

## ABSTRACT

Title of Dissertation / Thesis: East Asians' or East Asian Americans'  
Preferences for Different Types  
of Psychotherapy

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East Asians' or East Asian Americans' preferences for types of therapies were investigated. Fifty East Asian or East Asian Americans in Mid-Atlantic University completed a series of measures related to Asian values, preferences, and psychological/interpersonal characteristics. They then watched the four videotapes of Dr. Raskin (Client-Centered Therapy), Dr. Comas-Diaz (Ethnocentral Psychotherapy), Dr. Lazarus (cognitive behavioral segment in Multimodal Therapy), and Dr. Persons' (Cognitive Behavior Therapy) sessions, evaluated the session quality and the counselor credibility. They ranked the sessions in order of their preferences and were asked the reasons of their preference. The results indicated that Dr. Lazarus' session was most preferred, and Dr. Persons' session was least preferred by the participants. Participants' ratings of counselor credibility of Dr. Lazarus were significantly associated with participants' Interpersonal Dependency, and Preferences for Insight or Action-Oriented Therapy. The reasons of their preference are discussed.

EAST ASIANS' OR EAST ASIAN AMERICANS' PREFERENCES  
FOR DIFFERENT TYPES OF PSYCHOTHERAPY

By  
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## Chapter 1

### Introduction

According to the U.S. Bureau of the Census in 2002, the number of Asian Americans has been growing at the fastest rate among all ethnic groups in United States. As a result of the increase in population size, Asian Americans' psychological needs have received increased attention (Kim & Hong, 2004), and are the topic of an increased number of studies published in professional psychology and counseling journals over the last decades.

Researchers, however, have found that the rate at which Asian Americans use mental health services is lower than those of other Americans (Snowden & Cheung, 1990). According to Kim, Atkinson, and Umemoto (2001), the underutilization may be due to having negative attitudes about asking for psychological help about personal and family-related issues from non-family members, such as professional counselors. In addition, Asian Americans are often not familiar with mainstream Western therapy. According to Sue and Zane (1987), Asian American clients may lack experience with a Western style of therapy and be less confident in the efficacy of counseling that does not provide immediate and tangible benefits.

Sue and Sue (1999) suggested that counseling effectiveness might be affected by the match or mismatch among clients' cultural values, therapists' cultural values, and values inherent in the process of counseling. The style of counseling used in the United States is typically based on Western values, which may be in conflict with Asian cultural values, and which Asian Americans may perceive as ineffective. Thus, to increase Asian Americans' utilization of mental health services, it is necessary to have a better understanding of Asian Americans' preferred style of counseling.

Several researchers have examined Asian Americans' preferred style of counseling. Sue and Zane (1987) suggested that Asian Americans prefer immediate and tangible resolution of their psychological problems in therapy, which they named "gift giving". Kim, Li, and Liang (2002) also found that Asian Americans are likely to ask for immediate resolution in therapy and that those clients, who receive therapy focusing on immediate resolution, tend to perceive a stronger working alliance than those who receive insight-oriented therapy. Getting "immediate resolution" is often cited as the primary reason for seeking counseling among Asian Americans. Insight-oriented therapy is perceived as lacking "immediate resolution," whereas action-oriented approaches are perceived as providing "immediate resolution" (Sue & Zane, 1987).

In this study, I will examine Asian Americans' preferences for insight-oriented versus action-oriented therapy. Asian American students will watch representative videos of insight- or action-oriented therapy and indicate their preferences.

## Chapter 2

### Review of the Literature

In this review, I first discuss preferences in psychotherapy. I define the terms, discuss types of preferences, and then review the empirical findings about effects of preferences on session outcome. Next, I discuss insight-oriented and action-oriented therapy. Finally, I present Asian Americans and therapy, focusing on underutilization of mental health services; preferences for therapist roles in therapy, types of therapy, and demographic features of therapists, and the potential influences of Asian values on preferences.

#### *Preferences*

A number of definitions of preferences have been given. Client preference has been defined by some authors as a desired or valued behavior or attribute of the therapist or therapy (Berzins, 1977; Richert, 1983). Another definition of preference focuses on clients' beliefs about what components of therapy or kinds of therapy will be helpful and what the client positively values before therapy, regardless of what client expected (Richert, 1983).

Preferences have been contrasted with expectations for therapy; expectations are what clients anticipate before therapy about what will happen during therapy whereas preferences refer to what they would like to have happen (Safran, 1980). Some researchers, unfortunately, have confused the definitions of preference and expectation. For example, Tinsley and Benton (1978) and Tinsley, Workman, and Kass (1980) used the terms expectancy, expectations, and preferences interchangeably. Grantham and Gordon (1986) suggested that Tinsley and colleagues "destroyed the distinction that theorists have been trying to draw for the last 30 years" (p. 397). They differentiated

between expectation as anticipation and expectation as preference by suggesting that these two types are different aspects of human cognition that warrant distinct treatment.

Thus, following the distinctions made by Grantham and Gordon (1986), clients can have preferences for the specific roles of therapists or clients, for the certain types of psychotherapy, or for therapists' demographic characteristics. Clients can anticipate or expect either the outcome of therapy or the role of clients or therapists in the therapy (Arnkoff, Glass & Shapiro, 2002).

### *Nature of Preferences*

The term "preference" refers to both the process of making preferences and the actual result of preferences (i.e. choice or judgment; Grantham & Gordon, 1986).

Grantham and Gordon (1986) differentiated between how things get chosen and what gets chosen, and between the act of deciding and preference (See Figure 1). When a person chooses something, he or she reacts to options at a sensory level and decides preference at a cognitive level, which leads to a choice of what she or she prefers.

Grantham and Gordon (1986) indicated that preference has the other two important elements: affect and idealism. In terms of affect, a person making a choice experiences both positive and negative feelings about alternatives. The weighing process is designed, consciously or unconsciously, to produce the alternatives or characteristics that would make the person feel most positive (Zajonc, 1980). It makes intuitive sense that we prefer alternatives that give us the most positive affect. Similarly, idealism plays an important role at this point since the preferred alternatives or features reflect what the person evaluates to be ideal (Grantham & Gordon, 1986). After adding all components related to the preference, Grantham and Gordon (1986) suggested a more complex figure of deciding and preference (See Figure 2).

In this figure, the affective component makes the act of deciding unique. When one prefers certain objects or characteristics, there is some extent of intensity related with the feelings, which can range from very weak to very strong (Grantham & Gordon, 1986). According to Zajonc (1980), a person makes sensory preferences at a precognitive level that includes affect, and the preference can result in an emotional tendency being established in either good-bad or pleasant-unpleasant way (Zajonc, 1980).

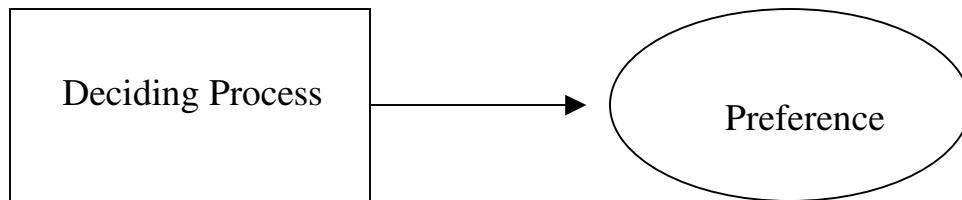
According to Grantham and Gordon (1986), preferences are dynamic and work at different cognitive levels. Because of this multidimensionality of preference, a person can prefer any of a number of characteristics at the same time. Furthermore, one can prefer different characteristics in different settings. The question, “what are the preferences of types of therapy when a poor, Hispanic, self-assertive, male client meets an affluent, Caucasian, directive, female therapist?” shows how the multiple variables can decide clients’ preferences.

A time factor is also related to both deciding and preferences (Grantham & Gordon, 1986). A person repeats the act of deciding again and again as he or she has new information and new experience. As a result of repeated deciding, preferences develop, evolve, and change as time passes. Hence, knowing a person’s preferences at one point in time is not sufficient to fully understand one’s preferences. For instance, Cross (1971) demonstrated that racial preferences for therapists may alter as the social climate changes in a less tense way. For this reason, researchers should assess important areas of preference at each encounter to discover their present status.

#### *Ways of Measuring Preferences*

Arnkoff, Glass and Shapiro (2002) suggested that preferences are typically measured in three ways: factor-based questionnaires, ratings of written descriptions of

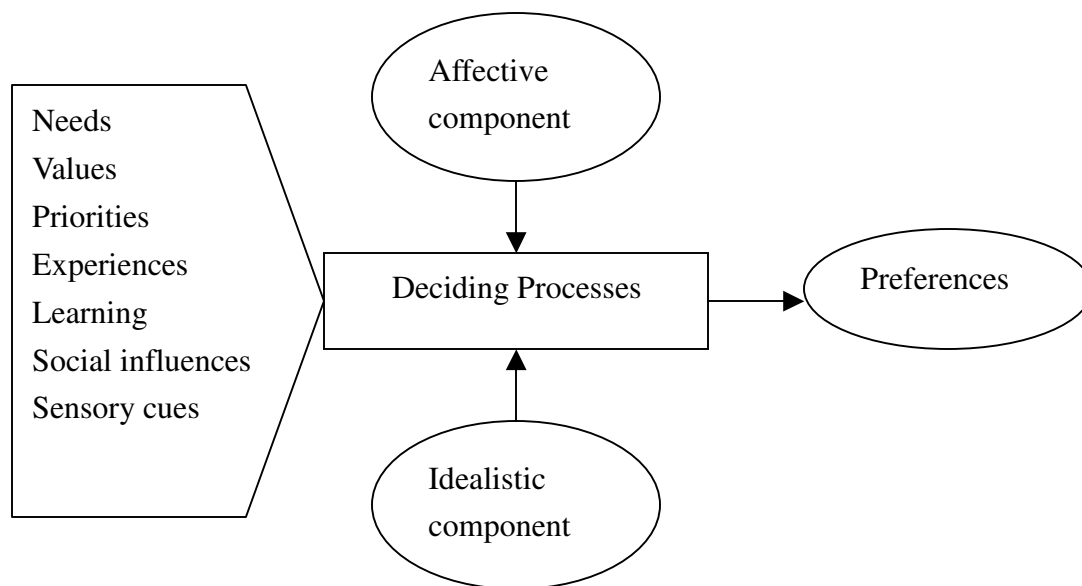
*Figure 1. Process of Preferences*



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From "The Nature of Preference" by R. J. Grantham and M. E. Gordon, 1986, *Journal of Counseling and Development*, 64, p. 396. Copyright 1986 by American Psychological Association.

Figure 2. Process of Preferences



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From "The Nature of Preference" by R. J. Grantham and M. E. Gordon, 1986, *Journal of Counseling and Development*, 64, p. 396. Copyright 1986 by American Psychological Association.



various treatments before therapy, and ratings after participating in a real session.

