Cultural Adaptation of the Systematic Treatment Selection Innerlife (STS-Innerlife) with An Urban Mainland China Sample

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ABSTRACT

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Cultural Adaptation of the Systematic Treatment Selection Innerlife (STS-Innerlife) with An Urban Mainland China Sample

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This study aims to examine the consistency of Systematic Treatment Selection Innerlife (STS-Innerlife) for China sample and develop a culturally adapted STS instrument in China. The STS-Innerlife was used as the measure of patient characteristics in this study. The STS instrument has been found in numerous studies to have sound reliability and validity in North American and Europe. This was a first attempt to assess the STS instrument‘s reliability in an Eastern country. In this study, the English language version was used as a template from which the translation (and back translation) was constructed for Chinese samples. A total of 300 non-clinical participants collected from Mainland China and 240 non-clinical US archival data were used. Confirmatory Factor Analysis (CFA) and Exploratory Factor Analysis (EFA) were used to assess the factor structure of the US and Chinese samples on STS treatment items. The EFAs evinced that the US and China samples share similar factor structure and they demonstrated two cross-culturally consistent factors, Externalized Distress and Internalized Distress.

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CHAPTER 1: INTRODUCTION

Issues of Adaptation of Theories and Measures to Other Cultures

It has been widely acknowledged that modern Western psychotherapies need to be adapted to different cultural regions especially under the current economic and cultural globalization (e.g., APA, 2002, pp.1062-1063; Sue, Zane, Hall, & Berger, 2009). China, as a country with 20% of the world population, has a long history of psychological thinking and yet has thus far little representation in worldwide scholarship of contemporary psychotherapy research and practice. The foundation of the clinical practice of therapy and the theories for understanding human nature, such as psychopathology, personality, are primarily based on the research and clinical experiences of Westerners (Tseng, Chang, Nishizono, 2005). Thus, an important question is to what extent are the constructs derived from Western-derived psychotherapy applicable with a Chinese population.

The Systematic Treatment Selection (STS; Beulter & Clarkin, 1990; Beutler & Harwood, 2000) is a treatment model that aims at capturing the key principles and mechanisms of change in psychotherapy across techniques and cultural contexts. By retaining sound principles of behavior change, the STS model was developed with the aim of providing clinicians with flexibility and creativity in diverse cultures and across a wide range of treatment approaches. The predictive validity of the scale has been found to be satisfactory in several different cultures- US, Argentina, Switzerland (Corbella, et al., 2003; Johannsen, & Beutler, 2008). However, there is yet no study examining the

reliability and validity of this instrument in Eastern countries. Undoubtedly, the adaptation of STS to China will bring mutual benefits.

An important issue in adapting and transporting Western-derived measures involves not only the important issue of converting language accurately, but also maintaining consistent content and construct validity (Ghorpade, et al., 1998; Guillemin, Bombardier, Beaton, 1993; Hendricson, 1989; Herdman, Fox-Rushby, Badia, 1997; Wagner, et al., 1998). Markus and Kitayama (1991) argue that cultural variations exist in psychological process such as cognition, emotion, or motivation. People from different cultures respond differently to patient variables or personality measures that implicate the self. According to Markus and Kitayama (1991), individuals with differing interdependent versus independent self-construals, will also vary in their cognitively processes of psychological information in terms of the self, interpersonal relationships, and perception of mental health. Therefore, researchers should be aware of how to make questionnaire items or scales equivalent in psychological meanings across cultures.

Some cross-cultural researchers have proposed several standards of equivalence that should be met when evaluating cross-cultural validity of measures (e.g. Guillemin, Bombardier, Beaton, 1993; Flaherty et al., 1988). Guillemin, Bombardier and Beaton proposed that the original scale and its adapted version should be equivalent in four areas: (a) Semantic Equivalence, which focuses on whether meanings of the words used in the items are consistent across different cultures; (b) Idiomatic Equivalence refers to whether the expression of colloquialisms is formulated equivalently in the target version; (c) Experiential Equivalence involves seeking to capture the experience of daily life. It‘s not

uncommon that one phenomenon widely accepted in one country is rarely seen or accepted in the other. For example, the item of STS measure ―Do you own a gun" would be strange to a population in China where gun is forbidden; and finally, (d) Conceptual Equivalence refers to whether the conceptual meanings of the underlying construct of the instrument would differ between two cultures.

In addition, Flaherty et al. (1988) proposed two more levels of equivalence that an adapted measure needs to demonstrate as evidence of cross-cultural validity: (a) Technical Equivalence which refers to whether the research method such as general data collection result in equivalent results in different cultures; and (b) Criterion Equivalence indicates establishing validity through parallel comparisons to within-culture norms (Mallinckrodt, & Wang, 2004).

The research method most frequently used for cross-cultural adaptation of self-report measures in verifying the equivalence of the adapted measures and the source questionnaires is the procedure of back-translation (Bjorner, Kreiner, Ware, et al., 1998; Beaton, et al, 2000; Mallinckrodt & Wang, 2004). The procedure of translation includes initial translation, synthesis of the translations and back translation (Beaton, et al., 2000).

Although it has been acknowledged that the process of translation is critical in establishing a reliable and valid cross-cultural adapted instrument, there are sparse literatures reporting their translation and adaptation process. Mallinckrodt and Wang (2004) reviewed articles in the field of counseling psychology and only found 7 articles that reported use of an adapted measure, and of these seven studies, only five used back-translation methods, and only two (Fouad et al., 1984; Tracey, Watanabe, & Schneider,

1997) extensively use quantitative methods to verify semantic equivalence of the adapted measure. Mallinckrodt and Wang (2004) developed "dual-language, split-half" quantitative methods of verification to supplement back-translation judgments and collected data on 30 bilingual Taiwanese samples on a Chinese version of the Experiences in Close Relationship Scale.

Chinese Culture

The process of cross-cultural translation and validation of measures used for Western psychotherapies to a form for Chinese cultural adaptation involves understanding the hypothetical similarities and differences of these cultures. This section will focus on Chinese culture and is written for a Western audience. Chinese culture has been understood to be high in power distance and hierarchical, high in collectivism, and low in individualism (e.g., Smith & Bond, 1993). The deep-rooted cultural values that sustain this system are the Confucian principles and morals. Confucius held that the society should be well-ordered, and each individual bearing the assigned roles and they should fulfill their duties and responsibilities. For instance, children should hold filial piety and they should comply with parents' intentions and expectations. Another core value strongly stressed in Chinese culture is "harmony". The implication of harmony originally is to transcend the physical world, and to have a holistic concept of the individual and the individual's environment. However, the concept of harmony in the contemporary Chinese culture also has been heavily influenced by Confucianism, which is more collectivism, and interpersonal-oriented. Individuals are fostered to fit personal life goals into a broad social context, and to take responsibility of family and society, and

individual‘s boundaries are fused with others, particularly family members (Tseng, et al., 2005). Family is considered to be the primary source of support (Tseng, et al., 2005). Children are taught from a very early age that they have responsibility to maintain and promote family –face.” The pattern of parent-child relationship is well embedded in other relationships, such as in workplace, husband-wife relations, and authority-subordinate relations.

These traditional Chinese philosophies facilitate the maintenance and perpetuation of the society and the family. However, it also grants power and authority to certain classes and fosters hierarchies in human relationships. Individuals are required to accept their duties and positions assigned to them and to play their parts in sustaining the system. Following social norms and moral rules by suppressing individual‘s needs represents a degeneration from Tao (autonomy and freedom of mind), which is also part of core value of Chinese culture. There have been tremendous Chinese literatures depicting the struggles that Chinese people have been facing in balancing the conflicts between individual‘s needs and social expectations. Some literatures pointed out a unique Chinese coping mechanism, —passive rationalization”, which is called –Ah-Q” spirit. It means to adjust the dissonant internal and external experiences by certain kinds of self-deceiving rationales in order to balance individual‘s needs and social demands. Maintaining social order and fulfilling social responsibility help individuals gain a sense of social belonging and find individual meaning in a broad social context. However, it may also constrict individual‘s autonomy. Individual may use it as a coping mechanism

to avoid experiencing feelings of shame, guilt, and anxiety related to their individual needs.

The admixture of patriarchal authority with harmony maintaining postures in family relationship may cause the parent-child relationship to remain as a surface quality only, and to mask some implicit conflicts that exist in family relationships. Evidence shows that expression of emotion is carefully regulated in Chinese people for its capacity to disrupt group harmony and status hierarchies (Bond, 1993). The phenomenon of dominating parental control and child indulgence is not uncommon in Chinese culture. Some studies showed that parental dominating control is negatively related to perceived parental warmth and family harmony in Chinese communities (e.g., Lau, Lew, Hau, Cheung, Berndt, 1990). Avoiding confrontation in relationships is interpreted in Chinese culture as ―prudent" and ―collectivism", but there are studies indicating that higher levels of conformance and social acquiescence (Tarwater, 1996; Wang, 1981) may mislead children who are weak-willed and cause harmful dependency. The unquestioning deference to authority figures may suppress ―original" self and individual's autonomy (Westwood, 1997).

Psychometry in China

There have been several well-known Western-originated psychological measures adapted in China.in the past decade. One type of instrument currently used for treatment planning, monitoring, and outcome assessment in China is the symptom-focused measures, such as the Symptom Checklist 90-R (SCL-90-R; Derogatis, 1994), the Beck Depression Inventory-II (BDI-II; Beck, Steer, & Brown, 1996), and the State Trait

Anxiety Inventory (STAI; Spielberger, et al., 1983). The cross-cultural studies reported good consistency and similar factor structure of these measures when used for China and US samples. For instance, a cross-cultural study (Feng, & Zhang, 2001) on the Chinese version of SCL-90 with 892 Chinese participants reported Cronbach‘s coefficient alpha ranged from .78 to .90. However, these measures are rarely used in the evaluation of therapy in China. For instance, the use of the SCL-90 reported among the published articles indicated that 69.23% of administrations were for mental health screening and only 10.60% of administrations were used in effective evaluation of therapy (Tang, et al., 1999).

Personality measures have thus demonstrated more consistency between the United States and China. For example, the NEO-PI-R five-factor structure of the China sample has been found to be similar to that of the US, especially for the Neuroticism, Openness and Conscientiousness factors (Yang et al., 1999). Nonetheless, salient group differences in the patterns of scoring may still exist when there are cross-cultural factorial commonalities. Cross-cultural differences in the norms may be an important source of bias and misinterpretation when using imported assessment tools. The Eysenck Personality Questionnaire (EPQ) appears structurally similar in the U.S. and China, but participants in China scored lower on E and higher on P than the Western participants (Cheung, Gan, & Lo, 2005).

However, despite the reliability of these measures, whether or not their constructs are relevant for Chinese culture is still questionable. In the meanwhile, Chinese psychologists have identified a number of culturally specific dimensions to explain social

behavior in Chinese cultural context. The Chinese Personality Assessment Inventory (CPAI; Cheung, et al., 1996) has gone through vigorous reliability and validity study and has been widely used in Mainland China and Hong Kong. Some other indigenous symptom measures, such as, the Chinese Health Questionnaire (CHQ; Cheng, & Williams, 1998; Chong, & Wilkinson, 1989) have been also extensively used.

