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Help-Seeking Avoidance Among College Students as a Function of Ethno-Cultural Identity

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HELP-SEEKING AVOIDANCE AMONG COLLEGE STUDENTS AS A FUNCTION OF ETHNO-CULTURAL IDENTITY

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CHAPTER I
INTRODUCTION

What makes ethnic groups different? Much of the research conducted on the differences between groups of different ancestry in the area of mental health utilization has grouped subjects by ethnicity (Asian, Japanese, Chinese, Korean, etc.). These labels refer to the country of origin for an individual's ancestors, but to what degree to these labels describe the individual or the behavior the individual will exhibit? To what degree do any people with a common country of ancestral origin behave, think, or feel similarly? How are those behaviors, thoughts, and feelings different from those of individuals with other ancestral origins? Most important to this study, what are the effects of ethnicity and the adherence to the cultural attitudes and behaviors on the utilization of mental health services? In particular, is avoidance of seeking help from mental health practitioners different across gender and the levels of ethno-cultural behavior for Asian ancestry and European ancestry students?

Many researchers have noted the underutilization of mental health services by Asian-Americans (Kinzie & Tseng, 1978; Kitano, 1970; Snowden & Cheung, 1990; Sue & Kirk, 1975; Sue & McKinney, 1975; Sue & Sue, 1971). Explanations for this underutilization have included differences in traditions and philosophies, fear of discrimination, fear of shame and dishonor for one's family, lack of knowledge of services, high cost of services, unavailability of services, and lack of convenient hours of

operation (Sue & Morishima, 1982; Uba, 1982). Some authors contend that Asian-Americans often use mainstream mental health services only when they or their families have exhausted the traditional resources available within Asian-American communities (Chin, 1982; Kinzie & Tseng, 1978; Lin, Tardiff, Donetz, & Goresky, 1978).

Research conducted on the help-seeking preferences of Asian-Americans has revealed that Asian-Americans rely almost exclusively on family, friends and other social networks when they are experiencing emotional difficulties (Christensen, 1987; Webster & Fretz, 1978). Arnemann (1993) found that different levels of identification with Asian ethnic values resulted in differences in help-seeking attitudes toward mainstream professional mental health providers among Midwestern university students. One group of researchers (Atkinson, Whiteley & Gim, 1990) reported that more Western acculturated Asian-American students rated therapists lower as help providers than less Western acculturated Asian-American students. They concluded that the values of more traditional Asian-American students did not appear antithetical to seeing a mental health professional for help with a personal problem.

Amato and Bradshaw (1985) stated that a greater understanding of people's reluctance to seek help will facilitate the development of a general decision-making model of help-seeking behavior. Exploration of the reluctance to seek help from a mental health professional based on acculturation, gender and willingness might further the understanding of help-seeking behavior. Although it has been hypothesized that for Asian-Americans the impediments to seeking help from conventional mental health professionals stem from cultural restrictions to seeking help and

acknowledging personal difficulties to strangers, to date no one has investigated how Asian-Americans differ from European-Americans in their avoidance of seeking help from mental health professionals.

Although Arnemann (1993) proposed that highly acculturated Asian-American undergraduates have attitudes similar to European-American undergraduates towards seeking help from mental health professionals, reasons for seeking help, and conversely, reasons for failing to seek help from mental health professionals among Asian-American students may be different than those of European-American students. Although the gender differences in help-seeking attitudes appear to follow the same pattern as those of European-American students (Arnemann, 1993), it is widely acknowledged that Asian-Americans do not utilize the services to the same degree as European-Americans (Sue & McKinney, 1975). If the impediments to seeking help from conventional mental health professionals stem from cultural restrictions on acknowledging personal difficulties to strangers, then there might be different reasons to avoid therapy. The intent of this research project is to determine the differences in how college students perceive and avoid seeking help from mental health professionals dependent on the degree of ethnic identity among Americans of Asian ancestry (Asian-Americans), and Americans of European ancestry (European-Americans).

CHAPTER II
REVIEW OF RELATED LITERATURE

Use of Terminology

As the literature on ethnicity, ethnic identity, acculturation, and assimilation has evolved, these terms have become intertwined in meaning and usage. To bring some clarity to this discussion, original wording by some authors has been changed. Domanico, DeWolfe, and Crawford (1994) point out that acculturation is "...taking on an identity as a member of the majority group (p. 197)." They state that assimilation involves an integration that ultimately includes "...acceptance by the majority group... along with some level of acculturation of the minority individual... (p. 198)." For example, these definitions are somewhat different from previous usage of terminology as evidenced by Fong (1965). He differentiated between assimilation and acculturation by maintaining that acculturation is the degree to which ethnic minority members have actually learned and acquired American values in their behavior, and assimilation occurs when the individual begins to imitate the behavior of members of the dominant culture. These would now be termed attitude and behavior acculturation respectively, and although they probably are essential to and part of assimilation as defined above, neither constitute assimilation by themselves.

Because of current political and social changes, the use of terms to refer to specific groups of people is even more confusing. In this study

individuals who have been referred to in previous literature as White or Caucasian will be termed European-American or individuals of European ancestry to conform with the currently popular terms of Asian-American or individuals of Asian ancestry. Although there are still some difficulties with these terms, they appear to be the least objectionable at this point in time.

Acculturation and Ethnic Identity

Most measures of ethnic identity assess an individual's orientation toward a specific culture and assume that if the individual does not adhere to the cultural norms of his or her ethnic group then the individual has begun the process of acculturation into the mainstream or majority. As Berry (1980) and other authors have pointed out, a lack of adherence to the attitudes and behavioral norms of one's ancestors does not necessarily mean that the individual has acculturated. Berry's model suggests that some individuals can become alienated from or integrated into both cultures. Birman's (1994) recent amendment of this model suggests that there are different types of integration.

After studying the physical, psychological, and social aspects of acculturative stress in Native Canadians, Vietnamese-Canadian immigrants, and international students from Malaysia, Singapore, Hong Kong, South America, Africa, India, the United Kingdom, and the U.S., Berry, Kim, Minde, and Mok (1987) proposed four "modes" of acculturation similar to the forms of acculturation outlined by Berry (1980). The first is assimilation in which the individual does not want to maintain his cultural identity. Separation is the second mode and defined as maintaining one's original culture in isolation from the cultural forces surrounding and threatening the

cultural identity of the individual. The third option is integration, a mode in which the individual maintains a part of his/her original culture while participating in the larger culture. Finally there is the option of maintaining none of the original culture and accepting none of the dominant culture as well. This mode is characterized by little interest in relations with others and was referred to as marginalization. Although other authors have proposed similar models (Sue & Morishima, 1982; Sue & Sue, 1971, Szapocznik, Scopetta, Kurtines, & Aranalde, 1978), no researcher has produced definitive evidence that the model corresponds to scores on acculturation measures.

Berry et al. (1987) identified several demographic factors that affected acculturation: education, age, gender, attitude toward acculturation, prior intercultural experiences, and group contact experiences with the dominant culture. Higher levels of education, more willingness to acculturate, similarity of pre-contact experiences to the experiences that the individual has with the dominant culture, and the degree to which the individual's ethnic group participates in the dominant culture (if the contact is desired by the ethnic group and perceived by the individuals as a positive experience) all predict a greater likelihood of acculturation.

Birman (1994) presented an integrated model of identity that is an extension of the model explicated by Berry (1980). The author contends that the different models in the literature represent the variety of bicultural styles possible in different cultural contexts. Two frameworks were identified by this author. The first emphasizes cultural competence in a bicultural/multicultural system and was developed within the context of immigration (Berry, 1980; Szapocznik et al., 1980). The second is one

which developed from the ethnic/racial minority experience and emphasizes cultural identification (Helms, 1985; Phinney, 1989). Although both consider with how individuals deal with their membership in two distinct cultures, their different bases have resulted in different emphases. The Model described in Berry (1980) and Szapocznik et al. (1980) is simpler because maintaining a sense of identity is probably easier for immigrants who have a more recent and living memory of a culture of origin. The focus and challenge of the immigrant is on survival in and adaptation to a new environment.

Birman (1994) noted that minority identity development models have emphasized the consequences of oppression. The primary concern of these models is having a positive sense of cultural identity within the pressures of conforming to a different set of values and behavior norms, those of the larger, majority culture. Within this context, the author discussed the distinction between attitudinal and behavioral acculturation. Two approaches were suggested; one of fused identity incorporating two cultures in one identity, the other alternating between two cultures utilizing different identities for different settings. This resulted in an expanded model of sixteen different acculturative styles with 13 types of biculturalism possible. Birman explains that four of those styles are most frequently adapted by acculturating persons: blended bicultural, instrumental bicultural, integrated bicultural, and identity exploration.

The blended bicultural person is highly identified with both cultures and participates in both. This individual is likely to have fused or synthesized an identity which operates in both but is likely to live among others who have a similar identity. Instrumental bicultural people are similar

to the blended bicultural individuals described above but their involvement is limited to behavioral participation, alternating between the two cultures and feeling torn about their loyalties. These individuals are more likely to have emotional reactions similar to the marginalized person but are different in that they can function in either culture even if only superficially. Integrated biculturals function well in either culture but maintain a traditional identity. These individuals usually have a strong commitment and pride in their ethnicity and survive in the majority culture with confidence and integrity. Identity exploration describes individuals who are highly involved behaviorally in the majority culture and not their culture of origin. They often find themselves wishing to become connected with their roots but feel unable to because of lack of knowledge or opportunity.

The findings of several authors support a non-linear, non-progressive model of acculturation. Although Masuda, Matsumoto, and Meredith (1970) found significant successive attenuation of ethnic identity in three generations of Japanese-Americans, indicating a gradual erosion of ethnic identification, later generations show considerable behavioral acculturation with less structural assimilation (i.e., establishing social relationships outside of the ethnic group). In contrast, earlier generations may show greater structural assimilation but continue to display more traditional Japanese behavior. Masuda, Matsumoto, and Meredith interpreted this as evidence of the non-linearity of the acculturation process. Conner (1974) also found increasing acculturation across successive generations of Japanese-Americans in Sacramento, California; however, even third generation Japanese-Americans rated themselves considerably more Japanese than American, especially on items that reflected family-oriented values. Conner

(1977) found that third generation Japanese-Americans are psychologically and behaviorally closer to European-Americans than first generation Japanese-Americans, but seek to preserve the artistic and aesthetic aspects Japanese ethnic identity. Newton, Buck, Kunimura, Colfer, and Scholsberg (1988) found that ethnic identity is more reliant on the social and political climate than on biological and cultural inheritance.

Another difficulty occurs when assessing the acculturation of Americans of European ancestry. One of the assumptions of many studies is that there is a unified culture in the United States comprised mainly of English ancestry people which is more individualistic and more desirable than other cultures. If there is variance in attitudes towards seeking help and reasons for avoiding seeking help from mental health professionals among Asian-Americans, is there also similar variation among European-Americans due to level of adherence to American culture or any of the European cultures from which American culture is primarily derived?

There is also direct evidence of the interaction of psychological factors and acculturation. The results of Smither and Rodriguez-Giegling (1982) and Pierce, Clark, and Kaufman (1979) suggest that acculturation is not determined solely by age and generation but also by personality factors. In support of this, Meredith and Meredith (1966) found that female Japanese-American university students had personality traits more similar to their European-American counterparts than did Japanese-American males. Meredith and Meredith took this as evidence that Japanese-American females were acculturating at a faster rate than Japanese-American males.

Although acculturation has been demonstrated to correspond to a number of demographic variables, many contradictions exist. Some

researchers (Matsumoto, Meredith, & Masuda, 1970; Masuda, Matsumoto, & Meredith, 1970; Meredith, 1967a, 1967b) have not found differences in acculturation by gender, while others (Berry, Kim, Minde, & Mok, 1987; Bourne, 1975) have. Similar conflicting findings have been reported on the significance of age and length of time spent in the U.S. (Masuda, Matsumoto, & Meredith, 1970; Yu, 1984). The complicated patterns woven by these studies suggest that demographic indicators such as gender, ethnicity, and generation since immigration may not be as conclusive in determining mental health service utilization as once thought. As models are changed to conform with new findings, stereotypes of group behaviors fade and are replaced by an increasing awareness of intragroup as well as intergroup diversity.

Ethnicity and Ethnic Identity

For some authors, building or retaining an identification with an ancestral culture and rejecting the attitudes and behaviors associated with the majority culture is referred to as forming an ethnic identity (Chance, 1965; Dashefsky, 1975; Isajiw, 1974). Some authors have maintained that the level of acculturation of an individual can be determined by the degree to which they fail to adhere to the language, values, and behaviors of his or her ancestral heritage (Suinn, Rickard-Figueroa, Lew, & Vigil, 1987). This rationale assumes that in the process of attaining the values, behaviors, language, and customs of a host culture, the individual is forced to relinquish those aspects of his or her own ethnic culture that conflict with aspects of the host culture. Lebra (1972) maintains that this is not necessarily true. She contends that individuals, depending upon the situation, may select and

choose their identity within the limits allowed by a culture. Conner (1977) found that highly acculturated Japanese-Americans did, in fact, retain some Japanese identity. The values retained, however, where limited to aesthetic and artistic dimensions. Many current methods of determining the acculturation level of an individual involve measuring ethnic identity (Atkinson & Gim, 1989; Atkinson, Whitely, & Gim, 1990; Gim, Atkinson, & Whitely, 1990).

Phinney (1990) noted that although the terms acculturation and ethnic identity have been used almost interchangeably, they are related but not the same. Acculturation deals with the changes in cultural attitudes, values, and behaviors made as a result in differences between two cultures. The focus in acculturation studies is usually the group (Berry, Trimble, & Olmedo, 1986). Ethnic identity can be seen as a product of acculturative pressure and is usually an individual process. In more linear, bipolar models of identity, the acculturated individual who identifies with the mainstream culture is at one end of the continuum while the individual who identifies strongly with his or her ancestral culture and rejects the mainstream culture is at the other. Most authors have used measures of ethnic identity as acculturation indicators with the assumption that a strong ethnic identification precludes acculturation into the majority culture and that acculturation precludes the maintenance of ethnic identity (Arnemann, 1993; Atkinson & Gim, 1989; Atkinson, Whitely, and Gim, 1990; Gim, Atkinson, and Whitely, 1990; Oana, 1981). This line of research does not address the possibility that members of what is perceived as the majority may also vary in their identification with a culture. Consequently, these individuals may not

participate in what may be seen as common activities of the majority culture and may also have divergent attitudes and behaviors.

Phinney (1990) stated that "The task of understanding ethnic identity is complicated because the uniqueness that distinguishes each group makes it difficult to draw general conclusions" (p. 499). Establishing and maintaining an identity in a culture which does not fully value cultural contributions presents a challenge to the individual who receives constant reminders that he or she is in some way different from other members of the society. Although ethnic identity has received little attention among the white majority in the U.S., attitudes towards an individual's ethnicity are central to the psychological functioning of those who live in a society where their group and its culture are poorly understood and represented. This may include individuals who might nominally be included in the white, European ancestry majority. Phinney identified three universal elements important to development and maintenance of ethno-cultural identification: self-identification, sense of belonging, and pride in one's group.

Measurement of Ethnic Identity

While not many measures of ethnic identity have been developed for use with European-based cultures, several researchers have developed measures to assess ethnic identity in Asian-Americans (Conner, 1974; Fong, 1965; Meredith, 1967a, 1967b; Padilla, Wagatsuma, & Lindholm, 1985; Smither & Rodriguez-Giegling, 1982; Suinn, Rickard-Figueroa, Lew & Vigil, 1987; Yao, 1979). Two have been used in the bipolar, either/or approach to ethnic identity. Matsumoto, Meredith, and Masuda (1970), Masuda, Matsumoto, and Meredith (1970), and Meredith (1967a, 1967b)

developed the Ethnic Identity Questionnaire (EIQ), to evaluate the acculturation of Japanese-Americans. Suinn, Rickard-Figueroa, Lew and Vigil (1987) developed the Suinn-Lew Asian Self-Identity Acculturation Scale (SL-ASIA) for use with Asian-Americans. In both cases, the authors stated that their respective scales are based on the assumption that an individual more acculturated into the mainstream American culture would endorse fewer behaviors and attitudes associated with Asian cultures. Researchers using these scales have grouped the respondents into three categories: Asian-identified, transitional or "bicultural," and Western-identified. Those in the Asian-identified category are individuals who demonstrate the most identification with Asian cultural values, behaviors, and customs. Western-identified individuals are those in the category that have the lowest identification with Asian culture. Those in the transitional or bicultural category are the individuals whose total score on the scale falls between the scores that determine Asian- and the Western-identified individuals.

Phinney (1992) developed a measure of acculturative adaptation that addresses several of aspects of ethnic identity and the acculturation process. The major advantage of the Multigroup Ethnic Identity Measure (MEIM) is, as its name implies, that it is an instrument that can be used with different groups. Because of the intended comparisons between several diverse ethnic groups, this instrument was utilized in this study. Phinney designed the measure to examine elements of ethnic identity of individuals from different groups without targeting a specific group. It also assesses the individual's orientation to and interaction with other groups. It was developed utilizing high school and college populations and was intended for research with

those groups. Phinney noted that self-esteem was related to the development of a positive ethnic identity in all groups but particularly with ethnic minority students. The author also found that identity did not differ by gender or socioeconomic status as measured by this instrument.

Differential Utilization of Mental Health Services

Several authors have approached the assessment of utilization through the examination of statistical records. Early studies conducted in Hawai`i from 1945 to 1956 (Ikeda, Ball, & Yamamura, 1962; Kimmich, 1960) reported that Asian-Americans accounted for 15% of the admissions to the Hawai`i state mental hospitals, while they comprised 39.2% of the population. In their study of therapy modality and dropout rates in a hospital outpatient psychiatric clinic, Yamamoto, James, and Palley (1968) noted that there were few Asians who sought therapy and even fewer who stayed in therapy. To explain the underutilization of mental health services by Asian-Americans in this sample the authors suggested that the patient may feel that the therapist's ethnocentricity may cause the therapist to be less accepting and therefore less understanding of the Asian-American client.

Sue and Sue (1974) reported that Asian-American students at a West Coast university clinic presented with proportionately higher rates of severe disturbance, usually psychosis, than did non-Asian students. Similarly to Yamamoto, James, and Palley (1968), the authors found that the dropout rate following the first session (52%) was significantly higher for Asian-Americans than for European-Americans (29%), regardless of severity of pathology. Sue and McKinney (1975), following their analysis of data from 17 community mental health facilities in the Seattle area, found that there

was underutilization of these mental health services for Chinese-, Japanese-, and Filipino-American populations. Sue and McKinney (1975) emphasized the cultural value of shame and dishonor for one's family if one is diagnosed with mental problems. In contrast to the findings of Yamamoto, James, and Palley (1968), Sue and McKinney found that Asian-Americans in this study had longer periods of hospitalization than their European-Americans counterparts.

Kinzie and Tseng (1978) analyzed the relationship between ethnicity, demographic variables, welfare status, source of referral, primary complaints or symptoms, diagnoses, and duration of treatment for outpatients at a psychiatric clinic in Honolulu, Hawai`i, over a one year period. They found that European-Americans were over-represented in the patient population, whereas Asian-Americans, especially Japanese-Americans, were under-represented. In addition, European-Americans were more likely to be self-referred and less likely to suffer from a severe disorder than the Asian-Americans. Unlike Sue and McKinney (1975), these authors found no significant differences for length of treatment between European-American patients and Asian-American patients and no hindrance of therapy due to ethnic barriers between therapist and patient as suggested by Sue (1977).

Liu and Yu (1985) reported lower treatment rates for Asian-Americans than other groups based on patient census data from institutions, mental hospitals and correctional institutions. The age-adjusted commitment rates for Asian and Pacific Islanders males and females were .45/1000 and .24/1000 respectively, while commitment rates for European-American males and females were 1.20/1000 and .70/1000 respectively. Five years later, Snowden and Cheung (1990) reported that national admission statistics

for inpatient mental health services gathered for the National Institute of Mental Health continued to indicate underutilization of inpatient services by Asian-Americans.

Kitano (1969) conducted several surveys in various mental health agencies in Los Angeles in the years from 1960 to 1965. He found that Japanese-Americans seldom went to facilities that offered mental health care to families, child guidance and psychiatric clinics, and other counseling resources; however, a social service agency set up by the Japanese Chamber of Commerce with a Japanese-speaking worker had a steady clientele of Japanese-Americans. This evidence suggests that underutilization of mainstream services is not evidence that Japanese-Americans are a population without mental health problems. The treatment of parent-child difficulties, marital problems, intergenerational stress, and problems of ethnic identity only in a Japanese-American community agency indicates that mental health needs were not being met through mainstream professional resources. Like Yamamoto, James, and Palley (1968), Kitano cited differences in cultural styles of expressing problems between the therapist and client, the inappropriateness of current therapeutic organizations, and the lack of relevant connections to the therapeutic community as reasons behind the lack of use of the larger, mainstream community resources. He noted that the Japanese family and the Japanese community, in general, had a tendency to control and to "hide" problem behaviors, making it appear on the surface that Japanese-Americans did not need mental health services. He suggested that there was a possibility that the severity of the disorders seen in mainstream mental health facilities

resulted from only individuals with the most severe mental problems presenting for treatment.

To investigate this possibility, Kitano (1970) conducted a survey of schizophrenic Japanese patients in mental hospitals in four locations: Los Angeles, Hawai`i, Okinawa, and Japan. He found that tolerance of severe mental disturbance within the family, denial, and relabeling of symptoms was common in all locations. He suggested that the stigma associated with mental illness is not acceptable in Japanese families, and only when the behavior of the individual became intolerable did the family resort to outside help. Similarly, Munakata (1989) and Tsui and Schultz (1985) have suggested that potential Asian-American clients are kept out of the mental health systems and hence lower prevalence rates because their families maintain care and relinquish their family members to the system only when the family can no longer adequately cope with the symptoms. Kitano (1982) stated that an updated survey indicated no significant change in the pattern of utilization of mental health services by this community.

In a similar manner, Sue and Morishima (1982) emphasized that the most important difficulty in providing mental health services to Asian-Americans was the mismatch between what the therapist offered in terms of treatment and what the client perceived that he/she needed to alleviate his/her difficulties. Wu and Windle (1980) also attempted to link the number of Asian-American therapists in a facility with the number of Asian-American patients relative to the Asian-American population in the catchment area. Although their findings were not significant, they discovered a direct relationship between the number of Asian-American staff and the number of Asian-American clients. Wu and Windle suggested that

Asian-American utilization of mental health facilities might be increased if the numbers of Asian-American staff were increased.