In factor-based questionnaires, researchers ask questions about therapist roles; types of psychotherapy; therapists' sex, race/ethnicity, or sexual orientation. Most researchers have developed their own questionnaires to examine client preferences, although some researchers used pre-existing measures (Arnkoff, Glass, & Shapiro, 2002). This method of measuring preferences is largely dependent on how participants interpret questionnaires. In other words, it is possible that different participants understand and interpret a questionnaire differently, which affects their responses to the questionnaire.

Other studies used descriptions of various theoretical orientations or audio taped or video taped sessions and asked clients to rate their preferences. Clients in Devine and Fernald's (1973) study watched videotaped demonstrations of therapeutic techniques and rated how much they liked each of them. Van Dyck and Spinhoven (1997) gave participants a written description of an *in vivo* exposure therapy with and without hypnosis and asked them to rate the strength of their preferences. Rather than describing specific treatment modalities, Atkinson, Worthington, Dana and Good (1991) presented written descriptions of thinking, feeling, and action-oriented therapies, and asked clients to rank their preferences from highest to lowest. This method of using audio taped or video taped sessions provides more information about the sessions than using questionnaires. However, when participants watch the audio or video taped sessions, their points of view may be different from actual clients' points of view.

The final method is to measure clients' preferences after actual sessions. In Addis and Jacobson (1996), participants indicated at the end of each session how similar the session was to what they believed to be beneficial about therapy. Clients' preferences after receiving actual sessions are likely to be authentic since they decide what they

prefer after receiving actual therapy. However, most experimenters have provided only one session to participants and asked them to report their preferences based on the first session. In real therapy settings, however, clients' preferences are likely to change as they receive more sessions and establish therapeutic relationships.

### *Types of Preferences*

Researchers have identified at least three types of preferences: role preferences, preferences for types of psychotherapy, and preferences for demographic features of the therapist (Arnkoff, Glass & Shapiro, 2002). These will now each be discussed in turn.

*Role preferences.* Role preferences are the client's pre-therapy beliefs about which therapist behaviors will be beneficial, regardless of anticipation of what will happen (Richert, 1983). Role preferences have not been categorized within a systematic, integrative framework. At least two major dimensions, however, have been suggested to be involved in explaining role preferences in the research findings and clinical observation. One dimension is therapist power and position. At one end of this dimension, the client prefers a dominant, distant authority and at the other a sympathetic friend. Therapist orientation toward problem solvers is the second dimension. Some clients prefer that the therapist focus on solving their problems, whereas others prefer that the therapist attend to their feelings, recollections, and personal experiences.

Even though clients' preference may range along these continua, combination of the two dimensions yields a fourfold categorization of client role: medical modelers, revelationists, problem solvers, and explorers (Richert, 1983). Clients who prefer medical modelers want a therapist who is high on the authority aspect and concentrates on problems. For these clients, the ideal therapist status is much like a physician. These clients prefer the active and directive therapist who takes clear charge of the treatment

procedure allowing the client to be relatively passive and compliant. The client's primary focus in therapy is not on a warm, supportive relationship with the therapist but the therapist's great skill and knowledge. They want their therapists simply to tell them what to do to make their situations better. When the therapist takes on the medical modeler role, the client's role is only to provide enough information about his/her difficulties to the therapist and wait for the therapist's wise recommendations. If discussion of personal experience seems to be helpful for the therapist's ability to give answers, it is tolerated by the client, but not appreciated as an activity in its own right.

The revelationist therapist is similar to medical modelers in terms of power but different in terms of therapist orientation. The clients with this preference want the therapist to be rather distant and formal, emphasizing his/her knowledge and the power based on that expertise. However, in contrast to the clients preferring therapists to be medical modelers, the clients who prefer the therapists as revelationists want therapists to examine their personal recollections, feelings, and experiences from an expert's point of view as a means of providing an "objective view" of who they are and why they act as they do. These clients seek counseling because they want to understand themselves rather than because they want to resolve problems.

Problem solvers are located closer to the low end of the authority dimension and focus upon problems. Clients with problem-solver role preferences want the therapist to be a collaborator or coworker in handling problems in living. These clients are willing to take an active part in therapy and look to use the therapist as an expert and an accessible source of solving problem. Clients with problem solver role preferences want the therapist's fresh perspective, new knowledge, even suggestions, but reserve the right to make final decisions about matters. Hence, they prefer an active and knowledgeable but

not distant or dominant therapist. These clients tend to have a practical penchant, and often regard personal reactions and feelings as unrelated to their concerns. Furthermore, they do not want to form an affectionate self-disclosing alliance with the therapist.

In the last type of role preference, explorers, the therapist is low on authority and focus on personal feelings, recollections, and experiences. As with problem solvers, explorers want the therapist to be a supportive, knowledgeable collaborator rather than a distant, dominant authority. These clients want the therapist as a guide or companion on a journey into their psychological space. They want to focus on a review of their personal experience and develop change in real life by themselves rather than the therapist (Richert, 1983).

*Preferences for types of therapy.* Many researchers studied preferences for types of therapy and examined how matches and mismatches between clients' preferences and therapy assignments affect psychotherapy outcome (Arnkoff, Glass, & Shapiro, 2002).

Elkin et al. (1999) examined whether a match and mismatch between a client's preference for a type of therapy (Cognitive Behavior Therapy, Interpersonal Psychotherapy, Imipramine plus Clinical Management, and Placebo plus Clinical Management) and treatment assignment influences the therapeutic relationship in early sessions and premature termination of therapy. The researchers recruited 239 clients and asked clients' predilections for one type over and above other types prior to treatment assignments. Some clients received types of therapy they prefer (congruent group), while other clients received types of therapy they did not prefer (noncongruent group) and the researchers assessed clients' early termination, level of early attrition, perception of therapy, clients' contribution to establishing therapeutic alliance in congruent and

noncongruent group. They found that when the types of therapy were congruent with clients' preferences, the clients were more likely to remain in a therapy for the first four weeks and to establish better therapeutic relationship than their counterparts. However, the researchers did not include clients without a clear preference for one type of therapy over other types, so the research results may apply only to clients who prefer one type of therapy to others.

In Devine and Fernald (1973), the researchers showed snake-fearing participants a videotape in which four counselors explained the techniques they use to treat fear of snakes. The four techniques were encounter, a combination of behavioral rehearsal and modeling, rational emotional technique, and systematic desensitization. The clients were asked which of the four techniques they preferred before having sessions. Researchers randomly assigned participants to these different types of techniques: 16 clients received their preferred type of therapy. 16 clients received therapies that did not match their preferences, and 16 people did not watch the videotape. The researchers found that clients who were assigned to their preferred types of techniques reported more reduction in fear than those who received non-preferred types of therapy or those who were randomly assigned. However, the researchers recruited only 16 clients for each condition, which is not a large enough sample size to detect between-group differences.

By contrast, preference did not affect the outcome of therapy in Bakker, Spinhoven, van Balkom, Vleugel, and van Dyck (2000)'s study. In this study, the researchers divided clients with panic disorder into two groups. Thirty-five clients were assigned to cognitive therapy by the researchers without being asked their preference. Whereas, thirty-one clients were asked their preferences for cognitive therapy, expressed their preference for cognitive therapy, and then received cognitive therapy. The

researchers examined frequency and severity of agoraphobia, depression, and general anxiety before and after the 12 sessions of cognitive therapy. In both conditions, all clients reported significant reduction in symptoms after therapy, but the researchers did not find the evidence for differences between two groups of clients (those who chose to receive cognitive therapy and those who were assigned to cognitive therapy) in terms of symptom reduction. However, participants varied in terms of how severe these symptoms were, which may have resulted in confounding the findings given that certain types of therapy may work better for clients with certain severity of symptoms (Richert, 1983).

*Preferences for therapist demographic features.* Preferences for demographic features of the therapist relates to clients' preferences for therapist sex, race, ethnicity, age, or sexual orientation (Arnkoff, Glass & Shapiro, 2002; Atkinson, 1983, 1987; Harrison, 1975; Sue & Lam, 2002).

Many researchers studied whether male and female clients preferred male or female counselors and the effects of client-counselor sex matching and mismatching on therapy outcome (Fuller, 1964; Jones & Zoppel, 1982; Orlinsky & Howard, 1980; Pikus & Heavey, 1996; Sue & Lam, 2002). Zlotnick, Elkin, and Shea (1998) studied how gender preference affects treatment process and outcome. In this study, 203 clients with major depressive disorder were selected and were asked which sex of therapists they preferred. Then, they all received about 14 to 15 sessions of treatment to ensure the opportunity to interact with their therapists. Some of them had therapists of their preferred sex, and others had therapists whose sex was different from their preference. The researchers did not find significant difference on therapy outcome between matched and mismatched groups. In other words, clients who had therapists of their preferred sex were not significantly different than clients who did not have therapists of their preferred

sex in therapy process and outcome. In addition, the matched and mismatched groups did not differ in client-rated therapist empathy. However, in this study, all clients were volunteers and eager to participate in this study. Thus, the results might be applicable only to clients who were eager to engage in treatment.

Gim, Atkinson, and Kim (1991) studied how therapist ethnicity and cultural sensitivity affects clients' perception of therapists' trustworthiness and cultural competence. Asian American college students were recruited from a large West Coast university and asked to listen to tape-recorded counseling session. In the tapes, counselor ethnicities were described as either Asian-American or Caucasian American and portrayed as either culture-sensitive or culture blind. In each version, clients' responses were same across the versions. After listening to the taped sessions, clients rated the therapists on Cross-Cultural Counseling Inventory (CCCI) and Counselor Effectiveness Rating Scale (CERS). The researchers found that Asian American students in this study reported a racially/ethnically similar counselor to be more culturally proficient and trustworthy than a racially/ethnically dissimilar counselor. In addition, participants rated culture-sensitive therapists as more trustworthy and culturally proficient than culture-blind therapists. In this study, very few participants were low-acculturated. Thus, the results might be able to be applied only to Asian Americans who were acculturated.

By contrast, Atkinson and Matsushita (1991) found that ethnicity of counselor did not affect Asian Americans' rating of their counselors. Similarly, in Kim and Atkinson (2002), Asian American clients did not perceive the process of career counseling more positively when a counselor was culturally similar than when a counselor was culturally dissimilar. Furthermore, Asian American clients did not report the therapy process with an Asian American therapist was more effective than the therapy with a European

American therapist. More details about Atkinson and Matsushita (1991) and Kim and Atkinson (2002) will be discussed in the section of empirical evidence about Asian Americans' preferred style of counseling.

### *Summary*

Clients' preferences for therapists' sex did not influence therapy process or outcome (Zlotnick, Elkin, & Shea, 1998; Fuller, 1964; Jones & Zoppen, 1982; Orlinsky & Howard, 1980; Pikus & Heavey, 1996; Sue & Lam, 2002). Clients' preferences for therapists' ethnicities affected the therapy process or outcome in some studies (Atkinson, Poston, Furlong, & Mercado, 1989; Atkinson, Wampold, Lowe, & Ahn, 1998), while other studies (Atkinson & Matsushita, 1991) did not find the evidence that clients' preferences for therapists' ethnicities influenced therapy process or outcome. In studies examining effects of preferences on session outcome, inconsistent results have been found. Some research results (Elkin et al., 1999; Devine & Fernald, 1973) suggested clients rated therapists or therapy process positively when they received their preferred condition of therapy. On the contrary, other researchers (Bakker, Spinhoven, van Balkon, Vleugel, & van Dyck, 2000) suggested that match and mismatch between what clients preferred and what they actually received in therapy did not affect session outcome. However, there has been insufficient number of studies on preference, although preference is getting more empirical attention these days than in the past. In addition, researchers did not examine what factors moderate or mediate the relationship between clients' preferences and therapy process or outcome. Thus, we do not know when and why preferences affect or do not affect therapy process or outcome.



