individual level, one possesses an independent or interdependent self-construal, where independent construals of the self are associated with individualistic cultures (e.g., Europe, the United States, and Australia) and interdependent construals of the self are associated with collectivistic cultures (e.g., those of Asia, Africa, South America, and the Pacific Islands).

**Construals of the Self**

Where you come from, individual personalities happen to have relationships with others. Here... your relationship with others **is** your personality. People are never alone. People who enjoy spending time alone are suspect, because they seem to be developing some kind of marginal, extrasocial personality (Dooling, 1994, pp. 260-261).

This description contrasted individuals from the United States with people in West Africa; however, the description could be applied to any comparison between those from individualistic cultures and those from collectivistic cultures. As mentioned previously, individualism and collectivism are terms used to describe cultural groups, but when referring to individuals, other terms are used to delineate the differences between individuals from these two types of cultural backgrounds.

One such term is *self-construal*, as employed by Singelis (1994). Self-construal refers to the constellation of thoughts, feelings, and actions concerning the relationship of the self to others and the self as distinct from others (Singelis & Sharkey, 1995). Singelis and Sharkey define *independent self-construal* as a bounded, unitary, stable self that is
separate from social context, whereas *interdependent self-construal* is defined as a flexible, variable self that emphasizes external features such as status, roles, and relationships.

Like other cultural variables, such as acculturation, self-construals hold implications for psychological adjustment. Singelis (1994) makes a connection between Berry's two-dimensional model of acculturation (Berry & Kim, 1988) and self-construals by suggesting that acculturation can be understood as a process of adjusting or not adjusting one's self-image. Singelis hypothesizes that in the United States, those who *assimilate* replace their self-image with the most common self-image in the United States -- an independent self-construal. Those from a collectivistic culture who *integrate* develop an independent self in addition to his or her existing interdependent self, resulting in a bicultural self system. Those who *separate* retain a traditional interdependent self, and, finally, those who *marginalize* do so possibly as a result of degradation of the interdependent self without replacement by an independent self-image. These are intriguing hypotheses, but a full comprehension of their assertions first requires a discussion about definitions of "self" and the differences between independent and interdependent views of the self.

For some, the "self" is a separate, encapsulated originator, creator, and controller of behavior. Landrine (1992) describes this view of the self as the *referential self*, while the *indexical self* is a self that includes other people and portions of the natural world, encompasses all of a person's roles, and is easily changed or modified with the situation. Other researchers have also delineated these two types of self. Markus and Kitayama (1991) discuss the *independent self* versus the *interdependent self*, Hofstede (1980) describes the differences between *individualists* and *collectivists*, and Crocker and
Luhtanen (1990) depict dissimilarities between personal identities and collective identities.

The study of the self has not usually taken into consideration levels of analysis greater than the individual. As noted by Miller and Prentice (1994), psychology has moved from asking how individuals behave within groups to asking “How do groups behave within individuals?”. This has paralleled anthropology’s shift from defining culture behaviorally and imagining people within cultures to conceiving of culture within people, as a cognitive “conceptual structure”.

Markus and Kitayama (1991) explained that independent selves view certain aspects of their selves, such as desires, preferences, attributes, and abilities, as independent of specific others and, thus, invariant over time and context. On the other hand, interdependent selves view significant aspects of themselves in relation to others in particular contexts. Therefore, the self changes structure with the social context and persons cannot be understood when separated from the larger social whole. In general, White Americans as a group are predominantly composed of individuals for whom the referential/independent/individualistic self is most common, while racial/ethnic minorities in the United States more often possess indexical/interdependent/collectivistic selves.

In the case of Asian Americans, having an Asian cultural background can often explain the greater tendency toward collectivistic understanding of self. Differences between views of self in traditional Asian culture versus traditional American culture are exemplified by language. In English, “I” is the only pronoun capitalized no matter where it falls in a sentence; it stands alone. In Chinese, there are different words for older sister and younger sister, as well as for indicating whether someone is your grandfather on your mother’s side or your father’s side. Similarly, in the Korean language there are nine ways
to say "good-bye". These are based upon whether the person is your elder, peer, or a child
and whether the situation is such that "I'm going-You're staying", "You're staying-I'm
going", or "We're both going". These examples show how "self" is defined in relation to
others for those from Asian cultural backgrounds.

The importance of cross-cultural understanding of the self is evidenced in what this
holds as implications for counseling. According to Draguns (1996), the types of issues
clients are likely to want to focus on in counseling may be related to their understanding of
self. For example, indexical clients may be more likely to expect and want to focus on
issues dealing with social experiences and their reverberations in counseling rather than
intrapsychic growth and development issues. Indexical clients may also hold different
values about the goals of counseling; they may value help in promotion or maintenance of
interpersonal harmony over self-actualization.

Cross-cultural understanding of the self is also important in that it sheds light on
our conceptualizations of healthy, as well as unhealthy, mental functioning. Issues such as
maturity, which is commonly considered a sign of healthy mental functioning, are
influenced by view of self. According to Markus and Kitayama (1991), from the
independent view, a mature person is one who is autonomous, self-determined, separated
from others, assertive, and unencumbered. From the interdependent view, however, one's
opinions, abilities, and characteristics are assigned secondary roles; they must be constantly
controlled and regulated to come to terms with the primary task of interdependence. Such
control constitutes the core of the cultural ideal of maturity.

On the other end of the mental functioning spectrum, views of the self also
influence our ideas about psychopathology (Landrine, 1992). Western culture defines the
failure to construct and maintain a distinction between self and nonself as psychopathology (i.e., lack of ego boundaries, enmeshment, identity diffusion, delusion, or psychosis).

Landrine (1992) also points out that people with indexical views of the self experience psychopathology when they are failing in their roles or when they are considering rejecting their roles, since the self is understood as the roles it occupies. Clinicians who attempt to assist such clients in finding a "true self" (presumed to exist independent of the role and family) are engaging in an extremely inappropriate intervention— one that may precipitate a severe, iatrogenic depression or suicide attempt. The indexical client who fails in or violates his or her role is "dead" (i.e., being or fear of being disowned, rejected, and exiled permanently from families). What's at stake is not loss of mere "approval" but loss of being, existence, and life itself. Culturally sensitive treatment entails assisting the client in finding not a referential self, but a new social identity, a new role, a new self-for-family or being-for-others. Therapy could also entail a renegotiation of the construction of the self by and for all members of the relationship.

Empirical research on interdependent and independent selves shows this construct holds implications for psychological constructs such as cognition. Cousins (1989; cited in Markus & Kitayama, 1991) used the Twenty Statements Test (TST; Kuhn & McPartland, 1954) with American and Japanese students and found Japanese answered role-specifically (e.g., "I play tennis on the weekend."), while Americans answered using psychological traits (e.g., "I am friendly."). However, results were reversed when a version of the test that focused on specific situations was used. The authors speculated that the reversal was due to the fact that the original TST disembeds the "I" from the situational context, making self-description artificial for the Japanese.
Matsumoto, Kudoh, Scherer, and Wallbott (1988; cited in Markus & Kitayama, 1991) studied the consequences for emotion of independent versus interdependent views of self. Japanese participants reported feeling anger primarily in the presence of strangers, while American and Western European participants reported feeling anger primarily in the presence of closely related others. The authors explained that anger (along with frustration and pride) is one of the emotions labelled *ego focused* because they have the individual's internal attributes (needs, goals, desires) as the primary referent. *Other focused* emotions (e.g., shame, sympathy) have another person as the primary referent.

Consequences for motivation were examined by Iwao (1988; cited in Markus & Kitayama, 1991), who found that interdependent selves are not likely to feel cognitive dissonance from counterattitudinal behavior since one's internal attributes are not regarded as significant attributes of the self. In the study, for example, it was found that two percent of Americans and forty-four percent of Japanese rated the response “Father thought that he would never allow them to marry but told them he was in favor of their marriage” to the situation of “A daughter brings home a person from another race” as best, while forty-eight percent of Americans and seven percent of Japanese thought it was the worst response.

A study by Okazaki (1997) was conducted to examine the affect-specific hypothesis that some cultural values characteristic of Asian Americans might predispose them to express their emotional distress in specific ways. The cultural value examined was self-construals. In this study of 183 White and 165 Asian American college students, three hypotheses were made: 1) Asian Americans will report higher interdependent self-construal and lower independent self-construal compared to Whites, 2) Asian Americans will score in the more distressed direction than Whites on each measure of distress.
measures were for depression and social anxiety), and 3) independent and interdependent self-construals will account for a larger portion of Asian-White differences on social anxiety than depression. All three hypotheses were supported. Okazaki explained that social anxiety may constitute a form of distress that is particularly sensitive to cultural and ethnic variations in psychopathology among Asian Americans since it involves interpersonal difficulties, whereas the interpersonal components of depression lie in the stressors or consequences of symptoms.

Singelis (1994) has developed a measure of interdependent and independent self-construals, based on Markus and Kitayama's (1991) constructs, which has been used in several studies. For example, Singelis and Sharkey (1995) examined the interactions of self-construal and "embarrassability" with 503 European American and Asian American undergraduates. They found, as hypothesized, that stronger independent self-construals were correlated with resistance to embarrassment, whereas stronger interdependent self-construals were correlated with increased susceptibility to embarrassment. In addition, they found that Asian Americans were less independent, more interdependent, and more embarrassable than European American participants. They interpreted these results by suggesting that embarrassability functions as an adaptive mechanism in collectivist cultures in that it allows an individual experience to be shared within one's group, creating a sense of common fate. They equated this function with that of sensitivity to others' face, which is emphasized in Asian cultures.

In a related study, Sharkey and Singelis (1995) examined self-construals, "embarrassability", and social anxiety with 371 European American and Asian American undergraduates. They found that, as hypothesized, strength of independent self was negatively correlated with reported level of social anxiety. Also, they found that reported
level of embarrassability was positively correlated with reported levels of social anxiety and negatively correlated with reported levels of independence. Finally, they found that embarrassment is related to three unique variables (social anxiety, independence, and interdependence) that account for 28% of the variance in embarrassability altogether. Their interpretations of these findings point out the Western bias in theorizing that suggests embarrassability is a negative trait. Instead, embarrassability may also play a healthy, functional, and adaptive role, depending on the cultural context.

Singelis and Brown (1995) examined the relationship between culture, self-construals, and collectivist communication styles in a study with 364 undergraduates. Asian American participants were categorized as collectivist, while Caucasian participants were classified as individualist. The authors linked culture, self-construal, and communication in a path-analytic model. Collectivism was significantly positively related to the interdependent self and significantly negatively related to the independent self. They also found that interdependent self-construal was positively related to both the amount of meaning drawn from the context of a message, and the degree to which communicators attribute communication behavior to the influence of the context. They did not, however, find support for the hypothesis that strength of an individual's interdependent self-construal would be positively associated with the assigning of responsibility for miscommunication to the receiver of a message rather than the sender. An important conclusion the authors drew from their finding of a lack of effects for independence is that it supports the notion that independence is orthogonal, not the bipolar opposite, from interdependence. That is, independence refers to the self that is detached from the social context, not the self that has a tendency to be detached (Singelis & Brown, 1995).
The relationship between biculturalism and self-construal was examined by Yamada and Singelis (in press) in a study with 120 participants selected a priori to represent one of four categories: Bicultural (high independence and interdependence), Western (high independence, low interdependence), Traditional (low independence, high interdependence), or Culturally-Alienated (low independence and interdependence). The study also included a control group of 30 participants. They found that individuals who had been identified as bicultural did, on average, have an interdependent self comparable to that of the Traditional group, as well as an independent self comparable to that found in the Western group. They also found support for the idea that culturally-alienated individuals have an underdeveloped sense of both their independent and their interdependent self.

The link between self-esteem and self-construals was examined by Kwan, Bond, and Singelis (1996). Theoretically, they linked these variables by suggesting that the strength of one’s independent self-construal should be related to one’s sense of personal worth, while the strength of one’s interdependent self-construal should be related to one’s interpersonal achievements. In addition, they hypothesized that the effect of an independent self-construal on life satisfaction would be mediated through self-esteem, whereas the effect of an interdependent self-construal on life satisfaction would be mediated through relationship harmony. Participants in their study were 289 college students from Hong Kong and the United States.

Kwan, Bond, and Singelis (1996) found support for their proposed model in the direction hypothesized. In addition, no cultural differences were found in the model, indicating that self-construals play a similar role in determining level of life satisfaction for both Caucasians and Asians. Additionally, they found a negative relationship between
interdependent self-construal and self-esteem, highlighting the tradeoff between fitting in with others and being assertive.

In summary, the body of literature employing Singelis' (1994) measure of self-construal supports the examination of self-construal as a powerful variable, along with other robust cultural variables, such as acculturation. However, there has not been a previous examination of the relationship between self-construal and counseling variables such as those proposed in this study.

Collective Self-Esteem

The process of becoming an African American involves both becoming an American and not an American, being both successful and unsuccessful, and being both proud and ashamed of the same acts and abilities because of the fundamental rift created by membership in a group socially defined as negative (Gaines & Reed, 1995, p. 97).

In this quote, Gaines and Reed are describing the strong influence of social views on groups in which one is a member. This influence can extend to aspects of one's self-concept, such as self-esteem. Social psychology has recently begun to examine the impact of social factors, such as stigma based on sexual orientation or race, on aspects of self-concept such as self-esteem (see Crocker & Major, 1989; Crocker, Voelkl, Testa, & Major, 1991; Frable, Blackstone, & Scherbaum, 1990; Major, Sciacchitano, & Crocker, 1993). Social factors and their influence on the self had previously only been addressed in theory.

Social identity theory (Tajfel & Turner, 1986) emphasizes the importance of social group memberships to individuals' self-concept and posits that the self-concept is composed of two disparate aspects. One is personal identity, which includes attributes of the individual such as competence, talent, and sociability, and which refers to how people
view themselves as individuals (Luhtanen & Crocker, 1992). The other aspect of the self-concept is *social identity*, which is "that part of an individual's self-concept which derives from his [sic] knowledge of his membership in a social group (or groups) together with the value and emotional significance attached to that membership" (Tajfel, 1981, p. 255).

Luhtanen and Crocker (1992) redefined Tajfel's (1981) social identity construct as *collective identity*, which, according to the authors, refers to those aspects of identity that have to do with memberships in social groups. Just as individuals have a personal identity for which they can feel esteem (i.e., self-esteem), Luhtanen and Crocker extrapolated that individuals have collective identities, based on membership in social groups, for which they can also feel esteem. As such, *collective self-esteem* is the value one places on one's social groups.

To measure collective identity, Luhtanen and Crocker (1992) developed the Collective Self-Esteem Scale (CSE), which assesses individuals' collective self-esteem based on their memberships in ascribed groups pertaining to gender, race, religion, ethnicity, and socioeconomic class. The 16-item scale assesses four aspects of collective self-esteem: 1) *Membership esteem*: one's own judgment of how good one is as a social group member, 2) *Private esteem*: one's judgments of how good one's social groups are, 3) *Public esteem*: one's judgments of how other people evaluate one's social groups, and 4) *Identity esteem*: the importance of one's social group memberships to one's self-concept.

Several studies (e.g., Crocker & Luhtanen, 1990; Lay, 1992; Wann, 1994) have examined the relationship between collective self-esteem and ingroup-outgroup biases. For example, Crocker & Luhtanen (1990) hypothesized that because individuals are motivated to achieve and maintain a high level of collective self-esteem, people with high collective
self-esteem engage in ingroup-enhancing biases or distortion when faced with a threat to their collective identity, whereas low collective self-esteem subjects show an absence of ingroup-enhancing biases. Subjects in their study were 82 introductory psychology students of unknown ethnicity and gender. The study used a 2 X 2 X 2 design that crossed collective self-esteem (high or low) with feedback on a social-cognitive aptitude test (group success or group failure), as well as with target of subjects’ rating (above versus below-average scorers on the same test).

Crocker and Luhtanen (1990) found support for their hypothesis in that subjects high in collective self-esteem varied ratings of above- and below-average scorers as a function of their group’s performance feedback such that those whose group succeeded rated above-average scorers higher than did those whose group failed, while those whose group failed showed higher ratings of below-average scorers. Subjects low in collective self-esteem did not significantly alter their ratings as a function of their own group’s performance. These differences were not explained by personal self-esteem differences.

Other studies have addressed the relation between collective self-esteem and psychological well-being (see Blaine & Crocker, 1995; Crocker, Luhtanen, Blaine, & Broadnax, 1994; Kwan, Bond, & Singelis, 1996; Verkuyten, 1995). For instance, Crocker, Luhtanen, Blaine, and Broadnax (1994) examined the relationship between self-esteem and satisfaction with life, depression, hopelessness, and personal self-esteem in their study with 238 White, Black, and Asian American college students. The authors found that on both the general (where instructions ask participants to think about their memberships in groups based on gender, race, religion, nationality, ethnicity, and socioeconomic class) and the race-specific (where instructions ask participants to think only
about their membership in groups based on race) versions of the CSE, Whites' public and private collective self-esteem were correlated moderately. For African Americans the correlation was zero and for Asian Americans they were as highly correlated as measurable (i.e., Black subjects had learned to separate how they privately felt about their groups from how they believed others evaluated them; Asian American subjects did not separate public from private collective self-esteem). The authors felt this finding for Asian American subjects was consistent with evidence concerning the Asian culture's emphasis on the interconnected nature of the self and the importance of one's public image. In addition, all individuals were found to be more likely to identify with groups which they privately evaluated positively and which they felt they contributed to as members, but only Asian Americans disidentified with groups they believed were evaluated negatively by others (Crocker, Luhtanen, Blaine, & Broadnax, 1994). This may partially explain why Asian Americans often do not identify as a racial group, but more as a cultural or ethnic group.

Crocker, Luhtanen, Blaine, and Broadnax (1994) also found that high collective self-esteem on the membership and private subscales of both versions of the CSE was related to improved psychological well-being (i.e., decreased depression and hopelessness) for European American and Asian American subjects. For African Americans on the general version and Asian Americans on the race version of the CSE, scores on the identity subscale correlated negatively with hopelessness. Finally, when controlling for personal self-esteem, none of the measures of well-being were significantly related to collective self-esteem for Whites, although some subscales were related for ethnic minorities.

Based on the findings of Crocker, Luhtanen, Blaine, and Broadnax (1994), Kwan, Bond, and Singelis (1996) administered the race-specific form of the CSE to 137 American
and 125 Hong Kong college students. They found that the membership, private, and public subscales (but not the identity subscale) of collective self-esteem were positively correlated with life satisfaction and with Extroversion, but were negatively correlated with Neuroticism. In addition, a hierarchical regression analysis showed that none of the four subscales of collective self-esteem predicted life satisfaction after partialling out the effects of personal self-esteem and relationship harmony.

In summary, studies on collective self-esteem have moved from a purely social psychological focus on issues such as ingroup-outgroup biases to more of a clinical focus on psychological well-being. This study seeks to extend this clinical focus by examining the relationship between collective self-esteem and counseling variables.

Face

Face can be considered an orientation in viewing human behavior which emphasizes the reciprocity of obligations, dependence, and esteem protection (Ho, 1976). Face is both a social sanction for enforcing moral standards and an internalized sanction (Hu, 1944; cited in Domino, Affonso, & Slobin, 1987). In an analysis of the literature on face, Ho (1976) concluded that reciprocity is inherent in face behavior. Thus, the concept of face only has meaning when characterizing the behavior of one individual in relation to another (Ho, 1982).

Behavior in the service of maintaining face is universal (Ho, 1976). What constitutes a desirable face is, however, more culturally specific (Bond & Hwang, 1986). The Asian concept of face is explained most succinctly by Bond and Hwang in discussing the social psychology of Chinese people. They break the concept into its two component
parts: *lien* and *mianzi*. *Mianzi* refers to the concept of face more common in Western cultures; it refers to a reputation achieved through success. *Lien* is an Eastern-influenced concept referring to confidence of a society in the integrity of a person’s moral character.

Face is a very important construct within Asian culture. In fact, Domino, Affonso, and Slobin (1987) rank face as one of the five most influential societal forces in China (the others being the extended family, the government, filial piety, and Tao). For example, loss of face is a punishment that can be far greater than imprisonment or a fine.

The concept of face holds implications for cross-cultural differences. For instance, American culture values direct communication highly, while many Asian cultures value indirect communication (e.g., metaphor, insinuations, innuendos, hints, irony) more (Yum, 1988). Indirect speech serves people in the pursuit of politeness (Brown and Levinson, 1978; cited in Yum, 1988) and results from a concern for the other person’s face, while direct speech reflects a concern for one’s own face (Katriel, 1986; cited in Yum, 1988). According to Yum, indirect communication helps prevent the embarrassment of rejection by another person or disagreement among partners, which leaves the relationship and the face of each party intact.

American and Asian cultures also differ in the way social “games” are played. Stover (1974; cited in Bond & Hwang, 1986) contrasted the American game of one-upmanship (e.g., at a cocktail party) with the Chinese game of face by explaining that in one-upmanship, the game is the same for everyone involved, everyone has a free choice in use of the skills of language and action, and the limits of the game are set only by one’s ability and ambition. The game of face, on the other hand is different for each player because one has to speak in the language suited to one’s station and display appropriate
behavior and status symbols. Hwang (1983; cited in Bond & Hwang, 1986) explains that the Chinese game of face has evolved because of its historical functioning in a society where most social resources have always been controlled by a few allocators who may distribute resources in accordance with their personal preferences, leading to the need to strengthen connections with others in order to obtain resources. The strengthening of connections is best accomplished through playing the game of face.

Behaviors meant to save face have been categorized by several researchers. For example, Lebra (1976; cited in Yum, 1988) listed several mechanisms for defending face: 1) mediated communication (asking someone else to transmit a message), 2) refracted communication (talking to a third person in the presence of the hearer), and 3) acting as a delegate (conveying one's message as being from someone else).