Several studies have also addressed underutilization within a student population. Sue and Sue (1974) found that in comparison to the general university population, Chinese- and Japanese-American students, especially Chinese-American males, underutilized the mental health services. The authors also compared scores from the Minnesota Multiphasic Personality Inventory (MMPI) of the Chinese- and Japanese-American students with non-Asian-American students and found significantly higher levels of disturbance among the Asian-American populations. They found that Chinese- and Japanese-American clients were "...repressive, emotionally withdrawn, verbally inhibited and difficult to deal with therapeutically." (p. 426). Sue and Sue also found that the Asian-American clients tended to exhibit more somatic complaints, family discord, and social introversion than non-Asian clients. This lends some support to Kitano's hypothesis that Asian-Americans only seek mental health services when the disturbance is severe. Sue and Sue concluded that cultural factors are primarily responsible for fewer Asian-Americans seeking professional mental health care.

Sue and Kirk (1975) studied the help-seeking behavior of an entire college class for four years. The researchers reviewed service contracts for the campus counseling center, which deals with academic, vocational, and personal problems, and the psychiatric service, which deals with more severe emotional problems. The researchers found that the Asian-American students underutilized the psychiatric services and overutilized the counseling center services in comparison to their non-Asian classmates. They attribute this pattern of utilization to personality characteristics of the

Asian-American students. The authors refer to their earlier studies (Sue & Kirk, 1972; Sue & Kirk, 1973) that delineated the tendency of Asian-Americans students to somatize their emotional conflicts. The authors found that Asian-American students had a tendency to focus on academic difficulties even when other life problems might be more threatening to the individual's emotional stability. They also speculated that the Counseling Center may be less threatening to the Asian-American students because it did not carry the same stigma of mental illness as the Psychiatric Service.

Chataway and Berry (1989), in a study conducted on Anglo-Canadian, French-Canadian, and Hong Kong Chinese university students in Canada, found that the Chinese students utilized the university counseling services as much as the non-Chinese students. The authors noted that this group of students may differ from the Asian-American populations analyzed in the other studies cited above. The Asians in this study were not citizens but foreign nationals and destined to return to their country following graduation. The authors stated that the higher than expected utilization rate was probably because the Chinese students had less contact with their families and did not experience enough social support from their friends.

Some authors have found that there is a higher occurrence of certain types of disorders among Asian-Americans than other populations in the United States. Leong (1986) noted that personality problems are more prevalent among Asian-Americans. As noted above, Sue and Sue (1974), found that Asian-American university students indicated higher MMPI elevations involving somatic complaints, family conflicts, and social introversion. When compared to European-American patients, Asian-

American patients in Seattle mental health centers were more frequently diagnosed with psychotic disorders (Sue & McKinney, 1975).

One author, Flaskerud (1986), found that there was no increase in utilization of mental health facilities when therapist and client shared similar ethnicity and language. This seems to contradict the suggestions of Yamamoto, James, and Palley (1968) and Sue (1977) that ethnic similarity of the client and therapist would increase utilization. She also found no increase in utilization when the mental health agency was located within the same community as the clients. On the surface, this appears contradictory to Chin's (1982) contention that intermediaries that traditionally work within Chinese-American communities satisfy the needs of their Chinese-American clients better than the mental health professionals that are of a different ethnic origin, speak a different language and offer services outside of the community which they are attempting to serve; however, the mental health providers assessed in Flaskerud's study were practicing Western psychology, whereas Chin (1982) was writing about Chinese traditional folk healers.

In apparent contrast to some of the findings reviewed above (Kitano, 1969; Munakata, 1989; Sue & Kirk, 1975; Sue and Sue; 1974, Tsui & Schultz, 1985), Sue and Sue (1987) have suggested that part of the differences in utilization rates is due to the overall better adjustment of Asian-Americans which has led to fewer psychological difficulties. In another study, Sue and Morishima (1982) contended that the achievement-oriented Asian-American family places relatively fewer demands on the mental health system. On the other hand, Kitano and Matsushima (1981) and Yamamoto (1981) have commented that drawing conclusions from patient populations and utilization rates does not reflect the true situation.

There may be any number of reasons why the rates are different, some of which may be due to cultural factors.

In conclusion, different researchers have found conflicting results concerning the utilization of mental health services. These differences have led to many possible explanations to account for this phenomenon. Various researchers have hypothesized differences in ethnicity between client and therapist, inappropriateness of services offered, avoidance of shame, avoidance of the stigma attached to receiving treatment, avoidance of dishonor for the individual and his/her family, and a tendency to somatize or repress psychological problems. Also noted are differences in utilization rates between females and males, fewer sessions for Asian-Americans than European-Americans, a greater rate of severe disturbances among identified clients, and an underserved population in terms of available facilities. Regardless of the possible explanations for underutilization, it continues to be a problem (Kitano, 1982; Sue, 1987; Yamamoto, 1978).

Concepts of Mental Health

Yamamoto (1978), in a brief statement concerning current research on mental health delivery for Asian-Americans, wrote that the foundations for mental health services in the U.S. are derived from the philosophy of the Western European tradition and are in direct conflict with the philosophy and traditions of Eastern cultures. He asserts that it is the values of the American therapist that preclude the utilization of Western treatment by Asians and Asian-Americans. Yamamoto stated that as Asian-Americans become more acculturated to Western values, they utilize mental health services more.

White and Marsella (1982) stated that cultural conceptions of what constitutes mental health are drawn from common sense. People apply their everyday knowledge to understand their experiences. Conceptions of what constitutes a mental disorder is thus an interpretation of behavior based on the culture in which it occurs. In the current Western view, physical, spiritual, and mental disorders are commonly viewed as separate. As with physical disorders, the difficulty in mental disorders is viewed as residing within the individual, and his or her responsibility. Traditional Asian views of health and the individual are not as separate. Causative agency resides in the individual, supernatural forces, and the social network conjointly and inseparably.

Utilizing the Mental Illness Questionnaire (MIQ) developed by Nunnally (1961), Arkoff, Thaver and Elkind (1966) studied students at the University of Hawai`i. The authors noted some differences in the concepts of mental health between the Asian and European-American students. In addition to viewing "...counseling as a directive, paternalistic and authoritarian process" (p. 219), the Asian American group placed greater emphasis on willpower and the avoidance of morbid thoughts in maintaining mental health. The authors speculated that because of "...a greater tolerance and acceptance of eccentric or deviant patterns of behavior...Asian students would be less likely to define a situation as a 'Problem' and less likely to think of obtaining assistance" (p. 222). Based on the differences in perceptions of the role of the counselor, they concluded that the Asian ancestry students were less knowledgeable about counseling and less ready to make use of counseling facilities than European ancestry students.

Also Using the MIQ, Sue, Wagner, Ja, Margullis, and Lew (1976) found that ethnicity accounted for only small portions of the variances in attitudes and beliefs about mental illness. Having predicted that ethnicity would account for a larger proportion of the variance, they attributed this finding to the lack of adequate controls in the sample. Their contention that Asian values, which stress well-defined family roles, paternal dominance, respect for parents, self-control, and restraint over strong feelings (Fong, 1973; Kitano, 1969), were reflected by the belief that mental health is enhanced by the avoidance of morbid thoughts (maintenance of self-control). They proposed that insight-oriented psychotherapy may not be effective or culturally compatible for Asian-Americans, not because they are not willing to discuss problems, but because it causes them to dwell on morbid thoughts instead of avoiding them. Mental health in Asian-Americans appeared closely allied with more traditional Asian values such as avoidance of overindulge in sex, not getting overly angry at insults, being open, not talking back to parents, and the maintenance of the traditional family roles of father making the major decisions and mother being the emotional caretaker of the children.

Okano (1976) conducted an exploratory study of attitudes toward mental health among a sample of 235 Japanese-Americans of three generations in Los Angeles. Results from a four-part questionnaire assessing cultural orientation, conceptions of mental disorders, general attitudes on mental health-related concerns, and personal data showed that Japanese-Americans did not define mental disorders in radically different ways from the general population; however, they tended to reject the personal relevance of mental health concepts, and to define mental disorders

in terms of extreme deviance. Japanese-Americans did not appear to think in Western psychological terms, and the majority denied ever having felt a need for mental health counseling. Subjects identified problems in the areas of alcoholism, drug abuse, care for the elderly, and child-rearing as their concerns which fell within the mental health field.

Uba (1982) focused her discussion of the underutilization of mental health services by Asian-Americans on whether the underutilization might be better addressed by segregated or mainstream services. In her discussion, she cited six possible sources for the underutilization. The first source was racial discrimination, as evidenced by differential treatment. The second was the difference between characteristics of Western psychology and Asian-American personality characteristics. Uba noted that the premise of Western psychological treatment is based on the willingness of the client to examine his/her problems, whereas Asians believe that thinking about a problem can be harmful (Lum, 1982). The third was that Asian cultural values inhibit Asian-Americans from seeking mental health services. For Asian-Americans, seeking help outside the family would only bring disgrace on oneself and one's family. The fourth was that many Asian-Americans face language barriers in seeking services, not only in talking to mental health professionals but also in the bewildering array of forms and paperwork that come with seeking help. The fifth was that there are shortages of Asian-American mental health workers and even fewer culturally sensitive, bilingual non-Asian mental health professionals. The final source of underutilization was lack of knowledge of existing services. In addition, there is often little link between the services and organizations

available within Asian-American communities and mainstream mental health agencies.

Uba (1982) stated that these impediments to the utilization of mental health services are not uniform among all Asian-Americans. These differences may result from different degrees of acculturation, patterns of help-seeking, personality, mental health service needs, and attitudes toward treatment of mental disorders. Uba also stated that ethnicity and its manifestations (culture) plays an important role in the development and treatment of mental disorders. One problem in providing mental health services for Asian-Americans would be how to determine when a specific subsection of a population could and would utilize mental health services. Sue and Morishima (1982) named seven sources that could contribute to the underutilization of mental health services by Asian-Americans. They named different degrees of acculturation, patterns of help-seeking, personality, mental health service needs, and attitudes toward treatment of mental disorders, cost, and hours of operation as being possible but not necessarily important factors to underutilization.

Help-Seeking Behavior and Attitudes

Factors that have been investigated regarding the mental health care of Asians and Asian-Americans include help-seeking, preferences for help providers, attitudes towards help providers, needs for health services and paths to health. Several researchers (Cheung, 1987; Cheung, Lee, & Chan 1983; Johnson, Danko, Andrade, & Markoff, 1992; Li 1983) report a relationship between cultural concepts of mental illness and attitudes towards seeking help from mental health professionals. Several studies have

suggested that in seeking treatment for most mental health problems, mental health professionals are not the first choice of Asian-Americans with more adherence to Asian values (Atkinson, Whiteley & Gim, 1990; Cheung, 1984; Christensen, 1987; Johnson et al., 1992; Narikiya & Kameoka, 1992; Sue & Morishima, 1982).

Atkinson and Gim (1989) assessed the relationship between acculturation and attitudes towards seeking mental health services in Asian-American undergraduate students of Japanese, Chinese, and Korean descent. The less Asian-identified students were more likely to recognize the need for professional psychological help, to be tolerant of the stigma associated with seeking and receiving psychological help, and to be more open to discussing their problems with a psychologist than their more Asian-identified peers. There were no significant differences in attitudes between the three different ethnic groups The authors did not find any specific effects for gender and suggested that this result might indicate that the socialization paths of Asian-American males and females with respect to utilizing psychological services may be similar. In contrast, Fischer and Turner (1970) found differences in attitudes towards seeking professional help between male and female European-American undergraduate students.

In a similar study, Gim, Atkinson, and Whitely (1990) surveyed Asian-American undergraduates to determine the relationship between acculturation and the perception of severity for 24 different problems. The authors also assessed how willing the students were to see a counselor for each problem. Problems ranged from serious psychological difficulties (e.g., depression, general anxiety, drug addiction) to problems not usually handled by counselors (e.g., general health problems, racial discrimination). They

found that financial and academic problems received the highest severity rating. The authors also found that Asian-American women expressed greater willingness to see a counselor for all problems than Asian-American men.

Narikiyo and Kameoka (1992) studied the perceived causes of mental illness and help-seeking preferences among Japanese-American and European ancestry American college students. Japanese-American students were more likely to attribute mental illness to social causes, to resolve problems on their own, and to seek help from family members, friends or both. Barriers to utilization of services endorsed by this sample of Japanese Americans included both a preference for informal resources and stigmatization of mental illness. Although Japanese-American students differed from European-American students in the perceived causes of mental illness and help-seeking preferences, there was no difference in willingness to seek professional psychological treatment for more severe or chronic difficulties.

Bourne (1975) compared a group of Chinese and Chinese-American students who were patients in a mental health clinic at a large west coast university with a group of randomly selected Chinese and Chinese-American students from the same university who were not patients at the mental health clinic. He identified several areas affected by the stress associated with acculturation which were also very resistant to change across generations: demand for excellence from the parents and families of the students, the importance and value of education and scholarship over all other individual enterprises, and filial piety, which makes it difficult for the student to discuss his/her educational goals with his/her parents. Emotional problems for

males arose mainly from establishing an identity consistent with both the individual's ethnicity and the demands of the European-based culture. Bourne found that less Asian-identified Chinese-American males had lifestyles and problems most similar to those of European-American males.

As mentioned earlier, several authors (Atkinson, Whiteley & Gim, 1990; Cheung, 1984; Christensen, 1987; Narikiya & Kameoka, 1992; Sue & Morishima, 1982) have suggested that while mental health services may be underutilized by Asian-Americans, alternative help giving resources are preferred and utilized to cope with emotional difficulties. Because many Asian-Americans tend to attribute mental illness to organic factors (Tsui & Schultz, 1985), they often present physical and somatic symptoms as chief complaints, and therefore may seek medical treatment instead of psychotherapy (Brown, Stern, Huang, & Harris, 1973; Marsella, 1982; Sue & Sue, 1974).

Liu and Yu (1985) reported that Asian Americans tend to seek help from indigenous sources before and sometimes at the same time as seeking help from mainstream mental health services. The authors stated that often the focus of treatment from indigenous sources is on physical disorders as defined by the cultural understanding of the problem as it is expressed by the patient. In the view of the authors, mental health professionals were consulted only as a last resort, and their treatments were frequently regarded as irrelevant or ineffective.

Some authors have addressed the issue of attitudes toward mental health from the aspect of inappropriateness of Western models of therapy for more traditional Asian-American clients (Kitano, 1969; Yamamoto, James, & Palley, 1968). Tsui and Schultz (1985) reported that the failure of

treatment stems directly from the therapist's unfamiliarity with salient cultural issues. In apparent agreement with other authors (Arkoff, Thaver, & Elkind, 1966), Tsui and Schultz stated that more traditional Asian-Americans expect the therapist to be an authority figure who can solve their problems as would a physician or elderly family member. The authors suggest that the therapist should be prepared to educate the client about the process and expected outcome of therapy in a sensitive manner, as well as being prepared to be flexible with many of the restrictions that Western psychotherapy training instills in therapists. They concluded that Western-style psychotherapy was very possible with Asian-American clientele if the therapist were to become familiar with Asian cultural heritage.

In contrast, Brown et al. (1973) found that insight-oriented therapy was not very effective with Chinese patients. Their conclusion was based the emphasis of insight-oriented therapy on the analysis of thoughts which might be experienced by Asian-American clients as dwelling on morbid thoughts, a practice traditionally associated with mental illness in Asian cultures (Root, 1985). The authors suggested that therapies emphasizing direct problem-solving techniques, self-help, and involvement of family and friends may be more effective with Asian-Americans.

Lin, Inui, Kleinman, Womack (1982) conducted a study of the sociocultural determinants of help-seeking behavior of patients diagnosed with mental illness. The authors reported that help-seeking patterns of 48 outpatients of Seattle health care facilities differed by ethnicity. Asian-American patients consistently had a pattern of persistent family involvement, extensive utilization of the traditional, medical health care system, and long delays in seeking out mental health professionals even after

being referred by a physician. The authors also found that a referral by non-psychiatric health professionals and by friends or relatives who had previous contact with mental health professionals appeared to an essential factor in the help-seeking process.

Oumoto and Gorsuch (1984) examined referral patterns, attitudes and social norms of 106 Japanese Americans in response to psychological disorders as described in four vignettes (paranoid schizophrenia, major depression, agoraphobia, and family problems). Subjects responded to the vignettes with two possible solutions and estimates of the likelihood that they would utilize each solution. Results indicated that non-psychiatric health referrals were reported more frequently than referrals to mental health professional referrals. Although subjects' attitudes toward seeing a psychologist were mostly favorable when this option was presented, seeing a psychologist was rarely listed as either the first or second solution. Talking to family and friends were solutions listed as frequently as seeing mental health professionals. This appeared in contradiction to previous findings (Chen, 1977; Lin et al., 1978) and may have been due to the subjects seeing the intended referral for someone else instead of for themselves.

Suan and Tyler (1990) investigated underutilization of mental health services as a function of mental health values and provider preferences by comparing 90 Japanese American undergraduate students at the University of Hawai`i to 91 European-American students at the University of North Dakota. European-American students chose mental health professionals for help for serious problems while Japanese American students preferred close friends.

Preferences for Help-Givers

Webster and Fretz (1978) polled undergraduate students from five groups; international students, European-Americans, African-Americans, Asian-Americans, and Latinos/Latinas. The subjects were asked to rank order 12 types of help-givers for academic/vocational and personal/emotional problems. Rankings for the help-giving sources for either category of problem did not vary significantly by subgroup or gender. For educational/vocational problems, the top choice of both Asian- and European-American undergraduate males was parents. University counseling center personnel were ranked fifth by Asian-American males and third by European-American males. For Asian- and European-American females, the top choice was also parents. Asian-American females ranked university counseling center personnel third while European-American females ranked them fifth. For emotional problems, the top choice of both Asian-American undergraduate males and females was relatives while both European-American undergraduate males and females ranked parents as their top choice. Asian-American females ranked university counseling center personnel fourth and their male counterparts ranked them sixth. Exactly the reverse ranking occurred for European-Americans: females ranked university counseling center personnel sixth and their male counterparts ranked them fourth. Notable in this study was the consistently low ranking of private practice psychotherapists as the least preferred in all categories by all groups.

The data also indicated that Asian-American males and females ranked relatives above parents as the first choice in seeking help for an emotional problem. The authors maintained that the shame associated with

emotional problems might prevent Asian-American students from seeking help from their parents. Seeking help from relatives would keep knowledge of the problem within the family but be less disturbing to a relative than a parent. This was different from the other subgroups which reversed the order of these first two choices; however, there were no other significant differences in rankings between ethnic groups. The authors suggested that attending college may precipitate a change in reference groups and a greater degree of acculturation into the mainstream, European-American influenced society.

Atkinson, Whitely, and Gim (1990) surveyed Asian-American undergraduate students to assess the connection between their level of acculturation and preferences for help providers. Acculturation was measured with the Suinn-Lew Asian Self-Identity Acculturation Scale (SL-ASIA; Suinn, Rickard-Figueroa, Lew, & Vigil, 1987). Less Asian-identified respondents were assumed to be more Western-acculturated. The researchers found that less Western-acculturated students preferred counselors and psychologists, while more Western-acculturated students preferred friends as a source of help. There was also strong support for preferring a same sex helper within this population. The authors attribute the findings to the tendency for more Asian-identified students to assign greater credibility to authority figures and less to peers as compared to the more Western-identified students. These findings appear to be at least partially in agreement with Webster and Fretz (1978).

Atkinson, Maruyama, and Matsui (1978) assessed the ratings by Asian-Americans of a counselor's performance in a contrived counseling session. The subjects were university students and Japanese-American

members of the Young Buddhist Association. Participants were asked to listen to an audio tape depicting either a "directive" or a "non-directive" approach to psychological counseling. In addition, participants were also told that the counselors were either Asian-American or European-American, thus producing four conditions available for random assignment. The university students found the counselor more credible and approachable when he was perceived as an Asian-American than as a European-American, while the Japanese-American Young Buddhists did not perceive a difference in the approachability and credibility of the counselors. The authors note that the results point to differing views within the Asian-American community. They cautioned that asking a subject to listen to a tape is a different task than asking the subject to sit in a room and undergo counseling with a therapist. Because there was a preference for an Asian-American counselor as opposed to a European-American counselor among university students, the availability of an Asian-American counselor may influence the students' help-seeking behavior. Participants were questioned about perceived credibility of counselors which, although affecting the initial help-seeking behavior of the students, may not entirely negate counselor effectiveness for those students who do receive counseling from European ancestry counselors.

Tracey, Leong, and Glidden (1986) analyzed the presenting problems of university counseling center clients in Hawai`i as they varied by ethnicity, gender, and previous counseling experience. Asian-American clients were more likely to see themselves as having educational or vocational concerns, whereas the European-Americans were most likely to express personal or emotional concerns. The tendency of the Asian-Americans to endorse an

academic or vocational problem was less if the individual had previous counseling experience. The Filipino-American and biracial groups were most like the European-American group in the frequency of their endorsement of personal or emotional concerns. Despite these differences, the authors considered the Asian-American groups to be similar and significantly different from the European-American group in the type of presenting problem endorsed.

The authors found support for their hypothesis that Asian-Americans seek help in a different manner than European-Americans. They proposed that when Asian-Americans and European-Americans are subjected to the stresses associated with life in the university environment, the two groups focus on different problems. The authors proposed that Asian-Americans may be more sensitive to the stigma attached to expressing personal or emotional problems and more likely to focus on academic concerns if they perceive themselves as having personal difficulties. The authors also found that females and those with previous counseling experience were more likely to identify their problems as being personal/emotional in all ethnic groups in this sample.