### *Types of Therapy*

There are numerous types of therapies including psychodynamic, humanistic, cognitive, behavioral, eclectic therapy, and so forth. In this section, however, I will focus only on insight-oriented and action-oriented approach because getting “immediate resolution” is often cited as the primary reason for seeking counseling among Asian Americans. Insight-oriented therapy is perceived as lacking “immediate resolution,” whereas action-oriented approaches are perceived as providing “immediate resolution” (Sue & Zane, 1987).

#### *Insight-Oriented Therapy*

*Definition of and reasons for insight.* Attaining insight allows clients to have better understanding of themselves including their wishes, defenses, emotional conflicts, or insufficiency in their psychological growth and to accomplish a higher stage of ego integration (Boulware & Holmes, 1970; Brenner, 1982; Wallerstein & Robbins, 1956). Gelso, Kivlighan, Wine, Jones, and Friedman (1997) defined insight as the “extent to which the client displays accurate understanding of the material being explored.” (p. 212). This definition suggests that clients are able to see things from a new point of view, find links between things, or acknowledge the reason of their behavior (Elliott et al., 1994). One can gain insight as a sudden feeling of “aha” (Hill, 2004), or one may gain insight more slowly (Hill, 2004; Rogers, 1942). Moore and Fine (1999) also noted that it is generally regarded that insight is critical for therapeutic growth which typically “follows a slow, gradual accretion of self-knowledge” (p. 99). Unfortunately, there has been little information about how insight develops and can be measured or how insight and symptom change relate (Kivlighan, Multon & Patton, 2000).

*Goals in insight-oriented therapy.* The first purpose in the insight stage in Hill

(2004) is fostering awareness, which includes knowing “one’s thoughts, feelings, behaviors, and impact on others” (p. 220). Being conscious of what one thinks and how one behaves is crucial for personal growth. In the helping process, it is beneficial for clients to know others’ honest reactions to them, which can promote the clients’ self-investigation.

The second and major goal of the insight stage is fostering insight. After becoming aware of thoughts and feelings, a client usually wishes to have an insight in order to know more about him or herself. It is helpful for therapists to assist clients in developing new insights about their thoughts, feelings, and behaviors and to understand how they have started and sustained their problems (Hill, 2004).

People are likely to have increased control of their lives after being able to explain whether the insight or interpretation fits, which in turn becomes useful for clients to achieve therapeutic change (Hanna & Ritchie, 1995). Thus, in order to help clients get insight, counselors seek to find what causes clients’ sufferings or unhappiness and what prevents them from accomplishing what they can achieve (Hill, 2004).

The third goal of the insight stage is to help clients to be aware of and attain insight into their interpersonal relationships. Because clients are often not aware of their patterns in interpersonal relationships, therapists’ feedback about their interpersonal interactions can be helpful. It is assumed that clients interact with therapists in similar ways as with others in their non-therapy lives, even though their interactions with therapists are not exactly identical to their interactions with others and can be influenced by counselors’ countertransference. Hence, what the therapists observe in terms of the relationship in the therapy is useful when dealing with immediate relationships (Hill, 2004).

Several theorists have recognized the importance of insight in the therapeutic process. According to Freud (1963), people resolve their problems by getting insight into their problems. Freudian theories generally have explained symptoms are rooted in past and present life experiences (Hill, 2004). Insight was regarded as both working on past issues and acknowledging how past issues are related to present problems (Frank & Frank, 1991; Hill, 2004). Alternatively, Messer (1989) suggested that getting insight through interpretations of wishes, defenses and interpersonal patterns helps clients acknowledge and control emotions and mistaken beliefs. This corrective experience allows them to behave in more satisfying ways. Clients can feel enormously liberated by understanding themselves more deeply, which includes understanding their past, uncovering their past, finding its meaning, and connecting to their thoughts, emotions, and behaviors in the present (Messer, 1989).

*Skills in insight-oriented therapy.* Hill (2004) suggested that open questions for insight may be the most essential and frequently used skill in the insight stage. The first purpose of using open questions is to encourage clients to think about awareness and insights. By using open questions instead of challenges or interpretations, the clients are asked to “challenge or interpret themselves.” It can be empowering for clients to come to insights on their own with subtle therapist guidance and to think about their behaviors in a gentle and nonjudgmental way. The second purpose of open questions is to probe how the client reacts to the therapist’s challenge, interpretation, self-disclosure, immediacy, or paradoxical interpretation. Clarifying the client’s reaction and adjusting interventions according to the client’s needs can help the therapist not to force the client to follow the therapist’s intervention (Hill, 2004).

Challenges, interpretations, self-disclosures for insight and immediacy are used

primarily in the insight stage. Challenges can be used to encourage clients to think about what their behaviors mean. Interpretations can provide suggestions about the meaning of clients' behaviors. Therapists can challenge clients and provide examples and model by using self-disclosures of insight. In addition, immediacy is helpful for clients to attain insight into relationship issues. Since these skills are based more on therapists' perspective than on clients', it is important for the therapists to pay attention to maintaining an empathic and collaborative stance (Hill, 2004).

In addition, therapists frequently use the exploration skills of attending and listening, restatement, reflection of feelings, and silence to encourage clients to explore feelings and thoughts during the insight stage. After using a challenge, interpretation, self-disclosure, or immediacy, it is important for clients to be allowed to explore related thoughts and feelings.

### *Action-Oriented Therapy*

*Definition and reasons of action.* Some authors use the term "action" as synonymous with "behavior." On the contrary, Mahrer (1994) regarded action as including "identifying and challenging specific irrational thoughts" (p.414). Westerman (1989) suggested that thinking and acting are fundamentally related. Other authors also asserted that thoughts, emotions, and behaviors are mutually dependent on one another (Gibson, 1979; Safran, 1980; Shaw & Bransford, 1977; Weimer, 1977). On the other hand, Gendlin (1986) used the term "action" only for physical behaviors. For the purpose of this study, both "action" and "behavior" are defined broadly including thoughts and feelings as well as physical behaviors (Hill, 2004).

Westerman (1989) argued for the importance of action in therapy. According to Westerman (1989), practical activity is the main point for therapeutic growth, and

insights are valuable only when they lead to new ways of behavior in real life. Other authors also highlight the importance of action.

According to Hill (2004), when therapists and clients work on action, they have to focus on exploring feelings and thoughts about action as well as on making future plans in terms of behaviors, thoughts, and feelings. In addition, an empathic and supportive stance of the therapist is important when working on action. In other words, it is important for therapists to encourage clients to think about changes but not to force them to change in certain way. When clients themselves decide how to change, it is more likely that they will be responsible for making and maintaining the changes in their lives than when the changes are therapist-directed. Too much direction on the part of therapists may lead clients to become dependent on the therapists, especially for clients who tend to be dependent on others (Teyber, 2000). Instead of giving clients advice, it is often more useful to help clients learn how to explore and apply changes in their lives, which helps them use adaptive behavioral changes in the future.

Although client behavioral change may be an ultimate goal, Hill (2004) noted that it is important for therapists to be supportive and not invested in clients' change. Instead, therapists must facilitate clients in thinking about whether or not they want to change and help them carry out desired changes. In the process of making changes in the clients' lives, it is important for therapists to be objective and to be concerned with clients rather than their choices regarding action. Therapists who are too invested in clients' change are likely to be viewed as parental figures who allow clients to repeat childhood patterns where the clients behave simply to satisfy or disobey their parents.

Hill (2004) suggested a number of steps for exploring and deciding on action in therapy. First, therapists and clients identify the specific problem, and think about

whether the clients are interested in changing. Therapists and clients can then explore how the clients want to change, which options of change are available, and what situational factors must be considered. Then, the clients are encouraged to choose action plans, subsequently try out action in sessions, and finally attempt action outside of the therapeutic setting. Therapists also check on the clients' progress with behavioral change, and revise the action plan if necessary. These steps can be altered as needed for each client and presenting problem.

*Goals in action-oriented therapy.* Hill (2004) suggested several goals for working on action. These goals include encouraging clients to think about new ways of behaving, helping clients make decisions about changes, and offering clients feedback on their progress in making changes in their lives. The other goals include helping clients assess and revise their action plans as needed, and exploring feelings about making changes.

*Skills in action-oriented therapy.* According to Hill (2004), open questions related to action are the most frequently used skill when working on action. Therapists use open questions to gather information about clients' previous attempts to change and feelings about the change at the time of previous attempts. Restatements and reflections of feelings are also used to discover how clients feel about change, to show support from therapists, and to ensure that therapists listen to what clients say. The insight skills such as challenge, interpretation, self-disclosure, and immediacy can also be used to explore impediments to change.

According to Hill (2004), the distinctive skills when working on action are information, feedback about the client, process comments, direct guidance, and disclosure of strategies. Counselors use information to teach clients about options for action,

feedback to shape clients' action, direct guidance to provide advice about the best approach, and disclosure of strategies to minimize intrusion when the counselors suggest action plan (Hill, 2004).

### *Asian Americans in Therapy*

The U.S. Bureau of the Census in 2002 reported that Asian Americans are one of the fastest growing ethnic groups in the United States. The number of Asian Americans living in the United States was 12 million in 2000, which was an increase of 72% since 1990. Due to this increase in population size, psychologists have begun to pay attention to the psychological needs of Asian Americans (Atkinson, 2004).

Asian Americans have used psychological services less than would be expected, and Asian Americans' rate of entrance into hospitals for mental health concerns was the lower than any other racial and ethnic group. In addition, it is reported that Asians tended to terminate from therapy prematurely (Atkinson, 2004; Snowden & Cheung, 1990). According to S. Sue (1977), 50% of Asian American clients did not come back after the first intake interview, compared to 30% of European American clients. However, due to their status as a minority and possibility of experiencing racism, Asian Americans may need mental health services more than European Americans (Atkinson, 2004; Leong et al., 1995).

### *Reasons of Asian American's Underutilization of Mental Health Services*

One reason for Asian Americans' underutilization of mental health services may be that Asian Americans tend to utilize therapeutic systems in communities such as family, religious leaders, and respected elders when asking for help with psychological problems (Atkinson, Morten, & Sue, 1998; Sue & Sue, 1999). When Asian Americans

venture outside their internal therapeutic systems, one factor that may contribute to Asian Americans underutilization of therapy is that mainstream therapists often do not have the appropriate cultural relevancy, sensitivity, and competency to effectively counsel Asian Americans (Atkinson, Morten, & Sue, 1998; D.W. Sue & Sue, 1999; Kim & Atkinson, 2002).