Although a large body of studies have demonstrated the cross-cultural reliability of Western-originated personality measurement and symptom measurement, being reliable is not sufficient to indicate the relevance of their constructs to China samples nor to verify their capacity of adaptation to Chinese culture. It is noteworthy that western-derived personality measurement and symptom-focused measurement are based on the data collected from Westerners who value individualism and equalitarian. While in Chinese culture, people value interdependence and hold the holistic and contextual viewpoints when conceptualizing pathology or treatment. Therefore, the Western-originated measures may violate some central values of Chinese culture. It could be potentially problematic to use these Western-originated instruments in treatment planning given that they emphasize that pathology and assumedly treatment is an individualistic endeavor. The findings from indigenous studies of Chinese personality such as CPAI, which indicated specific personality dimensions of Chinese people alongside the universal personality traits with Westerners, may open the door to explore what principles of change can be adapted cross-culturally. In contrast to symptom and personality measures, the STS system emphasizes that all change is interactive and must

not be perceived in a vacuum. Hence, the principles of STS may be more consistent with the traditional Chinese values.

The Development of the STS and Its Feasibility in China

A large number of studies (e.g., Beutler et al., 1991; Norcross, 2002) have indicated that matching treatments with selected traits that define patient profiles facilitates treatment benefits. Reviews for treatment planning approach have indicated that, under optimal matching conditions, up to 64% of the outcome variance can be accounted for (Beutler, 1983, 1989). When nondiagnostic patient factors, therapist intervention, and treatment matching are combined with the quality of the therapeutic alliance, prediction of outcome increases to 90% (Beutler et al., 1999; Beutler, Moleiro, Malik, &Harwood, 2000, 2003). Along with this model, Beutler and colleagues developed Systematic Treatment Selection (STS) system, which provides clinicians with principles and strategies for addressing a wide variety of patient problems that crosscut specific techniques or theoretical orientations. In addition, the STS model dynamically integrates ongoing assessment into intervention.

Beutler and colleagues matched the clients and interventions‘ characteristics into clinically meaningful clusters, constructed largely from empirical findings on client characteristics associated with therapeutic change. For example, functional impairment, coping styles, levels of trait-like resistance to change, and level of distress were found to moderate corresponding treatment qualities (e.g., treatment intensity, insight-behavioral focus, therapist directiveness, and use of emotional confrontation) that had been identified. Several studies (e.g., Beutler, Harwood, Alimohamed, & Malik, 2002; Beutler,

Moleiro, & Talebi, 2002) have empirically supported that six patient variables (resistance, coping style, functional impairment, distress level, complexity and chronicity, and social support) can be reliably measured and consistently predict improvement among North American samples. The implication of these findings for assessment is that predisposing client characteristics can be used to identify relevant dimension. Furthermore, these dimensions should be used to develop optimum treatment plans.

STS Patient Variables

Instead of taking a categorical view of patient variables, STS approach relies on systematically identifying patient variables and tailoring treatment options based on empirically and clinically established relationships with treatment outcomes. These patient characteristics include levels of functional impairment, social support, level of problem complexity/chronicity, coping style, resistance, and subjective distress. In general, four dimensions are of interest in research: (1) level of functional impairment, (2) patient coping style, particularly level of externalization and impulsivity; (3) level of patient resistance; and (4) level of subjective distress (Beutler, & Harwood, 2000). In particular, three variables (impairment, coping style, and trait-like resistance) have been recognized as effective moderators of treatment by the American Psychological Association‘s Division 29 Task Force commissioned to identify qualities that enhance therapeutic change (Norcross, 2002). In the present study, these three variables that are relevant to cross-cultural study, are reviewed (See Table 1. in details)

The Development of STS Measures

The initial STS assessment, the Systematic Treatment Selection Clinician Rating Form (STS-CRF; Fisher, Beutler, & Williams, 1999), is a 226-item instrument designed to be completed by clinicians upon completion of the initial interview and intake procedure. However, the clinician-rating format may take away patient's motivation to assess his or her own progress in treatment over time. In addition, there might be discrepancy between scores rated by clinician and patient. Therefore, Beutler and colleagues revised the STS-CRF into a self-report format (STS-SRF). The updated STS-Innerlife version is a revision of the STS-SRF. One study was devoted to demonstrating internal consistency and construct validity for STS-CRF (Fisher, et al., 1999), and another was for STS-SRF (Corbella, Beutler, Fernandez-Alvarez, et al., 2003) and over 20 studies have been devoted to predictive validation (e.g., Beutler, et al., 2000; Karno, Beutler, & Harwood, 2002).

The Fisher, et al. (1990) study indicated the mean interrater concordance coefficients ranged from .77 (functional impairment) to .99 (presence of eating disorder). The mean levels of interrater agreement on dimensions were .82 (subjective distress), .86 (internalization), and .86 (externalization), and .80 (resistance) (Fisher, et al., 1999). The convergent validities were determined through a series of Pearson product moment correlations between STS dimensions and the independently derived criteria from the psychological tests of the same dimensions. For example, the STS clinician rating of subjective distress correlated ($p < .001$) at the highest levels with the external criteria (rs = .63 and .65 with Pt and BDI, respectively) (Fisher, et al., 1999).

The discriminant validities were assessed by testing the three internal constructs that are ideally both relatively independent, but also have a prescribed pattern of relationship with one another. For example, Internalization and Externalization were negatively correlated at a moderate level (r = -.44). It supported one of the assumptions that Internalization and Externalization are moderate correlated as they are at two extremes of the same domain. Subjective distress was correlated with internalization (r= .48) but not with externalization (r= -.03). Resistance traits were highly correlated with externalization (r = .70) but only modestly with the other dimensions (rs of .21 and -.26). In the sense, resistance is assumed to be associated with externalization as it comprises interpersonal competitiveness, negativity, acting out, low ego strength etc.

According to Fisher, et al. (1999), another set of construct validities was based on the patterns of scores across the three samples including major depression, mixed psychiatric patients, and people with substance use also supported the above findings. The depressed sample indicated higher subjective distress level than the other two groups. Persons with alcohol use have the highest externalization level and the depressed sample has the highest internalization scores. Persons with alcohol use and psychiatric patients have the higher levels of resistance traits compared to the depressed group.

The self-report form (STS-Innerlife) was a revision of the STS-SRF and initially contained 173 questions on a Likert-type scale. 151 of those questions were derived from the original STS-CRF and DSM-TR and broken up into 22 symptom scales and the six STS client characteristic dimensions listed previously. In addition, nine basic demographic questions were included such as age, ethnic identification, and marital

status. Lastly, 13 questions developed by John Norcross were added to assess client preferences to self-help resources such as movies, books, and web-resources as well as preferences for type of therapist. Ultimately, the self-report form was translated into an online form called innerlife that was easily accessible to both clients and mental health practitioners. Innerlife offered a unique client-centered approach to clinical assessment and provided them with options to track symptom progress. Most importantly, innerlife utilize answers taken from the questionnaire to create a computer-generated narrative report, which offered an extensive description of treatment factors about optimal matching between patient characteristics and treatment interventions, and self-help resources for the client to use outside of psychotherapy treatment.

The STS has also demonstrated some promise in prior attempts at cross-cultural adaptation. In a cross-cultural study (Corbella et al., 2003) for STS-SR Form, the reliability and construct validity were assessed for Argentina and Spain samples. The findings demonstrated that the internal consistency of STS-SR was acceptable. Cronbach‘s alpha was computed for each: the Resistance subscale earned an alpha of .68, the internalizing subscale earned an alpha of .72, and the Externalizing subscale earned an alpha of .65. These values were consistent with those obtained in the original STS-CRF version of the scales (Fisher et al., 1999). However, it is noteworthy that some factors might affect Cronbach‘s alpha in this study. There may be inequivalence in some areas given the cross-cultural study, such as semantic, idiomatic, experiential, or conceptual differences in items between English and Spain versions. Some of the items might need to be more refined and purified according to the indigenous cultures. Further,

high internal consistencies may be achieved because of more general inter-correlations that might exist among both the English and Spanish versions, which does imply that the factorial or structural validity is shared.

Given the results of the above cross-cultural studies on STS measure, it is assumed the STS can be adapted to Chinese culture. The present study predicted the following results. I) The original seven STS subscales fit with a seven-factor structure. II.) The China and US samples will share a similar factor structure. III.) There will be mean differences within subscales of STS-Innerlife between the U.S. and Chinese participants. For instance, Chinese sample is assumed to endorse higher score on internalization scale than American sample. It was also hypothesized that Chines participants would endorse the same level of resistance with American sample. Although Chinese people are conceptualized as resisting to receiving psychological therapy, their inclination of resistance may be offset by their tendency to maintain harmonious relationships.

CHAPTER 2: METHOD

The present study is a part of the Asian Project of –An investigation of the consistency of Systematic Treatment Selection (ST) Innerlife Form among both clinical and non-clinical samples in Mainland China, Taiwan, Korea and Japan." We collaborated with the Psychology Department and Psychological Research Center at Fudan University, China. Dr. Larry Beutler, (Palo Alto University, U.S.), one of the creators of the STS-Innerlife, and Dr. Shijin, Sun (Fudan University, China) were the two Principal Investigators. The author worked as a research assistant and the coordinator to the collaboration between these two institutions. It is the first phase reliability study for STS-Innerlife. Based on this study, the reliability of revised STS-Innerlife will be further assessed with the clinical data in the second phase, the predictive validity will be determined through assessing the outcome of psychotherapy and matching STS-Innerlife with therapist style.

Participants

Chinese Sample

Fudan University gathered the data in December 2009. Participants included a total of 300 participants (12=clinical, 282=non-clinical; 35% male, 64% female; 38% currently married, 30% in a relationship, 31% single; 94% age=20-40, 4% age=41-64). Some participants were undergraduate and graduate students of Fudan University who were from different programs, and the others were those who were attending Counselor Certificate Training Program and who were members of various academic, company, hospital, and government organizations. The majority of the samples were from Shanghai

city (n=273) and the rest were from some other cities in China. The inclusive standards of selection include 1) represent a range of age and gender and 2) are 18 years old or greater. No individually identifying information is retained or extracted beyond demographic characteristics and Innerlife responses.

United States Sample

Archival data were used for the North American sample. The participants were drawn from four locations within the Northern California area and the data was collected in face-to-face contact. These participants consisted of clinical and non-clinical samples (N= 240, 28= clinical, 212 = non-clinical; 27% male, 74% female; 40% currently married, 18% in a relationship, 24% single; 65% age=20-40, 34% age=41-64). Clinical samples included patients at both a mandatory mental health treatment program and outpatient community mental health training clinic. Non-clinical samples consisted of graduate students at a clinical psychology program as well as members of various religious, academic, and multicultural organizations across California, Oregon, and Pennsylvania.

Procedure

The present study has attained the consent of Institutional Review Board (IRB) through Palo Alto University‘s Pacific Graduate School of Psychology since 2009 and approval was attained through the Ohio University IRB. The China student samples were recruited via a recruitment flyer that were distributed to the classes and the students were informed that it was optional for them to fill out the questionnaire, and their decision wouldn‘t impact any of their school recorder. The counselor samples were recruited via a

recruitment flyer distributed to the Counselor Certificate Training Program and the participants were informed that it was optional for them to complete the questionnaire. All responses were anonymous and no names were used. Participants were notified that the process should take about 45 minutes in most cases and that a short section with three feedback questions would be at the end of the measure. Names were not be recorded in data transfer, at any point during the study, and ID numbers were used for each consent form and questionnaire.