Chataway and Berry (1989) conducted a study of university students in Canada to assess coping styles, psychological health, and satisfaction with their coping abilities. In a sample comprised of Chinese, French Canadian, and English Canadian students, the researchers found that the Chinese students possessed greater levels of trait anxiety, more perceived prejudice, adaptation and communication problems, lower English language competence, and lower perceived social support than their aforementioned counterparts. They responded to their problems with less positive thinking

and fewer tension-reducing coping strategies. Contrary to the expectations of the authors, the Chinese students used the counseling and academic advisors as often as the French and English speaking Canadian students. The authors speculated that this is probably due to the fact that the Chinese students had less frequent contact and therefore less support from their families. They went on to suggest that the higher anxiety scores of the Chinese students may also be the result of family separation. They noted that health and life satisfaction seem to be linked to social support. Another significant finding of this study was that Chinese students tended to report higher levels of stress and thus less support from friends than their French and English peers. As a consequence, the Chinese students made substantially more use of student counseling services. Despite the aforementioned stressors by the Chinese students, their academic performance did not appear to suffer. Chinese students in this study experienced more negative adaptation outcomes, in the form of greater psychological and physical distress and lower coping satisfaction. In summary, these studies suggest that in some cases Asian-American student populations have different help-seeking behaviors from their European-American peers; however, these differences are not always well defined.

Help-Seeking Behavior in Non-Student Populations

Studies on non-student Asian-American populations are more rare because of the relative inaccessibility of the subjects. Because Asian-Americans underutilize mental health services, they are less available for assessment. The studies in this section included efforts to delineate the chain of events which lead to treatment in mental health facilities, as well as

the preferences for mental health care providers. These studies are reviewed to shed more light on the underutilization phenomenon.

Several researchers have studied the preference for help providers and usage of mental health facilities in non-student Asian and Asian-American populations. While most of the studies utilizing students as subjects relied mainly on self-report measures (Atkinson & Gim, 1989; Atkinson, Whitely, & Gim, 1990; Chataway & Berry, 1989; Cheung, 1984; Gim, Atkinson, & Whitely, 1990; Webster & Fretz, 1978), the studies assessing the more general Asian and Asian-American populations have mostly used archival data and interviews (Kinzie & Tseng, 1978; Kitano, 1970; Lin, Inui, Kleinman, & Womack, 1982; Sue, 1977).

Kinzie and Tseng (1978) studied psychiatric clinic usage in Hawai`i by comparing a clinic population with the general population. They found that European-Americans were overrepresented and other groups, especially Japanese-Americans were greatly underrepresented. There was also a difference in the presenting problems. European-Americans most often presented with anxiety or depression, while Asian-Americans and Pacific Islanders usually were referred following the onset of a severe mental illness. The authors concluded that mental health agency usage was greatly affected by ethnicity. European-Americans were perceived as utilizing mental health care more readily than other groups, who seem to use the facilities only in a crisis situation. Although they had no assessment of adherence to cultural values, the authors reasoned that cultural values played an interactive role with ethnicity in determining utilization. They observed that European-American culture values independent action to solve one's problems. Consequently, most of the European-American patients were self-

referred with less family interaction. The Asian-American patients, whose culture values keeping individual difficulties within the family, were brought to the clinic by concerned relatives only after every other means of remediation had been exhausted and the patients were in a severely decompensated state. Stigma and shame were suggested as the primary motivating factors that contribute to the underutilization of mental health facilities by Asian-Americans.

Kitano (1970) compared the use of mental health facilities, demographic data, and pre-symptom conditions of Japanese and Japanese-Americans in Los Angeles, Hawai`i, Okinawa, and Japan. Interviews were conducted with subjects diagnosed with schizophrenia. The author found that differences in the recognition and treatment of the disorder varied by acculturation to the American norm and by locality (i.e., urban or rural). He also found that the first source of assistance was the family. Psychiatrists were sought out most often in Hawai`i and Okinawa, to a lesser extent in Los Angeles and not at all in Japan. No one source of assistance was consistent across all sites. The author concluded that acculturation to Western values was not very important in the process of recognition and treatment of mental illness with Japanese and Japanese ancestry clients.

Sue (1977) summarized the results of an analysis of client records of the entire metropolitan mental health care system in the city of Seattle. He concluded that Asian-Americans were several times underrepresented in comparison to other ethnic groups in this study, indicating that Asian-Americans underutilize mental health services. The Asian-American clients were significantly older than the clients in other groups. Also, over half of the Asian-American clients failed to return for treatment after the first

session. Sue suggested that this is an indication that Western mental health practices do not fit the Asian expectations. Other reasons listed by Sue that may have contributed to the high dropout rate by Asian-Americans and echoed by Uba (1982) and Sue and Morishima (1982) included cost, inconvenient times for therapy, and perceptions of racial discrimination.

Lin, Inui, Kleinman, and Womack (1982) administered a structured interview and a questionnaire to hospital patients with mental disorders to determine the sociocultural elements of the help-seeking process. They divided the process into two stages, recognition of the symptoms and contacting someone for assistance. They found that the help seeking process correlated strongly with ethnicity factors. Among the three groups (Americans of Asian, African, and European descent), Asian-Americans showed the longest delay from onset of symptoms to first contact with professionals of any of the groups. The Asian-American subjects also had the greatest amount of family involvement throughout the help-seeking process. As other researchers have discovered (Chin, 1982; Lin, Tardiff, Donetz, & Goresky, 1978), the health professional is often the first contact when the symptoms such as headache, stomachache, indigestion, and chest pain are recognized as serious enough to warrant outside intervention. These authors found no reason to believe that the delay in seeking help was attributable to degrees of modernization, parochialism, or alienation. They did attribute some of the delay to the tendency of the Asian populations to somatocize and thus repeatedly seeking other forms of treatment (i.e., from traditional folk herbalist or medical doctor) before contacting a mental health professional. These authors also cautioned that the data was collected retrospectively and relied on the memory of the subjects. Ethnicity referred

to in these articles was an indication of country of origin of ancestors and not a systematic measurement of social and cultural attitudes and behaviors.

Takeuchi, Leaf, and Kuo (1988) explored the differences among Native Hawaiians, European-, Filipino-, and Japanese-Americans in their perception of barriers to help seeking. Adult residents of the state of Hawai`i were interviewed concerning the perceived barriers to help-seeking for two problems, alcoholism and severe emotional problems. The major finding of the study was that European-Americans perceived fewer barriers (e.g., shame, stigma, cost knowledge of services) than other ethnic groups studied. They also found that gender and marital status did not relate significantly to perceived barriers for either problem. Lower income people (less than $5,000.00 per year) generally perceived more barriers for both types of problems. People with lower educational backgrounds tended to perceive fewer barriers. People in the age ranges of 18 to 24 and over 65 also anticipated more perceived barriers for both types of problems. There were significant variations in the perceptions of barriers for alcohol or emotional problems by ethnicity even when levels of formal education, income, age, gender, and marital status were controlled. The authors asked the participants to identify the barriers which inhibit help-seeking. Four major barriers were delineated: cost, availability, accessibility, and stigma associated with treatment.

Shame was a major barrier for all ethnic groups for both types of problems, but perceived barriers were more evident for alcohol problems than for emotional problems. The authors stated that removing structural barriers to utilization (e.g., awareness of services and cost) may not sufficiently reduce the perceived barriers to help-seeking (e.g., shame and

stigma) among ethnic minorities. This means that these perceived cultural barriers would continue to affect utilization even if all structural impediments were removed.

Christensen (1987) conducted a study in Canada which utilized a self-report survey to examine the nature and frequency of problems of Chinese immigrants in Montreal. A 43-item questionnaire was prepared to assess two categories, interpersonal/interactional problems and personal/ psychological problems. Results indicated that the family was the preferred source of assistance for most problems, followed by friends. The only other source of assistance, selected by only one subject, was that of mental health workers in community agencies. All sources of help selected by the respondents involved Chinese helpers. There were no significant differences between genders. A large portion (87%) knew of Chinese community services that could operate as help-giving sources, but only 48% had actually used these resources. Fewer respondents (27%) knew about the mainstream resources, and even fewer actually utilized them (3%).

The most frequently perceived problems for these subjects (mean age of 40) was "homesickness" and "worrying about relatives back home." These Chinese immigrants reported rarely experiencing the problems that European ancestry individuals present when seeking professional help. Most of the subjects felt that they were in control of their feelings and that even if they were experiencing potentially serious problems, they would prefer to see "no one" before seeking professional help. The author speculated that this group was not willing to use professional services because of the nature of the perceived problems, the nature of the help offered, and the structure of the agencies which offer help. The author cautioned that her findings would

not represent Chinese people as a whole because the population is not homogeneous, with extreme variations depending on several factors such as generation of individual since immigration, region of origin of the family in China, and language capabilities.

Although the concerns and foci of non-student populations might be somewhat different from the concerns of undergraduate students, it provides a basis of comparison for this study.

Avoidance of Help-Seeking

Amato and Bradshaw (1985) asked 24 males and 43 females between the ages of 14 and 72 years to rate the degree to which 25 motives contributed to their decision to delay or avoid seeking help for a distressing personal problem. The motives were identified separately in a pilot study with 30 other subjects. The authors found five general clusters of motives to avoid help-seeking: fear and stigma, problem avoidance and denial, helper evaluation, external barriers, and independence. Subjects who rated the fear and stigma items highly had problems that were seen as being intimate and internally attributed. Females were more likely than males to report problem avoidance and denial motives. Subjects with an external locus of control were somewhat more concerned with helper evaluation and external barriers, and somewhat less concerned with independence, than were subjects with an internal locus of control. This suggests that because females are more internally focused they will be more concerned with independence and demonstrate a higher degree of stigma and fear against seeking help from mental help professionals. By the same reasoning, Males are more likely to

be concerned with the external barriers and evaluation by the mental health professional.

Robbins and Greenley (1983) conducted a survey of university students to determine how subjective evaluations of severity, duration, and attributions of the cause of emotional problems, in addition to previous experience with mental health care, affected the decision to seek help from a mental health professional. The authors found that subjects who rated their problems as restrictive to their daily activities and their emotional stability, who saw themselves as responsible for their difficulties, or who had previous experience with mental health care were more likely to seek help from mental health professionals. Robbins and Greenley stated that their results suggest that clinical populations differ from non-clinical populations in both the level of severity of the difficulty and the personal meaning attributed to the problem. They contended that focusing exclusively on identified patients does not help researchers learn the patterns of those who do not seek help. The authors cited several reasons why this may be the case. First, people may act on problem definitions that might not be accurate. Second, personal and emotional problems are ambiguous and unfamiliar enough to the individual to lead to erroneous assumptions concerning severity, duration, and cause. Third, if personal inadequacy is accepted by the individual, the individual is less likely to expose that inadequacy to another individual. Fourth, lay advice may be crucial to the individual's understanding of the problem and may help attenuate the difficulties by normalizing them, emphasizing their inappropriateness for the situation, or helping to determine cause, duration, and approximate disruption of normal life. The authors conclude their discussion by noting that those have

previous experience with therapy and who define their problems as internally caused and disruptive to daily activity are already receptive and inclined to the idea of seeking help. We know little about those who do not have the same cognitive attributions.

Simoni, Adelman and Nelson (1991) researched which factors differentiated those who do and do not use mainstream psychological services. Seeking help from mental health professionals was associated with internal attributions for finding a solution suggesting that assuming personal responsibility was necessary to find a solution. Students surveyed in this research expected only cognitive help from mental health professionals but expected both affective and cognitive help when they sought help from family, friends and other non-professional sources.

In an exposition about reluctance to participate in the psychotherapeutic process, DeGood (1983) suggested that a significant portion of patients were reluctant to participate in an intervention strategy when the strategy was perceived as psychological rather than medical. He outlined several strategies for dealing with reluctance and enumerated some of the more common forms that reluctance to participate in psychological therapy has taken., failure to make an appointment and cancellation of previously arranged appointments being the most common forms. DeGood wrote that anger and resentment were usually the immediate consequences of a referral to a psychologist by a medical doctor or other health professional. The message to the individual is likely to be "The problem is in your head." If the resultant behavior is interpreted as an attempt to maintain self-esteem, then the individual would probably feel compelled to

prove his or her sanity rather than to consider the prospect of psychotherapy as the release from their difficult situation.

Summary

Underutilization of mental health services by individuals of Asian ancestry has prompted many researchers and authors to determine the reasons behind this phenomenon. Much of the research suggests cultural differences. Previous research to explore differential utilization has used various methods to assess adherence to cultural norms. The determination of what constitutes an ethnic or cultural identity has evolved considerably over the past decades. Although most research and writing assumes that acculturation is linear and bipolar, some authors have suggested that there might be a number of solutions to the process of attaining and maintaining a cultural identification. Determining the impact of the degree cultural identification on the utilization of mental health services has involved assessing preferences for caretakers, attitudes towards caretakers, and differences in concepts of mental health. Avoidance of mental health services has been studied in non-patient populations to determine the characteristics of help-seeking and how individuals conceptualize their problems.

CHAPTER III
STATEMENT OF PROBLEM AND HYPOTHESES

Rationale

As the above discussion indicates, many researchers have attributed differences in utilization rates for mental health services between Asian Americans and European-Americans to Asian cultural influences. The evaluation of help-seeking attitudes and preferences has led to an impressive list of Asian American cultural values which may account for these differences: bringing dishonor to the family name, avoiding shame and disgrace of admitting mental health problems, self-imposed restraint and control of emotion (Root, 1985; Sue & Kirk, 1975), conformity to the family or community (in contrast to Western values which encourage individualism and independence) (Sue & Morishima, 1982), deference to authority, strong family bonds, well-defined role expectations, and a pragmatic view of life (Tsui & Schultz, 1985).

Concepts of mental illness also appear to vary greatly between Asian-Americans and European-Americans (Leong, 1986; Marsella, 1982; Sue et al., 1976). These authors contend that many Asian Americans will exhaust all internal resources before turning to outside help. When outside help is sought for personal problems, family or close friends are preferred over professionals (Cheung, 1984). Previous studies have also reported that, among Asian-Americans, women are more willing than men to seek

professional help for emotional problems (Arnemann, 1993; Fischer & Turner, 1970; Gim, Atkinson, & Whiteley, 1990; Suan & Tyler, 1990; Tracey et al., 1986).

On the surface these previous findings suggest that a comparison between ethnic groups of the reasons for avoiding help would produce significant differences. The literature suggests that the degree to which an individual is acculturated to Western values is also an influence on help-seeking and preference. Acculturation, as one of the possible outcomes of the ethnic identity formation process, functions for Americans of European heritage as well as for members of other groups. Instead of comparing responses based solely on ethnicity, the comparison of responses to avoid help-seeking in the present study included level of adherence to ethno-cultural attitudes and behaviors as well.

Some of the studies reviewed found differences between ethnic subgroups of Asians and Asian-Americans in the types of problem presented (Tracey, Leong, & Glidden, 1986), preferences for ethnicity of counselor (Arnemann, 1993; Atkinson, Maruyama, & Matsui, 1978), and perceptions of barriers to help-seeking (Takeuchi, Leaf, & Kuo, 1988). One study found no intra-ethnic differences in help-seeking attitudes (Atkinson & Gim, 1989). Another classificatory variable that appears to produce different results from study to study is gender. Arnemann (1993), Cheung (1984), and Gim, Atkinson, and Whitely (1990) found differences between the help-seeking behaviors of males and females while Atkinson and Gim (1989), Tracey, Leong, and Glidden (1986), and Webster and Fretz (1978) did not. Persons of Asian heritage do not belong to a single cultural group. Rather, this group consists of individuals with different degrees of ethno-cultural

identification and different cultural heritages. Many studies use samples combining several Asian-American groups that are perceived as sharing similar characteristics; however, there are at least 29 distinct subgroups of Asian-Americans with significant cultural differences (Yoshioka, Tashima, Chew, & Murase, 1981). In a similar manner, persons of European ancestry also have diverse heritages. The consolidation of ethnic groups into larger groups becomes a necessity when the restrictions of sampling and statistical techniques were considered.

The sample in this study included males and females from both Asian and European origins. Adherence to ethno-cultural attitudes and behaviors was assessed by the Multi-Ethnic Identity Measure developed by Phinney (1992) which provides for usage by any English speaking group. While Phinney (1992) utilized Rosenburg's (1986) scale to assess self-esteem, this study measured self-satisfaction by a less direct and less culture-dependent method. Rosenburg's (1986) scale may be subject to extreme cultural bias because the questions are direct and based on the more Western-based notion of reinforcing the individual as a distinct and separate entity (Markus & Kitayama, 1991).

Classificatory variables were evaluated by demographic characteristics, utilizing a demographic questionnaire (Hollingshead & Redlich, 1958). Independent variables included the ways in which the individual interacts with the available cultures, utilizing the Multi-Ethnic Identity Measure (Phinney, 1992), the overall conceptions of cultural values, utilizing the Individualism/ Collectivism scale (Triandis, McCusker, & Hui, 1990), the congruence of self image, utilizing a semantic differential evaluation of self-esteem or self-satisfaction (Osgood, Suci, & Tannenbaum,

1957), and the attitudes towards seeking help from mental health professionals, utilizing the Attitudes Toward Seeking Professional Help Scale (Fischer & Turner, 1970). The dependent variables in the hypotheses were based on a factor analysis of the reasons for avoiding seeking help from mental health professionals (Amato & Bradshaw, 1985). The dependent variables in subsequent analyses included the total attitude towards seeking help from mental health professionals score, each of the four factors of which the total attitude score is comprised.

Hypotheses

1. Based on findings of Amato and Bradshaw (1985), it is hypothesized that males will rank order reasons attributed to external barriers to seeking help from mental health professionals (money, availability) and fear of evaluation by the mental health professional higher than females regardless of ethnic identity or self-satisfaction.

2. It is hypothesized that females with high self-satisfaction and high ethnic identity will rank order reasons attributed to denial and problem avoidance higher than males regardless of self-satisfaction or ethnic identity.

3. It is hypothesized that females with high level of self-satisfaction and high ethnic identity will rank order reasons attributed to denial and problem avoidance higher than females with low self-satisfaction and low ethnic identification.

4. It is hypothesized that males regardless of ethnic identity or self-satisfaction will rank order reasons attributed to denial and problem avoidance higher than females with low self-satisfaction and low ethnic identification.

5. It is hypothesized that males with low ethnic identity and high self-esteem will rank order reasons associated with denial and problem avoidance higher than males with low ethnic identity and low self-esteem, and males with high ethnic identity, regardless of self-esteem.

CHAPTER IV
METHOD

Participants

The 330 participants were solicited through flyers distributed on the campus of the University of Hawai'i at Manoa, through course instructors at Kapiolani Community College, Honolulu Community College, University of Hawai'i at West O'ahu, Hawai'i Pacific University, and the University of Oregon, and through the Psychology Department subject pool at the University of Oregon. Two of the returned measures were incomplete unable to be analyzed, resulting in 328 usable surveys. Demographic characteristics are displayed in Table 1.

Measures

Demographic Questionnaire (DQ)

The Demographic Questionnaire (Hollingshead & Redlich, 1958), is designed to obtain information concerning the age, sex, educational level, occupation, and marital status of the main provider of the household. To make the DQ more appropriate for cross-cultural comparisons, Ho (1995) modified the DQ to include additional questions concerning family constellation, language and ethnic background. The DQ is presented in Appendix B.

TABLE 1

LIST OF DEMOGRAPHIC VARIABLES, FREQUENCIES AND PERCENTS

Variable	N	%
Place		
Oregon	178	54
Hawai'i	150	46
Total	328	100
Gender		
Male	129	39
Female	199	61
Total	328	100

TABLE 1 -- Continued.

Variable	N	%
Age (at last birthday)		
17	4	1
18	84	26
19	68	21
20	51	16
21	26	8
22	20	6
23	8	2
24	10	3
25	10	3
>25	47	14
Total	328	100
Marital Status		
Single	291	89
Married	22	7
Divorced	13	4
Widowed	1	<1
Missing Data	1	<1
Total	328	100

TABLE 1 -- Continued.

Variable	N	%
Father's Level of Education		
No Formal Education	7	2
Some Elementary School	3	<1
Completed Elementary School/Equivalent	2	<1
Some High School	15	5
High School Graduate/Equivalent	51	16
Some College	75	23
Hold Bachelor's Degree/Equivalent	89	27
Some Graduate School	19	6
Hold Master's Degree/Equivalent	36	11
Hold Doctoral Degree/Equivalent	31	9
Total	328	100

TABLE 1 -- Continued.

Variable	N	%
Mother's Level of Education		
No Formal Education	9	3
Some Elementary School	4	1
Completed Elementary School/Equivalent	10	3
Some High School	7	2
High School Graduate/Equivalent	65	20
Some College	81	25
Hold Bachelor's Degree/Equivalent	90	27
Some Graduate School	11	3
Hold Master's Degree/Equivalent	39	12
Hold Doctoral Degree/Equivalent	12	4
Total	328	100

TABLE 1 -- Continued.

Variable	N	%
General Ethnic Group		
Asian	100	30
Pacific Islander	3	1
European	170	52
African American	3	1
Latino/Latina	3	1
Native American/ Eskimo	2	1
Mixed	47	14
Total	328	100

Attitudes Towards Seeking Professional Help Scale (ATSPHS)

The Attitudes Towards Seeking Professional Help Scale (Fischer & Turner, 1970) is a 29 item scale that assesses help-seeking behaviors and preferences of college students. It consists of four subscales. The first is Need which assesses the individual's recognition that he or she requires help. The second is Stigma which assesses the individual's tolerance of negative evaluations associated with seeking help. The third is Openness which assesses the ability of the person to be open about his or her problems. The fourth is Confidence which assesses how sure the individual is that the helper will be of assistance. Items are rated on a four point Likert-type scale with bipolar ratings (i.e. 1= strongly disagree to 4=strongly agree). Higher scores indicate a more positive attitude toward seeking help. The authors reported that the internal consistency of this scale is .86 and test-retest reliability is .83. The ATSPHS was amended for this study to make it more appropriate for use with the population examined. The words *psychologist or counselor* were substituted for *psychiatrist*, and *counseling center* was substituted for *mental health center* (Atkinson & Gim, 1989). As in Arnemann (1993), five questions of relevance to this study were added. The ATSPHS, as modified, is presented in Appendix C.

The Multigroup Ethnic Identity Measure (MEIM)

The initial version of the Multigroup Ethnic Identity Measure (Phinney, 1992) was developed to assess ethnic identity search and commitment. The final version of the scale assesses three aspects of ethnic identity: positive ethnic attitudes and sense of belonging; ethnic identity achievement, including both exploration and resolution of identity issues;

and ethnic behaviors or practices. Also included in the questionnaire are six items assessing other-group orientation. Although attitudes and orientation toward other groups are conceptually distinct from ethnic identity, they may interact with it as an aspect of one's social identity in the larger society. These items are also included to provide contrast items to balance the ethnic identity items. After three revisions, the scale was found to have the following reliability characteristics in a college sample, Cronbach's alpha of .90 for the overall scale, .86 for the Affirmation/belonging subscale, .80 for the Ethnic Identity Achievement subscale, and .74 for the other-group orientation subscale. No reliability data is reported for the Ethnic behaviors subscale.