Additional factors are that Asian Americans are not familiar with mainstream Western therapy and are reluctant to ask others help with their psychological issues, as such a request is contrary to Asian cultural norms. In addition, Asian Americans who are not familiar with American culture and have low levels of acculturation may experience Western therapy as foreign, not trustworthy, and intimidating. Thus, less acculturated Asian Americans tend to have more negative attitudes towards seeking professional mental health services than more acculturated Asian Americans (Atkinson, Morten, & Sue, 1998; Sue & Sue, 1999). These results also support the idea that Asian Americans' lack of familiarity with western culture is related to their underutilization of psychological therapy (Kim & Atkinson, 2002). In addition, according to Sue and Zane (1987), when Asian American clients are not familiar with a Western style of therapy and doubt professional counseling in general, they are not likely to be confident in the efficacy of therapy that does not give immediate benefits to them (Kim, Li, & Liang, 2002).

On the contrary, it has also been reported that the less Asian Americans are acculturated, the more they are willing to see a therapist (Gim et al., 1990). According to Gim et al. (1990) and Atkinson, Whiteley, and Gim (1990), even though the less acculturated Asian Americans tend to view seeking mental health services in a negative light, they may be eager to get help from professional counseling when they realize the



need for help.

*Empirical Evidence about Asian Americans' Preferred Style of Counseling*

In studying Asian Americans' preferences for counseling, Sue and Zane (1987) described Asian Americans' preference for "gift giving." "Gift giving" can be defined as reducing anxiety, having less depression, normalizing, and learning skills. They suggested that when therapists help clients see the immediate and tangible benefits of therapy in the first session, it is more likely that Asian American clients will perceive therapists as culturally sensitive and have not terminate prematurely. Some have argued that offering interpretation can be a kind of gift giving. However, Sue and Zane (1987) suggested that gift giving was more likely to be related to immediate relief in symptoms, which is more concrete and tangible than insight attainment.

In Kim, Li, and Liang (2002), 68 Asian American participants were given four types of career counseling; in one condition, therapists focused on immediate resolution of problems, and in another condition therapists focused on getting insight. Each condition was paired with therapists' emphasis of client expression; in one introduction, therapists encouraged clients to express emotion, and in another condition, therapists encouraged client to express cognition. After receiving a session of career counseling, the clients rated the therapists on the Counselor Effectiveness Rating Scale, the Relationship Inventory, Working Alliance Inventory, the Session Depth subscale of the Session Evaluation Questionnaire, and Cross-Cultural Counseling Inventory. The researchers found that when therapists work on solving problems immediately, Asian American clients are more likely to establish good working alliances with the therapists than when therapists focused on getting insight. They also found that Asian American clients with high adherence to Asian values rated the therapists who encouraged the clients to express

emotion as more cross-culturally competent than the therapists who encouraged the clients to express cognition. However, this study contains a limitation. The participants in this study rated working alliances and therapist cross-cultural competence after one session although these factors are difficult to rate after a first session and are likely to change after receiving more sessions.

Yau, Sue, and Hayden (1992) asked six international clients and one European American client which style of counseling they preferred within and across four therapy sessions. First, the researchers asked all participants to listen to an audio taped session using a problem-solving approach or client-centered approach, and clients rated both approaches. Then, the participants received both client-centered and problem-solving therapy and rated the actual counseling sessions. The researchers did not find an overall preference for either style of counseling in rating the audio-taped sessions and the action sessions. In addition, the clients tended to change their preferences for a specific counseling approach after having four actual sessions. The authors also reported that the clients' preferences after listening to the audio taped sessions were not same as their preferences while having actual therapies. The clients reported that both styles of counseling were helpful in different ways. They said the client-centered approach "was helpful in finding out what is exactly going on in my head," "helps me express my emotions," "helps me speak out my problems, rather than keeping it inside." The clients reported that the problem-solving approach "makes me think rationally," "helps me focus my problem," and "guides my thought and helps me solve my problem." Hence, it seemed that many of clients recognized that the two styles complemented each other. However, this study had some limitations. The participants of this study were only six international students who came from Japan and Iran, which limited the nationalities of

the participants, and five of the participants were women. In addition, the presenting problems of the participants were limited to conflicts in family and other interpersonal relationships. Thus, it is doubtful that these results apply to all Asian American populations and to all various range of presenting issues (Yau, Sue, & Hayden, 1992).

Atkinson, Maruyama, and Matsui (1978) asked 52 Asian American university students to rate counselors' performance in audio-taped sessions. The researchers recorded two audio taped sessions; in one condition, a therapist was directive, logical, and rational and in another condition, a therapist was nondirective, reflective, and affective. Each condition was paired with introductions with two different ethnicities of counselors; in one introduction, a therapist was described as Asian American and in another introduction, a therapist identified as White American. The researchers found that the participants rated the directive, logical, and rational therapist as more trustworthy and approachable than the nondirective, reflective, and affective therapist. In addition, the participants perceived the Asian American therapist as more approachable and trustworthy than the White American therapist. However, in this study, the researchers used the same actress for the therapist and the same actress for the client and same presenting problem in both conditions. Hence, it is possible that the clients' ratings of the therapists were influenced by the particular therapist and presenting issue, not by the therapists' ethnicities and the style of counseling.

Atkinson and Matsushita (1991) also studied how counselors' ethnicities and styles affected clients' rating of therapists. The researchers randomly assigned 68 Japanese Americans to one of four conditions produced by crossing the counselor ethnicity (Japanese American or White American) and the style of counseling (directive or nondirective). The participants listened to a tape in which a counselor's ethnicity was

introduced and another audio-taped session in which the counselor used directive or nondirective style of counseling. After listening to the two tapes, the participants rated the counselor using the Counselor Effectiveness Rating Scale (CERS). The researchers found that the Japanese-American counselor who used a directive approach was rated as most expert, attractive, trustworthy, and useful. On the other hand, the Japanese-American counselor who used a nondirective approach received the lowest scores in every subscale of the CERS (expertness, attractiveness, trustworthiness, and utility scales). The participants did not rate White-American counselors significantly differently according to the styles of counseling they used. These results suggested the possibility of an interaction between counselor ethnicities and styles of counseling. This study, however, used the same actress for all conditions, so it could be possible that particular characteristics of the actress affected the clients' ratings of therapist expertness, attractiveness, trustworthiness, and utility. In other words, the clients might respond to the particular actress rather than to therapist ethnicity or style of therapy.

Kim et al. (2003) studied counselor self-disclosure with 62 East Asian American clients. The participants discussed personal issues in therapy sessions; therapists either encouraged self-disclosed in sessions or refrained from using self-disclosures. The researchers did not find the evidence Asian American clients gave higher ratings to sessions in which counselors used self-disclosures than to those without therapist self-disclosures. The researchers, however, found that East Asian American clients evaluated counselor self-disclosure of strategies more effective than disclosure of approval/reassurance, facts/credentials, or emotions. In addition, therapists used disclosures of strategies more often in good sessions than in poor sessions. These findings may reflect Asian Americans' inclination for desiring gift giving; perhaps the clients in

the present study thought the disclosures of strategies would give them immediate help to solve their presenting problems (Kim et al., 2003). However, in this study the clients only received one session. It is possible that clients' ratings of self-disclosure could change as they have more sessions and establish a therapeutic relationship. In addition, all participants of this study received either course credits or money, thus the results may not generalize to clients in real therapy settings.

#### *Possible Factors Leading to Asian Americans' Preferences for Therapy Types*

Several researchers have suggested that cultural values and acculturation/enculturation levels may influence Asian Americans' preference for style of therapy. Enculturation refers to holding the cultural values and traditions of the native culture, whereas acculturation refers to adapting to the values of the dominant culture. According to Kim, Atkinson, and Umemoto (2001), adherence to Asian cultural norms is an important part of enculturation. Kim, Atkinson, and Yang (1999) suggested several cultural values that are salient and common to Asian Americans: collectivism, conformity to society's norms, emotional restraint, achievement for family recognition, modesty and devotion to parents and authorities. "Collectivism" means that Asians are more likely to strongly affiliate themselves to groups and emphasize interests of the groups rather than individuals' interests. "Conformity to society's norms" indicates the importance of not differing from the norms of one's family and society. "Emotional restraint" means one should not show emotions in front of others. Not expressing strong emotions like pain and anger is more encouraged than expressing them. "Achievement for family recognition" is another important value in Asian culture. In Asian society, achievement in education and occupation is the most primary factor in determining whether one succeeds or not, which also affects one's family's reputation. "Modesty" means the importance of

minimizing or devaluing one's achievement in front of others. "Devotion to parents and authority figures" indicates that children should always obey their parents; when parents get old, children have to take care of their parents. In addition, one should not talk a lot to authority figures or call authority figures by their first names; rather they should respect authority figures without questioning their authority.

Kim and Atkinson (2002) studied the relationship between the level of Asian cultural values and clients' rating of therapists. The clients were assigned to the Asian American therapists or European American therapists, and each received one session of career counseling. After the sessions, the clients rated therapists using the Counselor Effectiveness Rating Scale (CERS), the Cross-Cultural Counseling Inventory-Revised (CCCI-R) and Empathic Understanding Subscale of the Relationship Inventory (EUS). Asian American clients with high adherence to Asian cultural norms rated Asian American therapists as more empathic and trustworthy than Asian American clients who had low adherence to Asian cultural norms. In contrast, the less the clients adhered to Asian values, the more they perceived European American therapists as empathic. This study, however, used 30 minutes of session which may not be enough to communicate therapists' cultural values effectively to clients. Thus, clients might not have had enough information to rate therapists.

By contrast, in Kim et al. (2003), the researchers did not find the evidence that the level of Asian values affected the clients' ratings of counselor self-disclosure. In other words, Asian cultural values did not moderate the effect of counselor self-disclosure on therapy outcome. More details about Kim et al. (2003) were discussed in the previous section of empirical evidence about Asian Americans' preferred style of counseling.

*Summary*

Asian Americans give higher evaluation to therapy that provides “immediate resolution” than other types (Kim, Li, & Liang, 2002). In addition, Asian Americans preferred directive counseling to nondirective counseling (Atkinson, Maruyama, & Matsui, 1978; Atkinson & Matsushita, 1991). However, some other studies did not find that Asian Americans preferred directive counseling (Yau, Sue, & Hayden, 1992). Furthermore, although many researchers have hypothesized that the level of Asian values influences Asian Americans’ preferred style of counseling, inconsistent results have been found in studies examining the effect of Asian values on Asian Americans’ preferences for different types of therapy (Kim & Atkinson, 2002; Kim et al., 2003).

## Chapter 3

### Statement of Problem

The popular stereotype is that Asian American clients prefer action-oriented therapies to insight-oriented therapies. For example, Sue and Zane (1987) suggested that therapists give Asian American clients “gifts” in initial sessions of therapy by doing such things as helping to reduce anxiety, have less depression, normalize, and learn skills. Only two studies were found that directly addressed this question. Kim and Li (2002) found that Asian Americans give higher evaluations to therapy that provided “immediate resolution” than to other types. In contrast, Yau, Sue, and Hayden (1992) did not find Asian American clients to prefer a problem-solving approach, which is perceived as giving “immediate resolution”, to a client-centered approach, which is perceived as lacking “immediate resolution.”