Bond and Hwang (1986) classify face-saving behavior in Chinese society into six categories according to the target of the face behavior: 1) enhancing one's own face (by presenting those qualities most cherished by others in one's social network), 2) enhancing others' face (by adopting tactics of ingratiation such as presenting compliments, conforming with one's opinions, and giving gifts), 3) losing one's own face (through not living up to the moral standards of the society), 4) hurting others' face (through insensitivity to relationships with those higher or lower on the social scale), 5) saving one's own face (through compensatory, self-defensive, or retaliatory actions that are supposed to relieve the emotional arousal of losing face), and 6) saving others' face (through reluctance to criticize others and compensating if one has to reject another's request).

According to Ho (1982), face is a relational concept, as opposed to the individualistic concepts (e.g., ego, self, personality, authoritarianism, extraversion-
introversion) that serve as the fundamental building blocks of research in psychology.

Applied psychology is also fundamentally based on individualistic concepts. For example, Berg and Jaya (1993) discuss the fact that the Asian interpersonal relationship is based on shame, not guilt, which differs from the Judeo-Christian cultural emphasis on guilt, around which Western-based psychotherapeutic theory is built. Berg and Jaya use the concept of loss of face as a foundation upon which they make suggestions for family counselors in work with Asian American families. Their suggestions center around problem-solving methods that avoid embarrassing clients, while also preserving their dignity and roles in the family.

Interpersonal constructs, such as loss of face, that are more culturally-salient for some ethnic groups than others, can be important to understand given that change in therapy is mediated through the client-therapist relationship (Zane, 1991). A scale designed by Zane (1991) to measure loss of face has been used in only a few studies. In one study, Zane examined the relationship between loss of face and assertion among 121 White and Asian American students. It was found that: 1) Asians were more concerned with loss of face than Whites, and 2) loss of face was a significant predictor of assertion with strangers (but not with intimates or acquaintances) for both Asians and Whites.

In a study on group counseling expectations, Leong, Wagner, and Kim (1995) surveyed 134 Asian American students using measures of group counseling expectations, acculturation, and loss of face. It was hypothesized that Asian Americans with a higher sensitivity to loss of face would have more negative expectations of group counseling. They found that, contrary to their hypothesis, loss of face was not a significant predictor of positive orientations toward group counseling.
In summary, little research has been conducted examining loss of face for Asian Americans or Whites. Given that the relationship and comfort with self-disclosure (which can be inhibited by sensitivity to loss of face) are important in counseling, an examination of loss of face seems important in research with Asian Americans and counseling variables.

Conclusion and Hypotheses

The literature on mental health services utilization by Asian Americans documents a tendency to underutilize services and to prematurely terminate services, compared to Whites. Researchers in cross-cultural and multicultural counseling have hypothesized that cultural variables may influence Asian American barriers to utilization. Some research has been conducted with various cultural variables to address these patterns, but many cultural variables of interest remain unexplored. Thus, the literature on treatment acceptability, willingness to see a counselor, and counselor preferences/ethnic matching was reviewed in support of examining these variables as potential barriers to utilization of mental health services by Asian Americans. In addition, literature on cultural variables of interest in relation to these barriers was reviewed. These cultural variables are acculturation, construals of the self, collective self-esteem, and loss of face.

Based on this review of literature, exploratory questions were framed concerning each of the three potential barriers to utilization of mental health services by Asian Americans. In turn, the questions guided the development of the following 15 research hypotheses. For each dependent variable, the first hypothesis involves a between-groups comparison of Whites and Asian Americans, while the other hypotheses make within-group comparisons among Asian Americans. Each within-group hypothesis is
broken down into an initial exploratory premise concerning the relationship of each independent variable with each dependent variable, while the second premise concerns specific hypothesizing as to the relationship of the variables.

A. Treatment Acceptability. What kinds of counseling/psychotherapy treatments do Asian Americans find most acceptable?

Hypotheses:

1) Whites are hypothesized to find all four types of treatments (i.e., individual client-centered, individual cognitive-behavioral, group, and family therapies) more acceptable than Asian Americans will find these four treatments.

2a) Acculturation will be a significant predictor of treatment acceptability of all four types of treatments for Asian Americans.

2b) Asian Americans who are more acculturated will find all four treatments more acceptable than will those Asian Americans who are less acculturated.

3a) Loss of face will be a significant predictor of treatment acceptability of all four types of treatments for Asian Americans.

3b) Asian Americans who are more sensitive to loss of face are hypothesized to find individual counseling more acceptable than group or family counseling.

4a) Self-construal will be a significant predictor of treatment acceptability of all four types of treatments for Asian Americans.

4b) Interdependent and independent Asian Americans will not differ in acceptability of individual counseling, although independent Asian Americans will find group and family counseling more acceptable than do interdependent Asian Americans.
5a) Collective self-esteem will be a significant predictor of treatment acceptability of all four types of treatments for Asian Americans.

5b) There will be a positive relationship between collective self-esteem and acceptability of all types of counseling for Asian Americans.

B. Willingness to See a Counselor. For which types of problems are Asian Americans willing to see a counselor?

Hypotheses:

6) Whites will be more willing than Asian Americans to see a counselor for interpersonal/relationship problems, while Asian Americans will be more willing than Whites to see a counselor for academic/career problems.

7a) Acculturation will be a significant predictor of willingness to see a counselor for the three problem areas for Asian Americans.

7b) Asian Americans who are high acculturated are hypothesized to be more willing to see a counselor for all problem concerns, while those Asian Americans who are low acculturated are hypothesized to be more willing to see a counselor only for academic and career concerns.

8a) Loss of face will be a significant predictor of willingness to see a counselor for the three problem areas for Asian Americans.

8b) Asian Americans who are more sensitive to loss of face are hypothesized to be only willing to see a counselor for academic and career concerns, compared to Asian Americans who are less sensitive to loss of face.

9a) Self-construal will be a significant predictor of willingness to see a counselor for the three problem areas for Asian Americans.
9b) Highly independent Asian Americans will be more willing to see a counselor for all problems, compared to highly interdependent Asian Americans.

10a) Collective self-esteem will be a significant predictor of willingness to see a counselor for the three problem areas for Asian Americans.

10b) Asian Americans who are low in collective self-esteem will be less willing to see a counselor for problems that are race-related (i.e., ethnic or racial discrimination, ethnic identity confusion), while those Asian Americans who are high in collective self-esteem will be more willing to see a counselor for those same race-related concerns.

C. Counselor Preferences. What kinds of preferences do Asian Americans have for counselors they see?

Hypotheses:

11) It is hypothesized that Whites will be similar to Asian Americans in preference for cognitive match with a counselor, but will have less preference for demographic match with counselors than Asian Americans.

12a) Acculturation will be a significant predictor of preference for demographic and cognitive match with a counselor for Asian Americans.

12b) Low acculturated Asian Americans are hypothesized to strongly prefer demographically-matched counselors, high acculturated Asian Americans will prefer demographically-matched counselors the least, and medium acculturated/bicultural Asian Americans are hypothesized to be in between high and low acculturated Asian Americans in preferences for a demographically-matched counselor.
13a) Loss of face will be a significant predictor of preference for demographic or
cognitive match with a counselor for Asian Americans.

13b) The more sensitive Asian Americans are to loss of face, the more they are
hypothesized to prefer counselors with demographic and cognitive match, as
compared to Asian Americans who are less sensitive to loss of face.

14a) Self-construal will be a significant predictor of preference for demographic and
cognitive match with a counselor for Asian Americans.

14b) Asian Americans who are independent are hypothesized not to have strong
preferences for either demographic or cognitive match with counselors, while
Asian Americans who are interdependent are hypothesized to report strong
preferences for both cognitive and demographic match with counselors.

15a) Collective self-esteem will be a significant predictor of preference for
demographic and cognitive match with a counselor for Asian Americans.

15b) Asian Americans who are high in collective self-esteem will strongly prefer
demographically-matched counselors.
CHAPTER 3

METHOD

This chapter will describe the samples and procedure for the conduct of the current study. In addition, the development, scoring, and psychometric properties of the instruments and materials are specified. Finally, the design of the study and rationale for the statistical analyses used in the current study are presented.

Participants

Participants were 234 White university students with usable data from 232 participants, as well as 235 Asian American university students with usable data from 215 participants.

In this study, White participants (N = 232) were undergraduates enrolled in Introductory Psychology classes at The Ohio State University (OSU). Asian Americans were defined as individuals of Asian or Pacific Islander descent who were either U.S. citizens or U.S. Permanent Residents at the time of participation in the study. Of the total sample of Asian American participants (N = 215), approximately half were undergraduate students in Introductory Psychology classes at The Ohio State University (N = 120). The
other half of the Asian American sample was drawn from classes with a high Asian American enrollment at two California universities. These universities were the University of California, Irvine (UCI; $N = 73$), and the University of Southern California (USC; $N = 22$). See Table 1 in the Results section for a more complete description of the samples.

**Instruments and Materials**

**Solicitation statement.** Participants were given a written solicitation (see Appendix A) which briefly explained the nature of the study and what they were to do. They were informed that their participation was voluntary and anonymous, and that they were free to stop at any time.

**Suinn-Lew Asian Self-Identity Acculturation Scale (SL-ASIA).** The SL-ASIA (Suinn, personal communication, Fall 1994; see Appendix B) was used to assess acculturation level for Asian American participants. This instrument consists of 26 multiple-choice items that assess values, attitudes, behaviors, language, identity, friendships, and generational/geographic background. Participants are asked to choose the one response that best describes them for each item using a 5-point scale where responses on the low end reflect highly Asian-identified responses and responses on the high end of the scale reflect highly Western-identified responses.

Suinn, Rickard-Figueroa, Lew, and Vigil (1987) state that an acculturation score (the “SLASIA” score) is obtained by summing across the answers for the first 21 items, and then dividing the total score by 21, yielding scores ranging from 1 to 5. These scores can be used in correlational analyses since they fall on a continuum. Alternatively, another way to score the first 21 items would be to consider theoretical discussions on acculturation that suggest three levels of acculturation (low, high, and medium/bicultural). Thus, the
scale scores would be trichotomized into those entirely assimilated into Western culture ("Assimilated"), those who remain identified with their ethnic heritage alone ("Asian-Identified"), and those who identify with both worlds without denying either ("Bicultural").

Suinn (personal communication, Fall 1994) suggests that scoring of items 22-26 be done separately from scoring of the first 21 items in order to obtain additional classifications of data from a categorical viewpoint, as opposed to the continuum scoring for the first 21 items. First, items 22 and 24 should be reverse scored. Then, answers to questions 22 and 23 should be grouped together to produce an SL-ASIA "Values" score. Questions 24 and 25 are scored such that they produce an SL-ASIA "Behavioral Competencies" score. Finally, item 26 is examined independently to produce an SL-ASIA "Self-Identity" score.

In this study, a 27th item was added to the SL-ASIA based on the modified version of the SL-ASIA used by Atkinson and Gim (1989). They created a question to assess degree of commitment to cultural values. This item was included in the version of the SL-ASIA to be used in this study as a validity check against the SL-ASIA Values score. In addition, the SL-ASIA was modified for use in this study such that question 12 asks participants to directly assess their generational level, as opposed to the original item's use of subitems to aid participants in assessing generational level. This modification was made to enable the use of scantron sheets in the data collection.

The original SL-ASIA (Suinn, Rickard-Figueroa, Lew, & Vigil, 1987) was a 21-item scale that operationalized the S. Sue and Sue (1973) model of Asian American ethnic identity. This version of the SL-ASIA has been used extensively in research on Asian
American acculturation. The newer 26-item version of the scale was developed to account for research indicating acculturation is a multidimensional construct (Suinn, 1996). Thus, items 22 through 26 were added to address issues of behavioral competency (i.e., fit with the culture), values, behavioral preferences, and self-perception. These questions are designed to allow for orthogonal measures of acculturation such that individuals can, for example, believe strongly in both Asian values and Western values (Suinn, 1996).

Using a sample of Asian American university students \((N = 284)\), reliability, concurrent validity, and factorial validity was reported for the SL-ASIA (Suinn, Ahuna, & Khoo, 1992). Cronbach's alpha was found to be .91, which was consistent with alphas reported in other studies (.88 by Suinn, Rikard-Figueroa, Lew, & Vigil, 1987; .89 by Atkinson & Gim, 1989; .87 by Tata & Leong, 1994). Correlations between SL-ASIA scores and demographic information were in the expected directions. Finally, five factors were found, accounting for 69.7% of the variance.

White Racial Identity Attitudes Scale (WRIAS). The WRIAS (see Appendix C) was used with White participants in this study in place of the SL-ASIA. This scale was derived from Helms' (1984) model of White racial identity development. It is a 50-item scale with responses made on a 5-point Likert scale (1 = Strongly Disagree, 5 = Strongly Agree). The instrument consists of 5 subscales (Contact, Disintegration, Reintegration, Pseudo-Independence, Autonomy) reflecting stages of White racial identity development.

The WRIAS is scored by summing items that comprise each of the five subscales (Contact = 1, 6, 11, 16, 21, 26, 31, 36, 41, 46; Disintegration = 2, 7, 12, 17, 22, 27, 32, 37, 42, 47; Reintegration = 3, 8, 13, 18, 23, 28, 33, 38, 43, 48; Pseudo-Independence = 4, 9, 14, 19, 24, 29, 34, 39, 44, 49; and Autonomy = 5, 10, 15, 20, 25, 30, 35, 40, 45).
Higher scores on each of the subscales indicate stronger levels of the respective racial identity attitudes, but all five scores are used to form a profile, as opposed to using single scores.

Helms and Carter (1991) found reliabilities for the WRIAS ranging from .65 (Pseudo-Independence and Autonomy subscales) to .76 (Disintegration subscale) in a study \((N = 176)\) on counselor preferences. Tokar and Swanson (1991) administered the WRIAS to a sample of White university students \((N = 308)\) and found reliabilities of .61, .78, .84, .65, and .71 for the Contact, Disintegration, Reintegration, Pseudo-Independence, and Autonomy scales, respectively.

In terms of validity, interscale correlations show the subscales are measuring what they were intended to assess, but are not so highly correlated as to suggest redundancy (Helms & Carter, 1990). In addition, each of the subscales have been correlated with measures of other personality constructs in a direction hypothesized by identity theory, showing evidence of criterion validity (Helms & Carter, 1990). Finally, a factor analysis using data from several studies of White college students attending predominantly White universities in the Eastern United States \((N = 506)\) found that, while the items and subscales were factorially complex, most items from the same subscales tended to have factor loadings in the same direction.

Helms (1990) also proposes that the five stages of the WRIAS can be grouped such that they form two phases of White racial identity development. Phase 1, called “Abandonment of Racism”, is composed of the Contact, Disintegration, and Reintegration stages. Phase 2, called “Defining a Nonracist White Identity”, is composed of the Pseudo-
Independence and Autonomy stages. Thus, in this study scores for the stages were summed within each stage to produce a two-phase structure for the WRIAS.

**Self-Construal Scale (SCS).** The SCS (Singelis, personal communication, September 1997; see Appendix D) is a 30-item scale designed to measure the strengths of an individual's independent and interdependent self-construals. Singelis (1994) developed the original 24-item version of the SCS based on interdependent and independent views of the self as defined by Markus and Kitayama (1991). Six additional items (interdependent items 12, 14, & 30; independent items 5, 7, & 24) were added to improve internal reliabilities of the original scale and are relatively untried in research to this date (Singelis, personal communication, September 1997).

Responses to the SCS are made using a 7-point Likert scale (1 = Strongly Disagree, 7 = Strongly Agree). Two separate scores are calculated -- one for the strength of the independent self and one for the interdependent self -- since the two aspects of self are separate factors, not opposite poles of a single construct (Singelis & Sharkey, 1995). The SCS is scored by adding each subject's scores for the independent items (1, 2, 5, 7, 9, 10, 13, 15, 18, 20, 22, 24, 25, 27, 29), then for the interdependent items (3, 4, 6, 8, 11, 12, 14, 16, 17, 19, 21, 23, 26, 28, 30).

The SCS has been found to be reliable and valid. Singelis (1994) administered the original 24-item version of the SCS to African American, Caucasian, Chinese, Filipino, Hawaiian, Japanese, Korean, Samoan, and mixed undergraduates at the University of Hawaii (N = 364). Reliability of the SCS was adequately high in this sample; the two subscales had Cronbach’s alphas of independent = .70 and interdependent = .74. These were comparable to the reliabilities calculated in Singelis and Sharkey’s (1995) study with European, Chinese, Filipino, Japanese, and Korean American undergraduates at the
University of Hawaii (N = 503): independence = .70; interdependence = .73. Additional studies have also found reliability of the SCS to be strong. Cronbach’s alphas for bicultural, Western, Traditional (collectivistic), and culturally-alienated (marginal) participants (N = 120) in a study on biculturalism and self-construal were: independent = .67, interdependent = .74 (Yamada & Singelis, in press).

Loss of Face Scale (LOF). The LOF (Zane, 1991; see Appendix E) is a self-report instrument consisting of 21 items developed to measure individuals’ attitudes toward losing face in public and their behavioral attempts to maintain face for themselves or others. Items are responded to on a 7-point Likert scale (1 = Strongly Disagree, 7 = Strongly Agree). Scores are obtained by summing responses to individual items, with higher scores indicating greater sensitivity toward losing face.

In a developmental study, Zane (1991) found that the LOF had good internal consistency (α = .83) in a sample of Caucasian and Asian American undergraduates (N = 158). This was similar to the reliability coefficient of .85 found in a sample of Asian American students (N = 134) in a study on group counseling expectations (Leong, Wagner, & Kim, 1995).

In addition, Zane (1991) found concurrent and discriminant validity for the LOF in that it was significantly correlated with various constructs in the expected directions. Specifically, the LOF correlated positively with Other-Directedness, Private Self-Consciousness, Public Self-Consciousness, and Social Anxiety, while it correlated negatively with Extraversion, Acting, and Acculturation. Finally, Asians scored significantly higher on the LOF than Whites.
Collective Self-Esteem Scale (CSE). The CSE (Luhtanen & Crocker, 1992; see Appendix F) is a 16-item scale composed of four subscales (Membership, Private, Public, Identity) that measure collective self-esteem in line with social identity theory’s (Tajfel, 1981; Tajfel & Turner, 1986) conception of collective identity. Responses are made on a 7-point Likert scale (1 = Strongly Disagree, 7 = Strongly Agree). Items 2, 4, 5, 7, 10, 12, 13, and 15 are reversed for scoring. Item scores within each subscale are summed to derive the subscale score (Membership = 1, 5, 9, 13; Private = 2, 6, 10, 14; Public = 3, 7, 11, 15; and Identity = 4, 8, 12, 16). Separate CSE scores are obtained for each subscale rather than collapsing across subscales to arrive at a total score (Crocker, Luhtanen, Blaine, & Broadnax, 1994).

The scale is preceded by instructions to think about one’s memberships in various social groups (e.g., gender, religion, race), but can also be modified to instruct participants only to focus on membership in one group (e.g., race-specific collective self-esteem). In a study with White, Black, and Asian undergraduates (N = 238), the race-specific version of the CSE was highly correlated with the general version of the CSE (rs ranged from .39 to .69), but not so highly correlated that it measured the same construct (Crocker, Luhtanen, Blaine, & Broadnax, 1994). Because this study focused on cultural variables related to membership in either White or Asian racial/ethnic groups, the race/ethnic-specific instructions were used in the present study.

Luhtanen and Crocker (1992) conducted three studies in the process of developing the CSE. Subjects in Study 1 were White, Black, and Asian undergraduates (N = 887), while in Studies 2 (N = 83) and 3 (N = 180) they were predominantly White undergraduates. Overall, the authors found the reliability of the CSE to be good, with
Cronbach's alphas ranging from .85 to .89 on the subscales. These reliabilities were comparable to those found in a study (Crocker, Luhtanen, Blaine, & Broadnax, 1994) on collective self-esteem and psychological well-being among White, Black, and Asian college students (.63, .79, .86, and .81 for the Membership, Private, Public, and Identity subscales, respectively), as well as in a study (Lay, 1992) on collective enhancement (Cronbach’s alphas of .75 were found on both the private and public subscales).

Luhtanen and Crocker (1992) also found support for having four separate subscales. Racial minorities reported lower levels of public esteem than Whites and public esteem was negatively correlated with a belief in discrimination based on race and sex. The CSE showed good construct validity in that there were predictable correlations with other measures. For example, it was moderately positively correlated with measures of personal self-esteem.

Treatment Vignettes. Assessment of participants' treatment acceptability ratings involved the use of brief written vignettes depicting four types of treatments. A brief set of instructions preceded the vignettes instructing participants to imagine they are suffering from an emotional/personal problem for which they seek counseling help (see Appendix G). The treatments depicted in the vignettes are: individual client-centered counseling, individual cognitive-behavioral counseling, group counseling, and family systems counseling (see Appendices H, I, J, and K respectively). This method of providing written vignettes to assess treatment acceptability has been used previously (see Burgio, Sinnott, Janoskly, & Hohman, 1992; Hunsley, 1993; Sturmey, 1992). The vignettes depict interventions that occur in each type of counseling and do not mention outcomes so as to avoid confounding treatment acceptability ratings.
Although the vignettes were created by the primary investigator, they were based on descriptions of interventions used in individual (Shertzer & Stone, 1974), group (Corey, 1995), and family therapy (Nichols & Schwartz, 1995). Initially, only three vignettes were written: individual cognitive-behavioral counseling, group counseling, and family counseling. The discriminant validity of these vignettes was assessed to ensure that the vignettes were depicting different types of treatment. The vignettes were re-written, with mention of “individual”, “group”, or “family” counseling removed, and administered with an open-ended question asking what type of counseling raters thought was being depicted (see Appendix L). Raters were all in their early 30’s, and included one White male master’s level doctoral student in counseling psychology, one Asian American male master’s level doctoral student in counseling psychology, and one White female psychologist who had completed her doctoral degree. Two of the three raters had difficulty distinguishing the group vignette from the family vignette, leading to modification of the wording in these two vignettes.