Items are rated on a 4-point scale from strongly agree to strongly disagree. Scores are derived from reversing the negatively worded items, summing across items, and obtaining the mean; scores range from 4 (indicating high ethnic identity) to 1 (indicating low ethnic identity). In cases where subjects have missing items, means are calculated on the nonmissing items. Additional items, not part of the score, assess self-identification and ethnicity of parents. The MEIM is presented in Appendix D.

Semantic Differential Self-Esteem Instrument

This semantic differential instrument is based on the differences in ratings on bipolar scales related to self-worth. Each subject was asked to rate the "ideal me" and the "real me" for twenty-four sets of bipolar adjectives. The square root of the sum of the squared difference between the two scales is an indication of self-worth with greater differences indicating

lower evaluation of self-worth and consequent lower self-esteem. This method is based on Osgood *D* scores (Osgood, Suci, & Tannenbaum, 1957) with a semantic differential scale. The 24 bipolar scales used in the present study were selected from Semantic Differential items used in two previous studies (DeWolfe, DeWolfe, & McNulty, 1972; Johnson, Petzel, DuPont, & Romano, 1982). There are three forms of the Semantic Differential and each form consisted of a different concept to be rated: (1) "Swan" (as practice); (2) "Ideal Me" (how I would like to be); and (3) "Real me" (how I am now). The Semantic Differential Self-Esteem Instrument is shown in Appendix E.

Individualism-Collectivism Scale (ICS)

The Individualism-Collectivism Scale was developed by Triandis and his associates (Triandis, McCusker, & Hui, 1990) with the collaboration of researchers from nine countries. The scale consists of 14 of the original 63 questions of the Individualism-Collectivism Scale (INDCOL) developed previously by Hui (1988). Responses to the 14 items are rated on a 9-point scale ranging from strongly agree to strongly disagree. Odd-numbered items are components of the collectivism portion of the scale and the even-numbered items comprise the individualism portion of the scale. ICS total score is obtained by subtracting the total of the collectivism items from the total of the individualism items. The ICS is shown in Appendix F.

Scenario and Q-Sort

The scenario is based depressive symptomatology and similar to one of a the scenarios used in a study of help-provider values conducted in Hawai`i by Johnson et al. (1992). The reasons for avoiding therapy were

obtained by presenting the scenario to seven mental health professionals and asking them to list all the reasons which they think a person avoiding therapy might voice. Instructions for the Q-sort requests respondents to sort the 30 reasons for avoiding therapy among 7 categories, ranging from those with which they disagree most to those with which they agree most. A forced distribution (2,3,6,8,6,3,2) is used for the sort. Thus, the respondent is ranking the set of reasons for avoiding therapy according to the characteristic of the client. The Q-sort is a criterion-referenced test because the respondent describes his or her reaction to the scenario without reference to a normative scale; the pattern of placements of the reasons becomes the identification of the respondent's values and consequent behavior instead of scales devised by the researcher. This also compensates for a "no differentiation" response in which a subject might rate all reasons the same (e.g., all reasons might have a "4" circled on a 7-point Likert-like scale). The Q-Sort scenario and reasons are shown in Appendix G.

Informed Consent and Debriefing Forms

The informed consent form for subjects participating in the research and the debriefing statement are shown in Appendices A and H respectively.

Procedure

Each participant received the same form of the questionnaire. Once participants received questionnaires, they were able to complete them at their own convenience. Because each measure included instructions as part of the measure, no further instructions were given. Each packet included the consent form, the six self-report measures, and the debriefing letter.

Participants were instructed not to place their names on any of the measures or on the manilla envelope in which the measures came. The questionnaires took approximately 60 minutes on the average to complete. Participants placed the completed questionnaires back into the manilla envelopes provided and returned them to the classrooms, residence hall front desks, or the counseling center reception areas where they had received them. Participants who desired feedback regarding the results of the study put their address on a 3 inch by 5 inch card and returned the card separately from the questionnaires. All measures were filled out in complete confidentiality and anonymity.

CHAPTER V
RESULTS

Preliminary Analyses

Of the 328 subjects who completed the survey, 300 subjects completed the Q-sort of the reasons to avoid help seeking portion of the survey correctly. The relative rankings, means, standard deviations and modes for each of the reasons is shown in Table 2 and based only on those surveys completed correctly. The reasons were then evaluated by factor analysis utilizing an iterated principal axis factor extraction. Transformation was by varimax method. This yielded five significant factors with eigenvalues greater than one. A visual scan of the scree plot confirmed this decision. Composition of the factors is illustrated in Table 3.

Reasons to avoid seeking help used in this study were based in part on reasons generated by Amato and Bradshaw (1985) and by consultation with several counselors from two different university counseling centers. Because reasons were ranked by the subjects utilizing a Q-sort method to determine which would be most representative of the participant's efforts to avoid help-seeking, the resulting factor structure of reasons to avoid seeking help was somewhat different in this study from the relationships found by Amato and Bradshaw. Reasons with insufficient factor loadings (less than .300) in the final solution matrix were not included in the subsequent analyses utilizing factor scores as dependent measures.

TABLE 2

RELATIVE RANKING OF REASONS TO AVOID SEEKING HELP

	Rank	M	SD	Mode
If other people can overcome their difficulties, so can I	1	2.936	1.327	3
I can solve this using willpower and positive thinking	2	3.015	1.523	3
I would get more understanding from my friends	3	3.055	1.447	3
I can figure out new behaviors that will get me out of my old ways	4	3.137	1.362	3
I think that there are better methods of dealing with my problem	5	3.424	1.448	4
If I can wait this out, it will eventually go away	6	3.476	1.343	4
I am afraid to find out that I am worse off than I thought	7	3.555	1.606	3
I can't afford therapy	8	3.598	1.762	4
It is difficult to work counseling into my schedule	9	3.622	1.326	4
The counselor might suggest that I have long term counseling	10	3.643	1.331	4
I don't want to admit I have problems	11	3.851	1.467	4
If I focus on this problem, it may get worse	12	3.909	1.452	4
The counselor might think that I will need medication	13	4.052	1.292	4
I don't think the counselor will understand my problem	14	4.095	1.370	4
I don't know anyone at the counseling center	15	4.101	1.477	4
I work and have classes all day and the counseling center is closed at night	16	4.146	1.503	4

TABLE 2 -- Continued.

	Rank	M	SD	Mode
What if one of my friends sees me coming out of the counseling center?	17	4.174	1.489	
It would affect my career possibilities	18	4.201	1.312	4
My partner (boyfriend/girlfriend, wife/husband) would not understand and may disapprove of me	19	4.213	1.479	4
I don't think the counselor will understand the influence of my culture on my problems	20	4.308	1.379	4
The counselor will think that I might need hospitalization	21	4.308	1.540	4
People will think that I am crazy	22	4.354	1.501	4
I don't have insurance	23	4.412	1.631	4
I don't know where the counseling center is	24	4.421	1.522	4
I don't believe other people can help me	25	4.491	1.570	5
I am afraid to talk to strangers	26	4.619	1.571	5
It is too shameful for me to see a counselor	27	4.683	1.398	5
My family's reputation would be damaged by my actions	28	4.686	1.480	4
I think that the counselor will tell others	29	4.899	1.403	5
I might get kicked out of school	30	5.201	1.441	5

TABLE 3

FACTOR STRUCTURE FOR 30 REASONS TO AVOID THERAPY

	Factor Loading
Factor 1: Independence	
I can figure out new behaviors that will get me out of my old ways	.745
I can solve this using willpower and positive thinking	.727
Factor 2: External Barriers	
I can't afford therapy	-.649
I don't have insurance	-.840
Factor 3: Negative Helper Evaluation	
I don't believe other people can help me	-.415
The counselor might suggest that I have long term counseling	.549
The counselor might think that I will need medication	.673
The counselor will think that I might need hospitalization	.741
Factor 4: Fear and Stigma	
It would affect my career possibilities	.808
My family's reputation would be damaged by my actions	.369
Factor 5: Problem Avoidance and Denial	
I am afraid to find out that I am worse off than I thought	.695

Influences on Barriers to Seeking Help

Hypothesis 1 predicted that males would rank reasons attributed to external barriers and fear of evaluation by mental health professionals more highly than females. External barriers was the most appropriate title for factor two (i.e., "I can't afford therapy," "I don't have insurance") and negative helper evaluation appeared to best fit factor three (i.e., "I don't believe other people can help me," "The counselor might suggest that I have long term counseling," "The counselor might think that I will need medication," "The counselor will think that I might need hospitalization"). Because factors two and three related to hypothesis 1, they were tested by a one-tailed t-test; all other comparisons across gender were by two-tailed t-tests.

An independent groups, one-tailed, unpaired comparison t-test of factor two, "external barriers," revealed that there was not a significant difference between the mean scores of the male and female groups (t = -1.317, p =.9055). The number of subjects, the means and standard deviations, and the results for the t-test of "external barriers" are displayed in Table 4. An independent groups, one-tailed, unpaired comparison t-test of factor three, "negative helper evaluation," revealed that there was not a significant difference between the mean scores of the male and female groups (t = -.265, p =.6044). The number of subjects, the means and standard deviations, and the results for the t-test of "negative helper evaluation" are displayed in Table 5.

Hypotheses 2, 3, 4, and 5 were tested using a two (male or female) by two (higher or lower level of adherence to ethno-cultural attitudes and behaviors) by two (higher or lower level of self-satisfaction) factorial design

TABLE 4

UNPAIRED ONE-TAILED BETWEEN GROUP COMPARISONS: SEX OF SUBJECT AS THE INDEPENDENT VARIABLE AND EXTERNAL BARRIERS AS THE DEPENDENT VARIABLE

	n	M	SD	df	t	p
Female	184	7.788	3.034	1		
Male	116	8.241	2.685	1		
Total	300			298	-1.317	.9055

TABLE 5

UNPAIRED ONE-TAILED BETWEEN GROUP COMPARISONS: SEX OF SUBJECT AS THE INDEPENDENT VARIABLE AND NEGATIVE HELPER EVALUATION AS THE DEPENDENT VARIABLE

	n	M	SD	df	t	p
Female	184	16.076	3.346	1		
Male	116	16.181	3.330	1		
Total	300			298	-0.265	.6044

with problem avoidance and denial (factor five) as the dependent variable. The term "adherence to ethno-cultural attitudes and behaviors" is used in this discussion in place of "ethnic identity" to avoid confusion with "ethnicity" which is used in this discussion to indicate ancestral origins (i.e., Asian or European). The number of subjects in each group, and the means and standard deviations for this ANOVA are displayed in Table 6. Factor analysis of this sample isolated only one reason for this factor even though several other reasons are clearly associated with problem avoidance and denial; thus, the initial ANOVA was conducted with the reason, "I am afraid to find out that I as worse off than I thought" as a dependent variable (Table 7). The two levels of adherence to ethno-cultural attitudes and behaviors (higher and lower) were obtained by dividing the population using a median split of the total identity scores on the MEIM. The two levels of self-satisfaction were obtained by dividing the population using a median split of the Osgood *D* scores (Osgood, Tannenbaum, & Suci, 1957). The *D* scores were derived by taking the square root of the sum of the squared differences between the "Ideal Me" and the "Real Me" bipolar scale scores on the Semantic Differential Self-Esteem Instrument (DeWolfe, DeWolfe, & McNulty, 1972). Results indicate that the main effect for sex was significant ($F(1,292) = 15.749$, $p<.0001$) suggesting that women as a group rank problem avoidance and denial higher than men as a group. Additionally, the interaction between adherence to ethno-cultural attitudes and behaviors, self-satisfaction, and sex of subject was significant ($F(1,292) = 5.320$, $p = .0218$).

Utilizing the Scheffe test, post hoc analysis indicated that none of the group comparisons were significant. Under the less stringent post hoc comparison method (protected t-tests or Fisher 's PLSD - Protected Least

TABLE 6

MEANS AND STANDARD DEVIATIONS OF SEX OF SUBJECT, ADHERENCE TO ETHNO-CULTURAL ATTITUDES AND BEHAVIORS, AND SELF-SATISFACTION AS INDEPENDENT VARIABLES AND PROBLEM AVOIDANCE AND DENIAL AS THE DEPENDENT VARIABLE

Group	n	M	SD
Female	184	3.266	1.533
More Adherence to Ethno-Cultural Attitudes and Behaviors	93	3.204	1.479
More Self-Satisfaction	49	3.204	1.486
Less Self-Satisfaction	44	3.205	1.488
Less Adherence to Ethno-Cultural Attitudes and Behaviors	91	3.330	1.592
More Self-Satisfaction	39	3.026	1.478
Less Self-Satisfaction	52	3.558	1.650
Male	116	3.983	1.615
More Adherence to Ethno-Cultural Attitudes and Behaviors	61	3.984	1.565
More Self-Satisfaction	32	3.750	1.437
Less Self-Satisfaction	29	4.241	1.683
Less Adherence to Ethno-Cultural Attitudes and Behaviors	55	3.982	1.683
More Self-Satisfaction	28	4.321	1.442
Less Self-Satisfaction	27	3.630	1.864
More Adherence to Ethno-Cultural Attitudes and Behaviors	154	3.513	1.556
Less Adherence to Ethno-Cultural Attitudes and Behaviors	146	3.575	1.652
More Self-Satisfaction	148	3.486	1.527
Less Self-Satisfaction	152	3.599	1.673

TABLE 7

THREE-WAY ANALYSIS OF VARIANCE: SEX OF SUBJECT, ADHERENCE TO ETHNO-CULTURAL ATTITUDES AND BEHAVIORS, AND SELF-SATISFACTION AS INDEPENDENT VARIABLES AND PROBLEM AVOIDANCE AND DENIAL AS THE DEPENDENT VARIABLE

Source	df	MS	F	p
(A) Sex	1	38.436	15.749	<.0001
(B) Adherence to Ethno-Cultural Attitudes and Behaviors	1	.080	.033	.8567
(C) Self-Satisfaction	1	.204	.084	.7726
(AB)	1	.487	.200	.6554
(AC)	1	2.372	.972	.3250
(BC)	1	1.875	.768	.3815
(ABC)	1	12.982	5.320	.0218
Error	292	2.441		

Significant Difference), seven of the comparisons were significant. Of these seven, three are related to the stated hypotheses of this study. All of the significant comparisons occurred between groups of different sex. In addition, all seven of the significant group differences involved either males with less adherence to ethno-cultural attitudes and behaviors and more self-satisfaction or males with more adherence to ethno-cultural attitudes and behaviors and less self-satisfaction. The results relevant to the hypotheses are presented first followed by the aforementioned significant comparisons not associated with the hypotheses. All results for the protected t-test multiple comparisons are reported in Table 8.

Hypothesis 2 predicted that females with more self-satisfaction and greater adherence to ethno-cultural attitudes and behaviors would have a higher rating on the problem avoidance and denial factor than males regardless of level of self-satisfaction or level of adherence to ethno-cultural attitudes and behaviors. This hypothesis was partially supported in this sample. Males with less adherence to ethno-cultural attitudes and behaviors and a more self-satisfaction rated the problem avoidance and denial factor significantly lower than the females with more self-satisfaction and more adherence to ethno-cultural attitudes and behaviors ($t = -3.018$, $p = .0028$). In a similar manner, males with more adherence to ethno-cultural attitudes and behaviors and less self-satisfaction rated the problem avoidance and denial factor lower than the females with more self-satisfaction and more adherence to ethno-cultural attitudes and behaviors ($t = -2.833$, $p = .0049$). In contrast, the other two groups of males, those with more adherence to ethno-cultural attitudes and behaviors and more self satisfaction and those with less adherence to ethno-cultural attitudes and behaviors and less self-

TABLE 8

PROTECTED t-TEST MULTIPLE COMPARISONS OF THE THREE-WAY ANOVA: SEX OF SUBJECT, ADHERENCE TO ETHNO-CULTURAL ATTITUDES AND BEHAVIORS, AND SELF-SATISFACTION AS INDEPENDENT VARIABLES AND PROBLEM AVOIDANCE AND DENIAL AS THE DEPENDENT VARIABLE

	df	t	p
Hypothesis 2			
Female, More Adherence to Ethno-Cultural Attitudes and Behaviors, More Self-Satisfaction	1		
Male, Less Adherence to Ethno-Cultural Attitudes and Behaviors, More Self-Satisfaction	1		
Total	292	-3.018	.0028
Female, More Adherence to Ethno-Cultural Attitudes and Behaviors, More Self-Satisfaction	1		
Male, Less Adherence to Ethno-Cultural Attitudes and Behaviors, Less Self-Satisfaction	1		
Total	292	-1.168	.2567

TABLE 8 -- Continued.

	df	t	p
Female, More Adherence to Ethno-Cultural Attitudes and Behaviors, More Self-Satisfaction	1		
Male, More Adherence to Ethno-Cultural Attitudes and Behaviors, More Self-Satisfaction	1		
Total	292	-1.509	.1253
Female, More Adherence to Ethno-Cultural Attitudes and Behaviors, More Self-Satisfaction	1		
Male, More Adherence to Ethno-Cultural Attitudes and Behaviors, Less Self-Satisfaction	1		
Total	292	-2.833	.0049
Hypothesis 3			
Female, More Adherence to Ethno-Cultural Attitudes and Behaviors, More Self-Satisfaction	1		
Female, Less Adherence to Ethno-Cultural Attitudes and Behaviors, Less Self-Satisfaction	1		
Total	292	1.138	.2565

TABLE 8 -- Continued.

	df	t	p
Hypothesis 4			
Female, Less Adherence to Ethno-Cultural Attitudes and Behaviors, Less Self-Satisfaction	1		
Male, Less Adherence to Ethno-Cultural Attitudes and Behaviors, More Self-Satisfaction	1		
Total	292	-2.086	.0379
Female, Less Adherence to Ethno-Cultural Attitudes and Behaviors, Less Self-Satisfaction	1		
Male, Less Adherence to Ethno-Cultural Attitudes and Behaviors, Less Self-Satisfaction	1		
Total	292	-0.194	.8462
Female, Less Adherence to Ethno-Cultural Attitudes and Behaviors, Less Self-Satisfaction	1		
Male, More Adherence to Ethno-Cultural Attitudes and Behaviors, More Self-Satisfaction	1		
Total	292	-0.547	.5842

TABLE 8 -- Continued.

	df	t	p
Female, Less Adherence to Ethno-Cultural Attitudes and Behaviors, Less Self-Satisfaction	1		
Male, More Adherence to Ethno-Cultural Attitudes and Behaviors, Less Self-Satisfaction	1		
Total	292	-1.889	.0600
Hypothesis 5			
Male, Less Adherence to Ethno-Cultural Attitudes and Behaviors, More Self-Satisfaction	1		
Male, Less Adherence to Ethno-Cultural Attitudes and Behaviors, Less Self-Satisfaction	1		
Total	292	1.642	.1017
Male, Less Adherence to Ethno-Cultural Attitudes and Behaviors, More Self-Satisfaction	1		
Male, More Adherence to Ethno-Cultural Attitudes and Behaviors, More Self-Satisfaction	1		
Total	292	1.412	.1586

TABLE 8 -- Continued.

	df	t	p
Male, Less Adherence to Ethno-Cultural Attitudes and Behaviors, More Self-Satisfaction	1		
Male, More Adherence to Ethno-Cultural Attitudes and Behaviors, Less Self-Satisfaction	1		
Total	292	0.193	.8468
Other Significant Comparisons			
Male, Less Adherence to Ethno-Cultural Attitudes and Behaviors, More Self-Satisfaction	1		
Female, Less Adherence to Ethno-Cultural Attitudes and Behaviors, More Self-Satisfaction	1		
Total	292	-3.348	.0009
Male, Less Adherence to Ethno-Cultural Attitudes and Behaviors, More Self-Satisfaction	1		
Female, More Adherence to Ethno-Cultural Attitudes and Behaviors, Less Self-Satisfaction	1		
Total	292	-2.957	.0034

TABLE 8 -- Continued.

	df	t	p
Male, More Adherence to Ethno-Cultural Attitudes and Behaviors, Less Self-Satisfaction	1		
Female, Less Adherence to Ethno-Cultural Attitudes and Behaviors, More Self-Satisfaction	1		
Total	292	-3.174	.0017
Male, More Adherence to Ethno-Cultural Attitudes and Behaviors, Less Self-Satisfaction	1		
Female, More Adherence to Ethno-Cultural Attitudes and Behaviors, Less Self-Satisfaction	1		
Total	292	-2.775	.0059

satisfaction, had no significant group differences with the group of females with more self-satisfaction and more adherence to ethno-cultural attitudes and behaviors on the problem avoidance and denial factor.

It was predicted in Hypothesis 3, that females with more self-satisfaction and more adherence to ethno-cultural attitudes and behaviors would rank the problem avoidance and denial factor higher than females with less self-satisfaction and less adherence to ethno-cultural attitudes and behaviors. This was not supported in this sample.

Hypothesis 4 predicted that males, regardless of level of adherence to ethno-cultural attitudes and behaviors or self-satisfaction, would have a higher rating on the problem avoidance and denial factor than females with less adherence to ethno-cultural attitudes and behaviors and less self-satisfaction. Not only were the group means of each of the male groups lower for problem avoidance and denial than females with less adherence to ethno-cultural attitudes and behaviors and less self-satisfaction, one of the groups of males, those with less adherence to ethno-cultural attitudes and behaviors and a more self-satisfaction, ranked the reason associated with problem avoidance and denial significantly lower than the group of females with less adherence to ethno-cultural attitudes and behaviors and less self-satisfaction ($t = -2.086$, $p = .0379$). It is apparent that Hypothesis 4 was not supported in this sample.

Hypothesis 5 predicted that males with less adherence to ethno-cultural attitudes and behaviors and more self-satisfaction would have a higher rating on the problem avoidance and denial factor than the three other male groups. Although the group mean of males with less adherence to ethno-cultural attitudes and behaviors and a more self-satisfaction indicated

a higher ranking than the other three groups of males, the results were not significant; therefore, Hypothesis 5 also was not supported in this sample.