Measures

STS-Innerlife Form (English version)

The study used the newly developed Systematic Treatment Selection Innerlife Form, which consists of 172 questions on a 4 or 5-item Liket-type scale. Of those, 151 were included that composed each of the 27 symptom scales (22 scales and 5 sub-scales) and six STS treatment planning, or client characteristic. Questions in the treatment planning dimensions were composed of both unique questions and relevant questions contained in one or more of the symptom scales (e.g., resistance scale and substance abuse). In addition, nine basic demographic questions were included such as age, ethnic identification, and marital status. Lastly, thirteen questions developed by John Norcross were added to assess client preferences to self-help resources such as movies, books, and web-resources as well as preferences for type of therapist (Norcross, Santrock, Cambell, et al, 2003). The original clinician rated and self-report measures were found to have good levels of reliability and both construct and predictive validity. Two studies were devoted to demonstrating internal consistency and construct validity (Fisher, et al., 1999;

Corbella, et al., 2003) and over 20 studies have been devoted to predictive validation. In Corbella, et al. (2003) study, Cronbach's alpha for the Resistance subscale is .68, the internalizing subscale earned an alpha of .72, and the Externalizing subscale earned an alpha of .65.

STS-Innerlife Form (Chinese version)

The Chinese version of STS-Innerlife is developed from items on the English version of the STS-Innerlife and STS Self-Report Form. English version was used as a template from which the translation (and back translation) was constructed for Chinese samples.

Semantic equivalence was established with a translation-back translation process, which was the most common method of establishing semantic equivalence (Bjorner, et al., 1998; Beaton, et al., 2000; Mallinckrodt, et al., 2004). The process of translation-back translation in this study was conducted by an expert committee, which was composed of some experts of STS measures, and two groups of translators. One was from Palo Alto University, and the other from Fudan University.

The two groups of translators consist of bilingual psychologists who were proficient in both Chinese and English, and who served as a consensual panel of experts to check the translations. The first group of translators was composed of three native Chinese. Two of them were studying clinical psychology in the U.S. One has earned her Ph. D in U.S., the other was a graduate student in Ph. D clinical psychology program in U.S. The third translator was a faculty of Psychology Department at Fudan University,

China. Three translators made their draft translations respectively and then made a consensus on the first draft translation.

The second team of translators was composed of other three Chinese. One was a faculty of Psychology Department at Fudan University, another was a graduate student of Psychology Department at Fudan University, the other was a graduate student of English department at Fudan University who has no psychology background. The two graduate students made back-translation independently and the faculty made the final decision on the first draft back-translation.

In the following phase, the experts of the this measures in the committee was composed of four clinical psychology graduate students who were knowledgeable in STS measures, and a professor, who was one of the creators of the original STS instruments. Of the four graduate students, two are Americans, one was Japanese, and the other was Chinese. They ensured a process of translation, back-translation, revision, comparisons with the original English text, and refinement of items until a consensual list of items was obtained.

Content equivalence was established by determining the relevance of each item on the STS-Innerlife to Chinese culture. The expert committee gathered to determine if the text specification and content of STS-Innerlife were relevant to Chinese culture. The core items used in Chinese samples were the same as items in the North American version, but several items were revised for the Chinese version in order to accommodate language and cultural differences. First, eight items were restated according to Chinese culture. For instance, the item 8, —sexual partner" was changed to —significant partner",

the item 68 100 –people have it for me" were changed to –people intend to harm me". Second, the four cultural items, which include item 155, 156, 157, and 171, the responses were changed. For instance, –I have a preference for a non-Caucasian therapist" was changed to –I have a preference for a non-Chinese therapist".

Third, half of items had answer scores reversed to be consistent with other questions. Fourth, some items were omitted because of the cultural concern, but leave the item number in the test as a filler and so the item numbers would be the same as in the English version. That also would make easier to score on the computer. Sixth, some answer choices were changed from —strongly agree-strongly disagree" to –almost always-never". Seventh, three open-ended questions were added after the questionnaire aiming at getting narrative feedback about questionnaire. These were –Were there any items you could not understand or thought was poorly worded? If so, please explain below:" "Were there any items you thought could have been taken out or replaced? If so, please explain below:" –What suggestions would you have to improve the measure?" These narrative input would be used in assessing the content validity of each items. In addition, three additional supplemental questions were administered along with the questionnaire. These were: –Have you seen a mental health provider?" –Do you take medications? If yes, please list the names of medications" –Where are you living now?"

To establish conceptual equivalence or construct validity, correlations and factor analyses would be formed to measure the degree of similarity of the theoretical concepts between the STS-Innerlife English version and Chinese version. After modifying the STS-Innerlife measure through the present study, the convergent validity

of the STS-Innerlife Chinese version would be assessed through correlations with the therapy style and outcome measure in the next phase of this project.

Statistical Analyses

To investigate the factor structure of scores on STS-Inner life treatment planning scale items, linear exploratory and confirmatory factor analyses were conducted with maximum likelihood estimation using the programs SPSS and Amos. Subjective Distress scale (SD) was a factor that reflects general well-being rather than specific personality types, therefore, it is a general intensity factor that may undermine the underlying factor structures. Alden et al. (1990) indicated that a general tendency factor could raise or lower scores on all subscales, thus, it was recommended to remove the general factor in factor analysis. Also, the items of SD correlate with most of the items in other scales. Therefore, despite the Subjective Distress (SD) scale is a useful indicator of clients' distress level and it has tremendous clinical value in treatment planning, it was excluded from the factor analysis method used in the present study. Initially, the fit of the six-factor models (matching the Functional Impairment, Chronicity, Externalization, Internalization, Resistance, and Social Support subscales) for responses of the US and Chinese sample were conducted separately. The fit indices used are the root mean square error of approximation (RMSEA), the normed fit index (NFI), and the comparative fit index (CFI), and Tucker-Lewis Index (TLI). Inadequate model fit was identified for the six-factor models for both of the U.S. and Chinese samples.

Given these results, it was hypothesized that there might be an underlying measurement model to be discovered in the STS –Innerlife questionnaire. Therefore, a

series of exploratory factor analyses (EFA) were conducted on both US and Chinese samples separately to investigate whether the factor structures on US and Chinese sample are cross-culturally different. Not surprisingly, the results indicated a similarity of the factor structure of these two samples, as well as slight differences between the two. The first and second factors of the two samples are highly consistent. The mean differences were compared between the U.S. and Chinese samples.

CHAPTER3: RESULTS

The factor analyses included 51 items from the seven STS treatment scales (Functional Impairment, Chronicity, Social Support, Internalization, Externalization, Resistance, Subjective Distress). The Chinese non-clinical sample (n=288) and US non-clinical samples (n=216) were used for EFA analyses, and the results indicated that the factor structure of non-clinical samples was almost identical with those of the whole Chinese sample (n=300) and US sample (n=240), accordingly. Therefore, the Chinese samples (n=300) and US samples (n=240) were used for the present study for the sake of optimizing sample size. Missing items were replaced with the value of the series mean when there were less than 10 items missing. There were 6 cases in the U.S. sample and 3 cases in the Chinese sample that have more than 10 items missing and so they were deleted. Therefore, US sample left for the following analyses was 234 US sample, and 297 Chinese sample.

Tables 2 and 3 provide the zero-order correlations for the original subscales of the STS. It appeared that the subscales of FI, RE, and EX were highly correlated for both US and Chinese samples, and correlations among other subscales were medium to low. Table 4 showed the mean scores of U.S. and Chinese samples on the seven STS treatment scales. The mean score of the two STS treatment dimension scales for the U.S. were somewhat below the Chinese equivalents. They were FI ($t=-4.827$, $p<.001$, $d=-.186$) and CH ($t=-.305$, $p<.05$, $d=-.0125$) scales. The mean score of the other five scales for the U.S. were above the Chinese sample. They are SS ($t=2.223$, $P<.001$, $d=.087$), IN ($t=2.834$, $p=.001$, $d=.107$), RE ($t=1.700$, $p<.001$, $d=.0656$), EX ($t=.207$, $p<.001$, $d=.009$), and SD

(t=20.406, p<.001, d=.619). In order to test the equivalence of the two language versions of STS questionnaires, a series of Confirmatory Factor Analyses were conducted.

Factor Structure of the STS

When scores on the STS-Innerlife were used to evaluate the seven dimensions of patient functioning that could be matched with treatment styles, they were summed together within each of the scales. The underlying assumption was that there are seven dimensions investigated through a CFA of responses of both US and Chinese samples to the STS questionnaire. SD subscale was excluded from this FA method. Given that the factors would be highly correlated if the reverse and in-reverse dual-loaded items both included in the same CFA model and it could cause the program fail to run, the reverse items were removed. The total number of items used in CFA was 40. As evidenced by the values of the model fit indices for the six-factor model (see Table 5), the model couldn‘t adequately fit both of the samples, especially Chinese data (see Table 5).

The findings that the 6-factor model fit neither of Chinese nor US data did not support STS original dimensions. There might be a unique factor structure or no organization on these items. As exploratory factor analysis (EFA) is a tool to detect underlying structure of items, a series of EFA were conducted to investigate the item loading patterns on the samples from U.S. and China. MAP and parallel analyses, the percentage of variance accounted for each factor and by the total factor solution, and theoretical consideration were used to determine the number of factor to retain. MAP and parallel analyses are superior to criteria of scree plot or eigenvalue above 1(O‘Connor, 2000). The principal component method of EFA was utilized, as it is a preferred method

and also because MAP test involves a complete principal components analysis (O'Connor, 2000). Varimax rotation, as fairly standard method of rotation, was used in this study. When between factor correlations are below .32, varimax rotation is suggested (Tabachnik & Fidell, 2007). The correlation of factors for US sample were r=.09, r=-.14 and r=.38, and for Chinese sample the correlations ranged from r=.01 to r=.32, therefore, it appeared that the correlation of factors were low and thus varimax rotation was a preferred method in this study.

The results of MAP and parallel analyses suggested a three-factor solution for U.S. and a four-factor solution for Chinese sample. For the US sample, in the output, the first three eigenvalues from the actual data were larger than the corresponding first three 95% percentile random data eigenvalues. The fourth and remaining eigenvalues from the actual data were smaller than their corresponding 95% random data eigenvalues. In total, the first three factors accounted for 31.37%, 9.27%, and 5.11% of the total variance. The results of MAP and parallel analyses, however, suggested a four-factor solution for Chinese data. The four factors accounted for 43.68% of the total variance (See table 6). A cutoff of .40 (Cox, & Cox, 1991, Coyle et al., 1995, Niskanen, 1994) was used to identify items that loaded "substantially" on a factor, those items loading above .40 then were used to define the factor.

US Sample Factor Identification

Table 7 showed the factor loadings for both US and Chinese samples. Factor labels and loadings were described below. It was important to note that all of the items of FI and EX, and seven out of the eight items of RE lumped on the first factor. Nine out of

the ten items of CH scale loaded the second factor. Some items of IN, SS, RE also loaded on this factor. The third factor mainly consists of items from scale SS. Item 25 ("I have missed work or school because things just bothered me too much"), Items 27 ("I have had this problem or one similar to it, several times in my life") and item 28 ("Throughout my life, I have had recurrent depression or times when I had trouble getting along with others") loaded on both F1 and F2. It could be due to that "the problem" stated in these two items are too general and lack of specificity. There were only two items (items 48, 49) loading none of the three factors. The factor loadings were provided in Table 4. The internal consistency reliability (Cronbach's Alpha) of these three factors were .93, .81 and .42 respectively.

Factor I: Externalized Distress (23 items). This factor was a composite of EX, FI and RE scale items and include functional impairment in multiple life areas such as substance issues, legal issues, somatic problems, low social support, interpersonal difficulties, acting out etc. This factor appeared to capture externalized behaviors and their associated distress and functional impairment. For example, the highest loading items spoke to substance abuse and legal issues (items 103, 101, 106). Items demonstrating intense distress such as items 67 ("I don't want to live") also had high loading weight.

Factor II: Internalized Distress (14 items). These items included a variety of internalized symptom distress, such as somatic symptoms, psychological distress, and indecisiveness. For instance, the highest loading items on this factor involved client's

experience of ~~–s~~tressed out", "feeling unhappy or sad", and ~~–f~~eeling lonely" (items 31, 36, 47). As compared to Factor I, the distresses reported in Factor II are internalized.