These vignettes were then subjected to content validity checks to ensure that they depicted the three treatments in ways that were accurate and typical (see Appendix M). The three vignettes were each followed by two questions asking for ratings on a scale of 1 (Not realistic/Not Typical) to 10 (Very Realistic/Very Typical). Raters were: one 25-year-old White female master’s level doctoral student in counseling psychology, one 25-year-old African American female master’s level doctoral student in counseling psychology, and one 36-year-old biracial Asian American and White female psychologist on the staff of a university counseling center.

Based on the results obtained from this sample of people familiar with counseling therapies, it was determined that the content validity of the vignettes was satisfactory.
Specifically, raters gave the individual counseling vignette an average score of 8.67 for realism and 8.67 for typicality. For the group counseling vignette, an average score of 8.67 for realism and 7.67 for typicality was given by raters. Finally, raters gave average scores of 9.00 for realism and 8.00 for typicality on the family counseling vignette. One of the raters commented that she gave a lower score on typicality for the family counseling vignette because “families are even less likely than individuals to stay in counseling this long”. Thus, the wording of all vignettes was modified to reflect a duration of eight sessions, as opposed to twelve.

Following discussion during the proposal stage of this study, it was decided to include a fourth vignette depicting individual client-centered counseling (see Appendix H). This was done to address a potential confound between ratings of treatment acceptability for individual counseling based on theoretical orientation, as opposed to modality of counseling. That is, by including two types of individual counseling vignettes it was possible not only to compare the treatment ratings of individual counseling to group and family counseling, but also to examine the client-centered and cognitive-behavioral ratings separately. This provided a solution to the confound of theoretical orientation and modality. In addition, it allowed a test of the often-stated hypothesis (see D.W. Sue & D. Sue, 1990) that Asian Americans prefer directive (e.g., cognitive-behavioral) counseling over non-directive counseling that focuses more on affect.

A coin was tossed to determine which of the two individual counseling vignettes would be presented first in the questionnaire packets. It was determined, based on this coin toss, that the client-centered vignette (labeled “Approach A”) would be presented first, followed by the cognitive-behavioral vignette (labeled “Approach B”).
Treatment Evaluation Inventory - Short Form (TEI-SF). The TEI (Kazdin, 1980a) was developed to assess parents' ratings of treatment acceptability for behavioral interventions (e.g., time out, spanking) with children. The TEI was later modified by Kelley, Heffer, Gresham, and Elliott (1989) into a short form (TEI-SF) to make it a more useful clinical research instrument. The TEI-SF was further modified for use in this study (see Appendix N) such that items were slightly re-worded to be more applicable for use with college students rating acceptability of treatments for themselves, as opposed to a child. Minor modifications to the wording of the TEI have been done in previous studies on acceptability of martial therapies (e.g., Upton & Jensen, 1991).

The TEI-SF is a 9-item scale with responses made on a 5-point Likert scale (1 = Strongly Disagree, 5 = Strongly Agree). Item 6 ("I believe I would experience discomfort during the treatment") is reverse scored, yielding TEI-SF scores of 9 to 45, with higher scores representing greater acceptance of a given treatment.

The TEI-SF was created to address limitations (i.e., redundancy of items, length of time to complete, raters' tendency to use only anchor points on the scale, and readability) with the TEI (Kelley, Heffer, Gresham, & Elliott, 1989). The authors conducted two experiments in developing the TEI-SF. In experiment 1, Black, Hispanic, and White mothers with children 2-12 years of age (N = 153) read a case description of a child who misbehaved and was treated by having a privilege withdrawn. Two factors were extracted from the TEI-SF data in this study: an Acceptability factor (accounting for 42% of the variance) and an Ethical Issues/Discomfort factor (accounting for 19% of the variance).

In experiment 2, undergraduates (N = 264) were administered the same case example, but with three different types of treatment vignettes, and were asked to rate them
on both the TEI and the TEI-SF. An alpha of .85 for the TEI-SF in this study indicated good reliability. In addition, this was not very different from the alpha of .89 for the TEI, showing little reduction in internal consistency between the two forms. Finally, the TEI-SF discriminated among the three treatments (Kelley, Heffer, Gresham, & Elliott, 1989).

Spirrison and Noland (1991) conducted a study to ascertain whether measurement error between the original TEI and the short form (derived from a score representing the items used in the TEI-SF) varied in a systematic manner with 164 undergraduates who were administered the full original version of the TEI. The treatments they used — differential reinforcement of behavior, exclusionary time out, overcorrection, medical restraint, contingent electric shock, and physical restraint — were all presented in a case example of a 24-year-old severely mentally retarded individual (either male or female) who often engaged in either mild or severe self-injurious behavior. They found that, relative to the original scale, the TEI-SF tends to overestimate the acceptability of differential reinforcement and underestimates acceptability of overcorrection. Spirrison and Noland concluded that one cannot assume the short form yields data directly analogous to the full scale's data. However, given that neither the TEI nor the TEI-SF has been used in previous research on any of the variables being examined in this study, the more important question for the purposes of this study seemed to be about the reliability of the scale for use with this population and with these variables.

Personal Problems Inventory (PPI). This study used the same modified version of the PPI (Cash, Begley, McCown, & Weise, 1975) that Gim, Atkinson, and Whiteley (1990) used in a study on Asian American acculturation and willingness to see a counselor (see Appendix O). The version of the PPI Gim, Atkinson, and Whiteley used is a 24-item
measure which includes 15 original concerns of college students, 5 items added by Ponce and Atkinson (1989) to address concerns minority college students encounter, and 4 problems added by Gim, Atkinson, and Whiteley that are of particular concern to Asian American college students. Two items added by Gim, Atkinson, and Whiteley directly involve racial/ethnic-related concerns: ethnic or racial discrimination and ethnic identity confusion. The scale uses a 4-point Likert response scale (1 = Not Willing to See a Counselor, 4 = Willing to See a Counselor). Higher scores indicate more willingness to see a counselor for that particular problem.

Johnson and Holland (1986) investigated the internal structure of the original 15-item PPI to determine the factors involved in client expectations in the hopes of establishing an empirically-based organizational procedure to be used in future research with the instrument. Participants in their study were 207 undergraduates. Their responses to the PPI were subjected to Pearson product-moment correlations and then to principal components analysis using a varimax rotation. These analyses extracted four factors, which were determined to be the optimal model, and which together accounted for 61.8% of the variance. These factors were: Performance Anxiety problems, Interpersonal problems, Intrapersonal problems, and Substance Abuse problems. Internal consistency of each factor was found in that reliabilities for the four factors were as follows: Performance Anxiety = .81, Interpersonal = .76, Intrapersonal = .64, and Substance Abuse = .74.

Gim, Atkinson, and Whiteley (1990) factor analyzed responses to the 24 items in order to consolidate them into a smaller number of dependent variables using a principal-components factor analysis with varimax rotation. They selected a three-factor solution that accounted for 48% of the total variance. Items with loadings of .50 or higher were
included in a factor. The three factors they identified were: Relationship Concerns, Academic/Career Concerns, and Health/Substance Abuse Concerns. They also conducted analyses using as dependent variables five problems (Conflicts with Parents, Financial, Insomnia, Roommate, Ethnic Identity Confusion) that did not load over .50 on any factor. Thus, the use of principal components analysis to reduce the number of items has precedent. In the present study, a similar analysis was conducted prior to analyzing the data according to the hypotheses.

Counselor Preference Scale (CPS). For the purposes of this study, a brief (6-item) scale was created to measure counselor preferences (see Appendix P) for similarity in ethnicity, gender, sexual orientation, socioeconomic class, value orientation, and personality style of counselor with client. Each question can serve as a dependent variable in its own right, or items can be grouped to test demographic similarity matching (i.e., on ethnicity, gender, sexual orientation, and socioeconomic class) versus cognitive similarity matching (i.e., on value orientation and personality style) analyses for counselor preferences. Responses are made on a 10-point Likert scale from 1 = Do Not Prefer At All to 10 = Strongly Prefer. Higher scores indicate stronger preferences.

A pilot study was conducted with six Asian American participants who filled out a complete questionnaire packet similar to the one that will be used in this study. Participants in the pilot study were five females and one male who ranged in age between 24 and 32; there were two each in the Chinese American, Indian American, and Japanese American ethnic groups. All had never been married and were post-baccalaureate students. All but one had been in counseling before. Based on their responses to this scale, mean scores were calculated for each question. These averages, based on a scale of 1 (Do Not Prefer At
All) to 10 (Strongly Prefer), were: Ethnicity = 5.33, Gender = 6.17, Socioeconomic Class = 7.00, Sexual Orientation = 3.67, Value Orientation = 7.83, and Personality Style = 4.00. If questions are grouped, the Demographic Match variables' average was 5.54, while the average for the Cognitive Match variables was 5.92.

Marlowe-Crowne Social Desirability Scale - Brief Form (MCS-BF). The MCS-BF (Reynolds, 1982; see Appendix Q) is a brief form of the original 33-item Marlowe-Crowne Social Desirability Scale (Crowne & Marlowe, 1960). The original scale utilized a true-false response format and consisted of items chosen for inclusion in the scale on the basis of their description of culturally-approved behaviors with low incidence of occurrence and minimal implications for psychopathology. It has been used primarily to assess the impact of social desirability on self-report measures, but is not used as often as desirable because of its length (Reynolds, 1982).

Thus, Reynolds (1982) sought to construct reliable and valid brief forms of the scale in a study with 608 White, Black, and Hispanic undergraduates. A factor analysis, descriptives, and reliability analyses were conducted to extract six short form versions of the Marlowe-Crowne Social Desirability Scale. The strongest version was a 13-item form with a reliability of .76. It was significantly correlated .93 with the original scale and significantly correlated .41 with the Edwards Social Desirability Scale (Edwards, 1957). This version was recommended for use as a viable brief scale to measure social desirability.

Socially desirable responses to the MCS-BF for items 1, 2, 3, 4, 6, 8, 11, and 12 are “false”, while those to items 5, 7, 9, 10, and 13 are “true” (Crowne & Marlowe, 1960). Thus, items 5, 7, 9, 10, and 13 are reverse scored so that higher scores indicate greater social desirability bias in the response set.
Demographic Sheet. Demographic information regarding sex, age, citizenship, race, Asian ethnicity, marital status, income, occupation, education, academic major, and previous counseling experience was also gathered (see Appendix R).

Procedure

The solicitation statement, SL-ASIA (for Asian Americans; WRIAS for Whites), LOF, SCS, CSE, treatment vignettes and four administrations of the TEI-SF, PPI, CPS, MCS-BF, and demographic sheet were combined into questionnaires. The SL-ASIA, treatment vignettes/TEI-SF, PPI, and MCS-BF were grouped in that order because their response scales permitted use of a 5-choice scantron response sheet. Following this, the CPS, LOF, CSE, and SCS were grouped in that order because they required use of a 10-choice scantron sheet. Carryover effects between materials and participant fatigue were predicted to be minimal based on pilot study data indicating an average of 35 minutes to complete the questionnaire. During data collection, there were no noticeable carryover effects in that completion times for the questionnaire ranged between 30 and 60 minutes.

In addition, the materials as a whole and treatment vignettes in particular were not counterbalanced. This decision was made based on empirical research on order effects in survey research (Strack, 1992). Strack showed that contrast effects (i.e., suppression of extraneous influences on responding) are the likely outcome when respondents: 1) are aware that preceding questions are related to the current question and 2) do not perceive the second question to be a continuation of the first question. Thus, in the case of the four treatment vignettes, it should be clear that the vignettes are related to one another in that they all utilize the TEI-SF for responding, but it is also clear they are four separate
vignettes. Thus, participants are likely to suppress the effect of responses to the previous vignettes as they respond to questions about subsequent vignettes.

Participants were administered the questionnaire packets by the principal investigator of this study (when collecting from students at OSU) or an instructor in their class (when solicited through UCI or USC). Participants at OSU completed the questionnaires in the presence of the administrator during scheduled times for which the students signed up. Participants at UCI and USC took questionnaire packets home to complete and then returned them to their class instructors. Participants at OSU were recruited from the Introductory Psychology class subject pool and received partial credit toward their introductory psychology course for their participation. Participants at UCI and USC received extra credit in their psychology course for their participation. Permission to administer questionnaires was acquired from the Human Subjects Committee at OSU, as well as from the instructors in the classes at UCI and USC. Following completion of the packet, participants were provided with a debriefing statement (see Appendix S).

**Design and Statistical Analyses**

This study utilized both a between-groups and a within-groups design comparing Asian American college students with White college students, as well as examining differences within the Asian American group.

A power analysis to determine the number of participants necessary for the purposes of this study was conducted using a conventional definition of a medium effect size (Cohen, 1977). It was found that to detect a population correlation of .30 (medium effect size) with a power of .99 at an alpha level of .05, approximately 194 students would
be necessary in each ethnic group (Cohen & Cohen, 1983). Thus, the sample sizes of 232 White and 215 Asian American participants in this study are sufficient to meet the requirements of the power analysis.

**Preliminary Analyses.** Preliminary analyses were undertaken to establish comparability of samples, as well as to ascertain basic descriptive statistics and reliability scores for each scale. First, all subsamples of Asian American participants were compared using chi-square tests to ensure they were not significantly different from one another and could therefore be combined into a single group of Asian American participants for primary analyses. Second, Whites and Asian Americans were compared, using chi-square tests, to ensure the samples were not significantly different demographically.

Descriptive statistics (e.g., means, standard deviations, reliabilities) were calculated for each ethnic group, as well as for each scale and subscale. These analyses enabled the detection of outliers in the data.

A Pearson product-moment correlation analysis was conducted between all independent and dependent variables to examine the relationship between social desirability and responses to scales. High correlations were noted for possible indication of contamination of scale scores.

Finally, analyses were undertaken to determine whether the data posed a problem of multicollinearity through substantial correlation among independent variables (Cohen & Cohen, 1983). Multicollinearity was not found to be a problem among these data.

Prior to conducting the primary analyses, hierarchical regression analyses were run to test each hypothesis in order to rule out the effect of prior counseling experience. Thus, eight (four for Whites, four for Asian Americans) hierarchical regression analyses were run.
with the treatment acceptability dependent variable in which the covariate of prior
counseling experience (ascertained from a question on the demographic sheet) was entered
into the regression model first, followed by simultaneously entering the independent
variable scores for each of the four independent variables. Just as with treatment
acceptability, six hierarchical regression analyses were conducted to determine the amount
of variance each independent variable accounted for in ratings of willingness to see a
counselor over and above that attributable to prior counseling experience. Finally, four
hierarchical regression analyses were conducted to determine the amount of variance each
independent variable accounted for in counselor preferences over and above that attributable
to prior counseling experience.

Primary Analyses. Linear and multiple linear regression analyses were used to test
hypotheses about the independent variables (acculturation level, sensitivity to loss of face,
construals of the self, and collective self-esteem) as predictors of each of the dependent
variables (treatment acceptability, willingness to see a counselor, and counselor
preferences).

For each of the three between-groups hypotheses (Hypotheses 1, 6, and 11), t-tests
were run to compare mean levels of the respective dependent variables for the two racial
groups. For Hypothesis 1, four t-tests were run, each comparing Whites and Asian
Americans on their mean ratings of treatment acceptability for each of the four types of
treatments (i.e., individual client-centered, individual cognitive-behavioral, group, and
family). For Hypothesis 6, a principal-components analysis with varimax rotation was
first conducted to reduce the number of problems from 24 to a more manageable three
component factors. Then, three t-tests were run with each factor to compare Whites and
Asian Americans on their mean ratings of willingness to see a counselor. For Hypothesis 11, two t-tests were run, each comparing Whites and Asian Americans on their mean ratings of preference to see a counselor based on demographic similarity match and on cognitive similarity match.

For all other hypotheses (the within-group hypotheses), linear and simultaneous multiple regression analyses were used with each independent variable serving as a predictor of each of the three dependent variables. Thus, for Hypothesis 2, a linear regression analysis was conducted using acculturation scores to predict acceptability for each of the four types of treatments. For Hypothesis 3, a linear regression analysis was conducted using loss of face to predict acceptability for each of the four types of treatments. For Hypothesis 4, a simultaneous multiple regression analysis were conducted using construals of the self (independent and interdependent) to predict acceptability for each of the treatments. For Hypothesis 5, a simultaneous multiple regression analysis was conducted using each of the four collective self-esteem subscales (membership, private, public, identity) to predict acceptability for each of the four treatments.

Similar analyses were run for the dependent variable of willingness to see a counselor. Analyses similar to those of Gim, Atkinson, and Whiteley (1990) were conducted on the PPI to ascertain whether an approximation of their factors could be achieved from the data in this study. This principal components analysis with varimax rotation, which did not replicate Gim, Atkinson, and Whiteley's factors, yielded three new factors were created for this study using different items than those used by Gim, Atkinson, and Whiteley. Following this, a linear regression analysis was conducted for Hypothesis 7 using acculturation scores to predict willingness to see a counselor for each of the three
factors derived from the PPI. For Hypothesis 8, a linear regression analysis was conducted using sensitivity to loss of face to predict willingness to see a counselor for each factor. For Hypothesis 9, a simultaneous multiple regression analysis was conducted using construals of the self (independent and interdependent) to predict willingness to see a counselor for each factor. For Hypothesis 10, a simultaneous multiple regression analysis was conducted using each of the four collective self-esteem subscales (membership, private, public, identity) to predict willingness to see a counselor for each factor.

Regression analyses were also run for the dependent variable of counselor preferences. The two counselor preferences subscales were created by grouping the demographic similarity items (1, 2, 3, 4) into one variable and the cognitive similarity match items (5, 6) into one variable. Thus, for Hypothesis 12, a linear regression analysis was conducted using acculturation scores to predict counselor preferences for each preference choice. For Hypothesis 13, a linear regression analysis was conducted using sensitivity to loss of face to predict counselor preferences. For Hypothesis 14, a simultaneous multiple regression analysis was conducted using construals of the self (independent and interdependent) to predict counselor preferences for each preference choice. Finally, for Hypothesis 15, a simultaneous multiple regression analysis was conducted using each of the four collective self-esteem subscales (membership, private, public, identity) to predict counselor preferences for each preference choice.
CHAPTER 4

RESULTS

Results of the research will be presented in this chapter. First, results of preliminary analyses will be summarized in tables and text. Second, results of primary analyses run to test this study’s hypotheses will be presented in tables and text.

Preliminary Analyses

Demographic Characteristics of the Samples. A summary of the demographic characteristics of the samples are presented in Table 1. Briefly, Asian American participants were 124 (57.7%) female and 91 (42.3%) male students. The average age of the Asian American students was 20.41 years, ranging from 17 to 38 years of age. White participants were 147 (63.4%) female and 85 (36.6%) male students. The average age of the White students was 19.26 years, ranging from 17 to 42 years of age.

In terms of academic major, 34.6% of Asian American students were natural science majors, 29.9% were social science majors (other than psychology), 12.3% were psychology majors, 4.7% were humanities/fine arts majors, 1.9% were double majors in both social science and humanities, 1.4% were double majors in both social science and
natural science, 0.5% were double majors in both natural science and humanities, and 14.7% were either undecided or did not indicate an academic major. Among White students, 38.8% were natural science majors, 28.4% were social science majors (other than psychology), 5.2% were psychology majors, 5.2% were humanities/fine arts majors, 0.4% were double majors in both social science and humanities, and 22.0% were either undecided or did not indicate an academic major.

The Asian American sample consisted of 41.2% first-year college students, 10.0% college sophomores, 13.3% college juniors, and 33.6% college seniors. The White sample consisted of 74.1% first-year college students, 16.8% college sophomores, 6.0% college juniors, and 0.4% college seniors.

Participants’ socioeconomic levels ranged from working class to upper class; most were concentrated in the working and middle socioeconomic status levels.

Comparability of the Samples. In order to determine if there were significant demographic differences that might confound findings, ANOVAs were first conducted to ascertain the comparability of the California Asian American samples (i.e., UCI versus USC). Second, ANOVAs were conducted to assess comparability of the California and Ohio Asian American samples to determine if they could be combined into one Asian American sample group. Third, chi-square analyses were conducted to assess the comparability of the White and Asian American samples.

The UCI and USC samples of Asian American participants were not found to be significantly different on any of the variables in this study except treatment acceptability for family counseling \( F(1, 96) = 6.51, p < .05 \). Thus, the UCI and USC samples were combined to form one California sample of Asian American participants.
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</tr>
</thead>
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<td>%</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
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<td>51</td>
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<td>0.4</td>
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</table>

* The "Other" category included individuals of Thai, Pakistani, Indonesian, Laotian, Taiwanese, and Bengali ethnicities, as well as those Asian Americans who did not specify an Asian ethnicity.

Table 1: Summary of Demographic Characteristics for Study Samples

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The California and Ohio samples of Asian American participants were not found to be significantly different on any of the variables in this study except treatment acceptability for group counseling [F(1, 213) = 17.45, p < .001], willingness to see a counselor for academic/career concerns [F(1, 213) = 3.93, p < .05], independent self-construal [F(1, 213) = 14.72, p < .001], and interdependent self-construal [F(1, 213) = 5.82, p < .05]. Because these four variables constituted less than 20% of the total variables in the study, it was determined that the California and Ohio samples were similar enough to warrant combining the samples into one Asian American sample.