As mentioned earlier, the four of significant relationships revealed in the protected t-test post hoc multiple comparisons also occurred between two of the groups of males and females. The group of males with less adherence to ethno-cultural attitudes and behaviors and more self-satisfaction ranked the problem avoidance and denial factor significantly lower than females with more adherence to ethno-cultural attitudes and behaviors and less self-satisfaction (t = -2.957, p = .0034) and females with less adherence to ethno-cultural attitudes and behaviors and greater self-satisfaction (t = -3.349, p = .0009). Males with more adherence to ethno-cultural attitudes and behaviors and less self-satisfaction ranked the problem avoidance and denial factor significantly lower than females with more adherence to ethno-cultural attitudes and behaviors and less self-satisfaction (t = -2.775, p = .0059) and females with less adherence to ethno-cultural attitudes and behaviors and more self-satisfaction (t = -3.174, p = .0017).

Influences on Attitudes Towards Seeking Help from Mental Health Professionals

To explore how gender, ethnicity, self-satisfaction, and adherence to ethno-cultural behaviors and attitudes affect attitudes towards seeking help from mental health professionals, a series of two (male or female) by two (higher or lower level of adherence to ethno-cultural behaviors) by two (higher or lower level of self-satisfaction) by two (Asian ancestry or European ancestry) factorial ANOVAs were initiated utilizing the total score and the four factor scores from the ATSPHS as dependent variables.

When the total score of the ATSPHS was used as a dependent variable, two of the four main effects and one of the two way interactions were significant. The number of subjects in each group, and the means and standard deviations for this ANOVA are displayed in Table 9. The results of the analysis are displayed in Table 10. The Females had a significantly more positive attitude toward seeking help from mental health professionals ($F(1,254) = 6.289$, $p = .0128$) than males. Those subjects with a less adherence to ethno-cultural attitudes and behaviors had a significantly more positive attitude toward seeking help from mental health professionals ($F(1,254) = 7.524$, $p = .0065$) than those with a more adherence to ethno-cultural attitudes and behaviors. The two way interaction between ethnicity (Asian heritage and European heritage) and sex of subject was also significant ($F(1,254) = 7.524$, $p = .0088$). Scheffe post hoc tests of multiple comparisons indicate that European ancestry females hold significantly more positive attitudes towards mental health professionals than Asian ancestry females, European males, and Asian males, the latter three not differing significantly from each other (Table 10).

Utilizing the same independent variables, an ANOVA was conducted with factor 1 of the ATSPHS, labeled "recognition of need for psychotherapeutic help," as a dependent variable. The number of subjects in each group, and the means and standard deviations for this ANOVA are displayed in Table 11. The results of the analysis are displayed in Table 12. The same main effects and the same interaction were also significant here as well. Females had a significantly higher recognition of need for psychotherapeutic help ($F(1,254) = 3.915$, $p = .0489$) than males. Those subjects with a less adherence to ethno-cultural attitudes and behaviors had a

TABLE 9

MEANS AND STANDARD DEVIATIONS OF ETHNICITY, SEX OF SUBJECT, ADHERENCE TO ETHNO-CULTURAL ATTITUDES AND BEHAVIORS, AND SELF-SATISFACTION AS INDEPENDENT VARIABLES AND ATTITUDE TOWARD SEEKING PROFESSIONAL HELP AS THE DEPENDENT VARIABLE

Group	n	M	SD
Asian Ancestry	100	77.940	8.926
Female	68	78.515	8.461
Male	32	76.719	9.871
European Ancestry	170	80.629	11.520
Female	95	84.600	11.072
Male	75	75.600	10.075
Female	163	82.061	10.478
Male	107	75.935	9.981
More Self-Satisfaction	130	79.854	10.165
Less Self-Satisfaction	140	79.429	11.198
More Adherence to Ethno-Cultural Attitudes and Behaviors	133	77.526	10.374
Less Adherence to Ethno-Cultural Attitudes and Behaviors	137	81.679	10.643

TABLE 10

FOUR-WAY ANALYSIS OF VARIANCE: ETHNICITY, SEX OF SUBJECT, SELF-SATISFACTION, AND ADHERENCE TO ETHNO-CULTURAL ATTITUDES AND BEHAVIORS AS INDEPENDENT VARIABLES AND ATTITUDE TOWARD SEEKING PROFESSIONAL HELP AS THE DEPENDENT VARIABLE

Source	df	MS	F	p
(A) Ethnicity	1	17.360	.177	.6747
(B) Sex	1	686.209	6.977	.0088
(C) Self-Satisfaction	1	26.893	.273	.6015
(D) Adherence to Ethno-Cultural Attitudes and Behaviors	1	618.502	6.289	.0128
(AB)	1	739.992	7.524	.0065
(AC)	1	264.584	2.690	.1022
(BC)	1	28.257	.287	.5924
(AD)	1	18.179	.185	.6676
(BD)	1	44.641	.454	.5011
(CD)	1	216.380	2.200	.1392
(ABC)	1	6.652	.068	.7950
(ABD)	1	88.287	.898	.3443
(ACD)	1	247.452	2.516	.1139
(BCD)	1	7.161	.073	.7875
(ABCD)	1	10.017	.102	.7499
Error	254	98.350		

TABLE 10 -- Continued.

Signifcant Comparisons for Interaction AB by Scheffe Test

	Mean Diff.	Critical Diff.	p
Asian Ancestry Female European Ancestry Female	-6.085	4.490	.0027
Asian Ancestry Male European Ancestry Female	-7.881	5.778	.0025
European Ancestry Male European Ancestry Female	9.000	4.366	<.0001

TABLE 11

MEANS AND STANDARD DEVIATIONS OF ETHNICITY, SEX OF SUBJECT, SELF-SATISFACTION, AND ADHERENCE TO ETHNO-CULTURAL ATTITUDES AND BEHAVIORS AS INDEPENDENT VARIABLES AND ATTITUDE TOWARD SEEKING PROFESSIONAL HELP - FACTOR 1; RECOGNITION OF NEED FOR PSYCHOTHERAPEUTIC HELP AS THE DEPENDENT VARIABLE

Group	n	M	SD
Asian Ancestry	100	21.430	3.488
Female	68	21.632	3.246
Male	32	21.000	3.976
European Ancestry	170	21.982	4.250
Female	95	23.389	4.072
Male	75	20.200	3.799
Female	163	22.656	3.838
Male	107	20.439	3.851
More Self-Satisfaction	130	21.423	3.941
Less Self-Satisfaction	140	22.107	4.016
More Adherence to Ethno-Cultural Attitudes and Behaviors	133	21.105	3.877
Less Adherence to Ethno-Cultural Attitudes and Behaviors	137	22.431	3.998

TABLE 12

FOUR-WAY ANALYSIS OF VARIANCE: ETHNICITY, SEX OF SUBJECT, SELF-SATISFACTION, AND ADHERENCE TO ETHNO-CULTURAL ATTITUDES AND BEHAVIORS AS INDEPENDENT VARIABLES AND ATTITUDE TOWARD SEEKING PROFESSIONAL HELP - FACTOR 1; RECOGNITION OF NEED FOR PSYCHOTHERAPEUTIC HELP AS THE DEPENDENT VARIABLE

Source	df	MS	F	p
(A) Ethnicity	1	6.242	.440	.5077
(B) Sex	1	55.520	3.915	.0489
(C) Self-Satisfaction	1	15.581	1.099	.2956
(D) Adherence to Ethno-Cultural Attitudes and Behaviors	1	102.780	7.247	.0076
(AB)	1	120.890	8.524	.0038
(AC)	1	14.645	1.033	.3105
(BC)	1	5.539	.391	.5326
(AD)	1	21.674	1.528	.2175
(BD)	1	13.309	.938	.3336
(CD)	1	32.429	2.287	.1317
(ABC)	1	<.001	<.001	.9999
(ABD)	1	40.066	2.825	.0940
(ACD)	1	7.110	.501	.4796
(BCD)	1	<.001	<.001	.9829
(ABCD)	1	6.897	.486	.4862
Error	254	14.183		

TABLE 12 -- Continued.

Signifcant Comparisons for Interaction AB by Scheffe Test

Group	Mean Diff.	Critical Diff.	p
Asian Ancestry Female European Ancestry Female	-1.757	1.694	.0385
Asian Ancestry Male European Ancestry Female	-2.389	2.180	.0248
European Ancestry Male European Ancestry Female	3.189	1.647	<.0001

significantly higher recognition of need for psychotherapeutic help ($F(1,254) = 7.247$, $p = .0076$) than those with a more adherence to ethno-cultural attitudes and behaviors. The two-way interaction between ethnicity (Asian heritage and European heritage) and sex of subject was also significant ($F(1,254) = 8.524$, $p = .0038$). Scheffe post hoc tests of multiple comparisons indicate that European ancestry females had a significantly higher recognition of need for psychotherapeutic help than Asian ancestry females, European ancestry males, and Asian ancestry males, the latter three not differing significantly from each other (Table 12).

An ANOVA with "stigma tolerance," factor 2 of the ATSPHS, as the dependent variable revealed no significant differences for either main effects or interaction. The number of subjects in each group, and the means and standard deviations for this ANOVA are displayed in Table 13. The results of the analysis are displayed in Table 14.

The ANOVA using "interpersonal openness," ATSPHS factor 3, as a dependent variable showed that two main effects and a two-way interaction were significant. The number of subjects in each group, and the means and standard deviations for this ANOVA are displayed in Table 15. The results of the analysis are displayed in Table 16. Those students of European ancestry were significantly more open interpersonally ($F(1,254) = 9.082$, $p = .0028$) than were students of Asian ancestry. Females were significantly more open interpersonally ($F(1,254) = 5.791$, $p = .0168$) than were males. The two-way interaction between ethnicity (Asian heritage and European heritage) and adherence to ethno-cultural attitudes and behaviors was also significant ($F(1,254) = 3.942$, $p = .0482$). Scheffe post hoc tests of multiple comparisons indicate that European ancestry students with less adherence to

TABLE 13

MEANS AND STANDARD DEVIATIONS OF ETHNICITY, SEX OF SUBJECT, SELF-SATISFACTION, AND ADHERENCE TO ETHNO-CULTURAL ATTITUDES AND BEHAVIORS AS INDEPENDENT VARIABLES AND ATTITUDE TOWARD SEEKING PROFESSIONAL HELP - FACTOR 2; STIGMA TOLERANCE AS THE DEPENDENT VARIABLE

Group	n	M	SD
Asian Ancestry	100	13.410	2.366
European Ancestry	170	14.229	2.588
Female	163	14.196	2.570
Male	107	13.514	2.435
More Self-Satisfaction	130	14.215	2.189
Less Self-Satisfaction	140	13.657	2.800
More Adherence to Ethno-Cultural Attitudes and Behaviors	133	13.549	2.530
Less Adherence to Ethno-Cultural Attitudes and Behaviors	137	14.292	2.495

TABLE 14

FOUR-WAY ANALYSIS OF VARIANCE: ETHNICITY, SEX OF SUBJECT, SELF-SATISFACTION, AND ADHERENCE TO ETHNO-CULTURAL ATTITUDES AND BEHAVIORS AS INDEPENDENT VARIABLES AND ATTITUDE TOWARD SEEKING PROFESSIONAL HELP - FACTOR 2; STIGMA TOLERANCE AS THE DEPENDENT VARIABLE

Source	df	MS	F	p
(A) Ethnicity	1	9.305	1.536	.2163
(B) Sex	1	7.089	1.170	.2804
(C) Self-Satisfaction	1	12.127	2.002	.1583
(D) Adherence to Ethno-Cultural Attitudes and Behaviors	1	18.544	3.062	.0814
(AB)	1	11.281	1.863	.1735
(AC)	1	8.261	1.364	.2439
(BC)	1	6.722	1.110	.2931
(AD)	1	.081	.013	.9078
(BD)	1	4.770	.788	.3757
(CD)	1	12.405	2.048	.1536
(ABC)	1	4.952	.818	.3667
(ABD)	1	4.811	.794	.3736
(ACD)	1	9.317	1.538	.2160
(BCD)	1	4.119	.680	.4104
(ABCD)	1	1.495	.247	.6198
Error	254	6.057		

TABLE 15

MEANS AND STANDARD DEVIATIONS OF ETHNICITY, SEX OF SUBJECT, SELF-SATISFACTION, AND ADHERENCE TO ETHNO-CULTURAL ATTITUDES AND BEHAVIORS AS INDEPENDENT VARIABLES AND ATTITUDE TOWARD SEEKING PROFESSIONAL HELP - FACTOR 3; INTERPERSONAL OPENNESS AS THE DEPENDENT VARIABLE

Group	n	M	SD
Asian Ancestry	100	18.690	2.863
Female	68	18.779	2.747
Male	32	18.500	3.132
European Ancestry	170	20.041	3.304
Female	95	20.726	3.315
Male	75	19.173	3.099
Female	163	19.914	3.229
Male	107	18.972	3.110
More Self-Satisfaction	130	19.785	3.118
Less Self-Satisfaction	140	19.314	3.287
More Adherence to Ethno-Cultural Attitudes and Behaviors	133	19.038	3.132
Asian Ancestry	71	18.789	2.808
European Ancestry	62	19.323	3.468
Less Adherence to Ethno-Cultural Attitudes and Behaviors	137	20.029	3.220
Asian Ancestry	29	18.448	3.031
European Ancestry	108	20.454	3.149

TABLE 16

FOUR-WAY ANALYSIS OF VARIANCE: ETHNICITY, SEX OF SUBJECT, SELF-SATISFACTION, AND ADHERENCE TO ETHNO-CULTURAL ATTITUDES AND BEHAVIORS AS INDEPENDENT VARIABLES AND ATTITUDE TOWARD SEEKING PROFESSIONAL HELP - FACTOR 3; INTERPERSONAL OPENNESS AS THE DEPENDENT VARIABLE

Source	df	MS	F	p
(A) Ethnicity	1	85.771	9.082	.0028
(B) Sex	1	54.694	5.791	.0168
(C) Self-Satisfaction	1	9.627	1.019	.3136
(D) Adherence to Ethno-Cultural Attitudes and Behaviors	1	.461	.049	.8254
(AB)	1	5.201	.551	.4587
(AC)	1	29.280	3.100	.0795
(BC)	1	1.317	.139	.7091
(AD)	1	37.229	3.942	.0482
(BD)	1	5.466	.579	.4475
(CD)	1	7.115	.753	.3862
(ABC)	1	.060	.006	.9364
(ABD)	1	9.989	1.058	.3047
(ACD)	1	3.116	.330	.5662
(BCD)	1	7.784	.824	.3648
(ABCD)	1	.023	.002	.9607
Error	292	9.444		

TABLE 16 -- Continued.

Signifcant Comparisons for Interaction AB by Scheffe Test

Group	Mean Diff.	Critical Diff.	p
Asian Ancestry Female European Ancestry Female	-1.947	1.385	.0016
Asian Ancestry Male European Ancestry Female	-2.226	1.782	.0070
European Ancestry Male European Ancestry Female	1.553	1.346	.0158

Signifcant Comparisons for Interaction AD by Scheffe Test

Group	Mean Diff.	Critical Diff.	p
Asian Ancestry, Less Adherence to Ethno-Cultural Attitudes and Behaviors European Ancestry, Less Adherence to Ethno-Cultural Attitudes and Behaviors	2.038	1.836	.0223
Asian Ancestry, More Adherence to Ethno-Cultural Attitudes and Behaviors European Ancestry, Less Adherence to Ethno-Cultural Attitudes and Behaviors	1.698	1.340	.0060

ethno-cultural attitudes and behaviors were significantly more open interpersonally than Asian ancestry students with more adherence to ethno-cultural attitudes and behaviors, and Asian ancestry students with less adherence to ethno-cultural attitudes and behaviors, the latter two groups not differing significantly from each other (Table 16).

Finally, utilizing the same independent variables, an ANOVA was conducted with factor 4 of the ATSPHS, "confidence in mental health practitioners" the independent variable. The number of subjects in each group, and the means and standard deviations for this ANOVA are displayed in Table 17. The results of the analysis are displayed in Table 18. Three main effects and one two way interaction were significant. Females had a significantly higher level of confidence in mental health practitioners ($\underline{F}(1,254) = 6.765$, $\underline{p} = .0098$) than males. Those subjects with less adherence to ethno-cultural attitudes and behaviors had a significantly higher level of confidence in mental health practitioners ($\underline{F}(1,254) = 9.167$, $\underline{p} = .0027$) than those with more adherence to ethno-cultural attitudes and behaviors. Subjects of Asian ancestry had a significantly higher level of confidence in mental health practitioners ($\underline{F}(1,254) = 5.491$, $\underline{p}=.0199$) than did the subjects of European ancestry. The two-way interaction between ethnicity (Asian heritage and European heritage) and sex of subject was significant ($\underline{F}(1,254) = 8.205$, $\underline{p} = .0045$). Scheffe post hoc tests of multiple comparisons indicated that European ancestry males had a significantly lower level of confidence in mental health practitioners than Asian ancestry females and European ancestry females (Table 18).

TABLE 17

MEANS AND STANDARD DEVIATIONS OF ETHNICITY, SEX OF SUBJECT, SELF-SATISFACTION, AND ADHERENCE TO ETHNO-CULTURAL ATTITUDES AND BEHAVIORS AS INDEPENDENT VARIABLES AND ATTITUDE TOWARD SEEKING PROFESSIONAL HELP - FACTOR 4; CONFIDENCE IN MENTAL HEALTH PRACTITIONERS AS THE DEPENDENT VARIABLE

Group	n	M	SD
Asian Ancestry	100	13.980	2.265
Female	68	14.176	1.892
Male	32	13.562	2.895
European Ancestry	170	13.753	2.395
Female	95	14.632	2.053
Male	75	12.640	2.346
Female	163	14.442	1.994
Male	107	12.916	2.544
More Self-Satisfaction	130	13.838	2.285
Less Self-Satisfaction	140	13.836	2.410
More Adherence to Ethno-Cultural Attitudes and Behaviors	133	13.526	2.433
Asian Ancestry	71	13.620	2.219
European Ancestry	62	13.419	2.671
Less Adherence to Ethno-Cultural Attitudes and Behaviors	137	14.139	2.227
Asian Ancestry	29	14.862	2.167
European Ancestry	108	13.419	2.671

TABLE 18

FOUR-WAY ANALYSIS OF VARIANCE: ETHNICITY, SEX OF SUBJECT, SELF-SATISFACTION, AND ADHERENCE TO ETHNO-CULTURAL ATTITUDES AND BEHAVIORS AS INDEPENDENT VARIABLES AND ATTITUDE TOWARD SEEKING PROFESSIONAL HELP - FACTOR 4; CONFIDENCE IN MENTAL HEALTH PRACTITIONERS AS THE DEPENDENT VARIABLE

Source	df	MS	F	p
(A) Ethnicity	1	25.838	5.491	.0199
(B) Sex	1	31.833	6.765	.0098
(C) Self-Satisfaction	1	.326	.069	.7926
(D) Adherence to Ethno-Cultural Attitudes and Behaviors	1	43.135	9.167	.0027
(AB)	1	38.607	8.205	.0045
(AC)	1	14.825	3.150	.0771
(BC)	1	.935	.199	.6561
(AD)	1	18.211	3.870	.0502
(BD)	1	7.146	1.519	.2190
(CD)	1	1.624	.345	.5574
(ABC)	1	3.003	.638	.4251
(ABD)	1	11.925	2.534	.1126
(ACD)	1	17.650	3.751	.0539
(BCD)	1	.679	.144	.7044
(ABCD)	1	.891	.189	.6638
Error	254	4.706		

TABLE 18 -- Continued.

Significant Comparison for Interaction AB by Scheffe Test

Group	Mean Diff.	Critical Diff.	p
Asian Ancestry Female European Ancestry Male	1.536	1.043	.0008
European Ancestry Male European Ancestry Female	1.992	.962	<.0001

Signifcant Comparisons for Interaction AD by Scheffe Test

Group	Mean Diff.	Critical Diff.	p
Asian Ancestry, Less Adherence to Ethno-Cultural Attitudes and Behaviors European Ancestry, More Adherence to Ethno-Cultural Attitudes and Behaviors	-1.485	1.473	.0472

Avoidance of Help-Seeking as a Function of Ethno-Cultural Identification

The 30 reasons to avoid therapy were evaluated for differences in average ranking by ethnicity and adherence to ethno-cultural attitudes and behaviors. A series of separate 2 X 2 factor analyses were conducted with ethnicity (Asian and European ancestry) and adherence to ethno-cultural attitudes and behaviors (higher and lower as determined by median split) as independent variables and each of the 30 reasons to avoid therapy as dependent variables. On six reasons there was a significant difference for the main effect of ethnicity and on two of the reasons there was a significant difference for the main effect of ethnic identity. Only one reason had a significant interaction.

There was a significant interaction between ethnicity and adherence to ethno-cultural attitudes and behaviors for "I can solve this using willpower and positive thinking" ($F(1,242) = 5.116$, $p = .0246$). The number of subjects in each group, and the means and standard deviations for this ANOVA are displayed in Table 19. The results of the analysis are displayed in Table 20. Scheffe post hoc analyses of the four groups revealed no significant differences. Because the interaction was significant, further probing was conducted utilizing a protected t-test (Fisher's PLSD). Subjects of Asian ancestry and less adherence to ethno-cultural attitudes and behaviors ranked this reason significantly lower than subjects of Asian ancestry and more adherence to ethno-cultural attitudes and behaviors ($t = -2.458$, $p = .0146$) and subjects of European ancestry and less adherence to ethno-cultural attitudes and behaviors ($t = -1.983$, $p = .0484$).