Factor III: Interpersonal Isolation (4 items). This factor was mainly composed of items related to social support system. The highest negatively loading items (39, 40) were about the lack of primary social support including family (item 40, 93) and close friends (item39, 40, 46). At the first glance, item 46 (~~–I~~am socially unreserved and outgoing") should negatively load on this factor, but socially outgoing person might lack close friends with whom they can share common interests (item 39) and confide (item 40). Therefore, they might still feel interpersonally disconnected.

Chinese Sample Factor Identification

MAP and Parallel analyses suggested a four-factor solution. It might indicate that there was a slight difference of the factor structure between US and Chinese samples. The first four factors accounted for 24.33%, 9.36%, 5.43, and 4.56% of the total variance. It was noteworthy that the F1 and F2 in the factor structure on the US and Chinese samples were rather identical. Given that the weight of factor loading for item 22 on the first factor was .383, and its content was consistent with some other items that loaded in the first factor, item 22 could also be assigned to F1. Five out of the seven items of FI scale, four out of the eight EX scale items, and five out of eight the RE scale items loaded F1. F2 was primarily composed of items of CH (eight out of the ten items). The internal consistency (Cronbach's Alpha) of these four factors were .88, .78, .56 and 1.00 respectively. There were 8 items that did not load on any of the four factors (items 144, 27, 35, 40, 22, 73, 50, 51).

Factor I: Externalized Distress (13 items). This factor was fairly consistent with Factor I of US sample. It was a composite of items about externalized behaviors and associated distress, including substance abuse, legal issues, interpersonal difficulties, social functional impaired. For example, the highest loading items (105, 101, 103, 106) reported substance abuse, and legal issues. Some items demonstrated intense distress such as item 67 (–I don‘t want to live”) and item 100 (–Some of the people at work intend to harm me”).

Factor II: Internalized Distress (12 items). This factor was also quite identical with Factor II in the US sample as well. It was a composite of a variety of internalized symptom complaints. For instance, the highest loading items (32, 30, 33) reported experiences of –I feel like crying”, –worrying” and –sadness”. The two somatic items (33, 34) also loaded highly on this factor, while these two items scattered on Factor I and Factor II on US sample.

Factor III: Sociability (6 items). Conceptually, this factor was somewhat consistent with Factor III in US sample. FIII in US sample involved isolation from family and close friends, while FIII in Chinese sample also included introversions, interpersonally withdrawal, and associated distress. For example, the highest loading items (48, 46, 49) were about socially reservation, lack of confidence. Items 47, 120 also endorsed psychological complaints of –loneliness” and –humiliation” in social setting. In addition, Interestingly enough, US sample included family items in this factor, while none of the family items were included in FIII on Chinese sample. Although the content of FIII on both samples are relevant, the loaded items were quite

different. Except the common item 39, all of the other items loading on FIII were different between the US and Chinese samples.

Factor IV: Somatization (2 items). This scale only consisted of 2 highly loaded items (44 and 45). Two items seemed to be not sufficient to define a factor, but the weight of the factor loadings of these two items were both .959 and the content of these two items were highly identical (item 44 –I don't hesitate to tell friends or family about my physical problems"; item 45 –I am socially unreserved and outgoing") and matched well with the label of –Interpersonal Openness", In addition, Factor IV was extremely low correlated with the other three factors ranging from r=.04 to r=.11. The internal consistency (Cronbach's Alpha) of this scale was 1.0. Therefore, this was a unique factor for Chinese population. The factor loadings for Chinese sample were provided in Table 4.

Taken together, the first two factors were identical for the US and Chinese samples. A cutoff score of .45 was used to identify items that loaded –substantially" on a factor. Items that loaded below .45 on neither of the two samples were removed. Theoretical consideration was also taken to determine whether or not to retain the items. Items that didn't make sense on the factor that they loaded were also removed. As a result, there were 13 items (item 23, 24, 67, 95, 105, 93, 100, 22, 42, 103, 101, 99, 106) consistently loading on the first factor for both samples, and 10 items (item 25, 29, 30, 31, 32, 34, 36, 37, 38) consistently loading on the second factor. We used the identical labels to define these two new factors with the cross-culturally consistent items as 1) Externalized Distress and 2) Internalized Distress. These two new factors were moderately correlated (r=.55). Mean differences were compared with these two new

factors between US and Chinese samples (See Table 6). Interestingly, the mean scores of the two new factors, Externalized Distress (ED; $t(531)=-4.80$, $p<.001$) and Internalized Distress (ID; $t(531)=-3.93$, $p<.001$), for Chinese both are somewhat above than the U.S. equivalents (see table 8). The internal consistency (Cronbach‘s Alpha) of these two scales were .89 (ED) and .72 (ID).

CHAPTER 4: DISSCUSSION

This was the first study designed to assess the factor structure of STS treatment items and contrast the cultural differences between the US and Chinese samples. It was found in the present study that the six-factor model with the six STS treatment scales (SD scale was excluded from the factor analyses in this study) did not fit the US nor Chinese samples. The followed exploratory factor analysis indicated two cross-cultural factors that were composed of nearly the same items and the third factor, though composed of almost entirely separate items, shared some similarity in content in that both focused on different aspects of interpersonal functioning.

Thus, the findings give an assurance that the factor structure of the STS of the Chinese sample was rather similar to that of the United States, especially in the domains of Externalized Distress (ED; F1) and Internalized Distress (ID; FII). Externalized Distress was composed of impulsivity, seeing self as a victim and acting out, while Internalized Distress consists of introverted behaviors, such as self-blaming and indecisiveness. More specifically, it was noteworthy that items of the original STS treatment scales, FI, RE and EX, consistently loaded on the Externalized Distress factor on both US and Chinese samples. It might suggest that the Externalized Distress factor could be refined to three sub-factors, EX, FI and RE. Although it might not be sufficient, the findings might support the previous study that indicated high internal consistency of FI, RE, and EX scales across U.S., China and Japanese samples (Beutler et al., 2010). The correlations among these three scales in this study were rather high (see table 2 and 3). Externalization (EX) refers to impulsivity and lack of insight, hedonistic, and

aggressiveness (Beutler et al, 2011). Functional Impairment (FI) could be reduced to three main indices, family problem, social isolation, and absence of social support (Beulter, & Harwood, 2000). It is a general and inclusive factor, in a sense, reflecting individual‘s general well-being. Resistance refers to a combination of absence of openness, low emotional accessibility, directive avoidance, and low emotional accessibility. Beutler et al. (2011) consider resistance and reactance are interchangeable and they imply one‘s reactions to events that limit freedom. Clients with a highly resistant tendency most ascribe their oppositional response to the effect of being a victim of circumstance, or others‘ wrong doings (Kirmayer, 1990). They are characterized by lacking of insight and therefore more likely engage in externalized behaviors and impair in various social areas. Thus, it is not surprising that FI, RE and EX scales lump in one factor. However, another possibility is that some items of these three scales are conceptually overlapping. For instance, item 23 of FI scale (―I get high on alcohol or drugs almost everyday") is very similar to item 42 of EX scale (―I have used drugs or alcohol excessively at one time") and item 106 of RE scale (―Others have recently told me that I drink too much or abuse drugs").

The second factor, Internalized Distress, includes most of the chronicity (CH) items and half of the internalization (IN) items. Internalization (IN) is described as shy, retiring, self-critical, constrained, self-reflective (Beutler, & Harwood, 2000), and Chronicity (CH) refers to somatization, pervasive feelings of depression, anxiety and worry etc. Conceptually, these are two discrete yet highly correlated domains. A large body of research has supported that somatization is highly associated with depressive

symptoms (e.g., Lipowski, 1988). Social Support (SS) items load both the first and second factors. In a sense, social support affects both internalizers and externalizers. For instance, individuals with low social support may act out and reactive, but they may also withdraw and get depressed.

This finding was strongly congruent with a variety of two-factor models that has been widely accepted. One of them is the well-known Eysenck‘s personality model (1957) that involves introspective behaviors at one extreme and extroverted behaviors at the other, which were confirmed as universal personality factors among Chinese and US participants by using the Eysenck Personality Questionnaire (EPQ) (Barett et al. 1998). Also, in social psychology, one of the most studied personality variable is the internal versus external locus of control (Rotter, 1971), which refers to the degree to which individual expects that a reinforcement of their behavior is contingent on their personal characteristics versus on a function of external factors, such as chance or fate (Rotter, 1990). The internal and external locus of control factor structure has also been evinced to be generalized in some cross-cultural studies (e.g., Mahler, 1974; Parsons et al., 1970; Reitz & Groff, 1974; McGinnies et al., 1974). In addition, it was also generally in line with the concepts of externalization and internalization of the STS treatment dimensions, except that ED and ID in the present study also endorse distress. It appeared that these two factors are global client factors in clinical research on treatment planning.

Even though the first two factors were nearly the same, slight cross-cultural differences of the factor structure were noteworthy. For instance, for the factor structure of Chinese sample, the two somatization items consistently loaded the second factors

with other chronicity (CH) items that endorsed psychological symptoms, while the same somatization items scattered on both of the Externalized Distress and Internalized Distress factors on US sample. These findings might be in line with numerous previous studies that there was common for Chinese patients to express somatic symptoms, especially for those with depressive disorders. Some cross-cultural researchers (e.g., Kleinman & Good, 1985) argued that somatization was also common in the West, and the difference may lie in that cultural variations in how somatic experiences are expressed and accepted. Physical complaints may be more acceptable than psychological complaints for Chinese people, while the westerners may be more articulate in describing their psychological experiences. The finding in this study might imply that clinicians need to understand the means that clients use to convey their meaning under their own culture in order to connect with clients.

It was also of interest that US and Chinese samples share a factor (FIII) in social domain. The content of this factor in the US and Chinese samples were overlapping although slightly different, but they had different loading items. For the US sample, it mainly involved isolation from family and close friends, whereas, for Chinese sample, family items were not included, instead, social distress, such as feeling of "humiliation" and "lonely", were addressed in their sociability aspect. It seemed of consistence with the finding of a unique Interpersonal Relatedness factor in Chinese population with the Chinese Personality Assessment Inventory (CPAI, Cheung, Gan, & Lo, 2005). Chinese people highly value interdependence among family members, therefore, the family distress is either not to be addressed or they are discrete from other social distress. The

social distress, such as isolation from social setting, rejection from close friends, may cause –humiliation", –lack of self-confidence" for Chinese people. It may be because Chinese people value –social face". Rejection from social connection may mean –losing face" which causes embarrassment. Therefore, it was most likely that FIII for the US and Chinese samples were the same, but it had different manifestation due to the cultural difference. The other unique factor with two extremely highly loaded items that matched with label –Interpersonal Openness" also endorses the unique interpersonal factor for Chinese population.

Surprisingly, the mean of the two cross-cultural consistent factors labeled with –Externalized Distress" and –Internalized Distress" for Chinese sample were significantly above US equivalents. The finding that Chinese sample had higher internalized distress was consistent with the widely recognized notion that Chinese people was more internalized than American people. However, the finding that Chinese people also had higher externalized distress than US sample was somewhat counterintuitive. This factor of –Externalized Distress" was composed of the traditional STS scales of FI, EX and RE. This counterintuitive finding might be due to the complex relationships among these three STS scales. It might be advisable to refer to the mean differences of these original STS treatment scales between US and Chinese samples. It is conventionally believed that American people is more externalized than Chinese, which is also supported by the findings of the mean comparison of the traditional STS treatment scale of EX (see Table 2).