In comparing the White and Asian American samples, it was determined that the samples did not differ significantly by gender or marital status, confirming that results of the present study were not confounded by these effects. However, the two samples were significantly different in age, education level, and previous counseling experience. These chi-square analyses are detailed below.

When looking at gender, the two ethnic groups were not found to be significantly different in a 2 X 2 chi-square test [χ² (1, N = 447) = 1.51, p = .219]. In both the Asian American and White groups, there were more females than males.

In regards to marital status, the two ethnic groups were not found to be significantly different in a 2 X 4 chi-square test [χ² (3, N = 443) = 2.22, p = .529]. In both the Asian American and White groups, most participants indicated they had never been married.

A 2 X 10 ethnic group by age group chi-square test was conducted. The two ethnic groups' distributions among age ranges were significantly different [χ² (9, N=447) = 89.70, p < .001]. Overall, 18-19-year-old participants made up a larger proportion of
Whites than Asian Americans, while 21-23-year-old participants made up a larger proportion of Asian Americans than Whites.

In regards to education level, the two ethnic groups were found to be significantly different in a 2 X 4 chi-square test \( \chi^2 (3, N = 437) = 94.33, p < .001 \). Proportionately, first-year college students and sophomore participants made up a larger proportion of Whites than Asian Americans, while junior and senior participants made up a larger proportion of Asian Americans than Whites. The findings from the age and education level chi-square analyses are in accord with one another in that typically age varies along with education level such that if one variable differs between groups, the other is also expected to differ in the same direction.

Finally, a 2 X 2 ethnic group by previous counseling experience chi-square test was conducted. The two ethnic groups were significantly different \( \chi^2 (1, N=443) = 6.79, p < .01 \) in previous counseling experience such that a larger percentage of Whites than Asian Americans indicated having previous counseling experience. This finding was expected in that, according to the literature and previous research, Asian Americans typically underutilize counseling services when compared to Whites.

Thus, based on the findings from chi-square analyses comparing the Asian American and White samples, it was determined that the only problematic demographic characteristic upon which the two samples were different was age/education level. This fact was taken into consideration in interpreting the results from this study.

**Self-Construal Scale Version Comparisons.** Preliminary analyses were conducted using both the original 24-item version of the Self-Construal Scale (SCS), as well as the newer 30-item version, to validate Singelis' (Singelis, personal communication, September 85...
1997) assertion that the additional items were added to improve the internal reliabilities of the original scale. Internal consistencies were indeed improved using the newer 30-item version of the SCS. Thus, it was decided that all primary analyses for this study would be conducted using the 30-item version of the SCS.

Factor Analysis on Personal Problems Inventory Items. The 24 Personal Problems Inventory (PPI) items were factor analyzed using the same procedure Gim, Atkinson, and Whiteley (1990) used in an attempt to replicate their three-factor solution. The procedure used in both their study and the present study was a principal-components analysis with varimax rotation. However, both the White and Asian American samples in this study failed to replicate Gim, Atkinson, and Whiteley's factors. Thus, two sets of analyses were conducted to determine the optimal factor solution for this study.

First, the White and Asian American samples in the present study were combined and subjected to a principal-components analysis with varimax rotation and three-factor specification. The factors extracted through this analysis were very similar to the three factors Gim, Atkinson, and Whiteley (1990) extracted in their study (i.e., Relationship Concerns, Academic/Career Concerns, & Health/Substance Abuse Concerns). Internal consistency statistics and correlations were then calculated using these three factors (hereafter referred to as the “combination factors”).

Second, the three-factor solution extracted from the White sample was imposed upon the Asian American sample since the White sample is viewed in this study as the control group. This resulted in the deletion of two items from the Asian American relationship factor and the addition of three items to the Asian American academic/career
factor. Internal consistency statistics and correlations were then calculated using these three factors (hereafter referred to as the "imposed factors").

The reliabilities calculated for each set of factors were very similar, but the alpha for the imposed academic/career concerns factor was slightly higher than for the combination academic/career concerns factor. Similarly, the pattern of correlations of the factors with this study's variables were not very different between the combined and the imposed factors. However, the imposed factors were slightly stronger. Thus, it was decided that the imposed factor items would be used in this study.

Items with loadings over .50 on a factor were included. The items used in this study to compose each factor, for both Whites and Asian Americans, are as follows: relationship concerns factor (general anxiety, shyness, depression, conflicts with parents, dating or relationship problems, loneliness or isolation, inferiority feelings, alienation, problems making friends), academic/career concerns factor (college adjustment problems, academic performance problems, speech anxiety, financial concerns, career choice problems, test anxiety, trouble studying, ethnic or racial discrimination, roommate problems, ethnic identity confusion), and substance abuse concerns factor (alcohol problems, drug addiction). This solution accounted for 52% of the total variance, which was comparable to the 48% of total variance accounted for in the Gim, Atkinson, and Whiteley (1990) study.

Means, Standard Deviations, Internal Consistency, and Intercorrelations. All scales were scored according to the published standards. Mean scores, standard deviations, and internal consistency statistics are summarized in Tables 2 and 3. All mean scores for participants on the scales in this study were comparable to those found in other studies on university students.
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Table 2: Means, Standard Deviations, and Internal Consistency of Study Variables for Asian Americans (N = 215)
Table 3: Means, Standard Deviations, and Internal Consistency of Study Variables for Whites (N = 232)
Reliability analyses were conducted for each scale and subscale. Cronbach's alpha for the WRIAS contact, disintegration, reintegration, pseudo-independence, and autonomy subscales, respectively, were .36, .77, .79, .65 and .49. These were comparable to the internal-consistency estimates reported in studies on White college students by Helms and Carter (1991) and Tokar and Swanson (1991), with the exceptions of the contact and autonomy subscales. The alphas for these subscales were much lower in this study than in the two aforementioned studies. It is possible that the items used to measure the beginning and end stages of White racial identity were not capturing the essence of these two stages for this particular sample of White college students.

Cronbach's alpha for the SL-ASIA was .91, which was consistent with alphas reported in other studies (Suinn, Rikard-Figueroa, Lew, & Vigil, 1987; Atkinson & Gim, 1989; Tata & Leong, 1994). Additionally, the validity check included in this study yielded results as expected. The 27th item, which assessed degree of commitment to cultural values, was highly positively correlated with the SL-ASIA Values score (r = .23, p < .001). Means and standard deviations for the SL-ASIA were also comparable to those found in other studies with Asian American college students. For example, Suinn, Khoo, and Ahuna (1995) found a mean score of 3.38 (SD = .67) for their sample of Asian American university students. Likewise, Tata and Leong (1994) found a mean score of 2.95 (SD = 0.60) in their study with Chinese American college students.

On the TEI, Cronbach's alpha for Whites for the individual client-centered administration was .81, while for Asian Americans it was .84. For the individual cognitive-behavioral treatment, alpha was .84 for Whites and .85 for Asian Americans. With the group counseling treatment, alphas were .88 and .90 for Whites and Asian
Americans, respectively. Finally, for the family counseling treatment, alphas were .85 and .89, respectively, for Whites and Asian Americans. These were comparable to alphas reported in other studies with university students.

Cronbach’s alpha for the PPI relationship concerns, academic/career concerns, and substance abuse concerns, respectively, were .88, .86, . and .73 for Asian Americans, while they were .89, .86, and .76 for Whites. These were comparable to the internal-consistency estimates reported in a study on college students by Johnson and Holland (1986). Unfortunately, Gim, Atkinson, and Whiteley (1990) did not report reliability statistics for their study using the PPI.

The MCS-BF was found to be moderately reliable for both Whites (α = .71) and Asian Americans (α = .67) in this study. Because social desirability was not an independent or dependent variable in this study, but was included as a validity check for the variables in this study, these moderate reliability statistics were deemed acceptable for the purposes of this study.

The CPS demographic similarity preference subscale was found to be highly internally consistent for both Whites (α = .79) and Asian Americans (α = .76) in this study. However, while the cognitive similarity preference subscale was reliable for Asian Americans (α = .75), it was less so for Whites (α = .59) in this study. It is not exactly clear why this would be the case. Because the cognitive similarity preference subscale is composed of only two items (i.e., preference for a counselor with the same value orientation and preference for a counselor with the same personality style), it is obvious that these two items are not highly homogenous for the White participants in this study. Perhaps it does not make sense for Whites that value orientation and personality style be
grouped together. In fact, when looking at the mean scores for White participants on the individual items in the CPS, mean scores on preference for similarity in value orientation were the highest of all six items in the CPS.

Cronbach’s alpha for the LOF was .86 for Whites and .89 for Asian Americans, which was consistent with alphas reported in other studies with undergraduates of each racial group (Zane, 1991; Leong, Wagner, & Kim, 1995).

The CSE yielded alphas of .68, .73, .71, and .71 for Whites on the membership, private, public, and identity subscales, respectively. These were comparable to estimates of internal consistency reported in other studies (Crocker, Luhtanen, Blaine, & Broadnax, 1994; Luhtanen & Crocker, 1992) with undergraduates. For Asian Americans, however, the alphas on these same subscales were .68, .65, .60, and .63, respectively. It is disturbing that the reliabilities for Asian American participants in this study were consistently low (i.e., αs less than .75) for all four subscales of the CSE. Although Asian Americans were participants in many of the studies used to validate the CSE, they were usually grouped together with participants who were members of other racial/ethnic minority groups. Thus, it may be that the CSE is a less reliable scale for Asian Americans alone than in conjunction with other groups.

Finally, the alphas for the SCS were .81 and .79 for Whites on the independent and interdependent subscales, respectively. For Asian Americans, both subscales had alphas of .81. Based on the comparisons of descriptive statistics for each scale, it is clear that the data in this study is comparable to that of other studies on college students.

Matrices of Pearson product-moment intercorrelations between all independent and dependent variables are presented in Tables 4 (Asian Americans) and 5 (Whites).
## Table 4.
Intercorrelations of Study Variables for Asian Americans ($N = 215$): Pearson Product-Moment Correlation Coefficients

**NOTE 1:** * $p < .05$; ** $p < .01$; *** $p < .001$

**NOTE 2:** For all subsequent tables:

- **ASIA** = Acculturation
- **TEIA** = Individual Client-Centered Treatment Acceptability
- **TEIB** = Individual Cognitive-Behavioral Treatment Acceptability
- **TEIG** = Group Treatment Acceptability
- **TEIF** = Family Treatment Acceptability
- **REL** = Willingness to See a Counselor for Relationship Concerns
- **ACA** = Willingness to See a Counselor for Academic/Career Concerns
- **ABU** = Willingness to See a Counselor for Substance Abuse Concerns
- **DEM** = Demographic Similarity Counselor Preference
- **COG** = Cognitive Similarity Counselor Preference
- **LOF** = Loss of Face
- **MER** = Membership Collective Self-Esteem
- **PRI** = Private Collective Self-Esteem
- **PUB** = Public Collective Self-Esteem
- **ID** = Identity Collective Self-Esteem
- **DEP** = Independent Self-Construal
- **TER** = Interdependent Self-Construal
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Table 4.
expected, significant correlations were found between many of the variables for both
Whites and Asian Americans. For Asian Americans, acculturation was significantly
negatively correlated with loss of face (r = -.20, p < .01) and significantly positively
correlated with independent self-construal (r = .14, p < .05), as would be expected. In
addition, acculturation was negatively correlated with preference for counselor
demographic similarity (r = -.17, p < .05).

Loss of face was significantly negatively correlated with membership (r = -.13, p <
.05), private (r = -.18, p < .01), and public (r = -.14, p < .05) collective self-esteem, as
well as significantly positively correlated with demographic similarity counselor preference
(r = .18, p < .01), cognitive similarity counselor preference (r = .15, p < .05), and
interdependent self-construal (r = .53, p < .001).

Membership (r = .27, p < .001), private (r = .18, p < .01), and public (r = .21, p <
.01) collective self-esteem all were significantly positively correlated with independent self-
construal, while membership (r = .17, p < .05), private (r = .18, p < .01), public (r = .15,
p < .05), and identity (r = .15, p < .05) collective self-esteem were all positively correlated
with interdependent self-construal. Collective self-esteem was also significantly correlated
with treatment acceptability. Membership esteem was positively correlated with treatment
acceptability for individual client-centered (r = .23, p < .001), individual cognitive-
behavioral (r = .24, p < .001), and group (r = .20, p < .01) counseling. Private esteem
was positively correlated with treatment acceptability for individual cognitive-behavioral (r
= .20, p < .01) counseling, and public esteem was positively correlated with treatment
acceptability for individual cognitive-behavioral (r = .25, p < .001) and group (r = .20, p <
.01) counseling. Public esteem was significantly positively correlated with willingness to
see a counselor for substance abuse concerns (r = .14, p < .05), demographic similarity
counselor preference (r = .16, p < .05), and cognitive similarity counselor preference (r =
.18, p < .01). Membership esteem was significantly positively correlated with both
demographic preference (r = .23, p < .001) and cognitive preference (r = .22, p < .01), as
was public esteem (demographic preference: r = .16, p < .05; cognitive preference: r =
.18, p < .01). Identity esteem was significantly positively correlated only with
demographic preference (r = .15, p < .05).

Finally, independent self-construal was significantly positively correlated with
individual client-centered treatment acceptability (r = .22, p < .01), individual cognitive-behavioral treatment acceptability (r = .28, p < .001), group treatment acceptability (r =
.27, p < .001), and family treatment acceptability (r = .14, p < .05), while interdependent
self-construal was positively correlated with individual client-centered treatment
acceptability (r = .21, p < .01), individual cognitive-behavioral treatment acceptability (r =
.16, p < .05), and cognitive similarity counselor preference (r = .22, p < .01).

For Whites' scores on the racial identity attitudes, contact attitudes significantly
positively correlated with individual client-centered treatment acceptability (r = .25, p <
.001), individual cognitive-behavioral treatment acceptability (r = .20, p < .01),
willingness to see a counselor for academic/career concerns (r = .13, p < .05), public
collective self-esteem (r = .14, p < .05), independent self-construal (r = .16, p < .05), and
interdependent self-construal (r = .16, p < .05). Disintegration attitudes significantly
positively correlated with demographic counselor preference (r = .39, p < .001), cognitive
counselor preference (r = .19, p < .01), and loss of face (r = .18, p < .01). Reintegration
attitudes significantly positively correlated with demographic counselor preference (r = .38,
Table 5: Intercorrelations of Study Variables for Whites (N = 232): Pearson Product-Moment Correlation Coefficients

NOTE 1: * p < .05; ** p < .01; *** p < .001

NOTE 2: CON = White Racial Identity Contact Stage
DIS = White Racial Identity Disintegration Stage
REI = White Racial Identity Reintegration Stage
PSE = White Racial Identity Pseudo-Independence Stage
AUT = White Racial Identity Autonomy Stage
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Table 5.
p < .001) and loss of face (r = .14, p < .05). Pseudo-independence attitudes significantly negatively correlated with willingness to see a counselor for relationship concerns (r = -.16, p < .05), demographic counselor preference (r = -.26, p < .001), and loss of face (r = -.15, p < .05), while they significantly positively correlated with independent self-construal (r = .30, p < .001). Autonomy attitudes significantly positively correlated with willingness to see a counselor for academic/career concerns (r = .17, p < .05), private collective self-esteem (r = .16, p < .05), public self-esteem (r = .14, p < .05), independent self-construal (r = .34, p < .001), and interdependent self-construal (r = .20, p < .01).

Loss of face significantly positively correlated with individual client-centered treatment acceptability (r = .16, p < .05), demographic counselor preference (r = .16, p < .05), and interdependent self-construal (r = .42, p < .001), while it significantly negatively correlated with membership collective self-esteem (r = -.18, p < .01).

Membership collective self-esteem significantly positively correlated with individual client-centered treatment acceptability (r = .19, p < .01) and individual cognitive-behavioral treatment acceptability (r = .15, p < .05). Private collective self-esteem significantly positively correlated with individual client-centered treatment acceptability (r = .23, p < .001) and cognitive counselor preference (r = .13, p < .05). Public collective self-esteem significantly positively correlated with individual client-centered treatment acceptability (r = .20, p < .01), willingness to see a counselor for substance abuse concerns (r = .17, p < .01), and cognitive counselor preference (r = .20, p < .01). Identity collective self-esteem significantly positively correlated with individual client-centered treatment acceptability (r = .16, p < .05) and group treatment acceptability (r = .20, p < .01).
Finally, Independent self-construal significantly positively correlated with individual client-centered treatment acceptability ($r = .21, p < .01$), while interdependent self-construal significantly positively correlated with individual client-centered treatment acceptability ($r = .17, p < .01$) and willingness to see a counselor for academic/career concerns ($r = .14, p < .05$).

Correlations of Study Variables with Social Desirability. A correlation analysis was conducted to examine the relationship between social desirability and responses to each of the scales. Results indicated that for Whites, there were significant correlations between social desirability and the disintegration ($r = -.16, p < .05$), reintegration ($r = -.14, p < .05$), and pseudo-independence ($r = .20, p < .01$) subscales of the WRIAS. In addition, there were significant correlations between social desirability and the counselor ethnicity ($r = -.15, p < .05$), counselor gender ($r = -.20, p < .01$), and counselor socioeconomic status ($r = -.13, p < .05$) items on the CPS, as well as on the counselor demographic ($r = -.19, p < .01$) subscale of the CPS.

For Asian Americans, there were significant correlations between social desirability and the SL-ASIA acculturation score ($r = -.15, p < .05$). In addition, there were significant correlations between social desirability and the interdependent ($r = .16, p < .05$) subscale of the SCS. These social desirability correlations were taken into consideration in interpreting results of this study.

Results of T-Tests for Between-Group Comparisons on Study Independent Variables. The t-tests for between-group comparisons of Whites and Asian Americans on this study’s independent variables are summarized in Table 6. Results indicate significant
between-group differences on the independent variables of loss of face, identity collective
self-esteem, and independent self-construal.

Hierarchical Regression Analyses. Hierarchical regression analyses were
conducted between the independent and dependent variables in order to partial out the
potential confounding effects of prior counseling experience. A summary of these results
is provided in Table 7. Only one of the eighteen analyses conducted was significant.
Among White participants, prior counseling experience accounted for 8% of the variance in
ratings of willingness to see a counselor for relationship concerns, yielding a significant
squared multiple correlation ($R^2$) of .08 [$F(1, 229) = 19.83, p < .001$]. This finding was
noted in interpreting results of the primary analyses. For all other hypotheses, prior
counseling experience was ruled out as an explanatory factor.

Primary Analyses

Results of T-Tests for Between-Group Comparisons on Study Dependent
Variables. The t-tests for between-group comparisons of Whites and Asian Americans on
this study’s dependent variables are summarized in Table 8. Results indicate significant
between-group differences on all dependent variable measures except counselor cognitive
similarity match.

Hypothesis 1 was supported in that Whites found all four types of treatments
significantly more acceptable than did Asian Americans. Specifically, White participants
found individual client-centered counseling ($t = 3.68, p < .001$), individual cognitive-
behavioral counseling ($t = 2.66, p < .01$), group counseling ($t = 2.21, p < .05$), and family
counseling ($t = 2.56, p < .05$) significantly more acceptable than did Asian Americans.
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* p < .05  ** p < .01  *** p < .001

Table 6: T-Tests for Between-Groups Comparisons on Measures of Loss of Face, Collective Self-Esteem, and Self-Construal
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*** p < .001

Table 7: Summary of Statistics for the Prior Counseling Experience Covariate in Hierarchical Regressions for the Prediction of Study Dependent Variables for Asian Americans and Whites
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* p < .05  ** p < .01  *** p < .001

Table 8: T-Tests for Between-Groups Comparisons on Measures of Treatment Acceptability, Willingness to See a Counselor, and Counselor Preferences
Hypothesis 6 was partially supported in that Asian Americans were no different from Whites in willingness to see a counselor for relationship ($t = -0.26, p = .792$) and substance abuse concerns ($t = -1.03, p = .304$). However, Asian Americans did differ significantly from Whites in willingness to see a counselor for academic/career concerns ($t = -3.33, p < .001$) such that Asian Americans were more willing to see a counselor for these problems than were White participants.

Hypothesis 11 was supported in that Asian Americans were found to have significantly stronger preferences for counselor demographic similarity match than did Whites ($t = -2.38, p < .05$).

**Results of Regressions for White Racial Identity Phases.** The two WRIAS phases were entered as predictors in regression analyses with each of this study’s dependent variables. Both the Abandonment of Racism ($t = 3.88, p < .001$) and the Defining a Nonracist White Identity ($t = 4.08, p < .001$) phases were found to be significant predictors of treatment acceptability for individual client-centered counseling [$F(2, 229) = 10.90, p < .001$]. Only the Abandonment phase ($t = 6.43, p < .001$) was found to be a significant predictor of preference for counselor demographic similarity [$F(2, 229) = 26.69, p < .001$]. Similarly, only the Abandonment phase ($t = 3.03, p < .01$) was found to be a significant predictor of preference for counselor cognitive similarity [$F(2, 229) = 4.59, p < .05$]. Finally, both the Abandonment of Racism ($t = 3.13, p < .01$) and the Defining a Nonracist White Identity ($t = 2.21, p < .05$) phases were found to be significant predictors of willingness to see a counselor for academic/career concerns [$F(2, 229) = 5.29, p < .01$].

**Linear Regressions and Simultaneous Multiple Linear Regression Analyses.** Linear regression analyses were performed to examine what cultural independent variables...
accounted for significant portions of the variance in the counseling dependent variables.
Summaries of statistics for all linear and multiple linear regression analyses for both Asian Americans and Whites are provided in Tables 9, 10, 11, 12, 13, 14, 15, 16, and 17.