European ancestry subjects ranked "I don't know where the counseling center is" significantly higher than Asian ancestry subjects ($F(1,242) =$

TABLE 19

MEANS AND STANDARD DEVIATIONS OF ETHNICITY AND ADHERENCE TO ETHNO-CULTURAL ATTITUDES AND BEHAVIORS AS INDEPENDENT VARIABLES AND THE REASON, "I CAN SOLVE THIS USING WILLPOWER AND POSITIVE THINKING," AS THE DEPENDENT VARIABLE

Group	n	M	SD
Asian Ancestry	92	3.141	1.531
More Adherence to Ethno-Cultural Attitudes and Behaviors	65	2.938	1.435
Less Adherence to Ethno-Cultural Attitudes and Behaviors	27	3.630	1.668
European Ancestry	154	2.909	1.531
More Adherence to Ethno-Cultural Attitudes and Behaviors	57	3.088	1.596
Less Adherence to Ethno-Cultural Attitudes and Behaviors	97	2.804	1.491
More Adherence to Ethno-Cultural Attitudes and Behaviors	122	3.008	1.508
Less Adherence to Ethno-Cultural Attitudes and Behaviors	124	2.984	1.562

TABLE 20

TWO-WAY ANALYSES OF VARIANCE: ETHNICITY AND ADHERENCE TO ETHNO-CULTURAL ATTITUDES AND BEHAVIORS AS INDEPENDENT VARIABLES AND THE REASON, "I CAN SOLVE THIS USING WILLPOWER AND POSITIVE THINKING," AS THE DEPENDENT VARIABLE

Source	df	MS	F	p
(A) Ethnicity	1	5.697	2.462	.1179
(B) Adherence to Ethno-Cultural Attitudes and Behaviors	1	2.069	.894	.3452
(AB)	1	11.836	5.116	.0246
Error	242	2.314		

Signifcant Comparisons by Protected t -Test for Interaction AB for "I Can Solve This Using Willpower and Positive Thinking"

Group	t	p
Asian Ancestry, Less Adherence to Ethno-Cultural Attitudes and Behaviors European Ancestry, Less Adherence to Ethno-Cultural Attitudes and Behaviors	-2.458	.0146
Asian Ancestry, Less Adherence to Ethno-Cultural Attitudes and Behaviors Asian Ancestry, More Adherence to Ethno-Cultural Attitudes and Behaviors	-1.983	.0484

9.328, p = .0025). The number of subjects in each group, and the means and standard deviations for this ANOVA are displayed in Table 21. The results of the analysis are displayed in Table 22.

Asian ancestry subjects ranked five reasons significantly higher than European subjects. The number of subjects in each group, and the means and standard deviations for the reason, "I don't think that the counselor will understand the influence of my culture on my problem" (F(1,242) = 10.886, p = .0011), are displayed in Table 23. The results of the ANOVA are in Table 24. The number of subjects in each group, and the means and standard deviations for the reason, "I think that there are better methods of dealing with my problem" (F(1,242) = 3.957, p = .0478), are displayed in Table 25. The results of the ANOVA are in Table 26. The number of subjects in each group, and the means and standard deviations for the reason, "If I focus on this problem it may get worse" (F(1,242) = 5.461, p = .0203), are displayed in Table 27. The results of the ANOVA are in Table 28. The number of subjects in each group, and the means and standard deviations for the reason, "It would affect my career possibilities" (F(1,242) = 11.114, p = ..0010), are displayed in Table 29. The results of the ANOVA are in Table 30. The number of subjects in each group, and the means and standard deviations for the reason, "My family's reputation would be damaged by my actions" (F(1,242) = 7.315, p = .0073), are displayed in Table 31. The results of the ANOVA are in Table 32.

Those subjects with more adherence to ethno-cultural attitudes and behaviors rated "I don't think that the counselor will understand the influence of my culture on my problem" (F(1,242) = 5.321, p = .0219) higher than subjects with less adherence to ethno-cultural attitudes and behaviors Tables

TABLE 21

MEANS AND STANDARD DEVIATIONS OF ETHNICITY AND ADHERENCE TO ETHNO-CULTURAL ATTITUDES AND BEHAVIORS AS INDEPENDENT VARIABLES AND THE REASON, "I DON'T KNOW WHERE THE COUNSELING CENTER IS," AS THE DEPENDENT VARIABLE

Group	n	M	SD
Asian Ancestry	92	4.837	1.550
More Adherence to Ethno-Cultural Attitudes and Behaviors	65	4.815	1.609
Less Adherence to Ethno-Cultural Attitudes and Behaviors	27	4.889	1.423
European Ancestry	154	4.253	1.435
More Adherence to Ethno-Cultural Attitudes and Behaviors	57	4.053	1.552
Less Adherence to Ethno-Cultural Attitudes and Behaviors	97	4.371	1.356
More Adherence to Ethno-Cultural Attitudes and Behaviors	122	4.459	1.622
Less Adherence to Ethno-Cultural Attitudes and Behaviors	124	4.484	1.382

TABLE 22

TWO-WAY ANALYSES OF VARIANCE: ETHNICITY AND ADHERENCE TO ETHNO-CULTURAL ATTITUDES AND BEHAVIORS AS INDEPENDENT VARIABLES AND THE REASON, "I DON'T KNOW WHERE THE COUNSELING CENTER IS," AS THE DEPENDENT VARIABLE

Source	df	MS	F	p
(A) Ethnicity	1	20.426	9.328	.0025
(B) Adherence to Ethno-Cultural Attitudes and Behaviors	1	1.914	.874	.3507
(AB)	1	.748	.341	.5595
Error	242	2.190		

TABLE 23

MEANS AND STANDARD DEVIATIONS OF ETHNICITY AND ADHERENCE TO ETHNO-CULTURAL ATTITUDES AND BEHAVIORS AS INDEPENDENT VARIABLES AND THE REASON, "I DON'T THINK THE COUNSELOR WILL UNDERSTAND THE INFLUENCE OF MY CULTURE ON MY PROBLEMS," AS THE DEPENDENT VARIABLE

Group	n	M	SD
Asian Ancestry	92	3.793	1.271
More Adherence to Ethno-Cultural Attitudes and Behaviors	65	3.615	1.295
Less Adherence to Ethno-Cultural Attitudes and Behaviors	27	4.222	1.121
European Ancestry	154	4.552	1.314
More Adherence to Ethno-Cultural Attitudes and Behaviors	57	4.404	1.147
Less Adherence to Ethno-Cultural Attitudes and Behaviors	97	4.639	1.401
More Adherence to Ethno-Cultural Attitudes and Behaviors	122	3.984	1.286
Less Adherence to Ethno-Cultural Attitudes and Behaviors	124	4.548	1.352

TABLE 24

TWO-WAY ANALYSES OF VARIANCE: ETHNICITY AND ADHERENCE TO ETHNO-CULTURAL ATTITUDES AND BEHAVIORS AS INDEPENDENT VARIABLES AND THE REASON, "I DON'T THINK THE COUNSELOR WILL UNDERSTAND THE INFLUENCE OF MY CULTURE ON MY PROBLEMS," AS THE DEPENDENT VARIABLE

Source	df	MS	F	p
(A) Ethnicity	1	18.090	10.886	.0011
(B) Adherence to Ethno-Cultural Attitudes and Behaviors	1	8.842	5.321	.0219
(AB)	1	1.716	1.033	.3105
Error	242	1.662		

TABLE 25

MEANS AND STANDARD DEVIATIONS OF ETHNICITY AND ADHERENCE TO ETHNO-CULTURAL ATTITUDES AND BEHAVIORS AS INDEPENDENT VARIABLES AND THE REASON, "I THINK THAT THERE ARE BETTER METHODS OF DEALING WITH MY PROBLEMS," AS THE DEPENDENT VARIABLE

Group	n	M	SD
Asian Ancestry	92	3.163	1.409
More Adherence to Ethno-Cultural Attitudes and Behaviors	65	3.031	1.323
Less Adherence to Ethno-Cultural Attitudes and Behaviors	27	3.481	1.578
European Ancestry	154	3.649	1.449
More Adherence to Ethno-Cultural Attitudes and Behaviors	57	3.702	1.295
Less Adherence to Ethno-Cultural Attitudes and Behaviors	97	3.619	1.537
More Adherence to Ethno-Cultural Attitudes and Behaviors	122	3.344	1.347
Less Adherence to Ethno-Cultural Attitudes and Behaviors	124	3.589	1.541

TABLE 26

TWO-WAY ANALYSES OF VARIANCE: ETHNICITY AND ADHERENCE TO ETHNO-CULTURAL ATTITUDES AND BEHAVIORS AS INDEPENDENT VARIABLES AND THE REASON, "I THINK THAT THERE ARE BETTER METHODS OF DEALING WITH MY PROBLEMS," AS THE DEPENDENT VARIABLE

Source	df	MS	F	p
(A) Ethnicity	1	8.134	3.957	.0478
(B) Adherence to Ethno-Cultural Attitudes and Behaviors	1	1.683	.818	.3665
(AB)	1	3.551	1.727	.1900
Error	242	2.056		

TABLE 27

MEANS AND STANDARD DEVIATIONS OF ETHNICITY AND ADHERENCE TO ETHNO-CULTURAL ATTITUDES AND BEHAVIORS AS INDEPENDENT VARIABLES AND THE REASON, "IF I FOCUS ON THIS PROBLEM, IT MAY GET WORSE," AS THE DEPENDENT VARIABLE

Group	n	M	SD
Asian Ancestry	92	3.652	1.330
More Adherence to Ethno-Cultural Attitudes and Behaviors	65	3.815	1.345
Less Adherence to Ethno-Cultural Attitudes and Behaviors	27	3.259	1.228
European Ancestry	154	4.032	1.479
More Adherence to Ethno-Cultural Attitudes and Behaviors	57	3.912	1.430
Less Adherence to Ethno-Cultural Attitudes and Behaviors	97	4.103	1.510
More Adherence to Ethno-Cultural Attitudes and Behaviors	122	3.861	1.381
Less Adherence to Ethno-Cultural Attitudes and Behaviors	124	3.919	1.490

TABLE 28

TWO-WAY ANALYSES OF VARIANCE: ETHNICITY AND ADHERENCE TO ETHNO-CULTURAL ATTITUDES AND BEHAVIORS AS INDEPENDENT VARIABLES AND THE REASON, "IF I FOCUS ON THIS PROBLEM, IT MAY GET WORSE," AS THE DEPENDENT VARIABLE

Source	df	MS	F	p
(A) Ethnicity	1	11.024	5.461	.0203
(B) Adherence to Ethno-Cultural Attitudes and Behaviors	1	1.662	.824	.3650
(AB)	1	6.950	3.443	.0647
Error	242	2.019		

TABLE 29

MEANS AND STANDARD DEVIATIONS OF ETHNICITY AND ADHERENCE TO ETHNO-CULTURAL ATTITUDES AND BEHAVIORS AS INDEPENDENT VARIABLES AND THE REASON, "IT WOULD AFFECT MY CAREER POSSIBILITIES," AS THE DEPENDENT VARIABLE

Group	n	M	SD
Asian Ancestry	92	3.946	1.455
More Adherence to Ethno-Cultural Attitudes and Behaviors	65	4.108	1.393
Less Adherence to Ethno-Cultural Attitudes and Behaviors	27	3.556	1.553
European Ancestry	154	4.383	1.195
More Adherence to Ethno-Cultural Attitudes and Behaviors	57	4.649	1.126
Less Adherence to Ethno-Cultural Attitudes and Behaviors	97	4.227	1.212
More Adherence to Ethno-Cultural Attitudes and Behaviors	122	4.361	1.299
Less Adherence to Ethno-Cultural Attitudes and Behaviors	124	4.081	1.317

TABLE 30

TWO-WAY ANALYSES OF VARIANCE: ETHNICITY AND ADHERENCE TO ETHNO-CULTURAL ATTITUDES AND BEHAVIORS AS INDEPENDENT VARIABLES AND THE REASON, "IT WOULD AFFECT MY CAREER POSSIBILITIES," AS THE DEPENDENT VARIABLE

Source	df	MS	F	p
(A) Ethnicity	1	18.319	11.114	.0010
(B) Adherence to Ethno-Cultural Attitudes and Behaviors	1	11.829	7.176	.0079
(AB)	1	.210	.127	.7215
Error	242	1.648		

TABLE 31

MEANS AND STANDARD DEVIATIONS OF ETHNICITY AND ADHERENCE TO ETHNO-CULTURAL ATTITUDES AND BEHAVIORS AS INDEPENDENT VARIABLES AND THE REASON, "MY FAMILY'S REPUTATION WOULD BE DAMAGED BY MY ACTIONS," AS THE DEPENDENT VARIABLE

Group	n	M	SD
Asian Ancestry	92	4.250	1.720
More Adherence to Ethno-Cultural Attitudes and Behaviors	65	4.231	1.721
Less Adherence to Ethno-Cultural Attitudes and Behaviors	27	4.296	1.750
European Ancestry	154	4.877	1.254
More Adherence to Ethno-Cultural Attitudes and Behaviors	57	4.579	1.375
Less Adherence to Ethno-Cultural Attitudes and Behaviors	97	5.052	1.149
More Adherence to Ethno-Cultural Attitudes and Behaviors	122	4.393	1.572
Less Adherence to Ethno-Cultural Attitudes and Behaviors	124	4.887	1.333

TABLE 32

TWO-WAY ANALYSES OF VARIANCE: ETHNICITY AND ADHERENCE TO ETHNO-CULTURAL ATTITUDES AND BEHAVIORS AS INDEPENDENT VARIABLES AND THE REASON, "MY FAMILY'S REPUTATION WOULD BE DAMAGED BY MY ACTIONS," AS THE DEPENDENT VARIABLE

Source	df	MS	F	p
(A) Ethnicity	1	15.167	7.315	.0073
(B) Adherence to Ethno-Cultural Attitudes and Behaviors	1	3.607	1.740	.1884
(AB)	1	2.064	.996	.3194
Error	242	2.074		

23 & 24). Subjects with less adherence to ethno-cultural attitudes and behaviors rated "It would affect my career possibilities" ($F(1,242) = 7.176$, $p = .0079$) higher than subjects with more adherence to ethno-cultural attitudes and behaviors (Tables 29 & 30).

CHAPTER VI
DISCUSSION

Amato and Bradshaw (1985) found five factors in their study of reasons for avoiding help-seeking. The five factors found in the present study correspond approximately to the five found by Amato and Bradshaw. The major difference is that in the present study, only eleven reasons loaded sufficiently onto the five factors. In the study conducted by Amato and Bradshaw, 24 of the 25 reasons loaded onto the five factors. The difference between these two factor structures may be because of dissimilarities in sample homogeneity and methodology. The sample from Amato and Bradshaw was from a single small town in Northern Australia. Participants were recruited by asking the initial subjects to pass copies of the survey to their friends and relatives. In addition, each subject rated reasons on a four point Likert-like scale and utilized an event in their own recent experience as a reference from minor incidents to ongoing difficulties as the range. In the present study, subjects were all university students, from a broader geographic region, and were more likely to not know each other or come from the same social group. Subjects responded to a standardized vignette, with mental health professionals as the specified help-givers. Ratings for reasons to avoid seeking help were determined by forced Q-sort. In summary, the population in the Amato and Bradshaw study was more homogeneous in respect to many demographic variables, the stimulus to

which the subjects responded was more variable with no targeted source of help, and the method of measurement was less comparable across subjects.

In spite of differences in factor structure, sampling strategies, diversity of population, and ranking strategies, several consistencies emerged. The top rated reason in the Amato and Bradshaw study was "Knew I could solve the problem myself" which loaded onto the fifth factor of their structure, "Independence." The highest rated reason in the present study was, "If other people can overcome their difficulties, so can I," which loaded most heavily on the first factor of this study, "Independence." Although the two are not identical, they are very similar. The lowest ranked item in the study conducted by Amato and Bradshaw was "Could not afford to spend the time." Similar items in the present study "I work and have classes all day and the counseling center is closed at night" and "It is difficult to work counseling into my schedule" were ranked sixteenth and ninth respectively. Oddly enough, students receive treatment free of cost as a benefit of being students. It is possible that students are unaware of this benefit, and this lack of knowledge may be responsible for its higher ranking with this population. Subjects in Amato and Bradshaw ranked items related to cost and other external barriers as the least important. The lowest ranked reasons in the present study were "I might get kicked out of school" and "I think that the counselor will tell others."

Hypothesis 1 stated that males would rank order reasons attributed to external barriers to seeking help from mental health professionals and fear of evaluation by the mental health professional higher than females regardless of adherence to cultural attitudes and behaviors (ethnic identity) or self-satisfaction. This was not confirmed by this study. This hypothesis was

based on previous findings about counseling center and mental health professional utilization by sex (Veroff 1981), and the findings of Amato and Bradshaw (1985) related to external barriers and negative evaluation by the helper as reasons to avoid seeking help. The current findings suggest that females are just as likely as males to endorse external barriers, in this case the afford-ability of therapy, and fear of helper evaluation as reasons to avoid therapy. In addition, neither of the reasons which comprise the external barriers factor was in the top or bottom seven of the relative rankings, suggesting that they are neither the least nor most important considerations in the delay of seeking help.

Hypothesis 2 stated that females with more self-satisfaction and more adherence to cultural attitudes and behaviors will rank reasons attributed to problem avoidance and denial higher than males regardless of level of self-satisfaction or level of adherence to cultural attitudes and behaviors. This hypothesis was also based on the findings of Amato and Bradshaw (1985) who found that females were significantly more likely to utilize reasons associated with denial and problem avoidance to avoid or delay help-seeking. Of the four group comparisons that were necessary to test this hypothesis, two were significant. Females with more self-satisfaction and more adherence to cultural attitudes and behaviors ranked problem avoidance and denial significantly higher than did males with less adherence to cultural attitudes and behaviors and more self-satisfaction and males with more adherence to cultural attitudes and behaviors and less self-satisfaction. In both of these comparisons the two male groups being compared have one and only one common element with the female group, either self-satisfaction or adherence to cultural attitudes and behaviors. If both or neither of these

two elements were similar, there was no significant difference between the groups.

This pattern may indicate several things. First, these comparisons are about the use of denial and problem avoidance as compared to other styles of delaying or avoiding seeking help from mental health professionals. That is, males with either higher levels of self-satisfaction or strong ethnic group identification but not both are significantly more likely to use other reasons to avoid seeking professional help. Second, the hypothesis was based on the assumption that denial and problem avoidance reasons would be ranked as highly in this sample as they were in Amato and Bradshaw. Although the group of females with more self-satisfaction and more adherence to cultural attitudes and behaviors ranked the reason associated with denial and problem avoidance higher than the general sample as a whole, it was ranked only seventh with all subjects, fifth with females and eleventh with males.

It may be instructive to take each comparison as a separate issue. Those males with less self-satisfaction and less adherence to cultural attitudes and behaviors are likely to be very aware of their difficulties, making denial and problem avoidance a more likely choice if they are confronted with the symptoms described in the vignette. Males with more self-satisfaction and more adherence to cultural attitudes and behaviors, like their female counterparts, are likely to look at the symptoms as incompatible with their strong self-image. Those males with either less self-satisfaction or less adherence to cultural attitudes and behaviors might recognize one of those areas as a possible source of difficulty. The symptoms described in the vignette might summarize the result of lower self-satisfaction or less ethnic identity development and lead to a lower ranking of denial and problem

avoidance as mechanisms to avoid seeking help. They were not denying or avoiding the problem as much as females with more self-satisfaction and more adherence to cultural attitudes and behaviors; they chose a different tact.

Hypothesis 3 stated that females with more self-satisfaction and more adherence to cultural attitudes and behaviors would rank reasons attributed to problem avoidance and denial higher than females with less self-satisfaction and less adherence to cultural attitudes and behaviors. This was not supported in this study. In a manner similar to those discussed above in the comparison between females with more self-satisfaction and more adherence to cultural attitudes and behaviors and males with less self-satisfaction and less adherence to cultural attitudes and behaviors, females with less self-satisfaction and less adherence to cultural attitudes and behaviors, like their male counterparts, might utilize denial and problem avoidance as a major reason for not seeking professional help when help is needed.

Hypothesis 4 stated that males, regardless of level of self-satisfaction or level of adherence to cultural attitudes and behaviors, would rank order reasons attributed to denial and problem avoidance higher than females with less self-satisfaction and less adherence to cultural attitudes and behaviors. The group mean of each of the male groups indicated a lower ranking of the reason most attributed to denial and problem avoidance than the group of females with less self-satisfaction and less adherence to cultural attitudes and behaviors. One of the groups, those males with more self-satisfaction and less adherence to culturally based attitudes and behaviors, displayed a significantly lower rating of the denial and problem avoidance factor.

Although none of the group means among the females were significantly different, the group mean for females with less self-satisfaction and less adherence to cultural attitudes and behaviors indicated the lowest ranking of denial and problem avoidance of all the female groups. The means for each of the male groups indicated a lower ranking for this reason than any of the female groups. Thus, regardless of the level of self-satisfaction or the level of adherence to culturally-based attitudes and behaviors, females as a group ranked denial and problem avoidance higher than males as a group as a reason to delay help-seeking from mental health professionals. It must be remembered that males are not less likely to delay seeking help, only that they are less likely to utilize denial and problem avoidance.

Hypothesis 5 stated that males with less self-satisfaction and more adherence to cultural attitudes and behaviors would rank order reasons attributed to problem avoidance and denial higher than males with less adherence to cultural attitudes and behaviors and less self-satisfaction and also higher than males with more adherence to cultural attitudes and behaviors, regardless of level of self-satisfaction. As with the female groups, there were also no significant differences between the means of any of the male groups. Tentatively, this could indicate that sex is a more robust predictor than ethno-cultural identification for the use of avoidance and denial as a reason to avoid psychotherapy.

In summary, hypotheses two, three, four, and five were constructed to further explore the finding by Amato and Bradshaw (1985) that females were significantly more likely than males to utilize reasons attributed to denial and problem avoidance. Reasons associated with denial and problem avoidance comprised three of the top five reasons to avoid seeking help in

the Amato and Bradshaw study. Although it is clear from the findings of the present study that denial and problem avoidance cannot be determined by sex alone, sex is an important determiner of the utilization of denial and problem avoidance as a mechanism to delay seeking help when help is clearly needed. Sex of subject, level of ethno-cultural identification and level of self-satisfaction interact to reveal a complex pattern of influence on attitudes and behavior. That an individual with more self-satisfaction and more adherence to culturally-based attitudes and behaviors would want to avoid or deny the problem as described in the vignette seems somewhat intuitive. The depressive symptoms portrayed in the vignette might seem incongruent with the individual's self-image. Alternatively, avoidance and denial might indicate fragility in an individual's maintenance of self-image. This type of individual might construct a self image to ward off depression and self-examination that appears strong but may require rigid denial to maintain. In contrast, the individual with less self-satisfaction and less adherence to culturally-based attitudes and behaviors might fear total collapse of self-image and be hanging on to whatever part of a "healthy self" that they can. Those with either more adherence to culturally-based attitudes and behaviors or more self-satisfaction utilize a different tactic to delay help-seeking. Two possible explanations are that these individuals recognize the degree of difficulty that they are having or know that denial is not beneficial.