In this study, I will examine Asian Americans’ preferences for action-oriented or insight-oriented counseling. I developed the following hypotheses.

Hypothesis 1. Asian Americans will prefer action-oriented counseling to insight-oriented counseling.

In action-oriented counseling, clients work on specific action strategies during sessions, so that they typically leave with clear ideas of things to change. On the other hand, clients in insight-oriented counseling do not typically focus on action. Because the suggestion is that Asian Americans prefer action (Sue & Zane, 1987), I speculate that Asian Americans are likely to prefer action-oriented counseling that provides immediate resolution to insight-oriented counseling that does not give immediate resolution.



Hypothesis 2. Asian Americans will regard action-oriented counseling as deeper than insight-oriented counseling.

Asian Americans in general seem to view action-oriented sessions as more valuable, more powerful, and better than insight-oriented session since action-oriented sessions provide visible outcomes (Atkinson, Maruyama, & Matsui, 1978; Kim, Li, & Liang, 2002; Sue & Zane, 1987). Hence, I predict that Asian Americans will rate action-oriented session higher than insight-oriented counseling on depth.

Hypothesis 3. Asian Americans will regard action-oriented counseling as smoother than insight-oriented counseling.

According to Leong (1986), Asian Americans might not be comfortable in situations where they are asked to share their personal issues and insights with therapists whom they might regard as authority figures. Asian Americans might worry whether they are presenting the wrong information to therapists. In addition, most Asian Americans have difficulty tolerating ambiguity, which is more likely to occur in insight-oriented sessions. In contrast, action plans are usually clearer and less ambiguous than insight. For this reason, I hypothesize that Asian Americans will evaluate action-oriented counseling as smoother (i.e., more comfortable) than insight-oriented counseling.

Hypothesis 4. Asian Americans will regard a therapist in an action-oriented condition as more credible, expert, and attractive than a therapist in an insight-oriented condition.

Asian Americans might like the therapists' focus on concrete action plans in action-oriented sessions. Hence, Asian Americans might regard a therapist in action-oriented sessions as more competent than a therapist in insight-oriented sessions. They also might think that therapists in action-oriented sessions are more credible, expert, and

attractive than therapists in insight-oriented sessions.

Research Question 1. Can we discriminate participants who prefer insight-oriented counseling from participants who prefer action-oriented counseling in terms of the Asian values, interpersonal pattern, interpersonal dependency, and emotional reliance in therapy?

Since preference for a specific style of counseling may be related to interpersonal pattern and interpersonal dependency as well as Asian values, I want to determine whether I could distinguish Asian Americans who prefer action-oriented counseling from Asian Americans who prefer insight-oriented counseling. Likely variables are Asian values, interpersonal patterns, interpersonal dependency, and emotional reliance in therapy since these variables may relate with participants wanting immediate resolution in therapy.

Research Question 2. Does participants' willingness to receive psychotherapy increase after watching the videotaped sessions?

I want to determine how watching videotaped sessions influences participants' willingness to receive psychotherapy. Asian American participants may doubt the efficacy of Western style of counseling before watching video taped sessions. Since their doubt might result from their lack of experience to some extent, watching video taped sessions might affect their willingness to receive psychotherapy.

Research Question 3. Is preference for action-oriented or insight-oriented therapy after watching the videotaped sessions related to preference on a self-report measure before watching the videotaped sessions?

I want to determine whether preference for action-oriented or insight-oriented therapy after watching the videotaped sessions matches preferences on a

self-report measure before watching the videotaped sessions. I will measure participants' preference for action-oriented or insight-oriented therapy twice. Before they watch videotaped sessions, they will be asked to choose between insight-oriented items and action-oriented items in the Counseling Preference Form (Goates-Jones, in prep). After they watch videotaped sessions, they will be asked again which approach they prefer. I will examine whether their preferences for action-oriented or insight-oriented therapy are consistent with their preferences on the Counseling Preference Form.

## Chapter 4

### Method

#### *Design*

This study examined East Asian or East Asian Americans' preferences for four different types of therapy. The participants completed a series of measures including the AVS-R, Interpersonal Dependency Inventory (IDI), Counseling Preference Form, Willingness to See the Counselor, and Inventory of Interpersonal Problems (IIP-S), the Five Item Mental Health Index (MHI-5), and the Attitude toward Seeking Professional Psychological Help-Abbreviated Scale (ASPPH-A). They then watched the four videotapes of Dr. Raskin (Client-Centered Therapy), Dr. Comas-Diaz (Ethnocentral Psychotherapy), Dr. Lazarus (Multimodal Therapy - cognitive behavioral segment was used), and Dr. Persons' (Cognitive Behavior Therapy) sessions, evaluated the session quality and the counselor credibility. They ranked the sessions in order of their preferences and were asked the reasons of their preference.

#### *Participants*

Fifty East Asians or East Asian Americans (12 men, 32 women, 6 didn't answer; 23 Koreans, 13 Chinese, 11 Taiwanese, 2 Japanese, and 1 Taiwanese/ Chinese) were recruited from Psyc 100 classes through Experimentrix as well as from announcements in other classes and in Asian Organizations. Age ranged from 18 to 34 years ( $M = 22.55$ ,  $SD = 4.26$ ). Participants were not told about the hypotheses of the study.

#### *Measures*

*Demographics.* Participants were asked about their age, sex, generation status, country of origin, years in USA, and perceived English proficiency. See Appendix A.

*The Asian Values Scale-Revised.* The AVS-R (Kim & Hong, 2004) assesses several Asian values such as collectivism, conformity to norms, emotional self-control, family recognition through achievement, and filial piety, and humility. The AVS-R contains 25 items, all measured on a 5-point Likert-type scale (1 = strongly disagree, 4 = strongly agree). Using Rasch's (1960) modeling on data from 618 Asian Americans, Kim and Hong (2004) reduced the number of items from 36 in the AVS (Kim, Atkinson, & Yang, 1999) to 25 in the AVS-R. Reliability was acceptable ( $\alpha = .86$ ). Kim, Yang, Atkinson, Wolfe, and Hong (2001) performed a confirmatory factor analysis and found that the AVS on which the AVS-R was based and the two Individualism-Collectivism scales (Triandis, 1995) served as a value adaptation construct, which provides evidence of construct validity. In the current study, internal consistency of the AVS-R was .76. See Appendix B.

*The Inventory of Interpersonal Problems-Short (IIP-S; Horowitz et al., 1988)* measures the degree to which behaviors, thoughts, and feelings have been problematic for participants in significant relationships on the dimensions of *domineering, vindictive, cold, socially avoidant, nonassertive, exploitable, overly nurturant, and intrusive*. The IIP-S contains 64 items, which are measured on a 5-point Likert type scale. The internal consistency of the IIP-S ranged from .76 to .88 and the test-retest reliability ranged from .58 to .84 (Horowitz et al., 2000). In addition, moderate correlations with self-report inventories of social adjustment (range = .16 - .49; Weissman & Bothwell, 1976), anxiety (range = .31 - .39; Beck & Steer, 1990), depression (range = .33 - .43), and general mental health functioning (range = .48 - .59) provide evidence of concurrent validity. In

the current study, internal consistency of IIP-S was .94. See Appendix C.

*The Five Item Mental Health Index (MHI-5; Ware & Sherbourne, 1992 )*

measures levels of psychological distress. The MHI-5 contains five items all measured on a 6-point Likert type scale (1 = All of the time, 6 = none of the time). An example of MHI-5 is “How much of the time, during the past month, have you felt downhearted and blue?” Sums of scores in MHI-5 can range from 0 to 100, and low scores indicate high psychological distress. The cut-off point to diagnose major depression or other psychological problems has not been established (Strand et al., 2003). The internal consistency of the MHI-5 was .82 (Strand et al., 2003). MHI-5 was negatively correlated with the SCL ( $r = -.77$ ; Hopkins Symptom Checklist), which provides evidence of adequate concurrent validity (Strand, Dalgard, Tambs, & Rognerud, 2003). In the current study, internal consistency of the MHI-5 was .88. See Appendix D.

*The Interpersonal Dependency Inventory (IDI; Hirschfield et al., 1977)* measures the thoughts, behaviors, and feelings revolving around the need to associate closely with valued people. IDI contains 48 items scaling on a 4- point scale, ranging from 1 (disagree) to 4(agree). The three subscales of IDI are (a) Emotional Reliance on Others (ER; 18 items; e.g., “the idea of losing a close friend is terrifying to me”), Lack of Social Self-confidence (LS; 16 items; e.g., “when I have a decision to make I always ask for advice”), and Assertion of Autonomy (AA; 14 items; e.g., “what people think of me doesn’t affect how I feel”). The split-half reliability of total IDI ranged from .72 to .91 and the internal consistency ranged from .75 to .88. No test-retest reliability was reported (Bornstein, 1994; Bornstein, 1998; Hirschfield et al., 1977). The first two subscales of the IDI (i.e. emotional reliance on another person, lack of social self-confidence) were significantly correlated with measures of depression (range = .42 - .44), interpersonal

sensitivity (range = .45 - .53), anxiety (range = .27 - .34), and general neuroticism (range = .47 - .49), which provides evidence of adequate concurrent validity. For the current study, internal consistency of IDI was .71. See Appendix E.

*Counseling Preference Form.* Goates-Jones (in prep) developed this client preference form (Appendix F) which was based on the Hill and Kellems' (2003) Helping Skills Measure. The HSM (Hill & Kellems, 2003) asked clients asked how much their counselors used a specific skill. In this version, Goates-Jones changed the stem from "*In this session, my counselor. . .*" to "*I prefer my counselor to. . .*" Participants are given 20 sets of dichotomous statements, each contrasting one action-oriented item ("Identify useful resources", "Discuss specific things I can do to make change happen", "Teach me specific skills to deal with my problems", "Figure out how to solve a specific problem", "Think about changes I could make in my life") and one insight-oriented item ("Encourage me to think about changes I could make in my life", "Help me become aware of contradictions, "Help me gain a new perspective on my problem", "Encourage me to challenge my beliefs", "Help me understand reasons behind my thoughts") and asked to choose between insight-oriented items and action-oriented items. For example, a participant is asked to choose whether he or she would prefer the counselor to teach specific skills or help understand reasons behind the thoughts.

When a participant chooses the action preference in an item, a value of -1 is assigned to the item; when a participant chooses the insight preference in an item, a value of +1 is assigned to the item. Hence, the scores in this scale can range from -20 to +20. As the score in this scale becomes positive, the preference for insight-oriented approaches becomes stronger. As the score becomes negative, the preference for action-oriented approaches becomes strong. The score becomes zero when one does not have

preference either for insight or for action. Test-retest reliability in Goates & Hill (in prep.) was .89. In the current study, internal consistency of Counseling Preference Form was .89. See Appendix F.