Models using acculturation, loss of face, self-construals, and collective self-esteem to predict treatment acceptability for individual client-centered counseling were analyzed. A summary of these results can be found in Table 9. The analysis for acculturation did not indicate significant results \( F(1, 212) = 1.74, p = .188 \) for Asian Americans. The model using loss of face as a predictor was also analyzed. Results were not significant for Asian Americans \( F(1, 213) = 2.21, p = .138 \), but results were significant for Whites \( F(1, 230) = 5.73, p < .05 \), for whom loss of face accounted for 2.4% of the variance in treatment acceptability for individual client-centered counseling. A model using independent and interdependent self-construals as simultaneous predictors was analyzed. Results indicated that this model significantly accounted for 6.8% of the variance in treatment acceptability for individual client-centered counseling \( F(2, 212) = 7.73, p < .001 \) for Asian Americans. For Whites, self-construals significantly accounted for 5.4% of the variance in treatment acceptability for individual client-centered counseling \( F(2, 228) = 6.52, p < .01 \), but in the model only independent self-construal was a significant predictor. Finally, a model using membership, private, public, and identity collective self-esteem as simultaneous predictors was analyzed. For both Asian Americans \( F(4, 210) = 4.82, p < .01 \) and Whites \( F(4, 226) = 3.85, p < .01 \), the model significantly accounted for variance (8.4% and 6.4% for Asian Americans and Whites, respectively) in treatment acceptability for individual client-centered counseling. However, for Asian Americans it
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<tr>
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<td>-0.89</td>
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<tr>
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<tr>
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<td>-0.82</td>
</tr>
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* $p < .05$  ** $p < .01$  *** $p < .001$

Table 9: Regressions for Predictors of Treatment Acceptability: Individual Client-Centered Counseling
was the membership and public subscales that were significant predictors and for the Whites, only the overall model was significant.

Models using acculturation, loss of face, self-construals, and collective self-esteem to predict treatment acceptability for individual cognitive-behavioral counseling were analyzed. A summary of these results can be found in Table 10. The analysis for acculturation did not indicate significant results [$F(1, 212) = 0.80, p = .371$] for Asian Americans. The model using loss of face as a predictor was also analyzed. Results were not significant for Asian Americans [$F(1, 213) = 1.82, p = .179$] or for Whites [$F(1, 230) = 2.25, p = .135$]. A model using independent and interdependent self-construals as simultaneous predictors was analyzed. Results indicated that this model significantly accounted for 8.3% of the variance in treatment acceptability for individual cognitive-behavioral counseling [$F(2, 212) = 9.56, p < .001$] for Asian Americans. For Whites, self-construals were not significant predictors of treatment acceptability for individual cognitive-behavioral counseling [$F(2, 228) = 0.71, p = .494$]. Finally, a model using membership, private, public, and identity collective self-esteem as simultaneous predictors was analyzed. For Asian Americans [$F(4, 210) = 4.04, p < .01$], the model significantly accounted for variance (7.1%) in treatment acceptability for individual cognitive-behavioral counseling, with the membership subscale being the only significant predictor. For Whites, collective self-esteem was not a significant predictor [$F(4, 226) = 2.31, p = .059$].

Models using acculturation, loss of face, self-construals, and collective self-esteem to predict treatment acceptability for group counseling were analyzed. A summary of these results can be found in Table 11. The analysis for acculturation did not indicate significant
<table>
<thead>
<tr>
<th>Predictor</th>
<th>Asian Americans (N = 215)</th>
<th>Whites (N = 232)</th>
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<td></td>
<td>R²</td>
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<td>Loss of Face</td>
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<td>Self-Construals</td>
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<td>.08</td>
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<tr>
<td></td>
<td>Identity</td>
<td>-.07</td>
</tr>
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</table>

* p < .05  ** p < .01  *** p < .001

Table 10: Regressions for Predictors of Treatment Acceptability: Individual Cognitive-Behavioral Counseling
<table>
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<tr>
<th>Predictor</th>
<th>Asian Americans (N = 215)</th>
<th>Whites (N = 232)</th>
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</thead>
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<td>R²</td>
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<td>Loss of Face</td>
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<td>Self-Construals</td>
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<td>Private</td>
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<td>Public</td>
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<tr>
<td>Identity</td>
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<td>0.11</td>
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</table>

* p < .05  ** p < .01  *** p < .001

Table 11: Regressions for Predictors of Treatment Acceptability: Group Counseling
results \(F(1, 212) = 0.79, p = .374\) for Asian Americans. The model using loss of face as a predictor was also analyzed. Results were not significant for Asian Americans \(F(1, 213) = 2.42, p = .121\) or for Whites \(F(1, 230) = 0.77, p = .380\). A model using independent and interdependent self-construals as simultaneous predictors was analyzed. Results indicated that this model significantly accounted for 7.4% of the variance in treatment acceptability for group counseling \(F(2, 212) = 8.45, p < .001\) for Asian Americans. For Whites, self-construals were not significant predictors of treatment acceptability for group counseling \(F(2, 228) = 1.86, p = .158\). Finally, a model using membership, private, public, and identity collective self-esteem as simultaneous predictors was analyzed. For both Asian Americans \(F(4, 210) = 2.88, p < .05\) and Whites \(F(4, 226) = 3.09, p < .05\), the model significantly accounted for variance (5.2% for both Asian Americans and Whites) in treatment acceptability for group counseling, with the membership subscale being the only significant predictor for Asian Americans and the identity subscale the only significant predictor for Whites.

Models using acculturation, loss of face, self-construals, and collective self-esteem to predict treatment acceptability for family counseling were analyzed. A summary of these results can be found in Table 12. The analysis for acculturation did not indicate significant results \(F(1, 212) = 1.08, p = .300\) for Asian Americans. The model using loss of face as a predictor was also analyzed. Results were not significant for Asian Americans \(F(1, 213) = 1.41, p = .237\) or for Whites \(F(1, 230) = 0.01, p = .927\). A model using independent and interdependent self-construals as simultaneous predictors was analyzed. Results indicated that this model was not a significant predictor for treatment acceptability for family counseling for either Asian Americans \(F(2, 212) = 2.07, p = .128\) or for Whites.
<table>
<thead>
<tr>
<th>Predictor</th>
<th>Asian Americans (N = 215)</th>
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</thead>
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<td></td>
<td>R²</td>
<td>β</td>
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<tr>
<td>Acculturation</td>
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<td>1.08</td>
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<td>Loss of Face</td>
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<td>Self-Construals</td>
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<td>Private</td>
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<td>Public</td>
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<td>-0.38</td>
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</table>

* p < .05  ** p < .01  *** p < .001

Table 12: Regressions for Predictors of Treatment Acceptability: Family Counseling
Finally, a model using membership, private, public, and identity collective self-esteem as simultaneous predictors was analyzed. For neither Asian Americans \([F(4, 210) = 0.83, \ p = .505]\) nor Whites \([F(4, 226) = 1.27, \ p = .282]\) was the model a significant predictor of treatment acceptability for family counseling.

Models using acculturation, loss of face, self-construals, and collective self-esteem to predict willingness to see a counselor for relationship concerns were analyzed. A summary of these results can be found in Table 13. The analysis for acculturation did not indicate significant results \([F(1, 212) = 0.16, \ p = .689]\) for Asian Americans. The model using loss of face as a predictor was also analyzed. Results were not significant for Asian Americans \([F(1, 213) = 0.00, \ p = .987]\) or for Whites \([F(1, 230) = 0.15, \ p = .699]\). A model using independent and interdependent self-construals as simultaneous predictors was analyzed. Results indicated that this model was not a significant predictor for treatment acceptability for willingness to see a counselor for relationship concerns for either Asian Americans \([F(2, 212) = 0.42, \ p = .659]\) or for Whites \([F(2, 228) = 0.42, \ p = .660]\).

Finally, a model using membership, private, public, and identity collective self-esteem as simultaneous predictors was analyzed. For neither Asian Americans \([F(4, 210) = 1.24, \ p = .295]\) nor Whites \([F(4, 226) = 0.20, \ p = .940]\) was the model a significant predictor of willingness to see a counselor for relationship concerns.

Models using acculturation, loss of face, self-construals, and collective self-esteem to predict willingness to see a counselor for academic/career concerns were analyzed. A summary of these results can be found in Table 14. The analysis for acculturation did not indicate significant results \([F(1, 212) = 3.62, \ p = .058]\) for Asian Americans. The model using loss of face as a predictor was also analyzed. Results were not significant for Asian
## Table 13. Regressions for Predictors of Willingness to See a Counselor: Relationship Concerns

<table>
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* p < .05  ** p < .01  *** p < .001
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<th>Whites (N = 232)</th>
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* p < .05  ** p < .01  *** p < .001

Table 14: Regressions for Predictors of Willingness to See a Counselor: Academic/Career Concerns
Americans \( F(1, 213) = 0.00, p = .987 \) or for Whites \( F(1, 230) = 0.63, p = .430 \). A model using independent and interdependent self-construals as simultaneous predictors was analyzed. Results indicated that this model was not a significant predictor for treatment acceptability for willingness to see a counselor for academic/career concerns for either Asian Americans \( F(2, 212) = 1.36, p = .259 \) or for Whites \( F(2, 228) = 2.63, p = .074 \). Finally, a model using membership, private, public, and identity collective self-esteem as simultaneous predictors was analyzed. For neither Asian Americans \( F(4, 210) = 0.44, p = .777 \) nor Whites \( F(4, 226) = 0.66, p = .619 \) was the model a significant predictor of willingness to see a counselor for academic/career concerns.

Models using acculturation, loss of face, self-construals, and collective self-esteem to predict willingness to see a counselor for substance abuse concerns were analyzed. A summary of these results can be found in Table 15. The analysis for acculturation did not indicate significant results \( F(1, 212) = 0.61, p = .436 \) for Asian Americans. The model using loss of face as a predictor was also analyzed. Results were not significant for Asian Americans \( F(1, 213) = 0.60, p = .441 \) or for Whites \( F(1, 230) = 0.15, p = .692 \). A model using independent and interdependent self-construals as simultaneous predictors was analyzed. Results indicated that this model was not a significant predictor for treatment acceptability for willingness to see a counselor for substance abuse concerns for either Asian Americans \( F(2, 212) = 0.81, p = .446 \) or for Whites \( F(2, 228) = 0.88, p = .417 \). Finally, a model using membership, private, public, and identity collective self-esteem as simultaneous predictors was analyzed. For neither Asian Americans \( F(4, 210) = 1.96, p = .101 \) nor Whites \( F(4, 226) = 1.89, p = .114 \) was the model a significant predictor of willingness to see a counselor for substance abuse concerns.
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<th>Predictor</th>
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<th>Whites</th>
<th>Predictor</th>
<th>Asian Americans</th>
<th>Whites</th>
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<td>(N = 215)</td>
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<td></td>
<td>(N = 232)</td>
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<td>F</td>
<td>β</td>
<td>t</td>
<td>%R²</td>
<td>F</td>
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<td>.01</td>
<td>.008</td>
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* p < .05  ** p < .01  *** p < .001

Table 15: Regressions for Predictors of Willingness to See a Counselor: Substance Abuse Concerns
Because Hypothesis 10 proposed a relationship between collective self-esteem and individual items on the PPI (i.e., those related to race), analyses were needed that examined the PPI item by item rather than using the three factors derived through the principal components analysis. First, to determine whether Asian Americans and Whites differed in their willingness to see a counselor for specific concerns on the PPI, a multivariate analysis of variance (MANOVA) was performed. The overall $F$ ratio was significant, $F(24, 416) = 2.62, p < .001$, with Wilks' Lambda $= .869$. Because the overall MANOVA was significant, the univariate $t$-test analyses were examined next. Significant differences were found on five of the 24 PPI items: Financial Concerns ($t = -2.69, p < .01$), Career Choice Problems ($t = -2.98, p < .01$), Test Anxiety ($t = -2.02, p < .05$), Ethnic or Racial Discrimination ($t = -4.92, p < .001$), and Ethnic Identity Confusion ($t = -3.00, p < .01$). Asian Americans were significantly more willing to see a counselor for all five concerns than were Whites. However, no significant within-group differences were found among Asian Americans in terms of level of collective self-esteem when examining willingness to see a counselor for Ethnic or Racial Discrimination concerns or for Ethnic Identity Confusion concerns. Specifically, neither regression analyses nor ANOVAs for the two race-related PPI concerns yielded significant findings for collective self-esteem.

Models using acculturation, loss of face, self-construals, and collective self-esteem to predict counselor preferences for demographic similarity match were analyzed. A summary of these results can be found in Table 16. The analysis for acculturation yielded significant results $[F(1, 212) = 6.22, p < .05]$ for Asian Americans, in which acculturation accounted for 2.9% of the variance in preference for demographic similarity match with
<table>
<thead>
<tr>
<th>Predictor</th>
<th>Asian Americans (N = 215)</th>
<th>Whites (N = 232)</th>
</tr>
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<tr>
<td></td>
<td>R²</td>
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<td>Acculturation</td>
<td>.029</td>
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<tr>
<td>Loss of Face</td>
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<td>Self-Construals</td>
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<td>Collective Self-Esteem</td>
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<td>Membership</td>
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* p < .05  ** p < .01  *** p < .001

Table 16: Regressions for Predictors of Counselor Preferences: Demographic Similarity Match

119
counselors. The model using loss of face as a predictor was also analyzed. Results were significant for both Asian Americans \(F(1, 213) = 7.07, p < .01\) and Whites \(F(1, 230) = 6.15, p < .05\). Loss of face significantly accounted for 3.2% of the variance for Asian Americans and 2.6% of the variance for Whites in preferences for demographic similarity match with counselors. A model using independent and interdependent self-construals as simultaneous predictors was analyzed. Results indicated that this model was not a significant predictor for either Asian Americans \(F(2, 212) = 1.17, p = .312\) or for Whites \(F(2, 228) = 1.86, p = .158\). Finally, a model using membership, private, public, and identity collective self-esteem as simultaneous predictors was analyzed. For Asian Americans \(F(4, 210) = 3.46, p < .01\) the model was a significant predictor of preferences for demographic similarity match with counselors, with membership esteem as the only significant predictor. For Whites \(F(4, 226) = 0.49, p = .741\), collective self-esteem was not a significant predictor of preferences for demographic similarity match with a counselor.

Models using acculturation, loss of face, self-construals, and collective self-esteem to predict counselor preferences for cognitive similarity match were analyzed. A summary of these results can be found in Table 17. The analysis for acculturation was not significant \(F(1, 212) = 1.10, p = .295\) for Asian Americans. The model using loss of face as a predictor was also analyzed. Results were significant for Asian Americans \(F(1, 213) = 4.70, p < .05\), in which it accounted for 2.2% of the variance in preference for cognitive similarity match with a counselor. For Whites \(F(1, 230) = 1.79, p = .183\), loss of face was not a significant predictor. A model using independent and interdependent self-construals as simultaneous predictors was analyzed. Results indicated that this model was
Table 17: Regressions for Predictors of Counselor Preferences: Cognitive Similarity Match

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<td></td>
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<td>1.10</td>
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<tr>
<td>Loss of Face</td>
<td>.022</td>
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<tr>
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<td>5.89**</td>
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<tr>
<td>Independent</td>
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<tr>
<td>Interdependent</td>
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<td>2.80**</td>
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<td>Membership</td>
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<td>1.54</td>
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<tr>
<td>Identity</td>
<td>.01</td>
<td>0.18</td>
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</table>

* p < .05  ** p < .01  *** p < .001
a significant predictor for Asian Americans \[
F(2, 212) = 5.89, \ p < .01 \]
, in which it accounted for 5.3% of the variance in preference for cognitive similarity match with a counselor. Only interdependent self-construal was a significant predictor, however. For Whites \[
F(2, 228) = 2.55, \ p = .081 \]
self-construal was not a significant predictor. Finally, a model using membership, private, public, and identity collective self-esteem as simultaneous predictors was analyzed. For Asian Americans \[
F(4, 210) = 3.23, \ p < .05 \]
the model was a significant predictor of preferences for cognitive similarity match with counselors, although none of the individual subscales were significant predictors. For Whites \[
F(4, 226) = 2.77, \ p < .05 \]
collective self-esteem was a significant predictor of preferences for cognitive similarity match with a counselor, with public collective self-esteem as the only significant predictor. For Asian Americans, collective self-esteem explained 5.8% of the variance in preference for cognitive similarity match with a counselor, while for Whites it explained 4.7% of the variance.

**Summary of Results of Regression Analyses.** Hypotheses 2a and 2b were not supported in that none of the regression analyses using acculturation as a predictor of treatment acceptability were significant. Hypotheses 3a and 3b were also not supported in that none of the regression analyses using loss of face as a predictor of treatment acceptability were significant. Hypothesis 4a was partially supported in that self-construal was a significant predictor of acceptability for all but the family treatment. It was difficult to interpret the results of the regression analyses run to test Hypothesis 4b in that each participant received both an independent and an interdependent score. Thus, additional analyses were conducted to enable better interpretation of results. These are detailed in the section below. Hypothesis 5a was partially supported in that collective self-esteem was a
significant predictor of acceptability for all but the family treatment. Hypothesis 5b was also partially supported in that only membership collective self-esteem showed a significant positive relationship with acceptability of group counseling for Asian Americans.

Hypotheses 7a, 7b, 8a, 8b, 9a, and 9b were all not supported in that none of the regression analyses using acculturation, loss of face, or self-construal as predictors of willingness to see a counselor were significant. Hypothesis 10 was not supported in that collective self-esteem was not a significant predictor of willingness to see a counselor for any of the three PPI factors, nor of willingness to see a counselor for any of the two race-related concerns.

Hypothesis 12a was partially supported in that acculturation was found to be a significant predictor of preference for demographic similarity with a counselor, but was not found to be a significant predictor of preference for cognitive similarity with a counselor. It was difficult to interpret these results in terms of support or non-support for Hypothesis 12b without first trichotomizing the acculturation scores. Thus, additional analyses were conducted to enable better interpretation of results. These are detailed in the section below. Hypotheses 13a and 13b were supported in that loss of face was found to be a significant predictor of preference for both demographic and cognitive similarity with counselor. Hypothesis 14a was partially supported in that self-construal was a significant predictor of preference for counselor cognitive similarity, but not counselor demographic similarity. Hypothesis 14b was partially supported in that having a independent self-construals were not significant predictors of counselor preferences, whereas interdependent self-construals were a significant predictor of preference for cognitive similarity with counselor.

Additional analyses were conducted to aid in interpreting these results. These are detailed
in the section below. Finally, Hypotheses 15a was supported in that collective self-esteem was a significant predictor of both demographic and cognitive similarity preference for counselor match. Specifically, membership esteem was a significant predictor of preference for demographic match in the direction hypothesized, thus lending partial support to Hypothesis 15b.

ANOVA to Test Hypotheses Concerning Acculturation and Self-Construal as Categorical Variables. Because the models (see Berry, 1980; Markus & Kitayama, 1991) upon which the SL-ASIA and the SCS were designed propose that the acculturation and self-construal variables, respectively, are both better viewed as categorical variables than continuous variables, additional analyses were conducted in which both variables were trichotomized.

The SL-ASIA was trichotomized by grouping the highest scoring 15% of participants into a category called “High Acculturated/Western-Identified”, grouping the lowest scoring 15% of participants into a category called “Low Acculturated/Asian-Identified”, and grouping the remaining 70% of participants into a category called “Medium Acculturated/Bicultural”.

Following this, ANOVAs were run for each of the dependent variables. Results are presented in Table 18. Only preference for demographic similarity with a counselor was significant \(F(2, 212) = 3.86, p < .05\) such that the low acculturated Asian Americans had the greatest preference for demographic similarity, followed by the bicultural Asian Americans and then the high acculturated Asian Americans. In this analysis, the low acculturated Asian Americans were significantly different from the high acculturated Asian Americans, but neither the high nor the low groups were significantly different from the
bicentral Asian Americans on preference for demographic similarity with a counselor. Thus, this analysis provided support for Hypothesis 12b.

Given the theoretical foundations of the SCS as detailed by Markus and Kitayama (1991), it was decided that analyses utilizing a between-groups design would better capture the essence of the self-construal construct, rather than the within-groups design necessitated by viewing self-construal as a continuous variable in the regression analyses. The SCS scores were trichotomized by first eliminating those participants who were untrated on the self-construal dimension. This was done by eliminating those whose total score on each of the subscales (independent and interdependent) was 3 or below. Following this, remaining participants were trichotomized by subtracting participants' interdependence score from their independence score. If the difference was greater than one standard deviation (0.82 in this study), the individual was classified as "Independent". If the difference was less than the negative of one standard deviation, the individual was classified as "Interdependent". If the difference was greater than or equal to the negative of one standard deviation and less than or equal to one standard deviation, then the individual was classified as part of the "Mixed" group (i.e., those high on both independence and interdependence).

Following this, 2 (Participant Race) X 3 (Self-Construal Category) ANOVAs were conducted for each of the dependent variables. Results are summarized in Table 19. In terms of treatment acceptability for group counseling, a main effect was found for self-construal \( F(2, 421) = 4.60, \ p < .05 \) such that independent individuals of both races found it most acceptable \( (M = 27.73) \), mixed individuals found it next most acceptable \( (M = 26.66) \), and interdependent individuals found it least acceptable among the three groups.
<table>
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<tr>
<th>Dependent Variable</th>
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<th>Low N</th>
<th>Medium M</th>
<th>Medium N</th>
<th>High M</th>
<th>High N</th>
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* p < .05  ** p < .01  *** p < .001

Table 18: Means and F-tests for Trichotomized Acculturation Scores by Treatment Acceptability, Willingness to See a Counselor, and Counselor Preferences
<table>
<thead>
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<th>Dependent Variable</th>
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<td>Whites and Asian Americans Combined</td>
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* p < .05 ** p < .01 *** p < .001

Table 19: Means and F-tests for Trichotomized Self-Construal Scores by Racial Group, Treatment Acceptability, Willingness to See a Counselor, and Counselor Preferences

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the interdependent group was significantly different from both the independent and the mixed groups. In terms of treatment acceptability for family counseling, the analysis resulted in a significant main effect for self-construal \( \text{[F(2, 421) = 3.11, } p < .05] \) such that independent individuals of both races found it most acceptable (\( M = 29.86 \)), mixed individuals found it next most acceptable (\( M = 28.08 \)), and interdependent individuals found it least acceptable among the three groups (\( M = 27.81 \)).