It was also of interest that the mean of the original resistance (RE) scale for Chinese sample was significantly lower than US participants. According to the definition of resistance for STS therapists, it was posited that Chinese people in a sense had higher resistant level than the Westerners, as Chinese culture values hierarchical order and de-individualization, which may threatens an individual‘s sense of freedom and integrity. However, it seems there are some culturally specific dimensions mediating Chinese people‘s resistance level. Chinese culture highly value interpersonal harmony, social conformance (Tarwater, 1996; Wang, 1981) and deference to authority, which may lead to Chinese people to avoid interpersonal conflicts and strive for interpersonal cohesion. Some researchers have reported that Chinese clients in actuality are very open to inner experience exploration. Some researchers reported the prevalence of directives by Chinese therapists and clients (e.g., Liu, et al., 2012), which may match with Chinese clients‘ low resistant level.

However, the mean of the STS scale of Functional Impairment for Chinese sample was significantly higher than that of US participants. Taking all of these findings together, it appeared that the coping style of Chinese people with low externalized behaviors, low resistant level might not redeem them from impairment in social functioning. There might be culturally unique coping mechanisms used by Chinese people in dealing with reality problems without over acting out or internalizing. For instance, Chinese people might use the defense mechanism of passive rationalization (Cheung, Gan, & Lo, 2005) dealing with their inner conflicts, which might help Chinese people adjust to their cultural context yet impair their social functioning on the other

hand. One of the implications of the current findings was that it might be advisable to place psychotherapy in a broad cultural context.

Clinical Implication and Limitation

This study rigorously supported the cross-cultural factors of Externalized Distress and Internalized Distress. It indicated the cultural adaptation of the Chinese version of STS-Innerlife in China. The study also demonstrated the complexity of STS dimensions. In clinical practice, it is not uncommon to use both the factor structures and subscales in interpretations. For instance, the Wechsler scales get 4-5 factors, but individual subscales are considered to have added clinical meanings and utility beyond these factors. The seven STS subscales were created based on theoretical consideration and they have clinical meanings. Therefore, it might be suggested to use STS seven subscales, including Subjective Distress scale that was excluded in the factor analyses in this study, and used new factoring as well, For instance, it would be meaningful to get FI, EX, RE scale scores separately, and also take the total score of these three scales for a new factor. Alternatively, the two new scales of Externalized Distress and Internalized Distress with the cross-culturally consistent items could also be used to assess patient‘s variables.

Given the complexity of the STS constructs, there were no external measures that can be used to capture the various components of the STS construct. The EFA used in the present study was a way to capture the complexity of the STS components. The new factors were based on analysis of items that allowed for unique re-distribution of the items of the traditional STS treatment scales in order to find a culturally adapted structure for the STS components.

The present study was also unique to other EFA in that it used Velicer‘s minimum average partial (MAP) and parallel analyses to determine the appropriate number of factors to retain. MAP and parallel analyses are validated vigorously that it‘s superior to the conventional rules such as eigenvalues-greater-than-one rule or scree plot (O‘ Connor, 2000), as eigenvalues-greater-than-one rule may overestimate or underestimate the number of component, and the reliability of scree plot interpretation is low Despite of the superiority of MAP and Parallel analyses, they haven‘t been widely used in psychology research. Although the superiority of EFA analyses used in this study, it is a limitation of EFA that it tends to generate too general factors to refine the constructs. For instance, the first and second factors lump several STS original scales, yet whether there are complex relationships among these scales or there are more refined components within these items are still unknown.

Although the previous study has demonstrated high internal consistency of the STS treatment scales, the content of some items were overlapping even they are in different scales, and some items seemed not pure in the content wise to the scales. It was perhaps that the internal consistency procedures jeopardized the content validity of the scales, as we moved some items for the sake of increasing Cronbach‘s alpha value, while sacrificing the consistency of the content of the items in the same scale. In the future study, it might be helpful to start from scratch to identify a group of items that have content validity and then verify their internal consistency.

The samples used in the current study are primarily non-clinical samples as to both US and China. The responses of these samples are clustered around the non-

pathological end of each of the items and lack of sufficient variability. It was clear that we need to collect more clinical samples in the future study in order to verify construct validity. Also, the samples used in this study were rather specific. The Chinese samples were primarily collected from a big city, Shanghai, which may not be a good representation of the Chinese population given the huge mental health disparity in Chinese among big cities and rural areas. The US samples were collected from California where the culture is diverse and Asian culture is a big part of it. In addition, the age ranges of US and China sample were discrepant. The majority of the Chinese participants were at the age range of 20-40. This group of population who live in big cities like Shanghai that has been westernized may share American culture at a large degree. Therefore, the findings in this study may be resulted from some degrees of similarity in their cultural background, so they couldn‘t be well generalized to be as the contrast between Chinese and American cultures. In addition, it was hard to explain whether the cultural difference between these two samples were due to the differences in their psychopathology or the differences in the manifestation of psychopathology. Therefore, one of the methods to resolve this dilemma is to match patients‘ variables with adapted therapist style questionnaires in the future predicative validity study.

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Table 1

Descriptions of STS Variables

Resistance	Definition	The term ―resistance" implies both a state and a trait-like quality that is associated with psychopathology. When applied to client's behavior, resistance takes place when individuals' sense of freedom, psychological integrity, or power is threatened (Beutler & Clarkin, 1990; Beulter & Harwood, 2000; Nguyen, 2007).
	Characteristics	• Need for control • Impulsivity • Eager for attention • Directive avoidance (Beutler, Moleiro, & Talebi, 2002)
	Resistance of Chinese people	Factors that may impact Chinese people's resistance level • Hierarchical social structure

		• Mediator: Interpersonal Relatedness (Cheung, et al., 2004) and Emphasis on interpersonal Harmony
Coping Style	Definition	Beutler and Harwood (2000) indicated when facing stresses, patients who respond with focusing on personal responsibility and internal experience was identified as ~~–in~~ternalizer" and patients who respond with focusing on other's responsibility and external experiences was ~~–e~~xternalizer."
	Characteristics	• Internalizer Socially isolated, self-inspection, social withdrawal, more subjective distress • Externalizer Gregarious, aggressive, acting out, prone to avoid their problem
	Coping skills of Chinese people	• The ~~–s~~elf" of the Chinese people is more interpersonally oriented • To maintain interpersonal harmony is highly regarded. • Over stressing the social responsibility and lack of spontaneity and self-expression (Sue & Sue, 2002) • Culture-Bound Syndromes (Kleinman, 1982; Tseng, 1975; Marsella, Kinzie, &

		Gordon, 1973), such as Neurasthenia and Somatization
Functional Impairment	Definition	The degree to which the patient‘s problem interferes with his or her ability to deal effectively with everyday social, occupational, and interpersonal problems.
	Characteristics	Functionally impaired in family problems, social isolation and withdrawal, and supportive relationships (Beutler & Harwood, 2000).

Table 2

Bivariate Correlations of the STS Original Scales for US Sample

	FI	CH	SS	IN	RE	EX	SD
FI	1.00						
CH	.555**	1.00					
SS	.594**	.418**	1.00				
IN	.387**	.497**	.417**	1.00			
RE	.830**	.555**	.641**	.465**	1.00		
EX	.788**	.487**	.529**	.372**	.818**	1.00	
SD	.652**	.828**	.502**	.604**	.711**	.598**	1.00

Note: FI=Functional Impairment; CH=Chronicity; SS=Social Support; IN=Internalization; RE=Resistance; EX=Externalization; SD=Subjective Distress.

Table 3

Bivariate Correlations of the STS Original Scales for China Sample

	FI	CH	SS	IN	RE	EX	SD
FI	1.00						
CH	.442**	1.00					
SS	.480**	.370**	1.00				
IN	.168**	.349**	.369**	1.00			
RE	.631**	.543**	.520**	.313**	1.00		
EX	.653**	.416**	.453**	.212**	.724**	1.00	
SD	.260**	.436**	.148*	.206**	.234**	.190**	1.00

Note: FI=Functional Impairment; CH=Chronicity; SS=Social Support; IN=Internalization; RE=Resistance; EX=Externalization; SD=Subjective Distress.

Table 4

Means and SDs of the Seven STS Treatment Scales on US and China Samples

	US (n=234)		China (n=297)	
	Mean	SD	Mean	SD
FI	3.452	.511	3.640	.333
CH	2.790	.499	2.803	.425
SS	1.925	.503	1.837	.372
IN	2.755	.479	2.648	.365
RE	3.230	.498	3.165	.357
EX	3.273	.576	3.264	.332
SD	2.954	.444	2.334	.154

Note: FI=Functional Impairment; CH=Chronicity; SS=Social Support; IN=Internalization; RE=Resistance; EX=Externalization; SD=Subjective Distress.

Table 5

Model Fit Indices for CFAs on the US and Chinese Samples.

Sample	$\chi 2$	DF	NFI	CFI	RMSEA	TLI
U.S. (n=234)	1922.8	680	.64	.73	.09	.69
China (n=297)	4238.2	680	.45	.48	.13	.40

Table 6

Eigenvalues of MAP and Parallel analyses of US and Chinese data

	US		China	
	MAP	Parallel	MAP	Parallel
1	**12.5495**	1.9940	**9.7327**	1.8657
2	**3.7077**	1.8415	**3.4735**	1.7636
3	**2.0440**	1.7564	**2.1729**	1.6755
4	1.6449	1.6951	**1.8237**	1.6036
5			1.3713	1.5448
Percentage of factors accounted for the total variance	45.75%		43.68%	

Table 7

Factor Loadings for STS Treatment Items on US and Chinese Samples: Principal Component Factoring with Varimax Rotation

Item #	Short description of item	US Sample			Chinese sample			
		FI	FII	FIII	FI	FII	FIII	FIV
FI23	Drug and alcohol use	**.551**	.111	-.008	.**682**	.218	-.013	.026
FI24	Legal issues	**.687**	-.035	.197	**.491**	-.054	-.095	.040
FI25	Work functional impairment	**.514**	.**428**	-.011	.123	**.446**	-.028	-,131
FI_SS67	Suicidality	**.600**	.290	.298	**.505**	.325	.009	.063
FI95	Job loss or demotion at work	**.658**	.171	.277	**.554**	.115	.130	-.006
FI144	Concentration difficulties	.**601**	.355	.196	.234	.320	-.047	.067
FI105	Drug use	**.703**	.115	-.138	**.891**	.105	.053	.013
CH27	Recurrence of this problem	**.491**	**.474**	.013	.101	.336	.313	-.204
CH29	Content and satisfied	.008	**.569**	.395	-.028	**.444**	.286	-.021
CH30	Worry	.068	**.696**	-.059	.047	**.687**	.345	-.136
CH31	Stressed out	-.096	**.731**	-.225	.051	**.534**	.178	-.126