*Willingness to See the Counselor Scale* (WSCS; Dowd & Boroto, 1982) is a single-item that measures how much participants are willing to work with the counselor they had just seen on a videotape. Participants rate their willingness on a 10 point scale ranging from 1(not willing) to 10 (very highly willing). As evidence of predictive validity, Haley and Dowd (1988) used WSCS to study deaf adolescents' responses to different communication methods in counseling and found that ratings on WSCS were higher when counselor used sign language or an interpreter than when written communication was used. See Appendix G.

*Session Evaluation Questionnaire- Depth and Smoothness Scales* (Stiles & Snow, 1984) measures session impact in terms of how participants feel about the depth and smoothness of the therapy process. In the Depth scale, the participants evaluate sessions as deep or shallow, valuable or worthless, full or empty, powerful or weak, and special or ordinary in a seven-point bipolar scale. The Smoothness scale consists of six items; smooth or rough, comfortable or uncomfortable, relaxed or tense, easy or difficulty, pleasant or unpleasant, and safe or dangerous. In terms of internal consistency, the coefficient alphas of the SEQ ranged from .84 to .91 for the depth scale, and from .78 to .90 for the smoothness scale (Stiles & Snow, 1984; Kim & Atkinson, 2002; Kim et al, 2002; Li & Kim, 2004). In addition, moderate to strong correlation ( $r = .44$  to  $.72$ ) between the Depth and Smoothness Scales and subscales of the Session Impacts Scale (the Understanding, Problem Solving, and Relationship Scale) and strong correlation ( $r = .72$ ) between the Smoothness Scale and the Positivity Index (e.g. clients' positive



mood) showed evidence of adequate concurrent validities (Stiles et al., 1994). In the current study, internal consistency ranged from .91 to .94 for the depth scale and .69 to .89 for the smoothness scale. See Appendix H.

*Counselor Effectiveness Rating Scale (CERS; Atkinson & Carskaddon, 1975; Atkinson & Wampold, 1982)* assesses clients' perception of counselor credibility. The CERS is a 10-item semantic differential questionnaire. Participants rate counselors' expertness, attractiveness, trustworthiness, and utility on a 7-point bipolar scale (1 = bad, 7 = good). The internal consistency of the CERS has ranged from .87 to .91 (Atkinson & Wampold, 1982; Kim & Atkinson, 2002; and Kim et al. 2002; Li & Kim, 2004). The CERS was correlated with the Counselor Rating Form ( $r = .80$ ; CRF; Barak & LaCrosse, 1975), which provides evidence of concurrent validity. In the current study, internal consistency of CERS total was .93. See Appendix I.

*Attitude toward Seeking Professional Psychological Help-Abbreviated Scale (ASPPH-A; Fischer & Farina, 1995)* assesses inclinations toward seeking counseling for psychological problems. The original ASPPH contains 29 items and the Abbreviated Scale of ASPPH contains 10 items using a 4 point scale, ranging from 1 (disagree) to 4 (agree). The internal consistency of the ASPPH-A was adequate ( $\alpha = .84$ ) and test-retest reliability was also acceptable ( $r = .80$ ; Fischer & Farina, 1995). Scores on the ASPPH-A successfully discriminated those who sought professional counseling from those who did not (Cash, Kehr, & Salzbach, 1978), which indicates adequate construct validity. In the current study, internal consistency ranged from .83 (pre-session) to .86 (post-session). See Appendix J.

*Post-session clients' preferences* assess clients' rank-ordered preference for the four sessions. They were asked to rank the four sessions in order of their preferences (1 =

what they liked best, 4 = what they like least). They were also asked to explain why they ranked the sessions as they did. See Appendix K.

### *Stimulus Material*

My advisor and I identified four video tapes of insight-oriented sessions; “Effective Psychoanalytic Therapy of Schizophrenia and Other Severe Disorders” by Dr. Karon, “Short-term Dynamic Therapy” by Dr. Freedheim, “Ethnocentral Psychotherapy” by Dr. Comas-Diaz, and “Client-Centered Therapy” by Dr. Raskin. In the insight-oriented sessions, the therapists generally helped the clients explore and facilitated insight about their presented issues. In “Effective Psychoanalytic Therapy of Schizophrenia and Other Severe Disorders,” Dr. Karon facilitated a client in becoming aware of the unconscious and encouraged her to replace the punitive superego with the less destructive superego. Dr. Freedheim, in “Short-term Dynamic Therapy,” helped a client gain insight into presenting issues that stemmed from the client’s previous experiences. In “Ethnocentral Psychotherapy,” Dr. Comas-Diaz facilitated a client’s recognizing “self as an internal ethnocultural representation.” “Client-Centered Therapy,” by Dr. Raskin, focused on helping a client clarify presenting problems and ways of resolving them, to be fully aware of herself, and to be the person she wanted to be.

My advisor and I also identified three videotapes of action-oriented sessions; “Cognitive Behavior Therapy” by Dr. Persons, “Cognitive-Affective Behavior Therapy” by Dr. Goldfried, and “Multimodal Therapy” by Dr. Lazarus. In these video tapes of action-oriented sessions, the therapists helped clients explore and facilitated action plans for the presenting issues. In “Cognitive Behavior Therapy,” Dr. Persons had a central goal of solving the client’s presenting symptoms and actively worked on the client’s problems using a problem-solving approach. Dr. Goldfried, in “Cognitive-Affective Behavior

Therapy,” asked the client to express feelings and work on negative emotions using behavioral rehearsals to train a client to be more assertive and expressive. “Multimodal Therapy,” by Dr. Lazarus, used an eclectic approach, but for this study, I only used the part where he used a cognitive-behavioral approach.

Since four one-hour tapes were too long to watch, I selected 10 minute segments from each tape that represented the types of therapies best. For example, In the Dr. Lazarus’ session, the segment in which role-plays were used was chosen, and in the Dr. Comas-Diaz’s session, the part in which the therapist and the client discussed how the client’s issues were related to her family was chosen.

I then asked 12 doctoral students in counseling psychology at a large mid-Atlantic university to rate the seven video tapes on insight versus action-orientedness, attractiveness of therapists, therapist competence, client involvement, and believability using 7-point scales. The judges’ ratings of insight-oriented therapies are shown in Table 1. Since Dr. Comas-Diaz’s session received the highest ratings for insight-orientedness, therapist attractiveness, therapist competence, client involvement, and believability, it was chosen as an insight-oriented session for the current study. Although Dr. Freedheim’s session received higher ratings for insight-orientedness than Dr. Raskin’s session, it obtained lower ratings for all the other variables. Thus, Dr. Raskin’s session was chosen as the other insight-oriented therapy session to be used.

*Table 1. Means and Standard Deviations of Ratings of Insight-oriented Therapies*

	Dr. Karon		Dr. Comas-Diaz		Dr. Raskin		Dr. Freedheim	
	M	SD	M	SD	M	SD	M	SD
Insight-	4.92	2.11	<b>6.08</b>	<b>.90</b>	<b>5.17</b>	<b>1.53</b>	5.92	1.56

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orientedness								
Action-	1.75	1.21	<b>1.25</b>	<b>.45</b>	<b>1.17</b>	<b>.58</b>	1.33	.49
orientedness								
Therapist	2.25	1.54	<b>5.83</b>	<b>.94</b>	<b>4.33</b>	<b>1.61</b>	3.75	1.42
Attractiveness								
Therapist	3.08	1.83	<b>6.00</b>	<b>.95</b>	<b>5.00</b>	<b>1.04</b>	4.92	1.62
Competence								
Client	3.16	1.34	<b>5.92</b>	<b>.79</b>	<b>5.92</b>	<b>.67</b>	4.58	1.51
Involvement								
Believability	4.17	1.75	<b>5.58</b>	<b>1.16</b>	<b>5.58</b>	<b>1.00</b>	4.25	1.60

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Note. The sessions shown in bold were selected.

Table 2 shows judges' ratings of action-oriented sessions. Dr. Person's session was chosen first because the rating for insight-orientedness was the lowest, action-orientedness was the highest, and it obtained adequate ratings for therapist attractiveness, therapist competence, client involvement, and believability. Because Dr. Goldfried's session and Dr. Lazarus's session received similar ratings for most variables, the counseling techniques in each session were examined. Dr. Goldfried used a two-chair technique and asked the client to perform a dialogue between two sides of herself, whereas Dr. Lazarus asked the client to do a role-play with his father to learn how to express his feelings toward his father. Because the role play is more reflective of an action-oriented session than is the dialogue between two sides of a person, Dr. Lazarus's session was chosen as the second action-oriented session.

*Table 2. Means and Standard Deviations of Ratings of Action-oriented Therapies*

	<b>Dr. Persons</b>		Dr. Goldfried		<b>Dr. Lazarus</b>	
	<b>M</b>	<b>SD</b>	M	SD	<b>M</b>	<b>SD</b>
Insight-orientedness	<b>1.58</b>	<b>1.16</b>	4.33	1.87	<b>4.08</b>	<b>1.51</b>
Action-orientedness	<b>7.00</b>	<b>0.00</b>	4.83	2.12	<b>4.67</b>	<b>1.87</b>
Therapist Attractiveness	<b>4.92</b>	<b>1.44</b>	5.00	1.35	<b>5.00</b>	<b>1.48</b>
Therapist Competence	<b>5.75</b>	<b>1.54</b>	5.58	1.38	<b>5.42</b>	<b>1.24</b>
Client Involvement	<b>5.83</b>	<b>1.27</b>	6.25	.87	<b>6.25</b>	<b>.87</b>
Believability	<b>5.50</b>	<b>.90</b>	4.92	1.31	<b>3.33</b>	<b>1.30</b>

Note. The sessions shown in bold were selected.

### *Procedures*

*Recruiting Participants.* East Asian American participants were recruited from an introductory psychology classes, upper level psychology courses, and Asian or Asian American Associations. Participants from psychology classes received 1.5 course credits for participating and other participants received \$5 for their participation. They were given a brief explanation about the study, but did not know the hypotheses of the study. Participants were told that the study would take about one and half hours.

*Gathering information.* When the participants arrived, they read and signed an

informed consent form. They also completed a demographic form. Finally, they completed the AVS-R, Interpersonal Dependency Inventory (IDI), Counseling Preference Form, Willingness to See the Counselor, the Five Item Mental Health Index (MHI-5), Attitude toward Seeking Professional Psychological Help-Abbreviated Scale (ASPPH-A), and Inventory of Interpersonal Problems (IIP-S) in a random order.

*Watching Four Video Clips.* After completing all the measures, the participants watched four video clips in a random order, each of which took 10 minutes. Two of the video tapes were insight-oriented therapy sessions and the other two were action-oriented sessions.

*Evaluation.* After watching each video clip, participants completed the Depth Scale, the Smoothness Scale, the CERS, and Willingness to See the Counselor Scale. After completing the evaluations for all four clips, participants were asked to rank the videotaped sessions in order of their preference and to explain the reasons of their preference. Pictures of four therapists in the videotaped sessions were shown to remind participants of each session. They were also asked again to complete the ASPPH-A.