In terms of counselor preferences for cognitive similarity, a significant main effect was found for self-construal \( \text{[F(2, 421) = 3.22, } p < .05] \) such that interdependent individuals of both races preferred it most (\( M = 12.96 \)), mixed individuals preferred it next most (\( M = 11.89 \)), and independent individuals preferred it least among the three groups (\( M = 11.25 \)); independent individuals were significantly different from interdependent individuals.

The next step was conducting ANOVAs for Asian Americans alone on each of the dependent variables with self-construal trichotomized. Results are summarized in Table 19. Asian Americans in different self-construal groups were found to be significantly different in their ratings of treatment acceptability for group counseling \( \text{[F(2, 203) = 5.39, } p < .01] \) such that independent individuals found it most acceptable (\( M = 28.76 \)), mixed individuals found it next most acceptable (\( M = 25.92 \)), and interdependent individuals found it least acceptable among the three groups (\( M = 23.18 \)); the interdependent group was significantly different from the independent group. There were also differences among Asian Americans on ratings of treatment acceptability for family counseling \( \text{[F(2, 203) = 4.24, } p < .05] \) such that independent individuals found it most acceptable (\( M = 31.00 \)), interdependent individuals found it next most acceptable (\( M = 27.39 \)), and mixed
individuals found it least acceptable among the three groups ($M = 27.04$); the independent group was significantly different from the independent and mixed groups. This result supported Hypothesis 4b.

In addition to testing specific hypotheses in this study, additional ANOVAs were run using some independent variables in this study to ascertain whether the self-construal construct behaved as would be hypothesized from the literature with Asian Americans. Asian Americans with different self-construals were found to be significantly different in level of acculturation [$F(2, 202) = 5.03$, $p < .01$] such that independent Asian Americans were the most acculturated ($M = 3.36$), Asian Americans in the mixed group were second most acculturated ($M = 2.980$), and interdependent individuals were least acculturated ($M = 2.978$). The independent Asian American group was significantly different from both the mixed and the interdependent groups. These findings conformed to expectations from theory.

Asian Americans of different self-construal categories also differed significantly in loss of face [$F(2, 203) = 25.16$, $p < .001$] such that interdependent Asian Americans were the most sensitive to loss of face ($M = 85.67$), Asian Americans in the mixed group were second most sensitive to loss of face ($M = 73.61$), and independent individuals were least sensitive to loss of face ($M = 53.62$). Each of the groups was significantly different from each of the other groups. These findings were also as theoretically expected.

Because social desirability can be viewed both as a response set and as a personality dimension, it was also examined. Asian Americans of different self-construal categories did not differ significantly in terms of social desirability [$F(2, 203) = 1.49$, $p = .227$]. This finding was not expected in that it was theoretically expected that interdependent individuals would score higher on social desirability.
CHAPTER 5

DISCUSSION

In this final chapter, the purpose of the study is reviewed, results are discussed, and findings are summarized. Following this, implications for counseling are suggested, directions for future research in this area are detailed, and limitations of the study are described.

Review of the Purpose of the Study

The purpose of this study was to increase knowledge regarding barriers to utilization of mental health services by Asian Americans. To that end, this study explored three previously unexamined or underexamined barriers to use of counseling services by Asian Americans. The questions this study sought to address were: What kinds of counseling/psychotherapy treatments do Asian Americans find most acceptable? For which types of problems are Asian Americans willing to see a counselor? What kinds of preferences do Asian Americans have for counselors they see? It was hypothesized that between-groups comparisons on the three dependent variables of treatment acceptability,
willingness to see a counselor, and counselor preferences would help answer the question of whether these were barriers to utilization for Asian Americans, as compared to Whites.

In addition, within-group comparisons were designed to address the question of how these barriers manifested for Asian Americans. Four variables culturally-relevant for Asian Americans were examined in terms of their relationship to each of the barriers to counseling. Specifically, it was hypothesized that acculturation, loss of face, self-construal, and collective self-esteem would be significant predictors of treatment acceptability, willingness to see a counselor, and counselor preferences.

Discussion of Results

Of the between-groups comparisons, all three hypotheses (1, 6, 11) were at least partially supported. Whites found individual client-centered, individual cognitive-behavioral, group, and family counseling treatments significantly more acceptable than did Asian Americans. Given that counseling/psychotherapy is more Western in its emphases on the intrapsychic realm and the individual, this finding is in accordance with theoretical expectations that Whites would find counseling treatments more acceptable than would Asians. Thus, this study provided support for viewing treatment acceptability as a possible barrier to utilization of counseling services by Asian Americans.

While Whites were not significantly different from Asian Americans in willingness to see a counselor for relationship concerns, Asian Americans were significantly more willing than Whites to see a counselor for academic/career concerns. As a result, this study seems to support Tracey, Leong, and Glidden’s (1986) finding that Asian Americans, more than Whites, are more willing to see a counselor for educational/vocational concerns than
for emotional/interpersonal problems. In addition, these results support the view that willingness to see a counselor for specific concerns or areas of concern may be a barrier to utilization of services.

Prior counseling experience may explain why this study was not able to support Tracey, Leong, and Glidden's (1986) finding that Whites, more than Asian Americans, perceive themselves as having interpersonal/relationship concerns. Hierarchical regression analyses showed that for Whites in this study prior counseling experience accounted for a significant portion of the variance in explaining willingness to see a counselor for relationship concerns over and above that accounted for by other factors. Whites (30%) in this study were significantly more likely than Asian Americans (19%) to have had prior counseling experience. Although in Tracey, Leong, and Glidden's study previous counseling experience was related to White clients being more likely to have emotional/interpersonal presenting problems, perhaps the effect is different when Whites are asked to rate their willingness to see a counselor for these types of problems. Another difference between the Tracey, Leong, and Glidden study and the present study is that their sample consisted of actual clients seen at a counseling center, whereas this study asked participants to make judgments about hypothetically seeing a counselor.

Asian Americans were found to have stronger preferences for both demographic and cognitive similarity with a counselor than Whites, as hypothesized. However, Whites and Asian Americans did not significantly differ in preference for cognitive similarity, which supported the etic view (Fukuyama, 1990) that there are some universal attributes of a counselor on which clients would like to be matched (e.g., value orientation). Thus, support was provided for the view that counselor preferences, especially for a counselor that is demographically similar, can be a barrier to utilization of mental health services.
Of the within-group analyses for Asian Americans on treatment acceptability, the hypotheses for self-construal and collective self-esteem were partially supported and the hypotheses for acculturation and loss of face were not supported. Self-construal and collective self-esteem were both significant predictors of treatment acceptability for all types of counseling except family counseling.

Specifically, being an Asian American who was highly independent or highly interdependent was a predictor of finding individual client-centered counseling acceptable. But only those Asian Americans who were highly independent found individual cognitive-behavioral, group, and family counseling acceptable. These findings make sense in that those Asian Americans who are more independent are, theoretically, also more Western-identified and therefore would find all counseling treatments more acceptable.

It is interesting, however, that interdependence was positively related to acceptability of individual client-centered counseling, but not to individual cognitive-behavioral counseling. This does not support the contention (see Atkinson, Maruyama, & Matsui, 1978; D.W. Sue & D. Sue, 1990; S. Sue & Zane, 1987) that directive and concrete cognitive-behavioral interventions are better than affect-oriented interventions with more traditional (and, hence, more interdependent) Asian Americans. It does seem to support the findings of Akutsu, Lin, and Zane (1990), who found that directive counseling style failed to be a significant predictor of utilization intent.

Trichotomizing the self-construal construct lead to support for the hypothesis that Asian Americans would not differ in terms of acceptability for individual counseling as a function of self-construal category, but would differ in terms of acceptability for group and family counseling. As hypothesized, independent Asian Americans found group and
family counseling more acceptable than did interdependent Asian Americans. Because trichotomizing the construct enabled participants to be divided into “pure” categories, this finding lends very strong support to the view that group and family counseling modalities are more threatening than individual counseling in that they require doing things (e.g., airing one’s “dirty laundry” in front of others) that would be more in line with Western/independent cultural norms.

For collective self-esteem, being an Asian American who had high membership collective esteem (i.e., feeling very good about being a member of the Asian American group) predicted finding individual client-centered, individual cognitive-behavioral, and group counseling acceptable. In addition, those Asian Americans who were high in public collective esteem (i.e., feeling others evaluate the Asian American group highly) found individual client-centered counseling acceptable. It makes sense that, as hypothesized, high collective self-esteem would predict acceptability for individual and group counseling since valuing one’s own racial/ethnic group could mean one has less need to be self-protective and is therefore less hesitant about accepting counseling as a viable form of help. This idea has precedence from studies looking at personal self-esteem. For example, Baumeister, Tice, and Hutton (1989) found that individuals with low self-esteem are more self-protective and, it can be hypothesized, are therefore less likely to find counseling acceptable.

The significant findings for self-construal and collective self-esteem as predictors of individual cognitive-behavioral counseling and for self-construal as a significant predictor of group counseling were not found for Whites. Thus, these are culturally-unique findings to Asian Americans. For example, having high membership collective esteem and being
more independent are predictors of finding individual cognitive-behavioral counseling acceptable for Asian Americans, but not for Whites.

Trichotomizing the acculturation construct did not result in findings that provided support for the hypothesis that Asian Americans who are more acculturated will find treatments more acceptable than those who are less acculturated. In fact, the low acculturated Asian Americans found all four treatments most acceptable, followed by the medium acculturated, and then the high acculturated Asian Americans. The lack of findings for acculturation as a predictor of treatment acceptability was contrary to theoretical and empirical expectations, especially the results for group counseling. In Leong, Wagner, and Kim's (1995) study on expectations about group counseling, they found that acculturation was a significant predictor of positive attitudes toward group counseling for Asian Americans. It may be that positive expectations about group counseling are not similar to acceptability of group counseling.

Alternatively, these findings may be explained by the significant correlation of social desirability with acculturation scores, particularly with low acculturated (social desirability $M = 18.69$) and medium acculturated ($M = 18.88$) Asian Americans being affected by social desirability. Since it is possible that low and medium acculturated Asian Americans responded with a bias toward providing socially desirable responses, this may have influenced their ratings of acceptability for treatments.

Similar to the results for acculturation, loss of face was not a significant predictor of acceptability for any of the treatments. This is consistent with the findings of Leong, Wagner, and Kim (1995), who did not find that loss of face was a significant predictor of positive attitudes toward group counseling. Because the Loss of Face scale used in both
this study and Leong, Wagner, and Kim's study has not been used much in empirical
research, there are still questions about the construct validity of the scale. Some research
supports its use (see Zane, 1991) and others (Leong, Wagner, & Kim, 1995) do not.
Further research is needed to resolve these inconsistencies. Alternatively, it may be that the
LOF is not as reliable a measure of self-disclosure (which is what is inhibited by sensitivity
to loss of face) as desired.

Of the regressions for Asian Americans on willingness to see a counselor, none of
the cultural variables were significant predictors of willingness to see a counselor for any of
the concern types. It may be that there are problems with the PPI. This study was unable
to replicate the exact factor structure that Gim, Atkinson, and Whiteley (1990) found,
although the same three general problem areas were replicated. In addition, the lack of
significant findings in this study seem to support the findings of Watkins, Terrell, Miller,
and Terrell (1989), who also found no significant main effects or interactions in terms of
willingness to see a counselor with Black undergraduate students.

For the acculturation construct, the nonsignificant findings support the findings of
several previous studies. Although Atkinson and Gim (1989), Tata and Leong (1994), and
Ying and Miller (1992) found that high acculturated Asian Americans were more likely than
low acculturated Asian Americans to be open to discussing their problems with a
psychologist, Gim, Atkinson, and Whiteley (1990) found that acculturation was inversely
related to willingness to see a counselor. Similarly, Atkinson, Lowe, and Matthews (1995)
found no main effect for acculturation on willingness to see a counselor. This study is thus
the third to find that higher acculturation is not associated with increased willingness to see
a counselor, even though the theoretical literature and other empirical studies suggest
otherwise. In addition, this study assessed willingness to see a counselor by utilizing the
same scale used by Gim, Atkinson, and Whiteley, thus directly replicating their findings for acculturation. Perhaps the mixed findings are an artifact of the scales used to assess willingness to see a counselor. In both Atkinson and Gim (1989) and Tata and Leong (1994), the Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPH; Fischer & Turner, 1970) was used, whereas in the Gim, Atkinson, and Whiteley (1990) study and in this current study, the PPI was used.

Of the regressions for Asian Americans on counselor preferences, acculturation was found to be a significant predictor of demographic, but not cognitive, similarity preference. Thus, the hypothesis that acculturation would be a significant predictor of both types of preferences was only partially supported. The less acculturated Asian American participants were, the more they preferred to see a counselor with whom they were demographically similar. Specifically, preference for counselor ethnicity similarity accounted for the significant findings for demographic preference (as opposed to similarity in gender, socioeconomic class, or sexual orientation). This was theoretically expected and supports the idea that less acculturated Asian Americans, being more traditional, will value highly the ascribed credibility (i.e., credibility based upon who you are) of an Asian American counselor. According to S. Sue (1993), it is precisely this type of credibility, and not achieved credibility (based upon what you do), that accounts for utilization rates of mental health services by racial/ethnic minorities such that if a counselor is low in ascribed credibility (e.g., is not Asian American), clients tend not to utilize services.

Both hypotheses concerning loss of face as a predictor of counselor preferences were fully supported. The more sensitive to loss of face Asian American participants were, the more they preferred to be matched with a counselor to whom they were similar, both
demographically and cognitively. The particular ways in which Asian Americans who were highly sensitive to loss of face indicated they preferred to be similar with counselors were ethnicity, gender, sexual orientation, and personality style. This makes sense in that the game of face involves knowing one's station in relation to the station of the person to whom one is relating so that one can display appropriate behavior (Bond & Hwang, 1986). Asian Americans may prefer to interact with counselors with whom they are similar so as to enhance their ability to display the appropriate types of interactional behavior and therefore minimize the chances of losing face in the process of receiving help from that person.

Self-construal was only a significant predictor of preference for counselor cognitive similarity, and it was only interdependent self-construal that was positively associated with preference for cognitive similarity with counselor. Thus, the hypothesis that interdependent Asian Americans would have strong preferences for both demographic and cognitive match with counselors was only partially supported. It was hypothesized that interdependence would be positively related to preference for demographic match because interdependence is, theoretically, positively related to acculturation level. As predicted, acculturation was found to be significantly related to demographic preference in this study. Perhaps the lack of significant findings for self-construal with demographic similarity are explained by the negative correlation of independence with preference for demographic similarity.

Collective self-esteem was a significant predictor for both demographic and cognitive similarity preferences, thus supporting the hypotheses about collective self-esteem as a predictor of counselor preferences. Being high in membership collective self-esteem was positively related to preference for demographic similarity with a counselor.
Specifically, those Asian Americans who felt very good about being a member of the Asian American group also reported more preference for demographic similarity with a counselor, especially in terms of ethnicity. This finding provides empirical support for the explanation provided by Helms (1984) that those racial/ethnic minorities who are strongly affiliated with their cultural group underutilize mental health services if they are not matched with a culturally-similar counselor.

Findings of significance for collective self-esteem as a predictor of demographic similarity preference and for self-construal and loss of face as predictors of cognitive similarity preference were not also found for Whites. Thus, these are culturally-unique findings to Asian Americans. For example, having high membership esteem is a predictor of strong preferences for demographic similarity for Asian Americans, but not for Whites.

Finally, Asian Americans in this study were somewhat different from Asian Americans in other studies on counselor preferences in that Asian Americans in this study rated similarity in value orientation highest, followed in order by gender, personality style, ethnicity, sexual orientation, and socioeconomic class. For Whites in this study, the order was value orientation, sexual orientation, gender, personality style, ethnicity, and socioeconomic class. In a study by Carter (1993), Asian Americans stated a greater preference for a counselor with a similar socioeconomic background than for an ethnically-similar counselor, unlike the Asian Americans in this study. However, Mau and Jepsen (1988) found that international Chinese students were more concerned than American students about a counselors' racial background, which was true for the Asian American and White participants in this study as well.
Summary of Findings

Support was provided for viewing treatment acceptability, willingness to see a counselor, and counselor preferences as barriers to utilization of mental health services for Asian Americans. However, there were mixed findings among the various cultural variables in terms of viewing them as predictors of each of the barriers to utilization. In general, no single predictor variable consistently predicted variance in all dependent variables. The acculturation construct was, surprisingly, not a strong predictor. This result may have to do with possible response bias as evidenced by the correlation between acculturation and social desirability in this study's sample of Asian Americans. Similarly, loss of face was not a strong predictor of any counseling variables except counselor preferences, contrary to expected based on the theoretical literature.

Although both self-construal and collective self-esteem were fairly strong predictors, both of these constructs are relatively untried in prior research on underutilization of mental health services by Asian Americans. Therefore, findings regarding these constructs must be viewed as preliminary and will need to be replicated to enable firm conclusions to be made as to their influence on various barriers to utilization.

However, from the strongest findings in this study it is possible to make some conclusions. In this study Whites rated all forms of counseling significantly more acceptable than did Asian Americans, Asian Americans were significantly more willing to see a counselor for academic/career concerns than were Whites, and Asian Americans had significantly stronger preferences for demographic similarity (especially for ethnicity match) with a counselor than did Whites. All of these findings were as theoretically expected and consistent with what is already known about help-seeking and mental health service utilization.
Asian Americans were significantly more sensitive to loss of face than Whites in this study. Asian Americans found their membership in the Asian American group to be significantly more important to their self-concept than Whites did for their membership in the White racial group. In addition, Whites were significantly more independent than Asian Americans. All of these between-group differences were theoretically expected and supported prior research.

Acculturation was found to be a significant predictor of preference for demographic similarity with a counselor such that low acculturated Asian Americans were found to prefer demographic similarity more. When looking at self-construal, all participants who were independent, regardless of race, rated group and family therapy as more acceptable than did interdependent participants. In addition, Asian Americans who were more independent also rated group and family therapy as significantly more acceptable than did interdependent Asian Americans. These findings were all as theoretically expected.

An extension of the previous research was provided through the substantiation in this study that independent Asian Americans were more acculturated than interdependent Asian Americans. Also, interdependent Asian Americans were more sensitive to loss of face than independent Asian Americans. These findings were as theoretically expected.

Implications for Counseling

Based on the results of this study, implications can be proposed for counselors and other providers of mental health services to Asian Americans to better understand barriers to utilization of mental health services.
In general, results of this study support the idea that the help-seeking process is different for Asian Americans and Whites, which suggests that counselors and counseling centers cannot assume that the outreach and services we provide to White students are equally valid for Asian Americans. In this study, the treatments each group found acceptable, the types of concerns for which participants were willing to see a counselor, and the preferences each group had for counselor similarity were all different between Asian Americans and Whites.

For example, when compared to Whites, Asian Americans found individual client-centered, individual cognitive-behavioral, group, and family counseling all to be less acceptable. Thus, it may be that forms of help other than counseling are deemed more acceptable to Asian Americans who are suffering from an emotional or personal problem. Alternatively, it may be that these forms of counseling need to be modified to take into consideration the cultural values that Asian Americans are likely to bring into the counseling situation. To do so would require that counselors have the knowledge, skills, and attitudes of a competent cross-cultural counselor (D.W. Sue & D. Sue, 1990).

Similar to findings from Tracey, Leong, and Glidden's (1986) study, in which they found that Asian American students were more willing to see a counselor for educational/vocational concerns, and in Lee and Mixson's (1985; cited in Leong, 1986) study where they found Asian American college students were less willing to see a counselor for personal, social, or emotional concerns than were Whites, Asian American college students in this study were more willing than Whites to see a counselor for academic/career concerns. Tracey, Leong, and Glidden concluded that the distinction between academic/career counseling and individual emotional counseling was not useful for
Asian Americans in that Asian American culture values highly academic work and education. Thus, they suggested, working with Asian American students on academic concerns would indirectly aid in working with them on emotional/developmental issues.

Based on these findings in this study and previous studies, counselors and counseling centers are advised to be more mindful of not making such strong distinctions between “personal” and “career” counseling (see Betz & Comng, 1993, for a full discussion of the inseparability between these types of counseling). To increase the utilization of counseling services by Asian American students, efforts should be made to help Asian American students with academic/vocational concerns. In the process of doing this, students would likely be aided in working on emotional/personal concerns. In addition, utilization rates would likely increase if students felt counseling centers were addressing the issues they are concerned about in terms to which they relate (i.e., academic/career concerns).