Looking at the ANOVAs with sex, level of self-satisfaction, and level of adherence to culturally based attitudes and behaviors as the independent variables and the seven highest ranked reasons for the sample as dependent variables revealed that main effect for sex and the three-way interaction found for the reason "I am afraid to find out that I am worse off than I

thought" are two of only three significant effects. The other significant effect was for level of self-satisfaction for "I can solve this using willpower and positive thinking;" which was ranked higher by the group with more self-satisfaction as a reason to avoid seeking help than the group with less self-satisfaction. This is not surprising since it suggests that those with more self-satisfaction are more independent and self-reliant in their problem-solving, and are probably less likely to seek professional help.

Expanding the explanation offered above to include the other significant group comparisons found under the interaction of sex, level of self-satisfaction, and level of adherence to culturally-based attitudes and behaviors as it affects denial and problem avoidance, it appears that the either/or phenomenon of more self-satisfaction or more adherence to culturally-based attitudes and behaviors only holds true for males. Females in these two groups were not significantly different from the other two female groups.

The four-way ANOVA with ethnicity, sex, level of self-satisfaction, and adherence to ethno-cultural attitudes and behaviors as independent variables and attitudes toward seeking professional help as the dependent variable revealed several significant relationships. As Table 7 indicates, Scheffe post hoc tests showed three significant group differences. European ancestry students have more positive attitudes toward seeking help from mental health professionals than Asian ancestry students. Females have more positive attitudes toward seeking help from mental health professionals than males. Those individuals with less adherence to ethno-cultural attitudes and behaviors have more positive attitudes toward seeking help from mental health professionals than those with more adherence to ethno-cultural

attitudes and behaviors. Although each of these seems intuitive, only one of the comparisons, that of females to males, has been reported previously. It is of little surprise that European ancestry students as a group have more positive attitudes than Asian ancestry students since current systems of psychotherapy and counseling are mainly European in origin and have been expanded and utilized in the United States primarily by European ancestry individuals.

The significant main effect that bears closer scrutiny is adherence to ethno-cultural attitudes and behaviors. Because these groups were not determined by ethnicity but by adherence to perceived cultural values of some target culture (i.e., "American," "Asian," "European," etc.) it implies that even for western cultures, positive attitudes toward psychotherapy and psychotherapists may not be a product of culture. In other words, all European ancestry people may not necessarily embrace psychotherapy as a culturally relevant means of resolving personal difficulties. In fact, it may be that a strong adherence to cultural attitudes and behaviors acts in the stead of professional mental health caregiving. This is not to say that the only forms of psychotherapy offered today are European in origin, but it would be fair to say that the probable perception of the general population is that they are.

Looking at the single significant interaction for this ANOVA, that of ethnicity and gender, the picture becomes even clearer. European ancestry females have a significantly more positive attitude toward seeking professional help than any other group.

The four-way ANOVA with ethnicity, sex, level of self-satisfaction, and adherence to ethno-cultural attitudes and behaviors as independent

variables and recognition of need for psychotherapeutic services as the dependent variable revealed several significant relationships. As Table 8 indicates, Scheffe post hoc tests show two significant group differences. Females indicated a greater recognition of need for help than males. Those individuals with less adherence to ethno-cultural attitudes and behaviors also displayed more recognition of need for help than those with more adherence to ethno-cultural attitudes and behaviors. This comparison is different from that of the general attitude scale in the conspicuous absence of a significant group difference between European ancestry students and Asian ancestry students. This supports the writings of some authors (e.g., Sue & Sue, 1977) who have long contended that, despite lower utilization, the need for psychotherapeutic services is just as present within the Asian community as in the general population. The single significant interaction, again between sex and ethnicity, shows that the recognition of need for psychotherapeutic help is significantly greater for European ancestry students than for any other group. This may tie in with the previously mentioned finding that females use denial and problem avoidance more so than males. Denial and problem avoidance assume a recognition of need. It may be more prominent in European ancestry females than Asian ancestry females because psychotherapy is a system devised to address their needs or, as an alternative suggested earlier , psychotherapy may act as a substitute for strong ethno-cultural attitudes and behaviors.

The four-way ANOVA with ethnicity, sex, level of self-satisfaction, and adherence to ethno-cultural attitudes and behaviors as independent variables and interpersonal openness as the dependent variable revealed several significant relationships. As Table 9 indicates, Scheffe post hoc tests

show some significant group differences as well. Results suggest that females are more likely than males to be interpersonally open with mental health professionals. European ancestry students are more likely than Asian ancestry students to be interpersonally open with mental health professionals. When discussing the dimension of interpersonal openness across cultures, it is important to consider the context of the openness. Because most of the questions relating to this factor deal with openness with professionals or those outside of the extended family, extreme caution should be exercised in interpreting these results and their meaning.

Markus and Kitayama (1991) wrote about the contextually dependent nature of interpersonal openness among Asian ancestry individuals. Given the nature of this study and anonymity of the subjects, differences in interpersonal openness is to be expected. The significant interaction between ethnicity and adherence to ethno-cultural attitudes and behaviors was the result of two significant group differences. European ancestry students with less adherence to ethno-cultural attitudes and behaviors indicated significantly more interpersonal openness than students of Asian ancestry regardless of level of adherence to ethno-cultural attitudes and behaviors. There were not significant differences between students of European ancestry with more adherence to ethno-cultural attitudes and behaviors and either of the Asian ancestry groups. This suggests several things. First, like their Asian counterparts, students from European-based cultures differ in interpersonal openness depending on the degree of identification with a set of values; more identification with a specific culture means less revealing of one's personal life to outsiders, in this case mental health professionals. Secondly, There are differential influences of ethnicity

on interpersonal openness. Less culture-identified European ancestry students are more likely than less culture-identified Asian ancestry students to reveal personal difficulties to mental health professionals. This may be due to the political and social realities of the different immigration patterns and discrimination experienced by these two groups (Sue, 1994; Toupin, 1980). Many groups of Asian immigrants, although actively recruited as a cheap labor source beginning in the middle of the nineteenth century, were legally denied citizenship, the rights to own property and vote, and the right to bring spouses or family with them throughout most of the United States until the passing of the Civil Rights Amendment in 1965. Asians were the targets of hatred and violence from European ancestry groups and incapable uniting because of historical intergroup rivalries remaining from their homelands (Toupin, 1980). An alternative explanation for the differences in willingness to reveal personal problems could be that Asian cultures are less interpersonally open than European cultures in any context outside of their family or in-group.

The four-way ANOVA with ethnicity, sex, level of self-satisfaction, and adherence to ethno-cultural attitudes and behaviors as independent variables and confidence in mental health practitioners as the dependent variable revealed several significant relationships. As Table 18 indicates, Scheffe post hoc tests show some significant group differences as well. Females have significantly more confidence than males in mental health practitioners. Students of European ancestry have significantly more confidence than Asian ancestry students in mental health practitioners. Students with less adherence to ethno-cultural attitudes and behaviors have significantly more confidence than students with more adherence to ethno-

cultural attitudes and behaviors in mental health practitioners. The interaction between ethnicity and sex resulted in two significant group differences. European ancestry males have significantly less confidence than either European ancestry females or Asian ancestry females in mental health practitioners. It is interesting that there are no differences between Asian ancestry males and any of the other groups, indicating that as a group they are somewhere in the middle on this component of attitudes toward seeking professional help.

Finally, to explore which of the reasons to avoid seeking help from mental health professionals were influenced by ethnicity and adherence to ethno-cultural attitudes and behaviors, a series of two-way ANOVAs were conducted on each of the 30 reasons to avoid therapy. Each ANOVA had ethnicity and adherence to ethno-cultural attitudes and behaviors as independent variables and one of the reasons to avoid therapy as a dependent variable. The only significant interaction occurred on "I can solve this using willpower and positive thinking," which loaded on factor 1, independence. A *post hoc* protected t-test indicated that the group comprised of Asian ancestry individuals with less adherence to ethno-cultural attitudes and behaviors rated this reason significantly lower than the group composed of European ancestry individuals with more adherence to ethno-cultural attitudes and behaviors and the group composed of Asian ancestry individuals with more adherence to ethno-cultural attitudes and behaviors. Arkoff, Thaver and Elkind (1966) found that Asian ancestry students had significantly higher endorsement of willpower as a method of dealing with emotional difficulties than European ancestry students. Current findings suggest that the differences in the belief that willpower is an effective means

of dealing with emotional difficulties is not so much a result of ethnicity as it is an interaction between ethnicity and adherence to ethnocultural attitudes and behaviors. Asian ancestry individuals who have not formed a strong ethnic identity are less likely to be self-reliant in dealing with personal problems. Post hoc analysis of the ANOVA with factor four of the ATSPHS, confidence in the mental health practitioner, as a dependent variable indicates that this group has the most confidence in mental health practitioners. European ancestry and Asian ancestry students with more adherence to ethno-cultural attitudes and behaviors had significantly lower confidence in mental health practitioners.

The one reason which was ranked significantly higher by European ancestry students than by Asian ancestry students was "I don't know where the counseling center is." It is difficult to speculate why this would be ranked higher by European ancestry students given that there were no significant differences between these two groups in either counseling service utilization or the recognition that services existed on campus. One possible explanation could be that Asian ancestry students seek out possible resources beforehand whether they utilize the services or not.

There were five reasons which were rated significantly higher by Asian students than European ancestry students. The reason "I don't think the counselor will understand the influence of my culture on my problems" speaks directly to the often discussed issue of competency in multicultural counseling. It would be presumptuous to assume that matching client and counselor ethnicity would eliminate this concern (Flaskerud, 1986). This is not to say that interethnic differences in respect to understanding cultural influences is a big concern for members of any minority group that

consistently feels the influence of the majority group's influence (Sue 1988). It is also important note that despite the significant interethnic differences, this reason was ranked tenth out of thirty by the Asian ancestry students as a group. It is also not surprising that ranking on this reason is also dependent on the level of adherence to ethno-cultural attitudes and behaviors. Both European ancestry students and Asian ancestry students with more ethno-cultural identity ranked this reason higher than their respective ethnic group peers with less ethno-cultural identity. That is, within each ethnic group, concern for the impact of cultural identity on the therapeutic process is higher for those individuals who adhere more to identified ethno-cultural attitudes and behaviors.

The reasons "I think there are better methods of dealing with my problem" and "If I focus on this problem, it may get worse" were also ranked significantly higher by Asian ancestry students than European ancestry students. The first suggests that psychotherapy or counseling is not the first choice of the respondents. This is supported by some researchers (Cheung, 1987; Christensen, 1987). The second reason is related to the first in that its higher ranking by Asian ancestry students supports the suggestions by some authors (Sue & Sue 1977) that for Asian ancestry persons the best way to deal with a problem is to not think about it.

Finally, Asian ancestry students ranked the two reasons "It would affect my career possibilities" and "My family's reputation would be damaged by my actions" significantly higher than the European ancestry students. Both of these reasons deal with stigma and the fear of shame, which several authors have remarked as strong motivations within the Asian community to avoid treatment for mental difficulties (Sue & Sue, 1977).

This is also confirmed by the significantly less tolerance for the stigma associated with seeking help from a mental health professional as discussed above. One additional point is that those students who have less adherence to ethno-cultural attitudes and behaviors rank "It would affect my career possibilities" significantly higher than those students with more adherence to ethno-cultural attitudes and behaviors. This suggests that career is more important to students with less adherence to ethno-cultural attitudes and behaviors, and this focus may be more characteristic of individualistic behavior. Comparisons utilizing the individualism scale of the Individualism-Collectivism Scale indicate that those students with less adherence to ethno-cultural attitudes and behaviors are not significantly different in individualism from those students with more adherence to ethno-cultural attitudes and behaviors.

Limitations of this Study and Suggestions for Future Research

The Q-sort, although designed to allow more reliable comparisons across individuals and groups, proved difficult for many individuals. Many of the subjects wrote that it was too difficult to decide which reasons were more representative of their feelings. Some subjects replied that they resented the forced choice format and would have rather have had just two categories instead of seven. This might have influenced the accuracy of the reporting. Alternatively, several respondents wrote that they enjoyed the challenge, and that the survey helped them conceptualize their thinking on mental health help seeking. Although many individuals noted that they had difficulty with the Q-sort, less than nine percent of the subjects failed to complete it properly. The other portion of the survey which garnered

negative comments and similar numbers of improper completion was the self-satisfaction measure. Despite these limitations, more than sixty percent of the surveys distributed were returned completed. It is reasonable to assume that the results are representative of the population sampled.

The one area of the this study which needs vast improvement is the assessment of ethno-cultural attitudes and behavior. The measure utilized in the present study, the Multigroup Ethnic Identity Measure (Phinney, 1992), is the culmination of several years of research; however, it does not adequately assess all the dimensions of identity and day-to-day functioning. Theoretical structure research by some authors (Berry, Kim, Power, Young, & Bujaki 1989; Birman, 1994) outline multidimensional, non-linear models of personality and personality functioning within the context of a diverse and changing society. These dimensions have not been accounted for in current identity assessment measures.

This study was also limited by targeting a single source of help and a single type of helper. Reasons to avoid seeking help probably vary not only by the type of helper but also by the availability and accessibility of alternative forms of help. This includes, but is not limited to, indigenous healers, peer support systems, clergy, and family elders. As the number of help sources included in the study increases, the necessary number of participants must also increase, thus increasing the time, effort and other resources required to complete such a study.

Despite a large number of participants, this study also suffered from insufficient number of subjects in some categories, particularly male Asian ancestry students. To effectively complete the analyses required to test the effect of sex of subject, previous experience with mental health practitioners,

self-satisfaction, ethnicity, and adherence to ethno-cultural attitudes and behaviors on mental health utilization, an even larger number of subjects would be necessary. It would also be beneficial to investigate how these relationships change as individuals mature past college and face the difficulties of life. As with any study which utilizes a college population, these results may not be representative of populations which are more diverse in age and educational achievement. Further investigation with a non-college population, although likely to be time-consuming and expensive, would be one way to extend these results to a wider population. Finally, it would be beneficial to assess delay and avoidance of help-seeking in real life situations. This would involve a more active data collection process and the cooperation of providers of mental health services for an area with a population of sufficient diversity to study the factors which effect differential utilization.

Summary and Conclusions

Although many of the predicted relationships between sex of subject, level of self-satisfaction and level of adherence to ethno-cultural attitudes and behaviors were not confirmed in this study, it is clear that level of self-satisfaction and adherence to ethno-cultural attitudes and behaviors influence utilization of mental health services as seen by the differences in endorsement of different reasons to delay or avoid seeking professional help.

In addition, exploratory analyses revealed confirming evidence for a number of the differences between Asian ancestry and European ancestry students mentioned by previous authors. It is possible, given some of the findings of this present study that the present forms of counseling and

psychotherapy and the public's perception of them might be influencing the utilization.

APPENDIX A
CONSENT FORM

CONSENT FORM

December 1, 1994

Dear Participant:

Thank you for participating in this research project. The purpose of this study is to better understand the feelings and reactions of college students to different problems. This questionnaire consists of six parts and takes about 60 minutes to complete all of the items.

Please note that all of the information that we collect today is **confidential**. This means that it will only be seen by qualified researchers including myself and my research assistants and will only be used for research purposes. Further, the information is **anonymous**. Please do not place your name or any other personal identifier on the questionnaire itself. All of the information is coded by number and not by name. Although some of the questions we ask may seem personal and intrusive, we would like to emphasize that we are not interested in knowing how any particular individual answers each item. Instead, we want to understand the pattern of college students' experiences in general. Therefore, it is very important that you answer all of the items as accurately as you can. Should you decide at any point to discontinue your participation in our project, you are free to return the study to the researcher without incurring any kind of penalty or consequences.

If you have any questions, concerns or feelings about the questionnaire, or would like to know the results of the study, please write your name and address on a 3X5 card and mail it one of the addresses below. Please use an envelope to mail the card so that we can maintain confidentiality.

Address: Carl F. Arnemann, M.A.
2563 Dole St. #2B
Honolulu, HI 96822
Phone: (808) 956-4610

Or: Candace Fung Chu Ho, Ph.D.
University Counseling Center
1280 University of Oregon
Eugene, OR 97403
Phone: (503) 346-2703

I certify that I have read and fully understand the above material, and with my signature hereby give my consent to participate in this research project.

Signature _____ Date _____

APPENDIX B
DEMOGRAPHIC QUESTIONNAIRE

Part 1

Please answer all the questions as best as you can without skipping any of them.

1. Today's date: _____ _____ _____
   (Month) (Day) (Year)

2. Sex: _____ M _____ F 3. Age: _____

4. Birth date: _____ _____ _____
   (Month) (Day) (Year)

5. Your marital status: _____ Single
   _____ Married
   _____ Divorced
   _____ Widowed
   _____ Other (please specify _____)

6. Your major: _____

7. Your minor: _____

8. Please check the highest level of education that you have **completed**:

	High School/ Equi-valent	College Freshman	College Sopho-more	College Junior	Hold Bach-elor's Degree/ Equi-valent	Some Graduate School	Hold Master's Degree/ Equi-valent	Hold Doctoral Degree/ Equi-valent
Yourself								

9. Do you have any religious affiliation? _____ Yes _____ No

   If yes, please specify _____

10. What is your native language? (If their native language has multiple dialects like Chinese, for example, please specify which dialect e.g., Cantonese, Mandarin, Fukinese.)

    _____

11. Do you speak any languages besides your native language ? _____ Yes _____ No

    11a. If yes, please specify what languages
    (if more than one, circle the one you are most fluent in).

    _____

11b. Based on your answer to 11a above, please complete items (i) and (ii) below: (If your 11a answer consists of more than one language, refer only to the one you circled above.)

(i) At what age did you begin to learn the second language? _____

(ii) Have you ever lived in an environment where most people speak your second language?
_____ Yes _____ No

If yes, please specify where and for how long you lived in such an environment.

Place: _____ Time: _____

12. What is your parents' native language? (If their native language has multiple dialects like Chinese, for example, please specify which dialect e.g., Cantonese, Mandarin, Fukinese.)

Father: _____

Mother: _____

13. Your ethnicity: _____

14. Father's ethnicity: _____

15. Mother's ethnicity: _____

16. Your birthplace: _____ _____ _____
City/Town State/Province Country

17. Father's birthplace: _____ _____ _____
City/Town State/Province Country

18. Mother's birthplace: _____ _____ _____
City/Town State/Province Country

21. Parents' marital status: _____ Single
_____ Married
_____ Divorced
_____ Widowed
_____ Other (please specify _____)

22. Please indicate the age(s) of **all** of your brother(s) and sister(s).

Brother(s): _____

Sister(s): _____

23. Your birth order: _____ (for example; second of three children; 2/3)

24. Parents' occupation:

Father: _____

Mother: _____

25. Please check the highest level of education that each of your parents **completed**? (Check one for each parent.)

	No Formal Education	Some Elementary School	Completed Elementary School/ Equivalent	Some High School	High School Graduate/ Equivalent	Some College	Hold Bachelor's Degree/ Equivalent	Some Graduate School	Hold Master's Degree/ Equivalent	Hold Doctoral Degree/ Equivalent
Father										
Mother										

26. Are you an International student?

_____ Yes _____ No

27. How much did you enjoy completing this questionnaire?

1	2	3	4	5
Very much	Much	Somewhat	A little	Not at all

28. How difficult was this questionnaire for you to complete?

1	2	3	4
Not at all	A little	Somewhat	Very much

29. How much do you believe your responses are an accurate reflection of your feelings about the topics addressed?

1	2	3	4
Not at all	A little	Somewhat	Very much

30. Additional comments: _____

_____

_____

APPENDIX C

ATTITUDE TOWARD SEEKING PROFESSIONAL HELP SCALE

Part 2

Instructions. Listed below are a number of statements about which people often have different opinions. You will discover that you agree with some and that you disagree with others. Please read each statement carefully, then circle the letter that indicates the extent to which **you** agree or disagree with it. **Answer every statement**, even if you have to guess at some. There is no right or wrong answer. This information will be treated as confidential.

SA = Strongly Agree, A = Agree, D = disagree, SD = Strongly Disagree

1.	Although there are counseling centers for people with mental troubles, I would not have much faith in them.	SA A D SD
2.	If a good friend asked my advice about a mental problem, I might recommend that he see a counselor or a psychologist.	SA A D SD
3.	I would feel uneasy going to a psychologist or a counselor because of what some people would think.	SA A D SD
4.	A person with a strong character can get over mental conflicts by himself or herself and would have little need of a psychologist or a counselor.	SA A D SD
5.	There are times when I have felt completely lost and would have welcomed professional advice for a personal or emotional problem.	SA A D SD
6.	Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.	SA A D SD
7.	I would willingly confide intimate matters to an appropriate person if I thought it might help me or a member of my family.	SA A D SD
8.	I would rather live with certain mental conflicts than go through the ordeal of getting psychological treatment.	SA A D SD
9.	Emotional difficulties, like many other things, tend to work out by themselves.	SA A D SD
10.	There are certain problems which should not be discussed outside of one's immediate family.	SA A D SD
11.	A person with a serious emotional disturbance would probably feel most secure in a good mental hospital.	SA A D SD
12.	If I believed I was having a mental breakdown, my first inclination would be to get professional attention.	SA A D SD
13.	Keeping one's mind on a job is a good solution for avoiding personal worries and concerns.	SA A D SD
14.	Having been a psychiatric patient is a blot on a person's life.	SA A D SD

SA = Strongly Agree, A = Agree, D = disagree, SD = Strongly Disagree

15.	I would rather be advised by a close friend than by a psychologist, even for an emotional problem.	SA A D SD
16.	A person with an emotional problem is not likely to solve it alone; he is likely to solve it with professional help.	SA A D SD
17.	I resent a person - professionally trained or not - who wants to know about my personal difficulties.	SA A D SD
18.	I would want to get psychiatric attention if I was worried or upset for a long period of time.	SA A D SD
19.	The idea of talking about problems with a psychologist strikes me as a poor way of to get rid of emotional conflicts.	SA A D SD
20.	Having been mentally ill carries with it a burden of shame.	SA A D SD
21.	There are experiences in my life I would not discuss with anyone.	SA A D SD
22.	It is probably best not to know everything about oneself.	SA A D SD
23.	If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy.	SA A D SD
24.	There is something admirable in the attitude of a person who is willing to cope with his conflicts and fears without resorting to professional help.	SA A D SD
25.	At some future time, I might want to have psychological counseling.	SA A D SD
26.	A person should work out his own problems; getting psychological counseling would be a last resort.	SA A D SD
27.	Had I received treatment in a mental hospital, I would not feel that it ought to be "covered up."	SA A D SD
28.	If I thought I needed psychiatric help, I would get it no matter who knew about it.	SA A D SD
29.	It is difficult to talk about personal affairs with highly educated people such as doctors, teachers, and clergymen.	SA A D SD

In the following questions, circle the most appropriate answer.