## Chapter 5

## Results

*Preliminary Analyses*

Means, standard deviations, and internal consistency values of the measures are shown in Table 3. All measures had adequate internal consistency values. Table 4 shows correlations between variables. Unfortunately, the means, standard deviations, and internal consistency values could not be compared with data from other studies of East Asian or East Asian Americans, so they were compared with data from general American samples that were composed of participants with diverse racial/ethnic backgrounds. However, interpreting the results of the comparisons should be done with caution. Effect size analyses ( $M_1 - M_2 / \text{pooled SD}$ ) were used to compare scores of East Asian samples in this study and scores of the general American samples (Cohen, 1988). According to Cohen (1988), an effect size of .2 is considered as small, an effect size of .5 is considered as medium, and an effect size of .8 is considered as large.

*Table 3. Means, Standard Deviations and Internal Consistency of All Subscales*

Measures	M	SD	$\alpha$	M and SD of American population	Effect Size
AVS-R	2.45	.28	.76	NA	
IDI	50.09	10.91	.71	41.9 ( 12.76 )	.69

CPF		-2.18	10.85	.89	-2.32	.01
					(11.04)	
IIP-S		2.20	.51	.94	1.51	1.11
					(.73)	
MHI-5		69	15.61	.88	79.5 ( 19 )	.60
ASPPH-A		14.07	5.94	.83	20.5	1.05
					( 6.30 )	
	– Pre treatment					
Raskin	Depth	3.84	1.39	.94		
	Smooth	4.66	.79			
	CERS	3.66	1.02	.92		
	WSCS	4.27	2.57	NA		
Comas-Diaz		4.42	1.22	.94		
	Depth					
	Smooth	4.33	1.16			
	CERS	4.23	1.03	.95		
	WSCS	5.18	2.48	NA		
Lazarus	Depth	5.12	1.17	.93		
	Smooth	3.94	1.20			
	CERS	4.65	.88	.93		
	WSCS	5.90	2.53	NA		
Persons	Depth	3.87	1.19	.91		
	Smooth	4.76	1.09			
	CERS	4.09	1.05	.94		
	WSCS	4.68	2.57	NA		



ASPPH-S	14.69	6.51	.86
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-- Post treatment

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Note. AVS-R = The Asian Values Scale-Revised; IDI = The Interpersonal Dependency Inventory; CPF = the Counseling Preference Form; IIP-S = the Inventory of Interpersonal Problems-Short; MHI-5 = The Five Item Mental Health Index; ASPPH-A = Attitude toward Seeking Professional Psychological Help-Abbreviated Scale; CERS = Counselor Effectiveness Rating Scale; WSCS = Willingness to See the Counselor Scale

The effect size analyses show that East Asian or East Asian American participants in this study were significantly different (yielding at least medium effect sizes) from general American participants in other studies on the IDI ( $d = .69$ ), IIP ( $d = 1.11$ ), MHI-5 ( $d = .60$ ), and ASPPH-A ( $d = 1.05$ ), but not different in the CPF ( $d = .01$ ). Thus, East Asian samples in this study tended to be more interpersonally dependent; report more problematic behaviors, thoughts, and feelings in significant relationships; have more psychological distress; and be less willing to seek counseling for psychological problems than general American samples, but were not different in preferences for insight-oriented or action-oriented counseling. However, since all measures were developed by European American researchers, definitions and levels of interpersonal dependency, problems in significant relationships, psychological distress used in the measures might differ from those in the East Asian culture.

In terms of sex differences, ratings in attitude toward seeking professional psychological help was significantly higher for female than male participants (female = 16.20, male = 9.58,  $p < .001$ ), but other ratings (the IDI, IIP, MHI-5, AVS-R, Depth,

Smoothness, CERS, WSCS) did not yield differences between male and female participants' ratings.

In addition, according to t-tests, first generation Asian Americans were not significantly different from the second generation Asian Americans in every ratings (the IDI, IIP, MHI-5, AVS-R, SEQ, CERS, WSCS, ASPPH-A). Furthermore, according to Regression analysis, generation status, English proficiency, and time in the USA did not predict participants' ratings of psychotherapy sessions on the Depth, Smoothness, CERS, WSCS; except when English proficiency predicted willingness to see Dr. Raskin. In other words, the more fluent they were in English, the more they were willing to see Dr. Raskin ( $p = .03$ ). However, because only one analysis among 48 was significant, it might happen by chance.

Table 4. Correlations among variables

Variables	1	2	3	4	5	6	7	8	9	10	11	12
1. AVS	--											
2. IDI	-.06	--										
3. CP	-.04	-.09	--									
4. IIP	.26	.37**	.16	--								
5. MHI-5	-.05	-.42**	-.04	-.39**	--							
6. ASPPH-S—Pre	-.27	.03	.22	0	0	--						
7. Video1 Depth	-.05	-.28*	.24	-.10	.14	.33*	--					
8. Smoothness	0	-.13	.21	-.08	.12	0	.04	--				
9. CERS	.09	-.10	.13	-.10	.30*	.31*	.59**	.35	--			

Table 4. Correlations among variables (Cont.)

Variables	1	2	3	4	5	6	7	8	9	10	11	12
10.Video1	-.09	-.03	.15	-.08	.11	.46**	.66**	.18	.76**	--		
11.Video2 Depth	-.08	-.05	.07	-.10	.23	.18	-.02	.09	.14	.15	--	--
12. Smoothness	-.34*	.05	.14	-.04	-.34*	.19	.09	.08	.05	.06	.14	--
13. CERS	-.02	.03	.08	-.07	.03	.23	-.07	.18	.22	.21	.73**	.44**
14. WSCS	-.09	.01	.05	-.11	.21	.29*	.08	.19	.32*	.32*	.80**	.34*
15.Video3 Depth	-.11	.16	-.09	-.10	.24	.22	.21	0	.21	.18	.13	-.33*
16. Smoothness	.02	.09	-.19	.17	-.21	-.06	-.15	.10	.08	-.10	.10	.33*
17. CERS	.25	.29*	-.48**	-.05	.15	-.13	-.23	-.03	.10	.09	.12	-.17
18. WSCS	.16	.19	-.32*	-.12	.27	.10	-.02	-.12	.19	.18	.26	-.25

Table 4. Correlations among variables (Cont.)

Variables	1	2	3	4	5	6	7	8	9	10	11	12
19. Video4 Depth	-.06	.15	.04	-.05	.27	.06	.04	.01	.16	.05	.30*	-.40
20. Smoothness	-.06	-.02	-.04	-.26	-.05	-.18	-.32*	.17	-.22	-.25	.11	-.10
21. CERS	.09	.07	-.16	-.25	.08	-.13	-.20	.11	.04	-.11	.09	-.21
22. WSCS	0	.02	-.05	-.16	.31*	.20	-.10	.16	.21	.17	.35*	-.32*
23. ASPPH-S post	-.34*	.07	.18	-.07	.08	.84**	.26	.11	.29*	.38**	.16	.12

Table 4. Correlations among variables (Cont.)

Variables	13	14	15	16	17	18	19	20	21	22	23
13. CERS	--										
14. WSCS	.81**	--									
15.Video3 Depth	-.20	.03	--								
16. Smoothness	.39**	.20	-.05	--							
17.Video3 CERS	.08	.08	.48**	.37**	--						
18. WSCS	.11	.25	.60**	.13	.74**	--					
19.Video4 Depth	.05	.15	.45**	-.05	.08	.19	--				
20. Smoothness	.07	-.11	.07	.11	.11	.03	.36*	--			
21. CERS	.04	-.05	.24	.19	.38**	.26	.51**	.76**	--		

Table 4. Correlations among variables (Cont.)

Variables	13	14	15	16	17	18	19	20	21	22	23
22.Video4 WSCS	.16	.29*	.35*	-.03	.26	.46**	.60**	.44**	.65**	--	
23.ASPPH-S post	.23	.28*	.34*	-.03	.01	.19	.16	-.06	.04	-.01	--

\* Sig. at  $p < .05$ ; \*\* Sig at  $p < .01$

*Manipulation Checks.* T-tests were conducted to see if the two video tapes in each condition (insight-oriented and action-oriented therapies) were equivalent to each other. The results showed that there were significant differences between the two videotapes in the insight-oriented condition and between the two videotapes in the action-oriented condition for the Depth, Smoothness, CERS, and WSCS. The ratings of two action-oriented sessions were significant different from each other on all ratings ( $p < .001$ ). Table 5 shows the results of the paired-sample t-tests.

*Table 5. Paired Sample t-test between the two videotaped sessions in each condition*

Variable	Raskin		Comas-Diaz		Paired			
	(Insight 1)		(Insight 2)		Differences			
	M	SD	M	SD	M	SD	t	p
Depth	3.84	1.39	4.42	1.22	-.59	1.87	-2.23	.03
Smoothness	4.65	.79	4.33	1.15	.33	1.35	1.73	.09
CERS	3.66	1.01	4.23	1.03	-.58	1.28	-3.20	<.001
WSCS	4.27	2.57	5.18	2.48	-.91	2.95	-2.18	.03
Variable	Lazarus		Persons		Paired			
	(Action 1)		(Action 2)		Differences			
	M	SD	M	SD	M	SD	t	P
Depth	5.12	1.17	3.87	1.19	1.26	1.23	7.22	< .001
Smoothness	3.94	1.20	4.76	1.09	-.82	1.52	-3.81	< .001
CERS	4.65	.88	4.09	1.05	.56	1.08	3.66	< .001
WSCS	5.90	2.53	4.68	2.57	1.22	2.64	3.26	< .001



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*Note.*  $N = 50$

Because of the significant differences between videotapes in each condition, the two videotapes in each condition could not be combined. Hence, the four videotapes were analyzed separately in the remaining analyses.

### *Main Analyses*

*Hypothesis 1. Asian Americans will prefer action-oriented counseling to insight-oriented counseling.*

The mean score on the Counseling Preference Form was  $-2.18$  ( $SD = 10.85$ ), indicating a slight overall preference for action-oriented counseling. However, when looking at the data regardless of strength of preferences, individual participants' score shows that 23 participants (46%) preferred insight-oriented counseling (received positive scores on the CP), 23 participants (46%) preferred action-oriented counseling (received negative scores on the CP), and four participants (8%) did not have a preference for insight or action-oriented counseling (received 0 on the CPF), indicating no difference on the number of people who preferred insight-oriented counseling and those who preferred action-oriented counseling.

In the other study with a general American college sample (Goates & Hill, in prep.), the mean score on the Counseling Preference Form was  $-2.33$  ( $SD = 11.04$ ). The effect size analysis shows no difference between two samples ( $d = .01$ ). In the Goates and Hill sample, 34% of participants preferred insight-oriented counseling, 58% preferred action-oriented counseling, and 8% did not have a preference for insight or action-oriented counseling.

*Hypothesis 2. Asian Americans will regard action-oriented counseling as*

*deeper than insight-oriented counseling.*

*Hypothesis 3. Asian Americans will regard action-oriented counseling as smoother than insight-oriented counseling.*

*Hypothesis 4. Asian Americans will regard a therapist in an action-oriented condition as more credible, expert, and attractive than a therapist in an insight-oriented condition.*

Hypotheses 2, 3 and 4 could not be answered since the participants' ratings on the Depth and Smoothness scales and the CERS were significantly different across the two sessions in each condition.