Also, it is important for counselors in a university setting to take these suggestions into consideration in terms of outreach and consultation to the university community. When doing presentations to various student groups on campus, counselors can be mindful about presenting the counseling center as a place where students can receive help with all types of concerns, including academic or career concerns. In addition, workshops or groups focused on academic/career issues may be more attractive to Asian American students than other types of workshops/groups. For example, even though the same techniques may be taught in each workshop, a “mental skills” workshop advertised as helping students improve performance on tests may be perceived as more acceptable than a “relaxation skills” workshop advertised as a way to combat anxiety.
Asian American college students in this study also strongly endorsed, compared to Whites, demographic similarity with counselors, which was consistent with previous findings that Asian Americans utilizing community mental health services dropped out of therapy less when they were matched by ethnicity and/or gender with their therapist (S. Sue, Fujino, Hu, Takeuchi, & Zane, 1991). Based on these and similar findings, S. Sue (1993) recommends: 1) counselors be trained to be more culturally-responsive to members of racial/ethnic minority groups, 2) more ethnic counselors be recruited and hired, 3) development of ethnic-specific treatment facilities, and 4) the creation of new service delivery systems for specific ethnic groups.

From these recommendations and the specific findings in this study, it is suggested that ethnic matching of client with counselor may be important with Asian American clients, especially for low acculturated Asian Americans. This holds implications for staffing decisions, as well as for intake assignment of clients to counselors. In terms of staffing, utilization of mental health services by Asian Americans may be facilitated by the presence of Asian American counselors who are visible and familiar to the Asian American community.

The decisions that are made during intake sessions to assign clients to counselors can certainly be aided by knowledge of results from this study. For example, intake counselors may want to be vigilant about assigning low acculturated Asian American clients to an Asian American counselor, but would not necessarily want to match a high acculturated Asian American client with an Asian American counselor. To do this would entail an assessment of level of acculturation of the Asian American client during the intake session. This can be done in many ways, but some important questions to ask might be generation in the United States, degree of connection to an Asian American community,
and relationship with parents and relatives. Counselors can also indirectly infer level of acculturation through noting things such as English language ability, dress and appearance, and nonverbal behaviors that might be indicative of sensitivity to loss of face or reticence about self-disclosure.

Thus, counselors can use the findings from this study to inform decisions about all aspects of mental health provision, from staffing decisions to outreach and advertising, as well as client-counselor matching.

Directions for Future Research

Areas for future research stem first from the findings in this study. For instance, client matching, especially based on ethnicity, was supported in this study in that low acculturated Asian Americans were found to have strong preferences for demographic match with counselors. Although this study was not able to address the preference of Asian Americans for matching with a counselor of the same Asian ethnicity, this would be a fruitful path for future research. That is, would a Korean American client prefer a Korean American psychologist over a Japanese American counselor or would any Asian American counselor be sufficiently credible?

This study's test of S. Sue's (1993, 1998) demographic and cognitive similarity hypotheses was a promising initial investigation, but future research should be directed toward replicating results from the CPS, which was created for this study. In addition, alternative formulations of demographic and cognitive similarity preferences are possible and may yield different findings than those in this study.
Results from this study also conflicted with results from other studies with Asian Americans (see Carter, 1993 and Mau & Jepsen, 1988) in terms of which aspects of similarity were most important (e.g., ethnicity being more or less important than socioeconomic class). Future research could continue to address this construct in hopes of delineating more clearly which traits best predict preference for particular counselor attributes among Asian Americans.

Given the contradictory findings regarding acculturation and willingness to see a counselor, as opposed to attitudes toward seeking professional psychological help, it would be worthwhile to conduct a study in which both scales/constructs were used to enable a direct comparison within the same sample of these two operationalizations of the same barrier.

Although significant differences were found between Asian Americans and Whites on acceptability of treatments, as hypothesized, this was the first study to examine this construct for Asian Americans and, therefore, replication of these findings are needed before stronger conclusions can be stated.

In addition, based on results from this and other studies (e.g., Tracey, Leong, & Glidden, 1986) that Asian Americans are more willing to see a counselor for academic/career concerns, changing the directions for the treatment acceptability vignettes in future studies to instruct participants to think of an "academic or career concern", as opposed to the "emotional or personal concern" instructions in this study (see Appendix G), might yield different within-group findings among Asian Americans for how acceptable they find each treatment.
As mentioned in the discussion of results, the Loss of Face scale has not been used much in empirical research, leaving questions about the construct validity of the scale. Because some research (see Zane, 1991) has found it to be an adequate measure of the construct and others (Leong, Wagner, & Kim, 1995), including the current study, have not, further research is needed to resolve these inconsistencies.

It would also be worthwhile to replicate this study with a different group of Asian Americans in the hopes that social desirability would not be a confound in analyses with the acculturation and interdependent self-construal constructs. Doing so might yield additional significant findings with these variables.

Future research could also address the limitations of the current study, as discussed below. For example, although a true experimental design would not be ethical, the problems of the analogue nature of this study could be addressed by substituting actual clients for the university sample used in this study. Alternatively, it has been suggested (Miltenberger, 1990) that rather than conducting clinical studies, ecological validity can still be increased in analogue studies by using participants who would be soliciting the treatment, rather than using the ubiquitous undergraduate student. In the preliminary stages of researching a construct, such as this study’s examination of the treatment acceptability construct with Asian Americans, analogue studies are a less resource-intensive means of exploring variables to be examined under more exacting conditions (Gullone & King, 1989). The findings from this study suggest that future research with the treatment acceptability construct could be extended to examination within a population composed only of those Asian American college students who had previous counseling experience.
Limitations of the Study

Due to various limitations, care should be taken in interpreting results of the current study. First, causality can not be inferred due to the correlational nature of the data (Heppner, Kivlighan, & Wampold, 1992). Thus, it cannot be assumed that the independent variables caused the dependent variables in this study.

Second, this study is subject to the limitations of using self-report techniques (Heppner, Kivlighan, & Wampold, 1992). Given the significant correlations between scores on the social desirability scale and the SL-ASIA, for instance, it is possible that responses were biased on the measure of acculturation.

Third, although this study allowed a greater degree of generalizability to Asian Americans than studies using a sample from only one region of the United States, generalizability of findings to all Asian Americans is still limited in this study. Specifically, the sample consisted only of university students, so generalizations to Asian Americans in the community at large are not possible. In addition, although many Asian ethnic subgroups were represented, small numbers in some groups hinder generalizing results to members of all Asian ethnic groups.

Fourth, some of the instruments used in this study were not as reliable or valid as desired. The alphas for all four subscales of the CSE were low for Asian Americans, possibly suggesting that the validity of this scale for Asian Americans is questionable. In addition, the CPS was constructed for use in this study and therefore is not validated with other samples. Although the CPS showed adequate reliability in terms of the Cronbach's alphas for all but Whites' preference for cognitive similarity with a counselor, future research is necessary to fully test the validity of this scale.
Fifth, another limitation of this study is that it is an analogue study. According to Gullone & King (1989), although analogue designs may be useful in initial evaluations people may not respond to a brief, hypothetical description of a treatment as they would if they were experiencing the real situation. Using the treatment acceptability vignettes as an example, having participants read a written description of various treatments and imagine that they have specific problems may result in different ratings than experiencing counseling in an actual counseling session.

Related to this issue are the potential problems of using vignettes created by the principal investigator of this study for this study. Knowledge of the purpose and hypotheses of this study could have inadvertently influenced the writing of the vignettes. Additionally, although the treatment vignettes were based on treatment descriptions in the literature, they may not have captured completely what actually occurs in counseling.

Vignettes were presented such that participants were told to imagine they were receiving each treatment and that treatment was sought because of a “personal/emotional problem”. The choice to have participants imagine themselves receiving treatment, as opposed to having participants read about a hypothetical character receiving treatment, was made to increase personal identification with the treatment and, hopefully, elicit more accurate treatment acceptability ratings. However, by directing participants to come up with their own problem for which treatment was sought may have increased the likelihood of participants’ idiosyncratic interpretations influencing their ratings.

Sixth, although care was taken in designing the materials for this study, the use of three different individuals to administer questionnaires at three different locations may have introduced extraneous error. Even though the two California Asian American samples
were deemed comparable enough to combine with the Ohio Asian American sample, there were still some differences between the three groups which may have been eliminated if all participants were from the same location.

If one subscribes to the view, espoused by Holloway and Hosford (1983), that scientific research should proceed through the stages of descriptive observation, identification of and clarification of relationships between important variables, and development of theory, then this study has accomplished a small part of the second stage within Asian American mental health research. As we have moved from the descriptive stages of research where ethnicity and race were considered primarily as categorical variables, there has been an increasing recognition of the complexity of these constructs. For example, Phinney (1996) commented that research on ethnicity needs to focus on the recognition that it is a complex multidimensional construct. As such, Phinney recommends exploration of cultural attitudes influential in psychological processes to determine the extent to which they co-vary with membership in a particular group and have an impact on specific outcomes. This study has strived to do just that.
APPENDIX A

SOLICITATION STATEMENT
INTRODUCTION

Thank you for choosing to complete this questionnaire. Your efforts will help health care providers offer the best possible services to college students. The purpose of this study is to explore the relationships between certain cultural variables and factors that go into choices people make about seeking counseling. This is a straightforward study with several different types of scales. Please complete the questionnaire honestly and carefully. Be aware that questions appear on the front and back of each page. Make sure to match the items in the questionnaire with the item numbers on the scantron sheets you will be using to mark your responses.

It is important for you to know that I make the following two commitments to you:

1) Your participation is totally voluntary. You have the right to not participate and you may withdraw from the study at any time without negative consequences.

2) Your responses will be kept completely anonymous. No one will have access to your responses other than myself. I ask that you do not put your name anywhere on the questionnaire. Furthermore, when I receive the completed questionnaire, I will combine all the responses together so that no individual answers to the questions can be identified.

By completing this questionnaire, you indicate your agreement to participate in this study.

If you have questions about the study, you may contact me, Elayne L. Chou, M.A., at (614) 228-5048 (chou.55@osu.edu), or my research supervisor, Dr. Frederick Leong, Associate Professor, Department of Psychology, at (614) 292-8219.

Please feel free to take this Introduction sheet with you if you would like to have the above information with you for future reference. In addition, if you have any comments, please make those on the back of this page. Thank you very much for your time and cooperation!
APPENDIX B

SUINN-LEW ASIAN SELF-IDENTITY ACCULTURATION SCALE, MODIFIED
**Directions:** The questions which follow are for the purpose of collecting information about your historical background, as well as more recent behaviors which may be related to your cultural identity. Choose the one answer which best describes you and mark that letter or number on the BLUE computer scantron sheet with the corresponding item number.

1. **What language can you speak?**
   - A. Asian only (e.g., Chinese, Japanese, Korean, Vietnamese, etc.)
   - B. Mostly Asian, some English
   - C. Asian and English about equally well (bilingual)
   - D. Mostly English, some Asian
   - E. Only English

2. **What language do you prefer?**
   - A. Asian only (e.g., Chinese, Japanese, Korean, Vietnamese, etc.)
   - B. Mostly Asian, some English
   - C. Asian and English about equally well (bilingual)
   - D. Mostly English, some Asian
   - E. Only English

3. **How do you identify yourself?**
   - A. Oriental
   - B. Asian
   - C. Asian-American
   - D. Chinese-American, Japanese-American, Korean-American, Vietnamese-American, etc.
   - E. American

4. **Which identification does (did) your mother use?**
   - A. Oriental
   - B. Asian
   - C. Asian-American
   - D. Chinese-American, Japanese-American, Korean-American, Vietnamese-American, etc.
   - E. American

5. **Which identification does (did) your father use?**
   - A. Oriental
   - B. Asian
   - C. Asian-American
   - D. Chinese-American, Japanese-American, Korean-American, Vietnamese-American, etc.
   - E. American

6. **What was the ethnic origin of the friends and peers you had as a child, up to age 6?**
   - A. Almost exclusively Asians, Asian-Americans, Orientals
   - B. Mostly Asians, Asian-Americans, Orientals
   - C. About equally Asian groups and Anglo groups
   - D. Mostly Anglos, Blacks, Hispanics, or other non-Asian ethnic groups
   - E. Almost exclusively Anglos, Blacks, or other non-Asian ethnic groups
7. What was the ethnic origin of the friends and peers you had as a child, age 6 to 18?
   A. Almost exclusively Asians, Asian-Americans, Orientals
   B. Mostly Asians, Asian-Americans, Orientals
   C. About equally Asian groups and Anglo groups
   D. Mostly Anglos, Blacks, Hispanics, or other non-Asian ethnic groups
   E. Almost exclusively Anglos, Blacks, or other non-Asian ethnic groups

8. Whom do you now associate with in the community?
   A. Almost exclusively Asians, Asian-Americans, Orientals
   B. Mostly Asians, Asian-Americans, Orientals
   C. About equally Asian groups and Anglo groups
   D. Mostly Anglos, Blacks, Hispanics, or other non-Asian ethnic groups
   E. Almost exclusively Anglos, Blacks, or other non-Asian ethnic groups

9. If you could pick, whom would you prefer to associate with in the community?
   A. Almost exclusively Asians, Asian-Americans, Orientals
   B. Mostly Asians, Asian-Americans, Orientals
   C. About equally Asian groups and Anglo groups
   D. Mostly Anglos, Blacks, Hispanics, or other non-Asian ethnic groups
   E. Almost exclusively Anglos, Blacks, or other non-Asian ethnic groups

10. What is your music preference?
    A. Only Asian music (e.g., Chinese, Japanese, Korean, Vietnamese, etc.)
    B. Mostly Asian
    C. Equally Asian and English
    D. Mostly English
    E. English only

11. What is your movie preference?
    A. Asian-language movies only
    B. Asian-language movies mostly
    C. Equally Asian/English
    D. English-language movies mostly
    E. English-language movies only

12. Which generation best applies to you?
    A. 1st generation - I was born in Asia or someplace other than the U.S.
    B. 2nd generation - I was born in the U.S. and either parent was born in Asia or elsewhere
    C. 3rd generation - I was born in the U.S., both parents were born in the U.S., and all my grandparents were born in Asia or elsewhere
    D. 4th generation - I was born in the U.S., both parents were born in the U.S., and at least one grandparent was born in Asia or elsewhere and one grandparent born in U.S.
    E. 5th generation - I was born in the U.S., both parents and all grandparents were also born in the U.S.
13. Where were you raised?
   A. In Asia only
   B. Mostly in Asia, some in U.S.
   C. Equally in Asia and U.S.
   D. Mostly in U.S., some in Asia
   E. In U.S. only

14. What contact have you had with Asia?
   A. Raised one year or more in Asia
   B. Lived for less than one year in Asia
   C. Occasional visits to Asia
   D. Occasional communications (letters, phone calls, etc.) with people in Asia
   E. No exposure or communications with people in Asia

15. What is your food preference at home?
   A. Exclusively Asian food
   B. Mostly Asian food, some American
   C. About equally Asian and American
   D. Mostly American food
   E. Exclusively American food

16. What is your food preference in restaurants?
   A. Exclusively Asian food
   B. Mostly Asian food, some American
   C. About equally Asian and American
   D. Mostly American food
   E. Exclusively American food

17. Do you:
   A. read only an Asian language
   B. read an Asian language better than English
   C. read both Asian and English equally well
   D. read English better than an Asian language
   E. read only English

18. Do you:
   A. write only an Asian language
   B. write an Asian language better than English
   C. write both Asian and English equally well
   D. write English better than an Asian language
   E. write only English

19. If you consider yourself a member of an Asian group (Oriental, Asian, Asian-American, Chinese-American, etc.), how much pride do you have in this group?
   A. Extremely proud
   B. Moderately proud
   C. Little pride
   D. No pride but do not feel negative toward group
   E. No pride but do feel negative toward group

20. How would you rate yourself?
   A. Very Asian
   B. Mostly Asian
   C. Bicultural
   D. Mostly Anglicized
   E. Very Anglicized
21. Do you participate in Asian occasions, holidays, traditions, etc.?
   A. Nearly all          D. A few of them
   B. Most of them        E. None at all
   C. Some of them

22. Rate yourself on how much you believe in Asian values (e.g., about marriage, families, education, work, etc.) by filling in the circle corresponding to this item:
   A (do not believe) C (strongly believe)
   B C D E

23. Rate yourself on how much you believe in American (Western) values:
   A (do not believe) C (strongly believe)
   B C D E

24. Rate yourself on how well you fit with other Asians of the same ethnicity:
   A (do not fit) C (fit very well)
   B C D E

25. Rate yourself on how well you fit with other Americans who are non-Asian:
   A (do not fit) C (fit very well)
   B C D E

26. There are many different ways in which people think of themselves. Which ONE of the following most closely describes how you view yourself?
   A) I consider myself basically an Asian person (e.g., Chinese, Japanese, Korean, Vietnamese, etc.). Even though I live and work in America, I still view myself basically as an Asian person.
   B) I consider myself basically an American. Even though I have an Asian background and characteristics, I still view myself basically as an American.
   C) I consider myself an Asian-American, although deep down I always know I am an Asian.
   D) I consider myself an Asian-American, although deep down I view myself as an American first.
   E) I consider myself an Asian-American. I have both Asian and American characteristics, and I view myself as a blend of both.

27. Indicate which response best represents the degree of your commitment to cultural values:
   A. Strong commitment to both Anglo and Asian-American cultures.
   B. Strong commitment to Asian-American culture; weak commitment to Anglo culture.
   C. Strong commitment to Anglo culture; weak commitment to Asian-American culture.
   D. Weak commitment to both Anglo and Asian-American cultures.
APPENDIX C

WHITE RACIAL IDENTITY ATTITUDES SCALE
Directions: This questionnaire is designed to measure people's social and political attitudes. There are no right or wrong answers. Use the scale below to respond to each statement. On the BLUE scantron sheet, mark the number that best describes how you feel about each item.

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

1. I hardly think about what race I am.
2. I do not understand what Blacks want from Whites.
3. I get angry when I think about how Whites have been treated by Blacks.
4. I feel as comfortable around Blacks as I do around Whites.
5. I involve myself in causes regardless of the race of the people involved in them.
6. I find myself watching Black people to see what they are like.
7. I feel depressed after I have been around Black people.
8. There is nothing that I want to learn from Blacks.
9. I seek out new experiences even if I know a large number of Blacks will be involved in them.
10. I enjoy watching the different ways that Blacks and Whites approach life.
11. I wish I had a Black friend.
12. I do not feel that I have the social skills to interact with Black people effectively.
13. A Black person who tries to get close to you is usually after something.
14. When a Black person holds an opinion with which I disagree, I am not afraid to express my viewpoint.
15. Sometimes jokes based on Black people's experiences are funny.
16. I think it is exciting to discover the little ways in which Black people and White people are different.
17. I used to believe in racial integration, but now I have my doubts.
18. I'd rather socialize with Whites only.
19. In many ways Blacks and Whites are similar, but they are also different in some important ways.
20. Blacks and Whites have much to learn from each other.
21. For most of my life, I did not think about racial issues.
22. I have come to believe that Black people and White people are very different.
23. White people have bent over backwards trying to make up for their ancestors' mistreatment of Blacks, now it is time to stop.
24. It is possible for Blacks and Whites to have meaningful social relationships with each other.
25. There are some valuable things that White people can learn from Blacks that they can't learn from other Whites.
26. I am curious to learn in what ways Black people and White people differ from each other.
27. I limit myself to White activities.
28. Society may have been unjust to Blacks, but it has also been unjust to Whites.
29. I am knowledgeable about which values Blacks and Whites share.
30. I am comfortable wherever I am.
31. In my family, we never talked about racial issues.
32. When I must interact with a Black person, I usually let him or her make the first move.
33. I feel hostile when I am around Blacks.
34. I think I understand Black people's values.
35. Blacks and Whites can have successful intimate relationships.
36. I was raised to believe that people are people regardless of their race.
37. Nowadays, I go out of my way to avoid associating with Blacks.
38. I believe that Blacks are inferior to Whites.
39. I believe I know a lot about Black people's customs.
40. There are some valuable things that White people can learn from Blacks that they can't learn from other Whites.
41. I think that it's okay for Black people and White people to date each other as long as they don't marry each other.
42. Sometimes I'm not sure what I think or feel about Black people.
43. When I am the only White in a group of Blacks, I feel anxious.
44. Blacks and Whites differ from each other in some ways, but neither race is superior.
45. I am not embarrassed to admit that I am White.
46. I think White people should become more involved in socializing with Blacks.
47. I don't understand why Black people blame all White people for their social misfortunes.
48. I believe that White people look and express themselves better than Blacks.
49. I feel comfortable talking to Blacks.
50. I value the relationships that I have with my Black friends.
APPENDIX D

SELF-CONSTRUAL SCALE
**Directions:** These questions measure a variety of feelings and behaviors in various situations. Listed below are a number of statements. Read each one as if it referred to you. On the **GREEN** scantron sheet, mark the number that best matches your agreement or disagreement. Please respond to every statement. Thank you.