30.	I am aware of the availability of counseling services on campus.	Yes No
31.	I have had previous counseling experience with a counselor, psychologist, social worker, or other mental health care worker.	Yes No
32.	If the answer is **yes**, what gender was the mental health worker?	Male Female

33. To your knowledge, have any of your friends had counseling experiences with a counselor, psychologist, social worker, or other mental health care worker? Yes No

34. If Asian or Asian-American mental health care workers were available at the counseling service on campus, would you use the service? Yes No

35. If both Asian-American and Anglo-American counselors were available which would you choose if you needed help? (circle only one response)

    a. An Asian-American counselor
    b. An Anglo-American counselor
    c. Either one, it does not matter
    d. It depends on the type of problem
    e. Neither one

APPENDIX D

MULTIGROUP ETHNIC IDENTITY MEASURE

Part 3

In this country, people come from a lot of different cultures and there are many different words to describe the different backgrounds or ethnic groups that people come from. Some examples of the names of ethnic groups are Mexican-American, Hispanic, Black, Asian-American, American Indian, Anglo-American, and White. Every person is born into an ethnic group, or sometimes more than one group, but people differ on how important their ethnicity is to them, how they feel about it, and how much their behavior is affected by it. These questions are about your ethnicity or your ethnic group an how you feel about it or react to it.

Please fill in:

In terms of ethnic group, I consider myself to be:

_____

Please read each statement carefully, then circle the letter that indicates the extent to which **you** agree or disagree with it.

SA = Strongly agree, A = Agree somewhat, D = Disagree somewhat, SD = Strongly disagree

1.	I have spent time trying to find out more about my own ethnic group, such as its history, traditions, and customs.	SA	A	D	SD
2.	I am active in organizations or social groups that include mostly members of my own ethnic group.	SA	A	D	SD
3.	I have a clear sense of my ethnic background and what it means for me.	SA	A	D	SD
4.	I like meeting and getting to know people from ethnic groups other than my own.	SA	A	D	SD
5.	I think a lot about how my life will be affected by my ethnic group membership.	SA	A	D	SD
6.	I am happy that I am a member of the group I belong to.	SA	A	D	SD
7.	I sometimes feel it would be better if different ethnic groups didn't try to mix together.	SA	A	D	SD
8.	I am not very clear about the role of my ethnicity in my life.	SA	A	D	SD
9.	I often spend time with people from ethnic groups other than my own.	SA	A	D	SD
10.	I really have not spent much time trying to learn more about the culture and history of my ethnic group.	SA	A	D	SD

SA = Strongly agree, A = Agree somewhat, D = Disagree somewhat, SD = Strongly disagree

11.	I have a strong sense of belonging to my own ethnic group.	SA	A	D	SD
12.	I understand pretty well what my ethnic group membership means to me, in terms of how to relate to my own group and other groups.	SA	A	D	SD
13.	In order to learn more about my ethnic background, I have often talked to other people about my ethnic group.	SA	A	D	SD
14.	I have a lot of pride in my ethnic group and its accomplishments.	SA	A	D	SD
15.	I don't try to become friends with people of other ethnic groups.	SA	A	D	SD
16.	I participate in cultural practices of my own group, such as special food, music, or customs.	SA	A	D	SD
17.	I am involved in activities with people from other ethnic groups.	SA	A	D	SD
18.	I feel strong attachment towards my own ethnic group.	SA	A	D	SD
19.	I enjoy being around people from ethnic groups other than my own.	SA	A	D	SD
20.	I feel good about my cultural or ethnic background.	SA	A	D	SD

APPENDIX E

SEMANTIC DIFFERENTIAL SELF-ESTEEM INSTRUMENT

Part 4

At the top of each of the next three pages, you will find a different thing to be judged, and beneath it twenty-four sets of words which we would like you to use in making your judgments. For an example, look at the next page. The thing I would like you to judge here is a "**SWAN.**" This word appears at the top of the page.

If you think that a **SWAN** is **very Happy** or **very Sad**, place a "X" directly above the short line closest to the word **Happy** or the word **Sad.**

1. Happy _X_ ____ ____ ____ ____ ____ ____ Sad

or

1. Happy ____ ____ ____ ____ ____ ____ _X_ Sad

If you think that a **SWAN** is **somewhat Happy** or **somewhat Sad**, please place a "X" above one of the lines closer to the center, as follows:

1. Happy ____ _X_ ____ ____ ____ ____ ____ Sad

or

1. Happy ____ ____ ____ ____ ____ _X_ ____ Sad

If you think that a **SWAN** is only **slightly Happy** or **slightly Sad**, you would put your "X" in one of the following positions:

1. Happy ____ ____ _X_ ____ ____ ____ ____ Sad

or

1. Happy ____ ____ ____ ____ _X_ ____ ____ Sad

If you think that a **SWAN** is neither **Happy** nor **Sad**, or that a **SWAN** is **as Happy as it is Sad**, you would place your "X" above the middle short line.

1. Happy ____ ____ ____ _X_ ____ ____ ____ Sad

In the same way, we would like you to give us your judgments on **SWAN** using the remaining 23 pairs of words: Good-Bad, Sociable-Unsociable, and so on until you have completed the page.

Continue on through part 4 (pages 10, 11, &12) giving your opinions about each of the things listed at the top of each page.

On all of these we are interested mainly in your **FIRST** opinions. Therefore, we ask you to work as rapidly as possible.

SWAN

		Very	Some-what	Slightly	Neither/ equally	Slightly	Some-what	Very	
1.	Happy	____	____	____	____	____	____	____	Sad
2.	Good	____	____	____	____	____	____	____	Bad
3.	Sociable	____	____	____	____	____	____	____	Unsociable
4.	Inefficient	____	____	____	____	____	____	____	Efficient
5.	Cruel	____	____	____	____	____	____	____	Kind
6.	Foolish	____	____	____	____	____	____	____	Wise
7.	Beautiful	____	____	____	____	____	____	____	Ugly
8.	Pleasant	____	____	____	____	____	____	____	Unpleasant
9.	Worthless	____	____	____	____	____	____	____	Valuable
10.	Selfish	____	____	____	____	____	____	____	Unselfish
11.	Dangerous	____	____	____	____	____	____	____	Safe
12.	Strong	____	____	____	____	____	____	____	Weak
13.	Reputable	____	____	____	____	____	____	____	Disreputable
14.	Passive	____	____	____	____	____	____	____	Active
15.	Dishonest	____	____	____	____	____	____	____	Honest
16.	Cowardly	____	____	____	____	____	____	____	Brave
17.	Altruistic	____	____	____	____	____	____	____	Egotistic
18.	Grateful	____	____	____	____	____	____	____	Ungrateful
19.	Meaningful	____	____	____	____	____	____	____	Meaningless
20.	Unfair	____	____	____	____	____	____	____	Fair
21.	Immoral	____	____	____	____	____	____	____	Moral
22.	Dominant	____	____	____	____	____	____	____	Submissive
23.	Persistent	____	____	____	____	____	____	____	Yielding
24.	Static	____	____	____	____	____	____	____	Dynamic

THE IDEAL ME

		Very	Some-what	Slightly	Neither/ equally	Slightly	Some-what	Very	
1.	Happy	____	____	____	____	____	____	____	Sad
2.	Good	____	____	____	____	____	____	____	Bad
3.	Sociable	____	____	____	____	____	____	____	Unsociable
4.	Inefficient	____	____	____	____	____	____	____	Efficient
5.	Cruel	____	____	____	____	____	____	____	Kind
6.	Foolish	____	____	____	____	____	____	____	Wise
7.	Beautiful	____	____	____	____	____	____	____	Ugly
8.	Pleasant	____	____	____	____	____	____	____	Unpleasant
9.	Worthless	____	____	____	____	____	____	____	Valuable
10.	Selfish	____	____	____	____	____	____	____	Unselfish
11.	Dangerous	____	____	____	____	____	____	____	Safe
12.	Strong	____	____	____	____	____	____	____	Weak
13.	Reputable	____	____	____	____	____	____	____	Disreputable
14.	Passive	____	____	____	____	____	____	____	Active
15.	Dishonest	____	____	____	____	____	____	____	Honest
16.	Cowardly	____	____	____	____	____	____	____	Brave
17.	Altruistic	____	____	____	____	____	____	____	Egotistic
18.	Grateful	____	____	____	____	____	____	____	Ungrateful
19.	Meaningful	____	____	____	____	____	____	____	Meaningless
20.	Unfair	____	____	____	____	____	____	____	Fair
21.	Immoral	____	____	____	____	____	____	____	Moral
22.	Dominant	____	____	____	____	____	____	____	Submissive
23.	Persistent	____	____	____	____	____	____	____	Yielding
24.	Static	____	____	____	____	____	____	____	Dynamic

THE REAL ME

		Very	Some-what	Slightly	Neither/ equally	Slightly	Some-what	Very	
1.	Happy	____	____	____	____	____	____	____	Sad
2.	Good	____	____	____	____	____	____	____	Bad
3.	Sociable	____	____	____	____	____	____	____	Unsociable
4.	Inefficient	____	____	____	____	____	____	____	Efficient
5.	Cruel	____	____	____	____	____	____	____	Kind
6.	Foolish	____	____	____	____	____	____	____	Wise
7.	Beautiful	____	____	____	____	____	____	____	Ugly
8.	Pleasant	____	____	____	____	____	____	____	Unpleasant
9.	Worthless	____	____	____	____	____	____	____	Valuable
10.	Selfish	____	____	____	____	____	____	____	Unselfish
11.	Dangerous	____	____	____	____	____	____	____	Safe
12.	Strong	____	____	____	____	____	____	____	Weak
13.	Reputable	____	____	____	____	____	____	____	Disreputable
14.	Passive	____	____	____	____	____	____	____	Active
15.	Dishonest	____	____	____	____	____	____	____	Honest
16.	Cowardly	____	____	____	____	____	____	____	Brave
17.	Altruistic	____	____	____	____	____	____	____	Egotistic
18.	Grateful	____	____	____	____	____	____	____	Ungrateful
19.	Meaningful	____	____	____	____	____	____	____	Meaningless
20.	Unfair	____	____	____	____	____	____	____	Fair
21.	Immoral	____	____	____	____	____	____	____	Moral
22.	Dominant	____	____	____	____	____	____	____	Submissive
23.	Persistent	____	____	____	____	____	____	____	Yielding
24.	Static	____	____	____	____	____	____	____	Dynamic

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APPENDIX F

INDIVIDUALISM-COLLECTIVISM SCALE

Part 5

To the right of each statement below, there is a 9-point scale ranging from 1 = Absolutely Agree to 9 = Absolutely Disagree. Please read each of the 14 statements and circle the number that best describes how you feel about it, that is, the degree you agree or disagree with the statement. Please do not skip any statements.

		Absolutely Agree <——> Absolutely Disagree								
1.	I would help within my means, if a relative told me that s(he) is in financial difficulties.	1	2	3	4	5	6	7	8	9
2.	When faced with a difficult personal problem, it is better to decide what to do yourself, rather than follow the advice of others.	1	2	3	4	5	6	7	8	9
3.	I like to live close to my good friends.	1	2	3	4	5	6	7	8	9
4.	It does not matter to me how my country is viewed in the eyes of other nations.	1	2	3	4	5	6	7	8	9
5.	One of the pleasures of life is to be related interdependently with others.	1	2	3	4	5	6	7	8	9
6.	What happens to me is my own doing.	1	2	3	4	5	6	7	8	9
7.	What I look for in a job is a friendly group of coworkers.	1	2	3	4	5	6	7	8	9
8.	I would rather struggle through a personal problems by myself than discuss it with my friends.	1	2	3	4	5	6	7	8	9
9.	Aging parents should live at home with their children.	1	2	3	4	5	6	7	8	9
10.	The most important thing in my life is to make myself happy.	1	2	3	4	5	6	7	8	9
11.	When faced with a difficult personal problems, one should consult widely one's friends and relatives.	1	2	3	4	5	6	7	8	9
12.	One should live one's life independently of others as much as possible.	1	2	3	4	5	6	7	8	9
13.	One of the pleasures of life is to feel being a part of a large group of people.	1	2	3	4	5	6	7	8	9
14.	I tend to do my own things, and most people in my family do the same.	1	2	3	4	5	6	7	8	9

APPENDIX G
SCENARIO AND Q-SORT

Part 6

After reading the following description, sort the slips of paper provided into seven stacks on the template at the bottom of the page. Note that there is a legend above each of the seven rectangles on the template starting on the left with "least descriptive of my feelings" to "most descriptive of my feelings" on the right. There is a number below each of the legends. That number tells you how many slips of paper you can have in that stack. Thus, under the legend "most descriptive of my feelings," you will have 2 slips of paper on that stack, 3 in the next stack to the left, 6 in the next stack to the left and so on. When you have placed all 30 slips of paper in the stacks, use your pen or pencil to write the letter of the stack (which is at the bottom of the rectangle) in which each slip is located on each slip of paper. Finally, if you have a stapler handy, staple the slips of paper over their respective boxes, this will help speed up the scoring process.

Try to imagine that you are having the following difficulties:

You have been feeling down lately and it seems that you can't feel happy. You have frequent headaches, have your lost appetite, and feel that your thinking is slow. As you try to do your daily activities you find that you are preoccupied and that your thoughts are confused. Although not frequent, at times you have even had thoughts about ending your life. You notice that despite feeling lonely, you withdraw from friends when they try to engage you. You are beginning to feel that your existence has no value and you are powerless to do anything about it. Some of the people around you have suggested that you seek counseling at the Student Counseling Center on campus or through a private therapist.

Least descriptive of my feelings	**Less descriptive of my feelings**	**Somewhat less descriptive of my feelings**	**More or less descriptive of my feelings**	**Somewhat more descriptive of my feelings**	**More descriptive of my feelings**	**Most descriptive of my feelings**
2 statements	**3** statements	**6** statements	**8** statements	**6** statements	**3** statements	**2** statements
Stack A	**Stack B**	**Stack C**	**Stack D**	**Stack E**	**Stack F**	**Stack G**

The following 30 reasons were printed on slips of paper 3/4 inch by 3 inches

I am afraid to find out that I am worse off than I thought
I am afraid to talk to strangers
I can figure out new behaviors that will get me out of my old ways
I can solve this using willpower and positive thinking
I can't afford therapy
I don't believe other people can help me
I don't have insurance
I don't know anyone at the counseling center
I don't know where the counseling center is
I don't think the counselor will understand my problem
I don't think the counselor will understand the influence of my culture on my problems
I don't want to admit I have problems
I might get kicked out of school
I think that the counselor will tell others
I think that there are better methods of dealing with my problem
I work and have classes all day and the counseling center is closed at night
I would get more understanding from my friends
If I can wait this out, it will eventually go away
If I focus on this problem, it may get worse
If other people can overcome their difficulties, so can I
It is difficult to work counseling into my schedule
It is too shameful for me to see a counselor
It would affect my career possibilities
My family's reputation would be damaged by my actions
My partner (boyfriend/girlfriend, wife/husband) would not understand and may disapprove of me
People will think that I am crazy
The counselor might suggest that I have long term counseling
The counselor might think that I will need medication
The counselor will think that I might need hospitalization
What if one of my friends sees me coming out of the counseling center

APPENDIX H
DEBRIEFING STATEMENT

Debriefing Statement

Dear Participant,

The purpose of this study is relatively straightforward. It is to investigate the relationship between cultural and identity values and the avoidance of therapy or counseling if therapy or counseling would be helpful. Some of the scales you completed measure cultural values. Other measures assess attitudes towards seeking help. Still other measures look at how people see themselves. The responses of all participants will be compared to evaluate the influence of cultural values, identity, and satisfaction with the self.

Thank you for participating in my research project. Your responses to the questionnaire are very valuable, and will help us to better understand the feelings and reactions of college students to different problems. If you are interested in obtaining a summary of the results of this experiment once it is completed, please put your name and permanent address on a 3X5 index card and mail it to one of the addresses below. Please mail the card in an envelope so that we can maintain confidentiality.

Address: Carl F. Arnemann, M.A.
2563 Dole St. #2B
Honolulu, HI 96822
Phone: (808) 956-4610

Or: Candace Fung Chu Ho, Ph.D.
University Counseling Center
1280 University of Oregon
Eugene, OR 97403
Phone: (503) 346-2703

Thank you very much for your participation.

APPENDIX I
PERMISSION LETTERS

August 14, 1995

Carl F. Arnemann, M.A.
2819 Peter St.
Honolulu, HI 96816
(808) 739-9320

Alan S. DeWolfe, Ph.D.
Department of Psychology
Loyola University Chicago
6525 North Sheridan Road
Chicago, IL 60626

Dear Dr. DeWolfe:

I am completing a doctoral dissertation at Loyola University Chicago entitled "Avoidance of Help-Seeking as a Function of Ethno-Cultural Identity." I would like your permission to reprint in my dissertation a portion of the 14-item Semantic Differential Scale you used in:

DeWolfe, A. S., DeWolfe, R. K. S., & McNulty, J. (1972). Fear decrease and identifications in a psychiatric setting. Journal of Consulting and Clinical Psychology, 39(1), 160-165.

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Sincerely,
Carl F. Arnemann

PERMISSION GRANTED FOR THE USE REQUESTED ABOVE:

Alan S. DeWolfe, Ph.D. 9/13/95
Date

August 17, 1995

Carl F. Arnemann, M.A.
2819 Peter St.
Honolulu, HI 96816
(808) 739-9320

Edward H. Fischer, Ph.D.
Institute of Living Reasearch Department
400 Washington St.
Hartford, CT 06106

Dear Dr. Fischer:

I am completing a doctoral dissertation at Loyola University Chicago entitled "Help-Seeking Avoidance Among College Students as a Function of Ethno-Cultural Identity." I would like your permission to reprint in my dissertation the 29-item Attitudes Toward Seeking Professional Help Scale you developed. It is published in:

Fischer, E. H., & Turner, J. LeB. (1970). Orientations to seeking help: Development and research utility of an attitude scale. Journal of Counseling and Clinical Psychology, 35, 79-90.

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Sincerely,
Carl F. Arnemann

PERMISSION GRANTED FOR THE USE REQUESTED ABOVE:

Edward H. Fischer 8·22·95

Edward H. Fischer, Ph.D. Date

August 17, 1995

Carl F. Arnemann, M.A.
2819 Peter St.
Honolulu, HI 96816
(808) 739-9320

Fung Chu Ho, Ph.D.
1531 Wah Cheung House
Wah Fu Estate
Hong Kong

Dear Dr. Ho:

I am completing a doctoral dissertation at Loyola University Chicago entitled "Help-Seeking Avoidance Among College Students as a Function of Ethno-Cultural Identity." I would like your permission to reprint in my dissertation the 30-item Demographic Questionnaire you published in your dissertation entitled "A Cross-Cultural Study on the Expression and Presentation of Depressive Symptomatology among Americans and Chinese in the People's Republic of China (PRC), Taiwan, and Hong Kong."

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Sincerely,

Carl F. Arnemann

PERMISSION GRANTED FOR THE USE REQUESTED ABOVE:

F C Ho

Fung Chu Ho, Ph.D.

Aug. 30, 1995

Date

August 14, 1995

Carl F. Arnemann, M.A.
2819 Peter St.
Honolulu, HI 96816
(808) 739-9320

James E. Johnson, Ph.D.
Department of Psychology
Loyola University Chicago
6525 North Sheridan Road
Chicago, IL 60626

Dear Dr. Johnson:

I am completing a doctoral dissertation at Loyola University Chicago entitled "Avoidance of Help-Seeking as a Function of Ethno-Cultural Identity." I would like your permission to reprint in my dissertation a portion of the 23-item Semantic Differential Scale you used in:

Johnson, J. E., Petzel, T. P., DuPont, M. P., & Romano, B. M. (1982). Phenomenological perceptions of parental evaluations in depressed and nondepressed college students. Journal of Clinical Psychology, 38(1), 56-62.

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Carl F. Arnemann

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James E. Johnson

James E. Johnson, Ph.D.

9-12-95

Date

August 17, 1995

Carl F. Arnemann, M.A.
2819 Peter St.
Honolulu, HI 96816
(808) 739-9320

Jean S. Phinney, Ph.D.
Department of Psychology
California State University
Los Angeles, CA 90032

Dear Dr. Phinney:

I am completing a doctoral dissertation at Loyola University Chicago entitled "Help-Seeking Avoidance Among College Students as a Function of Ethno-Cultural Identity." I would like your permission to reprint in my dissertation the 20-item Multigroup Ethnic Identity Measure (MEIM) you developed. The measure appears in:

Phinney, J. S. (1992). The multigroup ethnic identity measure: A new scale for use with diverse groups. Journal of Adolescent Research, 7(2),156-176.

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Sincerely,
Carl F. Arnemann

PERMISSION GRANTED FOR THE USE REQUESTED ABOVE:

Jean S. Phinney Ph.D
Jean S. Phinney, Ph.D.

8/22/95
Date

August 12, 1995

Carl F. Arnemann, M.A.
2819 Peter St.
Honolulu, HI 96816
(808) 739-9320

Harry C. Triandis, Ph.D.
603 E. Daniel St.
Champaign, IL 61820

Dear Dr. Triandis:

I am completing a doctoral dissertation at Loyola University Chicago entitled "Help-Seeking Avoidance Among College Students as a Function of Ethno-Cultural Identity." I would like your permission to reprint in my dissertation the 14-item "Method 3: Attitudes" from the "Manual of Instruments for the Study of Allocentrism or Collectivism and Ideocentrism or Individualism" (1991).

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Sincerely,
Carl F. Arnemann

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H.C. Triandis — Aug. 21, 1995

Harry C. Triandis, Ph.D. — Date

September 26, 1995

Carl F. Arnemann, M.A.
2819 Peter St.
Honolulu, HI 96816

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August 27, 1995

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2819 Peter St.
Honolulu, HI 96816

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