CH32	Feel like crying	.384	**.532**	.075	.111	**.705**	.222	.092
CH33	Feel faint and dizzy	**.405**	.305	.167	.306	**.663**	.063	.063
CH34	Headaches or stomach pains	.257	**.435**	.077	.351	**.603**	.070	.059
CH35	Should be doing much more	.130	**.534**	.026	-.011	.238	.371	.041
CH36	Sadness	.289	**.709**	.191	.136	**.655**	.204	.113
CH_SS37	Indecisiveness	.193	**.666**	.201	.162	**.590**	.273	.149
SS_IN38	Loneliness	.295	**-.689**	-.264	-.143	**-.560**	**-.452**	-.094
SS39	Friends with common interests	.052	-.236	**-.581**	-.083	-.025	**-.458**	-.009
SS40	Close friend or family member	-.239	.040	**-.739**	-.235	-.325	-.089	-.129
SS_IN47	Loneliness	.235	**.691**	.227	.073	.387	**.526**	.120
SS93	Conflict with family members	**.499**	.153	**.428**	**.701**	.051	.146	.008
SS_RE100	Other people intend to harm me	**.607**	.006	.365	**.417**	.356	.297	-.146
EX_RE22	Somatization	**.589**	.257	.032	**.383**	.286	.038	-.115
EX42	Drug or alcohol use	**.463**	.234	-.331	**.657**	.147	.031	-.012
EX43	Conduct problems	**.774**	.177	.034	.333	**.479**	.057	-.089
EX44	Express physical	**.492**	.213	-.058	.033	.018	.075	.959

	problems							
EX73	Sprees	**.645**	.232	-.068	.073	.352	-.024	-.017
EX103	Legal issues caused by substance use	**.812**	.126	-.127	**.841**	.095	.052	.024
EX_RE101	Trouble caused by substance use	**.803**	.127	-.041	**.859**	.146	.086	-.003
IN45	Socially outgoing	-.152	.292	**.470**	.034	.019	.073	**.959**
IN46	Lacking of self-confidence	.050	**.698**	.181	.044	.299	**.668**	.112
IN48	Socially withdrawal	.149	.314	.017	.005	-.004	**.706**	-.009
IN49	Socially withdrawal	**.383**	.182	.055	.014	-.178	**.648**	.006
IN120	Embarrassment in social setting	**.405**	.369	.219	.169	.323	**.446**	.053
RE50	Miss or late to appointment	**.420**	.174	.134	.086	-.307	.136	.014
RE51	Interpersonal defensiveness	.243	**.397**	-.056	.170	.243	.337	-.201
RE99	Job loss	**.704**	.107	.349	**.552**	.100	.283	-.006
RE106	Drug use	**.798**	.149	-.126	**.746**	.171	.090	-.018
RE28	Recurrent depression when interpersonal	**.418**	**.533**	.126	.259	**.586**	.312	-.007

difficulties	

Note. Factor labels on US samples are F1=Externalized Distress; F2=Internalized Distress; F3=Interpersonal Isolation. Factor labels on Chinese samples are F1=Externalized Distress; F2=Internalized Distress; F3=Sociability; F4=Interpersonal Openness.

Table 8

Means and SDs of the Two Cross-cultural Factors on US and Chinese Samples

Externalized Distress				Internalized Distress			
US (n=234)		China (n=297)		US (n=234)		China (n=297)	
M	SD	M	SD	M	SD	M	SD
3.42	.55	3.60	.37	2.75	.43	2.88	.36

APPENDIX A

STS-INNERLIFE Form (English version)

Please, indicate <u>your one choice</u> crossing the appropriate space:

1. I am	☐ under age 20	☐ between 20 and 40	☐ between 41 and 64	☐ over age 64
2. In the past few days, things have annoyed and irritated me more than usual.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
3. When I am doing something I enjoy very much, I become restless or fidgety.	☐ Never	☐ Seldom	☐ Often	☐ Almost Always
4. Sometimes I feel that I can make people do things just by thinking about something really hard.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
5. I avoid meeting people or being around certain people because doing so makes me so upset or angry.	☐ Never	☐ Seldom	☐ Often	☐ Almost Always
6. I have very upsetting thoughts that won't go away and that keep repeating themselves.	☐ Never	☐ Seldom	☐ Often	☐ Almost Always

8. I am upset because of problems I have with my spouse or significant partner.	☐ Never	☐ Seldom	☐ Often	☐ Almost Always	☐ N/A

9. Sometimes unwanted memories come to mind so vividly as if they were happening all over again.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
10. I am very frightened when I am not close to home or in familiar surroundings.	☐ Never	☐ Seldom	☐ Often	☐ Almost Always
11. Over the past two weeks I have felt more full of energy and fantastic about everything than ever before.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
12. I have a strong fear, either of small animals (such as dogs snakes, or cats, etc.), certain types of places (elevators, high places, etc.), or certain kinds of activities (flying, driving, etc.)	☐ Strongly Agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
13. I am upset because of problems I am having with my children or stepchildren.	☐ Never ☐ Seldom	☐ Often	☐ Almost Always	☐ N/A
14. As a child, I had an unhappy relationship with my parents.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
15. Someone has recently told me that I drink or use drugs too much.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
16. I have stomachaches, 'the runs', or feel like throwing up.	☐ Never	☐ Seldom	☐ Often	☐ Almost Always
17. I have periods where I am filled with sudden fear and panic—I get the sweats and my heart pounds—without any real reason.	☐ Never	☐ Seldom	☐ Often	☐ Almost Always
18. Even though I am tired and worn out during the day, I have trouble falling asleep or staying asleep.	☐ Never	☐ Seldom	☐ Often	☐ Almost Always

19. No matter how much I weigh or how little I eat, I can't get past the feeling that I'm too fat.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
20. I cause myself to vomit after I eat a lot of food.	☐ Never	☐ Seldom	☐ Often	☐ Almost Always
21. I wish I were not living and have had thoughts of killing myself.	☐ Never	☐ Seldom	☐ Often	☐ Almost Always
22. Although I've asked doctors, no one has been able to give me a good reason for all of my aches and pains.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
23. I get high on alcohol or drugs almost everyday.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
24. Within the past year, I have been charged with a violent crime, threatened harm to another person, or destroyed property because I was angry or wanted to 'get even'.	☐ Strongly Agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
25. I have missed work or school because things just bothered me too much.	☐ Never	☐ Seldom	☐ Often	☐ Almost Always
26. My whole life seems to be affected by my current problem	☐ Strongly Agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
27. I have had this problem or one similar to it, several times in my life.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
28. Throughout my life, I have had recurrent depression or times when I had trouble getting along with others.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
29. I am content and satisfied.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
30. I worry a lot.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree

31. I feel stressed out.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
32. I often feel like crying.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
33. I feel faint and dizzy more often than most people.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
34. I have more headaches or stomach pains than most people.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
35. I think that I should be doing much more than I am.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
36. I feel unhappy or sad.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
37. I have trouble trusting my own decisions.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
38. I feel lonely most of the time.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
39. I have many friends with whom I share common interests.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
40. I have at least one friend or family member in whom I can confide.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
41. I have a supportive relationship with the people I currently live with.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
42. I have used drugs or alcohol excessively at one time.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
43. I have gotten into trouble quite often because of my behavior.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree

44. I don‘t hesitate to tell friends or family about my physical problems.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
45. I am socially unreserved and outgoing.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
46. I lack self-confidence.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
47. I am likely to feel lonely even when others are present.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
48. I do not often go to social events.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
I tend to be quiet in social settings.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
I spend a lot of time trying to figure out my problems.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
50. I miss or am late to appointments.	☐ Never	☐ Seldom	☐ Often	☐ Almost Always
51. If I'm not careful, people take advantage of me.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
52. I let others know when I disagree with them.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
54. I do not get a good night‘s sleep, or wake up too early.	☐ Never	☐ Seldom	☐ Often	☐ Almost Always
55. I feel guilty-as if I have done something wrong or am worthless.	☐ Never	☐ Seldom	☐ Often	☐ Almost Always
56. I can‘t keep my mind on what I am doing.	☐ Never	☐ Seldom	☐ Often	☐ Almost Always

57. I feel like I don‘t enjoy myself as much as I used to.	☐ Never	☐ Seldom	☐ Often	☐ Almost Always
58. I am in a sad, blue, or _down‘ mood.	☐ Never	☐ Seldom	☐ Often	☐ Almost Always
59. I feel tired almost everyday.	☐ Never	☐ Seldom	☐ Often	☐ Almost Always
60. I do much less than I used to do.	☐ Never	☐ Seldom	☐ Often	☐ Almost Always
61. I own a gun.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
62. It doesn't matter to anyone what happens to me.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
63. I secretly have a plan to kill myself if things get too bad.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
64. I have tried to kill myself in the past.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
65. I have had periods when I felt like killing myself.	☐ Never	☐ Seldom	☐ Often	☐ Almost Always
66. I have had strong desires to kill or seriously hurt other people.	☐ Never	☐ Seldom	☐ Often	☐ Almost Always
67. I don't want to live.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
68. People intend to harm me.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
69. If I choose to, I can hear other people's thoughts, even when they are not around.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree

70. Someday, people will come to know that I'm a special person.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
71. I can't seem to say the things that go through my mind.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
72. I have had hallucinations--seen or heard things that were not there.	☐ Never	☐ Seldom	☐ Often	☐ Almost Always
73. People have said that I don't think before I act.	☐ Never	☐ Seldom	☐ Often	☐ Almost Always
74. I sometimes go on spending sprees.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
75. My thoughts go faster than I can talk.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
76. Sometimes it occurs to me that I'm a truly wonderful person.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
77. There are just so many important things going on, that I can't concentrate.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
78. Sometimes I get so many thoughts in my head that I can't talk.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
79. I have moments when my heart beats so fast, I fear that it will burst.	☐ Never	☐ Seldom	☐ Often	☐ Almost Always
80. I have moments of intense fear, sweating, and panic.	☐ Never	☐ Seldom	☐ Often	☐ Almost Always
81. Sometimes, I start shaking so much that I can't walk or write.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
82. I get short of breath and fear that I will suffocate.	☐ Never	☐ Seldom	☐ Often	☐ Almost Always

83. I feel numb or tingling for no reason.	☐ Never	☐ Seldom	☐ Often	☐ Almost Always
84. I feel like people and things around me are not real.	☐ Never	☐ Seldom	☐ Often	☐ Almost Always
85. I become afraid that I am going crazy and won't be able to come back.	☐ Never	☐ Seldom	☐ Often	☐ Almost Always
86. I often express my anger directly to family members who upset me.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
87. Even if they were (are) present, I would not have much to do with my family.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
88. There are family members who make me so upset that I can't be around them.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
89. I wish I got along better with members of my family.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
90. My family kicked me out of the house.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
91. I have quit associating with one or more members of my family.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
92. I often feel anger at members of my family, whether or not I let them know.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
93. One or more members of my family refuse to have anything to do with me.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
94. I picked the wrong career.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
95. I have recently lost a job or been demoted at work.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree

96. I have had fights with my coworkers or supervisors.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
97. Work is extremely stressful.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
98. I don't like many of the people with whom I work.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
99. I've lost one or more jobs in the past few years because I didn't fit with the job.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
100. Some of the people at work intend to harm me.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
101. I have recently had a situation produced by drinking/drug use which caused me some problems or embarrassment.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
102. I usually lie about how much I drink or use drugs.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
103. Within the past two years I have been in trouble with the law because of alcohol or other drug use.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
104. I have severe hangovers or withdrawal effects from alcohol or other drugs.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
105. I use drugs to produce a pleasurable effect.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
106. Others have recently told me that I drink too much or abuse drugs.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree

107. I drink too much sometimes.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree	
108. I sometimes drive while under the influence of alcohol and/or another drug.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree	
109. My partner and I have had regular satisfying sex.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree	☐ N/A
110. I am separated from my spouse or partner.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree	☐ N/A
111. I am worried about the relationship between my spouse or partner.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree	☐ N/A
112. I am thinking about ending the relationship.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree	☐ N/A
113. I am confused about the future of the relationship.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree	☐ N/A
114. I am satisfied with the amount of support I get from my significant other.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree	☐ N/A
115. I feel pain in my back or neck.	☐ Never	☐ Seldom	☐ Often	☐ Almost Always	
116. I suffer from a stomach ache, bloating, and growling.	☐ Never	☐ Seldom	☐ Often	☐ Almost Always	
117. I am distressed by various physical problems.	☐ Never	☐ Seldom	☐ Often	☐ Almost Always	