A = Strongly Disagree  
B = Disagree  
C = Somewhat Disagree  
D = Don’t Agree or Disagree  
E = Agree Somewhat  
F = Agree  
G = Strongly Agree

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>1)</td>
<td>I enjoy being unique and different from others in many respects.</td>
</tr>
<tr>
<td>2)</td>
<td>I feel comfortable using someone’s first name soon after I meet them, even when they are much older than I am.</td>
</tr>
<tr>
<td>3)</td>
<td>Even when I strongly disagree with group members, I avoid an argument.</td>
</tr>
<tr>
<td>4)</td>
<td>I have respect for the authority figures with whom I interact.</td>
</tr>
<tr>
<td>5)</td>
<td>I do my own thing, regardless of what others think.</td>
</tr>
<tr>
<td>6)</td>
<td>I respect people who are modest about themselves.</td>
</tr>
<tr>
<td>7)</td>
<td>I feel it is important for me to act as an independent person.</td>
</tr>
<tr>
<td>8)</td>
<td>I will sacrifice my self interest for the benefit of the group I am in.</td>
</tr>
<tr>
<td>9)</td>
<td>I’d rather say “No” directly, than risk being misunderstood.</td>
</tr>
<tr>
<td>10)</td>
<td>Having a lively imagination is important to me.</td>
</tr>
<tr>
<td>11)</td>
<td>I should take into consideration my parents’ advice when making education/career plans.</td>
</tr>
<tr>
<td>12)</td>
<td>I feel my fate is intertwined with the fate of those around me.</td>
</tr>
<tr>
<td>13)</td>
<td>I prefer to be direct and forthright when dealing with people I’ve just met.</td>
</tr>
<tr>
<td>14)</td>
<td>I feel good when I cooperate with others.</td>
</tr>
<tr>
<td>15)</td>
<td>I am comfortable with being singled out for praise or rewards.</td>
</tr>
<tr>
<td>16)</td>
<td>If my brother or sister fails, I feel responsible.</td>
</tr>
<tr>
<td>17)</td>
<td>I often have the feeling that my relationships with others are more important than my own accomplishments.</td>
</tr>
<tr>
<td>18)</td>
<td>Speaking up during a class (or a meeting) is not a problem for me.</td>
</tr>
<tr>
<td>19)</td>
<td>I would offer my seat in a bus to my professor (or my boss).</td>
</tr>
<tr>
<td>20)</td>
<td>I act the same way no matter who I am with.</td>
</tr>
<tr>
<td>21)</td>
<td>My happiness depends on the happiness of those around me.</td>
</tr>
<tr>
<td>22)</td>
<td>I value being in good health above everything.</td>
</tr>
<tr>
<td>23)</td>
<td>I will stay in a group if they need me, even when I am not happy with the group.</td>
</tr>
<tr>
<td>24)</td>
<td>I try to do what is best for me, regardless of how that might affect others.</td>
</tr>
<tr>
<td>25)</td>
<td>Being able to take care of myself is a primary concern for me.</td>
</tr>
<tr>
<td>26)</td>
<td>It is important to me to respect decisions made by the group.</td>
</tr>
<tr>
<td>27)</td>
<td>My personal identity, independent of others, is very important to me.</td>
</tr>
<tr>
<td>28)</td>
<td>It is important for me to maintain harmony within my group.</td>
</tr>
<tr>
<td>29)</td>
<td>I act the same way at home that I do at school.</td>
</tr>
<tr>
<td>30)</td>
<td>I usually go along with what others want to do, even when I would rather do something different.</td>
</tr>
</tbody>
</table>
APPENDIX E

LOSS OF FACE SCALE
**Directions:** Use the scale below to indicate the extent to which you agree with each statement as it applies to you. Please provide your responses on the *GREEN* scantron sheet.

<table>
<thead>
<tr>
<th></th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Strongly</td>
<td>Moderately</td>
<td>Mildly</td>
<td>Neither Agree</td>
<td>Mildly</td>
<td>Moderately</td>
<td>Strongly</td>
</tr>
<tr>
<td></td>
<td>Disagree</td>
<td>Disagree</td>
<td>Disagree</td>
<td>nor Disagree</td>
<td>Agree</td>
<td>Agree</td>
<td>Agree</td>
</tr>
</tbody>
</table>

1. I am more affected when someone criticizes me in public than when someone criticizes in private.
2. During a discussion, I try not to ask questions because I may appear ignorant to others.
3. I maintain a low profile because I do not want to make mistakes in front of other people.
4. Before I make comments in the presence of other people, I qualify my remarks.
5. I downplay my abilities and achievements so that others do not have unrealistically high expectations of me.
6. I carefully plan what I am going to say or do to minimize mistakes.
7. I say I may be in error before commenting on something.
8. When I meet other people, I am concerned about their expectations of me.
9. I hesitate asking for help because I think my request will be an inconvenience to others.
10. I try not to do things which call attention to myself.
11. I do not criticize others because this may embarrass them.
12. I carefully watch others' actions before I do anything.
13. I will not complain publicly even when I have been treated unfairly.
14. I try to act like others to be consistent with social norms.
16. I prefer to use a third party to help resolve our differences between another person and me.
17. When discussing a problem, I make an effort to let the person know that I am not blaming him or her.
18. When someone criticizes me, I try to avoid that person.
19. When I make a mistake in front of others, I try to prevent them from noticing it.
20. Even when I know another person is at fault, I am careful not to criticize that person.
21. When someone embarrasses me, I try to forget it.
APPENDIX  F

COLLECTIVE SELF-ESTEEM SCALE, RACE/ETHNICITY-SPECIFIC FORM
Directions: We are all members of different social groups. Some such social groups or
categories pertain to race and ethnicity. I would like you to consider your membership in
those particular groups or categories, and respond to the following statements on the basis
of how you feel about those groups and your membership in them. There are no right or
wrong answers to any of these statements; I am interested in your honest reactions and
opinions. Please read each statement carefully, and mark your answer on the GREEN
scantron, using the following scale:

A  B  C  D  E  F  G
Strongly Disagree Disagree Neutral Agree Agree Strongly
Disagree Somewhat Somewhat Agree

1) I am a worthy member of the social groups I belong to.
2) I often regret that I belong to some of the social groups I do.
3) Overall, my social groups are considered good by others.
4) Overall, my group memberships have very little to do with how I feel about myself.
5) I feel I don’t have much to offer to the social groups I belong to.
6) In general, I’m glad to be a member of the social groups I belong to.
7) Most people consider my social groups, on the average, to be more ineffective than
other social groups.
8) The social groups I belong to are an important reflection of who I am.
9) I am a cooperative participant in the social groups I belong to.
10) Overall, I often feel that the social groups of which I am a member are not
worthwhile.
11) In general, others respect the social groups that I am a member of.
12) The social groups I belong to are unimportant to my sense of what kind of a person I
am.
13) I often feel I’m a useless member of my social groups.
14) I feel good about the social groups I belong to.
15) In general, others think that the social groups I am a member of are unworthy.
16) In general, belonging to social groups is an important part of my self-image.
APPENDIX G

VIGNETTE AND TREATMENT ACCEPTABILITY RATING INSTRUCTIONS
Directions: Please assume that you are faced with a personal/emotional problem and have tried unsuccessfully to work it out by yourself. Some examples of personal/emotional problems include: having difficulties in relationships with roommates, friends, or family members; experiencing a lack of interest in activities that you previously enjoyed; facing the challenge of making important life decisions; or feeling a great deal of anxiety or confusion for an extended period of time. Now, assume that you are going to seek help for this problem. On the following pages, you will read about several different counseling approaches. Please read each of the following vignettes describing these various counseling treatment options and make your ratings on the scale that follows each vignette by filling in the corresponding bubble for each item. Continue using the BLUE scantron sheet.
APPENDIX H

INDIVIDUAL CLIENT-CENTERED COUNSELING VIGNETTE
Individual Counseling (Approach A)

You seek help at the Counseling Center on campus and begin to work with a counselor on an individual basis. You go to eight sessions (two months) and during that time you examine your feelings of low self-worth. During the first session, the counselor tries to convey to you acceptance, respect, and understanding of your problems. This is done through the counselor's words of reassurance and encouragement, as well as the counselor's body language (e.g., nodding, smiling). Over the next few sessions, the counselor tries to help you gain insight about your positive and negative feelings in an attempt to increase your acceptance of your self. As the sessions continue, you and the counselor discuss ways in which you can become more open and receptive to various experiences in your life. Towards the end of the sessions, you and the counselor discuss ways in which you can bridge the gap between the person you would like to be and the person you actually feel you are.
APPENDIX I

INDIVIDUAL COGNITIVE-BEHAVIORAL COUNSELING VIGNETTE
Individual Counseling (Approach B)

You seek help at the Counseling Center on campus and begin to work with a counselor on an individual basis. You go to eight sessions (two months) and during that time you examine your negative thinking. During the first session, the counselor discusses your symptoms with you and talks about what will happen over the course of counseling. You are asked to keep a log of how active you are and to record how well you feel you are functioning. Over the next few sessions, you examine the relationship between your thinking, behavior, and feelings. The counselor asks you to record what you think about when you are having strong feelings and then the two of you look at how these thoughts influence your feelings. As the sessions continue, you and the counselor note common themes in your thinking and begin to look at other ways of viewing things. Towards the end of the sessions, you discuss how to spot your automatic negative thoughts and counter them with more realistic thoughts.
APPENDIX J

GROUP COUNSELING VIGNETTE
Group Counseling

You seek help at the Counseling Center on campus and begin to attend group counseling on a regular basis. You go to eight sessions (two months) of a group that is composed of yourself, four other members of both sexes, and two group leaders/counselors. In the initial sessions, you and the other members take turns clarifying what you want from the group. All of you are encouraged to notice that you are not the only ones with problems, anxieties, and fears. Over the next few sessions, members start to question their ability to trust the counselors and the other members. The group counselors encourage members to verbally express their fears about disclosing personal thoughts and feelings. As you speak, the counselors encourage other members to give feedback to you about how you are coming across to them. Towards the end of the sessions, the counselors encourage you and the others to express your feelings about the ending of the group and to discuss what you have learned from the experience.
APPENDIX K

FAMILY COUNSELING VIGNETTE
Because you are having these personal/emotional difficulties, your family takes you to seek help at the Family Counseling clinic on campus. You and your family work with a counselor for eight sessions (two months) and during that time the counselor helps your family examine the dynamics between family members in attempts to achieve harmony within the family. During the first session, the counselor does not focus very much attention on you, even though you are the only one identified as having problems. Instead, the counselor focuses on the dynamics between your parents and between siblings. The counselor avoids direct confrontation for the first few sessions until your family feels more comfortable with the format of counseling. Over the next few sessions, the counselor gets your family to enact interactions that have occurred during the week between sessions and encourages all of you to interact differently than usual. Towards the end of the sessions, your family works on communicating better with one another.
APPENDIX L

VIGNETTE DISCRIMINANT VALIDITY RATING FORM
VIGNETTE #1
You seek help for emotional/personal difficulties and attend twelve sessions (three months) of counseling. During that time you examine how your negative thinking contributes to your feelings. During the first session, you discuss your symptoms and talk about what will happen over the next 11 weeks. You are asked to keep a log of how active you are and to record how well you feel you are functioning. Over the next few sessions, you begin to examine the relationship between your thinking, behavior, and feelings. Whenever you notice you are having strong feelings, you are asked to record what you think about. In session, you begin to look at how these thoughts influence your feelings. As the sessions continue, you note common themes in your thinking and begin to look at other ways of viewing things. Towards the end of the sessions, you discuss how to spot your automatic negative thoughts and counter them with more realistic thoughts.

What type of counseling do you think this vignette describes?

VIGNETTE #2
You seek help for emotional/personal difficulties and attend twelve sessions (three months) of counseling with 4 other people. In the initial sessions you and the other participants take turns clarifying your goals for what you want from the experience. All of you are encouraged to notice that you are not the only ones with these problems, anxieties, and fears. Over the next few sessions, trust becomes a bigger issue as participants start to question their ability to trust the other participants and even themselves. All participants are encouraged to verbally express their fears about disclosing personal thoughts and feelings to the others. As you speak, the others are encouraged to give feedback to you about how you are coming across to them. Towards the end of the sessions, you and the other participants are encouraged to express your feelings about the ending of the sessions and to discuss what you have learned from the experience.

What type of counseling do you think this vignette describes?
You seek help for emotional/personal difficulties and attend twelve sessions (three months) of counseling with 4 other people. During that time you and the other participants examine dynamics between yourselves in attempts to achieve harmony. During the first session, not very much attention is directed toward you, even though you are the one identified with having problems. Instead, the focus is on the dynamics between certain dyads composed of other participants. There is little direct confrontation for the first few sessions until you and the other participants feel more comfortable with the format of counseling. Instead, you and the other participants are told to interact with one another during therapy sessions just as you do outside of therapy sessions. Over the next few sessions, all of you are encouraged to try on different roles than the ones you usually enact with one another. Towards the end of the sessions, you and the others work on communicating better with each other.

What type of counseling do you think this vignette describes?

Please respond to the following questions:

1) Your level of education (completed):
   _____M.A./M.S.
   _____Ph.D./Psy.D.

2) Your sex:
   _____Female
   _____Male

3) Your age:

4) Your race:
   _____White
   _____Black
   _____Asian/Pacific Islander
   _____Hispanic
   _____Native American
   _____Other (specify:_______)
APPENDIX M

VIGNETTE CONTENT VALIDITY RATING FORM
INDIVIDUAL COGNITIVE-BEHAVIORAL COUNSELING

You seek help at the Counseling Center on campus and begin to work with a counselor on an individual basis. You go to twelve sessions (three months) and during that time you examine how your negative thinking contributes to your feelings. During the first session, the counselor discusses your symptoms with you and the two of you talk about what will happen over the next 11 weeks. You are asked to keep a log of how active you are and to record how well you feel you are functioning. Over the next few sessions, you begin to examine the relationship between your thinking, behavior, and feelings. The counselor asks you to record what you think about when you are having strong feelings and then the two of you begin to look at how these thoughts influence your feelings. As the sessions continue, you and the counselor note common themes in your thinking and begin to look at other ways of viewing things. Towards the end of the sessions, you discuss how to spot your automatic negative thoughts and counter them with more realistic thoughts.

Using the following scale, how realistic do you think this vignette depicting individual cognitive-behavioral counseling is? __________

1 2 3 4 5 6 7 8 9 10
Not Neutral Very Realistic

Using the following scale, how typical of individual cognitive-behavioral counseling do you think this vignette is? __________

1 2 3 4 5 6 7 8 9 10
Not Neutral Very Typical
GROUP COUNSELING

You seek help at the Counseling Center on campus and begin to attend group counseling on a regular basis. You go to twelve sessions (three months) of a group that is composed of yourself, five other members of both sexes, and two group leaders/counselors. In the initial sessions of the group you and the other members take turns clarifying your goals for what you want from the group. All of you are encouraged to notice that you are not the only ones with these problems, anxieties, and fears. Over the next few sessions, trust becomes a bigger issue in the group as members start to question their ability to trust the group counselors and the other members. The group counselors encourage members to verbally express their fears about disclosing personal thoughts and feelings to the group. As you speak, the group counselors encourage other members to give feedback to you about how you are coming across to them. Towards the end of the sessions, the group counselors encourage you and the others to express your feelings about the ending of the group and to discuss what you have learned from the experience.

Using the following scale, how realistic do you think this vignette depicting group counseling is? __________

1 2 3 4 5 6 7 8 9 10
Not Neutral Very
Realistic

Using the following scale, how typical of group counseling do you think this vignette is? __________

1 2 3 4 5 6 7 8 9 10
Not Neutral Very
Typical
FAMILY SYSTEMS COUNSELING

Because you are having these personal/emotional difficulties, your family takes you to seek help at the Family Counseling clinic on campus. You and your family work with a counselor for twelve sessions (three months) and during that time the counselor helps your family examine the dynamics between family members in attempts to achieve harmony within the family. During the first session, the counselor does not focus very much attention on you, even though you are the only one identified as having problems. Instead, the counselor focuses on the dynamics between your parents and between siblings. The counselor avoids direct confrontation for the first few sessions until you and your family feel more comfortable with the format of counseling. During therapy sessions, the counselor gets you and members of your family to enact interactions that have occurred during the week between sessions. Over the next few sessions, the counselor tries to get members of the family to try on different roles than the ones they usually play in the family. Towards the end of the sessions, you and the others work on communicating better with each other.

Using the following scale, how realistic do you think this vignette depicting family counseling is? _________

1  2  3  4  5  6  7  8  9  10
Not  Neutral  Very
Realistic  Realistic

Using the following scale, how typical of family counseling do you think this vignette is? _________

1  2  3  4  5  6  7  8  9  10
Not  Neutral  Very
Typical  Typical

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Please respond to the following questions:

1) Your level of education (completed):
   _____M.A./M.S.
   _____Ph.D./Psy.D.

2) Your sex:
   _____Female
   _____Male

3) Your age:

4) Your race:
   _____White
   _____Black
   _____Asian/Pacific Islander
   _____Hispanic
   _____Native American
   _____Other (specify: ____________)

Additional Comments:

THANKS FOR YOUR HELP!!

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APPENDIX N

TREATMENT EVALUATION INVENTORY - SHORT FORM, MODIFIED
COUNSELING TREATMENT EVALUATION*

**Directions:** Please complete the items listed below by filling in the number on the scantron sheet that best indicates how you feel about the treatment. Make sure to do the items in the correct order.

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

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<table>
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<tr>
<th></th>
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<tbody>
<tr>
<td>1</td>
<td>I find this treatment to be an acceptable way of dealing with the problem.</td>
</tr>
<tr>
<td>2</td>
<td>I would be willing to use this procedure if I had to deal with this problem.</td>
</tr>
<tr>
<td>3</td>
<td>I believe that it would be acceptable to use this treatment without someone’s consent.</td>
</tr>
<tr>
<td>4</td>
<td>I like the procedures used in this treatment.</td>
</tr>
<tr>
<td>5</td>
<td>I believe this treatment is likely to be effective.</td>
</tr>
</tbody>
</table>

* The title was modified for each type of treatment such that it was descriptive of the treatment to be evaluated. For example, “Individual Counseling Treatment Evaluation (Approach A)”.

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APPENDIX O

PERSONAL PROBLEMS INVENTORY, MODIFIED
**Directions:** The following items represent problems that some college students have. Please rate your willingness to seek counseling for each of the problems listed below. Use the rating scale given below to indicate your willingness on the BLUE scantron sheet for each item.

1 = Not Willing to See a Counselor
2 = Probably Not Willing to See a Counselor
3 = Probably Willing to See a Counselor
4 = Willing to see a Counselor

<table>
<thead>
<tr>
<th>1. General Anxiety</th>
<th>13. Insomnia</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Shyness</td>
<td>15. Loneliness or Isolation</td>
</tr>
<tr>
<td>5. Sexual Functioning Problems</td>
<td>17. Test Anxiety</td>
</tr>
<tr>
<td>6. Depression</td>
<td>18. Alienation</td>
</tr>
<tr>
<td>10. Dating or Relationship Problems</td>
<td>22. Roommate Problems</td>
</tr>
</tbody>
</table>
APPENDIX P

COUNSELOR PREFERENCE SCALE
Directions: Please mark the number on the GREEN scantron sheet that corresponds best with your preference. Use the scale below to select your preferences.

1 2 3 4 5 6 7 8 9 10
Do Not Neutral Strongly
Prefer at
All

1) In seeking counseling, how much do you prefer to see a counselor of the same ethnicity as yourself?

2) In seeking counseling, how much do you prefer to see a counselor of the same gender as yourself?

3) In seeking counseling, how much do you prefer to see a counselor of the same socioeconomic class as yourself?

4) In seeking counseling, how much do you prefer to see a counselor of the same sexual orientation as yourself?

5) In seeking counseling, how much do you prefer to see a counselor with the same value orientation as yourself?

6) In seeking counseling, how much do you prefer to see a counselor with the same personality style as yourself?
APPENDIX Q

MARLOWE-CROWNE SOCIAL DESIRABILITY SCALE, BRIEF FORM
Directions: Listed below are a number of statements concerning personal attitudes and traits. Read each item and decide whether the statement is true or false as it pertains to you personally. Using the BLUE scantron sheet for each item, mark your responses using the scale given below.

1 = True  
2 = False

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

Sex: ___Female  ___Male

Age (in years):____________________

Citizenship: ___U.S. ___U.S. Permanent Resident ___Other (specify:__________)

Race (please check all that apply): ___White ___Asian/Pacific Islander
 ___Black ___Hispanic/Latino-a
 ___Native American ___Other (specify:________________)

Asian Ethnic Background (if applicable): (please check all that apply)
___Cambodian American ___Japanese American
___Chinese American ___Korean American
___Filipino/a American ___Vietnamese American
___Indian American ___Other (specify:____________________________________)

Marital Status: ___Never Married ___Common-Law Marriage
 ___Married ___Widowed
 ___Divorced/Separated ___Other (specify:________________________)

Personal (if you support yourself) or Family Annual Income:
___Under $10,000 ___$30,001 - $40,000
___$10,000 - $20,000 ___$40,001 - $50,000
___$20,001 - $30,000 ___Over $50,000

Occupation: ___Student ___Other (specify:___________________________)

Education: ___High School Graduate ___College Junior
 ___Vocational School ___College Senior
 ___College First-Year Student ___College Graduate
 ___College Sophomore ___Post-Baccalaureate Student

Academic Major (if applicable):____________________________________________________

Have you ever been in counseling/therapy? ___Yes  ___No
APPENDIX S

DEBRIEFING STATEMENT
DEBRIEFING FORM

Purpose of the Research Project

This study you have just participated in was designed to investigate the relationships between cultural variables and counseling variables. The cultural variables examined in this study are: acculturation level*; sensitivity to loss of face; independent versus interdependent views of the self; and level of collective self-esteem (how you feel about your membership in your racial/ethnic group). The counseling variables are: acceptability of four kinds of counseling treatments (individual client-centered therapy, individual cognitive-behavioral therapy, group therapy, and family therapy); willingness to see a counselor for various problems; and counselor preferences.

Participant’s Contribution

Your participation has contributed by helping psychologists research reasons for the low usage rates of psychological services by Asian Americans* *. It is hoped that the results of this study will help improve service delivery to Asian Americans seeking treatment in the mental health system.

If the process of participating in this study has led you to think about seeking counseling for yourself, this service is available to you at little or no cost through the Counseling and Consultation Service center on campus. Their number is 292-5766.

Your help with this study has been greatly appreciated and I hope that it was interesting and rewarding for you. Should you have any questions about the study, you may contact me at 614-228-5048 or chou.55@osu.edu.

Sincerely,

Elayne Chou, M.A.
Graduate Student

* This was changed to “White racial identity attitudes” for White participants
** This was modified for White participants to reflect their participation
LIST OF REFERENCES


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