118. I often have a headache.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
119. I feel fearful or frightened for no clear and particular reason.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
120. I feel extremely humiliated and embarrassed whenever I am around unfamiliar people or groups, especially if they are looking at me.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
121. I cannot control my fear whenever I am unable to avoid certain feared objects or situations like flying, heights, certain animals, injections, going outdoors, traveling, etc.	☐ Strongly Agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
122. I often worry over the possibility feeling extreme fear because of being forced to confront feared objects and situations.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
123. I have changed my life style in order to avoid feared objects or situations.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
124. I have nagging, unwanted thoughts I cannot get out of my head that cause a great deal of stress and worry.	☐ Never	☐ Seldom	☐ Often	☐ Almost Always
125. Once I do what the thoughts are nagging me about, I feel much better.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
126. I am angry with my children, and I let them know it.	☐ Never	☐ Seldom	☐ Often	☐ Almost Always ☐ N/A

127. I have little contact with most of my children.	☐Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree	☐ N/A
128. I usually become upset after seeing or hearing from one or more of my children.	☐Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree	☐ N/A
129. I would like to be closer to my children than I am now.	☐Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree	☐ N/A
130. At sometime in the past I had to leave my home because of my behavior toward my children.	☐Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree	☐ N/A
131. I try to avoid being around one or more of my adult children.	☐Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree	☐ N/A
132. I am often angry with my children, but many times I do not let it show.	☐Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree	☐ N/A
133. I do not see or speak to one or more of my adult children.	☐Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree	☐ N/A
134. I eat very little or almost nothing everyday.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree	
135. I still feel too fat no matter how much weight I lose.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree	
136. Even though people tell me I am too skinny, I continue to eat very little for fear of getting fat.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree	

137. I have lost a noticeable amount of weight since I cut back on my eating.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
138. People tell me that I am underweight.	☐ Never	☐ Seldom	☐ Often	☐ Almost Always
139. There are particular times during which I consume more food than most people would eat during a similar period.	☐ Never	☐ Seldom	☐ Often	☐ Almost Always
140. I feel like my appetite is out of control.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
141. In order to keep from gaining weight I make myself vomit or abuse laxatives.	☐ Never	☐ Seldom	☐ Often	☐ Almost Always
142. This problem has bothered me over at least a three-month period.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
143. Many times I have this problem even when I am not trying to lose weight.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
144. I cannot remain focused for longer than five minutes on activities I enjoy very much, like watching a favorite TV show or playing my favorite game.	☐ Never	☐ Seldom	☐ Often	☐ Almost Always
145. I am easily distracted by noises and other things going on around me.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
146. I frequently seek very exciting activities, like bungee jumping, parachuting, racing, gambling, etc.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree

147. I always seem to have difficulty following through on instructions from others.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
148. I often misplace things, forget appointments, and lose important paperwork (bills, receipts, tax documents, etc.).	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
149. I have had constant feelings and moments of ‗just not being myself' following a specific traumatic experience.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
150. I have had constant fear lasting for longer than two weeks, following a specific traumatic event.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
151. I have had increased problems with sleep, social, sexual, or work functioning after a specific traumatic event.	☐ Never	☐ Seldom	☐ Often	☐ Almost Always
152. I have relived a specific traumatic event as if it just happened.	☐ Never	☐ Seldom	☐ Often	☐ Almost Always
153. I have a preference for a female therapist	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
154 I have a preference for a male therapist.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
155. I have a preference for a non-Chinese therapist.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
156. I have a preference for a Chinese therapist.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
157. I have a preference for a non-Chinese	☐ Strongly	☐ Agree	☐	☐ Strongly

speaking therapist.	agree		Disagree	Disagree
158. I have a preference for a gay or lesbian therapist	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
159. I have a preference for a therapist with a particular religious background.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
160. If given the choice of self-help methods, I would probably select the option of reading a book.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
161. If given the choice of self-help methods, I would probably select the option of using a film or movie.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
162. If given the choice of self-help methods, I would probably select the option of using an autobiography of someone with similar concerns to mine.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
163. If given the choice of self-help methods, I would probably select the option of using a self-help or support group.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
164. If given the choice of self-help methods, I would probably select the option of using an Internet site.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
165. If given the choice of self-help methods, I would probably select the option of using an online support community.	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly Disagree
166. I am a	☐ Male	☐ Female		

167. I have	☐ Less than a high school education	☐ A high school education or GED	☐ Some College	
	☐ College Degree	☐ A Post-graduate degree		
168. I am	☐ Single-Never married and no significant other	☐ Single-Never married but have a significant other (not co-habitating)	☐ Married or significant other	☐ Separated from a marital partner or significant other
	☐ Divorced and have no steady partner or significant other	☐ Widowed and have no steady partner or significant other	☐ Widowed or Divorced and have a new sexual partner or significant other	
169. I consider myself to be:	☐ heterosexual	☐ homosexual (gay/lesbian)	☐ bisexual	
170. I have previously received psychotherapy for any reason.	☐ Yes	☐Don‘t know/uncertain	☐ No	

171. My Race or Ethnicity is best described as:	☐Chinese	☐other	
172. I have health insurance that pays for mental health and addiction treatment.	☐ Yes	☐ Don‘t know/uncertain	☐ No

FEEDBACK

1.) Were there any items you could not understand or thought was poorly worded? If so, please explain below:

_____
_____
_____

2.) Were there any items you thought could have been taken out or replaced? If so, please explain below:

_____
_____
_____

3.) What suggestions would you have to improve the measure?

_____
_____
_____

APPENDIX B

STS-INNERLIFE (Chinese version)

系统治疗选择自评表

请在合适的空格里，注明你的一个选择

1. 我是	☐ 不满 20 岁	☐ 20 和 40 岁之间	☐ 41 和 64 岁之间	☐ 大于 64 岁
2.在过去几天里，一些事情比平常更让我烦恼和不安。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
3.即使做着自己很喜欢做的事情，我依旧不安或者烦躁。	☐ 从不	☐ 很少	☐ 常常	☐ 几乎总是
4. 有时候我觉得只要我努力想一些事，我就可以让人去做那些事情。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
5.我回避见到一些人或者在某些人周围，因为这样会让我不安或者愤怒。	☐ 从不	☐ 很少	☐ 常常	☐ 几乎总是
6.我有一些很令人不安的，挥之不去的，不断重复的想法。	☐ 从不	☐ 很少	☐ 常常	☐ 几乎 总是
7.	☐非常同意	☐同意	☐不同意	☐非常不同意

8.我因为跟配偶或者伴侣之间的问题而感到心烦意乱。	☐ 从不	☐ 很少	☐常常	☐几乎总是	☐ 不相干
9.有时候一些不想要的记忆非常生动地浮现在脑海里，就象又重新发生一样。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意	
10.当不在家附近或者熟悉的环境中时，我会很害怕。	☐ 从不	☐ 很少	☐ 常常	☐ 几乎总是	
11.跟以前相比， 在过去两周内，我对任何事物都更有富有精力，也有更多幻想。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意	
12.我对一些小动物(如狗、蛇、猫等)，某些地方(电梯、高处等)或者某些活动(飞行，驾驶等)很恐惧。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 强烈不同意	
13.我为跟我孩子或前妻（前夫）所生的孩子之间的问题而心烦意乱。	☐ 从不	☐ 很少	☐常常	☐几乎总是	☐ 不相干
14. 当我是个孩子时，我跟父母的关系不融洽。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意	
15. 最近有人说我喝酒太多或者用药太多了。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意	
16. 在过去两周，我胃痛，腹泻，或者觉得想要吐出来。	☐ 从不	☐ 很少	☐ 常常	☐ 几乎总是	

17. 我会在有段时间里突然十分害怕和恐惧，我会没有任何原由地出汗和心跳。	☐ 从不	☐ 很少	☐ 常常	☐ 几乎总是
18. 即使白天筋疲力尽，我还是 晚上难以入睡或者保持睡眠。	☐ 从不	☐ 很少	☐ 常常	☐ 几乎总是
19.无论我的体重多轻或者我吃得多么少，我还是觉得自己太胖。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
20.在吃了太多食物之后，我会想办法让自己呕吐。	☐ 从不	☐ 很少	☐ 常常	☐ 几乎总是
21. 我不想活了，并有自杀的想法。	☐ 从不	☐ 很少	☐ 常常	☐ 几乎总是
22. 虽然我已经看过医生，但没人能够很好地解释我所有疼痛的原因。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
23. 我几乎每天都会借着酒精或者药物保持兴奋。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
24.在过去一年里，我因暴力犯罪，威胁伤害他人或者破坏财产而受指控，因为我很愤怒或者想要~~报~~复”。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
25.有些事情实在让我太苦恼，我会因此 而不去上班或者上学。	☐ 从不	☐ 很少	☐ 常常	☐ 几乎总是
26.我的整个生活似乎都受我目前问题的影响。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意

27. 在我生活中有几次，有过与目前问题同样的或者类似的问题。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
28.在我整个生活中，我曾经反复多次地抑郁过，或者经常跟他人相处不好。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
29. 我感到心满意足。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
30. 我常常担忧。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
31.我觉得压力太大了。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
32. 我常觉得想要哭。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
33.比起大多数人，我更常感觉头昏要晕倒。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
34.比起大多数人，我有更多的头痛或者胃痛。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
35.我认为自己应该做比实际更多的事。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
36 我感觉不幸福或者难受。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
37.我不能相信自己的决定。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
38.大多数时候我觉得孤独。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
39.我有很多志趣相投的朋友。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意

40.我至少有一个朋友或者家人可以说心里话。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
41.我能从现在跟我同住的人（们）那里得到支持。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
42. 在某个阶段，我曾经滥用药物或者酗酒。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
43. 我常因自己的行为而惹上麻烦。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
44. 我会毫不犹豫地告诉朋友或者家人自己的身体问题。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
45. 在社交上，我是个随意外向的人。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
46.我缺乏自信。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
47.哪怕有别人在，我可能还是觉得孤独。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
48. 我不常去 社交活动。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
49．在社交场合我总是比较安静。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
50. 我会错过会面或者迟到。	☐ 从不	☐ 很少	☐ 常常	☐ 几乎总是
51.如果我不小心，别人会占我的便宜。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
52.我比较固执己见。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意

53.				
54.我睡不好觉，或者醒得太早。	☐ 从不	☐ 很少	☐ 常常	☐ 几乎总是
55.我感觉内疚—好像我做错了什么或者我自己没有价值。	☐ 从不	☐ 很少	☐ 常常	☐ 几乎总是
56. 我无法集中思想在我做的事情上。	☐ 从不	☐ 很少	☐ 常常	☐ 几乎总是
57. 我觉得我好像不如以前那样能自我欣赏了。	☐ 从不	☐ 很少	☐ 常常	☐ 几乎总是
58. 我的情绪难受，忧伤或者低落。	☐ 从不	☐ 很少	☐ 常常	☐ 几乎总是
59. 几乎每天我都觉得疲惫。	☐ 从不	☐ 很少	☐ 常常	☐ 几乎总是
60.我比从前做得少很多。	☐ 从不	☐ 很少	☐ 常常	☐ 几乎总是
61． 我有枪	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
62. 发生在我身上的事情，跟别人无关。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
63. 我私下里有个计划：在当事情变得太糟糕的时候就杀了自己。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意

64. 我曾经试图自杀。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
65.曾经有时间我觉得想自杀。	☐ 从不	☐ 很少	☐ 常常	☐ 几乎总是
66.我有强烈的欲望去杀别人或者严重地伤害别人。	☐ 从不	☐ 很少	☐ 常常	☐ 几乎总是
67. 我不想活了。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
68. 有人想伤害我。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
69.如果我选择，我可以听见他人的思想，哪怕他们并不在周围。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
70. 总有一天，人们会认识到我是一个特殊的人。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
71. 我好像无法说出在我脑子里的想法。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
72.我曾经有 幻觉—看到或者听到实际上不在那里的事物。	☐ 从不	☐ 很少	☐ 常常	☐ 几乎总是
73. 别人曾说我在行动前不思考。	☐ 从不	☐ 很少	☐ 常常	☐ 几乎总是
74. 我有时会大放纵狂欢。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意

75. 我想的比说的快。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
76. 有时候我觉得自己真是个很棒的人。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
77. 因有太多重要的事情，我无法集中精神。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
78. 有时我脑子里有太多想法了以至于我无法讲话。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
79. 有时我的心跳得太快，我担心它会破裂。	☐ 从不	☐ 很少	☐ 常常	☐ 几乎总是
80.有时候，我会感到强烈的恐惧，出汗和惊恐。	☐ 从不	☐ 很少	☐ 常常	☐ 几乎总是
81. 有时候，我会厉害地摇晃，至于我不能走路或者写字。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
82. 我会呼吸短促，并担心我会窒息。	☐ 从不	☐ 很少	☐ 常常	☐ 几乎总是
83. 我会毫无原由地感到发麻或者刺痛。	☐ 从不	☐ 很少	☐ 常常	☐ 几乎总是
84.我觉得我周围的人和事情不是真实的。	☐ 从不	☐ 很少	☐ 常常	☐ 几乎总是
85.我会担心自己发疯并不能再回复正常。	☐ 从不	☐ 很少	☐ 常常	☐ 几乎总是

86. 我通常对那些让我烦心的家人，直接表达我的愤怒。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
87. 哪怕家人在场，我也觉得与他们没什么好说的或可做的	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
88. 家人中有人让我心烦意乱以至于我无法呆在他们身边。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
89. 我希望我跟家人能够相处得更好些。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
90. 我的家人将我赶出了家门。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
91. 我已经放弃跟一个或多个家人联系了。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
92. 我经常对家人感到愤怒，尽管我不一定让他们知道。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
93. 一个或多个家人拒绝跟我联系。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
94. 我选错了职业。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
95.我最近丢了工作或被贬了职。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
96.我曾经跟我的同事或者指导老师吵过架。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
97. 工作极其有压力。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
98. 很多跟我一起工作的人，我都不喜欢。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意

99. 因为不适合，我在过去几年里丢了一个或多个工作。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意	
100.工作中，有些人想要伤害我。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意	
101.最近由于酗酒/用药，给我带来一些困难或陷入尴尬的境地。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意	
102.我通常谎报饮酒量或用药量。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意	
103.在过去两年里，由于酗酒或者使用其他药物，我出了些与法律相关的问题	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意	
104. 我对酒精或者其他药物有强烈宿醉或者戒断效应。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意	
105. 我服药以制造一种欣快效果。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意	
106.最近别人说我喝酒太多或者用药太多。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意	
107.有时我喝酒太多。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意	
108. 我有时在饮酒和/或服用另一毒品后开车。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意	
109. 我和伴侣的性生活很规律也很令人满意。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意	☐ 不相干
110. 我跟配偶或者伴侣分居。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意	☐ 不相干
111. 我为和我配偶或者伴侣的关系担忧。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意	☐ 不相干

112. 我在想着要结束这段关系。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意	☐ 不相干
113. 我对这段关系的未来感到困惑。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意	☐ 不相干
114. 从对我重要的他人那里得到的支持，我感到满意。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意	☐ 不相干
115.我常觉得背部或者颈部疼痛。	☐ 从不	☐ 很少	☐ 常常	☐ 几乎总是	
116. 我常常胃痛、腹胀和肠鸣。	☐ 从不	☐ 很少	☐ 常常	☐ 几乎总是	
117. 我为各种身体问题所苦恼。	☐ 从不	☐ 很少	☐ 常常	☐ 几乎总是	
118.我常头疼。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意	
119. 我会无缘无故地感到害怕或者受惊。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意	
120.当我跟不熟悉的人或人群相处时，尤其当他们看着我的时候，我感到极度羞怯和尴尬。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意	
121. 每当我无法逃避让我害怕的事物或者情境的时候譬如飞行、高处、某些动物、注射、外出、旅行等时，我无法控制我的害怕。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意	

122. 我总过份担心自己会面对极度害怕的事物或情境而感到极度恐惧。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意	
123. 为了回避我害怕的事物或情境，我改变了我的生活风格。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意	
124.我有些驱之不去的，不想要的，却一直纠缠的想法，因此感到很多的压力和忧虑。	☐ 从不	☐ 很少	☐ 常常	☐ 几乎总是	
125.当我做了那些一直纠缠于脑中的想法的事情时，我感觉好多了。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意	
126..我对我的孩子发脾气，并让他们知道。	☐ 从不	☐ 很少	☐常常	☐几乎总是	☐ 不相干
127.我跟我大多数孩子都很少接触。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意	☐ 不相干
128. 当我见到我的一个或多个孩子，或跟他们过话后,常感到心烦意乱。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意	☐ 不相干
129. 我希望跟我的孩子更亲近。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意	☐ 不相干
130.在过去的某个时间，我曾经因为我对孩子的行为不得不离开家。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意	☐ 不相干
131. 我试图回避我的一个或几个成年的孩子。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意	☐ 不相干
132. 我常对我的孩子生气，但很多时候都不表现出来。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意	☐ 不相干
133. 我不会去看望我的成年孩子或是跟他们说话。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意	☐ 不相干

134. 每天我都吃得很少或者几乎不吃。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
135.无论我减了多少体重，我依旧觉得很胖。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
136. 虽然别人说我太瘦了，我依旧因为担心变胖而吃得很少。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
137. 自从我控制饮食以来，我的体重明显地减轻了。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
138. 别人说我体重太轻了。	☐ 从不	☐ 很少	☐ 常常	☐ 几乎总是
139. 在某段时间里，我比大多数的人吃的东西都要多。	☐ 从不	☐ 很少	☐ 常常	☐ 几乎总是
140. 我觉得我的食量失控了。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
141. 为了防止增加体重，我让自己呕吐或者滥用轻泻剂。	☐ 从不	☐ 很少	☐ 常常	☐ 几乎总是
142. 催吐或滥用轻泻药的问题至少困扰了我三个月。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
143.哪怕我不试图减肥，但我还是经常会催吐或滥用轻泻药。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
144. 在做我喜欢的活动时，比如看一个喜欢的电视节目或者玩我喜欢的游戏，我无法集中注意力超过五分钟，	☐ 从不	☐ 很少	☐ 常常	☐ 几乎总是

145. 我很容易就被噪音或者我身边的其他事情分散注意力	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
146. 我频繁地寻找刺激性的活动，比如蹦极跳、跳伞、赛 车, 赌博等。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
147.我总是觉得很难听从他人的指挥。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
148.我常乱放东西、忘记约会，或者丢失重要的文件（账单、收据、税务文件等）。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
149. 在一个特别的创伤体验后,我常有—我不是我自己的”的感觉。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
150. 在某次创伤事件后，我一直很害怕，这种情况超过两周。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
151. 在某次创伤性事件后，我的睡眠、社交、性、或者工作上都越来越困难。	☐ 从不	☐ 很少	☐ 常常	☐ 几乎总是
152.我仿佛又重新经历了一次创伤性事件，就象它刚发生一样。	☐ 从不	☐ 很少	☐ 常常	☐ 几乎总是
153. 我强烈偏向于找一个女性治疗师。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
154.我强烈偏向于找一个男性治疗师。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
155. 我强烈偏向于找一个非华人的治疗师。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意

156．我强烈偏向于找一个华人治疗师	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
157. 我强烈偏向于找一个讲外语的治疗师。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
158. 我强烈偏向于找一个同性恋的治疗师。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
159. 我强烈偏向于找一个有特别宗教背景 的治疗师。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
160. 如果让我选择自助的方法,我可能会选择读一本书。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
161. 如果让我选择自助的方法,我可能会选择看电影。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
162. 如果让我选择自助的方法,我可能会选择读一本跟我有相似问题的人的自传。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
163. 如果让我选择自助的方法,我可能会选择去参加一个自助或支持小组。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
164.如果让我选择自助的方法,我可能会选择上网。	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
165. 如果让我选择自助的方法,我可能会选择网络上的支持群体	☐ 非常同意	☐ 同意	☐ 不同意	☐ 非常不同意
166. 我是	☐ 男性	☐ 女性		
167.我的学历	☐ 高中以下的教育	☐高中毕业	☐ 上过一些大学	

	☐ 学士学位	☐ 硕士/博士学位		
168. 我的婚姻状况	☐ 单身--从未结过婚也没有重要他人	☐ 单身--从未结过婚但有一个重要他人(没有同居)	☐ 已婚或者跟性伴侣或重要他人生活在一起	☐与婚姻伴侣或者重要他人分居
	☐离异没有稳定的伴侣或者重要他人	☐ 丧偶没有稳定的伴侣或者重要他人	☐ 丧偶或者离异,有新的性伴侣或者重他的人	
169. 我认为自己是	☐ 异性恋者	☐ (男/女)同性恋者	☐ 双性恋者	
170. 我曾经因为某些原因接受过心理治疗.	☐ 是	☐不知道/不确定	☐ 否	
171. 我的民族是	☐中国人	☐ 其他		
172. 我的医疗保险可以支付精神疾病和成瘾的治疗	☐是	☐ 不知道/不确定	☐ 否	☐其他
173． 我花很多时间试图解决我的问题。	☐非常同意	☐同意	☐不同意	☐非常不同意

3.) 你觉得哪些条目无法理解或者用词不当？如果有, 请解释。

_____
_____

4.) 你觉得哪些条目可以剔除或者被替换，如果有,请解释。

_____
_____

5.) 你对如何改善该测试有什么别的建议吗？

_____
_____

APPENDIX C

ADDITIONAL SUPPLEMENTAL THREE QUESTIONS (English version)

You are being invited to help us develop a questionnaire that will be used to help people benefit from mental health treatment. Shijin Sun, Ph.D., Guohong Wu, Ph.D from Fudan University and Larry E. Beutler, Ph.D. Satoko Kimpara, M.S., Xiaoxia Song, M.A., from the Pacific Graduate School of Psychology, Palo Alto, California, USA will be conducting this study.

1) Have you seen a mental health provider?

Yes or No

If ~~y~~es", when did you first see a mental health provider? _____

How long it has been since you first sought mental health treatment? _____

2) Do you take medications? If yes, please list the names of these medicines.

Yes_____ or No

3) Where are you living now?

Choice: 1). Shanghai 2). Beijing 3). Wuhan 4). Shenzhen 5). Hangzhou 6). Guangzhou 7). Suzhou 8). Tianjin 9).Chongqing 10). Other _____

APPENDIX D

ADDITIONAL SUPPLEMENTAL THREE QUESTIONS (Chinese version)

补充题

您现获邀参与一项问卷的研发项目，该问卷致力于帮助人们心理健康中获益。本研究由中国复旦大学孙时进博士，吴国宏博士；美国 palo alto university larry e. beutler 博士，satoko kimpara 在读博士和宋小霞在读博士完成。

1）您是否曾经接受精神卫生服务？

是　否

2）离您第一次寻求心理治疗有多长时间了？

_____

3） 您是否接受药物治疗？

是　否

如果是，请罗列这些药物的名称

_____

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