Instead, ratings of the four sessions on the Depth and Smoothness scales, the CERS, and the WSCS were compared to one another using ANOVAs and post hoc comparison using paired sample t-tests with an alpha level of .008 (.5/6). Results are shown in Table 6 and 7.

*Table 6. Analysis of Variance for ratings of four sessions*

Variables		Sum of Squares	df	Mean Square	F	<i>p</i>
Depth	Between Groups	54.84	3	18.28	11.79	< .001
	Within Groups	303.83	196	1.55		
	Total	358.67	199			
Smoothness	Between Groups	20.56	3	6.85	5.99	.001
	Within Groups	224.43	196	1.15		
	Total	244.99	199			
CERS	Between Groups	24.96	3	8.32	8.37	<.001

	Within Groups	194.86	196	.99		
	Total	219.83	199			
WSCS	Between Groups	73.87	3	24.63	3.82	.01
	Within Groups	1262.37	196	6.44		
	Total	1336.24	199			

*Table 7. Paired Sample t-test between videotapes*

Variable	Comas-Diaz (Insight 2)		Lazarus (Action 1)		Paired Differences		t	p
	M	SD	M	SD	M	SD		
	Depth	4.42	1.22	5.12	1.17	-.70		
Smoothness	4.33	1.16	3.94	1.20	.39	1.37	2.01	.05
CERS	4.23	1.03	4.65	.88	-.41	1.30	-2.23	.03
WSCS	5.18	2.48	5.90	2.53	-.72	3.08	-1.65	.10

Variable	Raskin (Insight 1)		Persons (Action 2)		Paired Differences		t	P
	M	SD	M	SD	M	SD		
	Depth	3.84	1.39	3.87	1.19	-.03		
Smoothness	4.66	.79	4.76	1.09	-.10	1.23	-.60	.55
CERS	3.66	1.02	4.09	1.05	-.43	1.43	-2.12	.04
WSCS	4.27	2.57	4.68	2.57	-.41	.47	-.88	.39

Variable	Raskin		Lazarus		Paired			
	(Insight 1)		(Action 1)		Differences			
	M	SD	M	SD	M	SD	t	<i>p</i>
Depth	3.84	1.39	5.12	1.17	-1.29	1.62	-5.61	<.001
Smoothness	4.66	.79	3.94	1.20	.72	1.37	3.71	.001
CERS	3.66	1.02	4.65	.88	-.99	1.28	-5.47	<.001
WSCS	4.27	2.57	5.90	2.53	-1.63	3.27	-3.52	.001

Variable	Comas-Diaz		Persons		Paired			
	(Insight 2)		(Action 2)		Differences			
	M	SD	M	SD	M	SD	t	<i>p</i>
Depth	4.42	1.22	3.87	1.19	.56	1.42	2.77	.008
Smoothness	4.33	1.15	4.76	1.09	-.43	1.66	-1.84	.07
CERS	4.23	1.03	4.09	1.05	.15	1.66	.73	.47
WSCS	5.18	2.48	4.68	2.57	.50	3.02	1.17	.25

Variable	Raskin		Comas-Diaz		Paired			
	(Insight 1)		(Insight 2)		Differences			
	M	SD	M	SD	M	SD	t	<i>p</i>
Depth	3.84	1.39	4.42	1.22	-.59	1.87	-2.23	.03
Smoothness	4.65	.79	4.33	1.15	.33	1.35	1.73	.09
CERS	3.66	1.01	4.23	1.03	-.58	1.28	-3.20	<.001
WSCS	4.27	2.57	5.18	2.48	-.91	2.95	-2.18	.03

Variable	Lazarus		Persons		Paired			
	(Action 1)		(Action 2)		Differences			
	M	SD	M	SD	M	SD	t	P
Depth	5.12	1.17	3.87	1.19	1.26	1.23	7.22	< .001
Smoothness	3.94	1.20	4.76	1.09	-.82	1.52	-3.81	< .001
CERS	4.65	.88	4.09	1.05	.56	1.08	3.66	< .001
WSCS	5.90	2.53	4.68	2.57	1.22	2.64	3.26	< .001

*Note.*  $N = 50$

The results of the ANOVAs showed that evaluations of four sessions were significantly different from one another on the Depth, Smoothness, CERS, and WSCS.

In terms of the Depth scale, Dr. Lazarus' session was evaluated significantly higher than the other three sessions ( $p < .008$ ). Dr. Comas-Diaz's session was evaluated significantly higher than Dr. Persons' or Dr. Raskin's session, and Dr. Persons' and Dr. Raskin's session were not significantly different in the Depth scale. These results indicate that the participants perceived Dr. Lazarus' session as the deepest and Dr. Comas-Diaz's session as the second deepest.

In terms of the Smoothness scale, the only significant differences were between Dr. Persons' session and Dr. Lazarus' session and between Dr. Raskin's session and Dr. Lazarus' session. These results indicate that the participants perceived Dr. Lazarus' session as rougher than Dr. Persons' or Dr. Raskin's session ( $p < .008$ ).

When comparing the CERS of the four sessions, Dr. Lazarus received significantly higher ratings than Dr. Persons' and Dr. Raskin's sessions ( $p < .008$ ), and Dr. Comas-Diaz received significantly higher ratings than Dr. Raskin ( $p < .008$ ). These results indicate the participants perceived Dr. Lazarus as more credible than Dr. Raskin,

Dr. Persons, and they perceived Dr. Comas-Diaz as more credible than Dr. Raskin ( $p < .008$ ).

In the ratings on WSCS, Dr. Lazarus received higher ratings than Dr. Persons and Dr. Raskin ( $p < .008$ ). The result indicates that the participants were more willing to seek counseling with Dr. Lazarus than with Dr. Raskin or Dr. Persons.

Lastly, when the participants were asked to rank the four video-taped sessions in order of their preferences, 23 participants liked Dr. Lazarus' session best (46%), 13 participants liked Dr. Comas-Diaz's session best (26%), 10 participants reported that they liked Dr. Raskin's session best (20%), and four participants liked Dr. Persons' session best (8%).

*Research Question 1. Can we discriminate participants who prefer insight-oriented counseling from participants who prefer action-oriented counseling in terms of the Asian values, interpersonal pattern, interpersonal dependency, and emotional reliance in therapy?*

As in the ratings on the sessions, the participants' preferences for the two sessions in each condition were significantly different from each other, thus this research question cannot be answered as written. Thus, I changed this question to

*Research Question 1-1. Can we predict participants' ratings of the four sessions on the Depth and Smoothness scales, the CERS, and the WSCS from Client Asian Values, Interpersonal Dependency, Interpersonal Problems, and Counseling Preference?*

Regression Analyses were conducted to find client variables that predicted ratings of the sessions. Table 8, 9, 10 and 11 show the results of the regression analyses.

*Table 8. Summary of Simultaneous Regression Analysis for Variables Predicting ratings of Raskin on the Depth Scale*

Variables	B	SE B	$\beta$	P
AVS-R	-.25	.73	-.05	.74
IDI	-.03	.02	-.25	.11
CP	.03	.02	.22	.14
IIP	-.09	.44	-.03	.85

Note. N = 50,  $R^2 = .13$ ,  $\Delta R^2 = .05$  ( $ps > .05$ ) IV= AVS-R, IDI, CP, IIP; DV= the Depth Scale

*Summary of Simultaneous Regression Analysis for Variables Predicting ratings of Comas-Diaz on the Depth Scale*

Variables	B	SE B	$\beta$	P
AVS-R	-.21	.68	-.05	.76
IDI	0	.02	-.01	.97
CP	.01	.02	.08	.61
IIP	-.24	.41	-.10	.57

Note. N = 50,  $R^2 = .02$ ,  $\Delta R^2 = -.07$  ( $ps > .05$ )

*Summary of Simultaneous Regression Analysis for Variables Predicting ratings of Lazarus on the Depth Scale*

Variables	B	SE B	$\beta$	P
AVS-R	-.25	.64	-.06	.70
IDI	.02	.02	.20	.21
CP	-.01	.02	-.04	.77

IIP	-.35	.38	-.15	.38
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Note. N = 50,  $R^2 = .06$ ,  $\Delta R^2 = -.03$  (ps > .05)

*Summary of Simultaneous Regression Analysis for Variables Predicting ratings of Persons on the Depth Scale*

Variables	B	SE B	$\beta$	P
AVS-R	-.04	.65	-.01	.95
IDI	.02	.02	.21	.21
CP	.01	.02	.08	.58
IIP	-.31	.40	-.13	.44

Note. N = 50,  $R^2 = .04$ ,  $\Delta R^2 = -.04$  (ps > .05)

*Table 9. Summary of Simultaneous Regression Analysis for Variables Predicting ratings of Raskin on the Smoothness Scale*

Variables	B	SE B	$\beta$	P
AVS-R	.07	.43	.03	.87
IDI	-.01	.01	-.08	.63
CP	.02	.01	.22	.16
IIP	-.14	.26	-.09	.59

Note. N = 50,  $R^2 = .06$ ,  $\Delta R^2 = -.02$  (ps > .05)

*Summary of Simultaneous Regression Analysis for Variables Predicting ratings of Comas-Diaz on the Smoothness Scale*

Variables	B	SE B	$\beta$	P
AVS-R	-1.36	.61	-.33*	.03



IDI	.01	.02	.04	.78
CP	.01	.02	.14	.36
IIP	.01	.37	.01	.98

Note. N = 50,  $R^2 = .13$ ,  $\Delta R^2 = .06$  (ps > .05), \* Sig. at p < .05

*Summary of Simultaneous Regression Analysis for Variables Predicting ratings of Lazarus on the Smoothness Scale*

Variables	B	SE B	$\beta$	P
AVS-R	-.22	.64	-.05	.74
IDI	0	.02	-.02	.90
CP	-.03	.02	-.23	.12
IIP	.55	.39	.23	.17

Note. N = 50,  $R^2 = .08$ ,  $\Delta R^2 = 0$  (ps > .05)

*Summary of Simultaneous Regression Analysis for Variables Predicting ratings of Persons on the Smoothness Scale*

Variables	B	SE B	$\beta$	P
AVS-R	.11	.59	.03	.86
IDI	.01	.02	.10	.52
CP	0	.02	.03	.86
IIP	-.67	.36	-.31	.07

Note. N = 50,  $R^2 = .08$ ,  $\Delta R^2 = 0$  (ps > .05)

*Table 10. Summary of Simultaneous Regression Analysis for Variables Predicting ratings of Raskin on the CERS*

Variables	B	SE B	$\beta$	P
AVS-R	.47	.56	.13	.40
IDI	0	.02	-.03	.87
CP	.02	.01	.16	.30
IIP	-.29	.34	-.15	.39

Note. N = 50,  $R^2 = .04$ ,  $\Delta R^2 = -.04$  (ps > .05)

*Summary of Simultaneous Regression Analysis for Variables Predicting ratings of Persons on the CERS*

Variables	B	SE B	$\beta$	P
AVS-R	.08	.57	.02	.89
IDI	.01	.02	.09	.60
CP	.01	.01	.11	.48
IIP	-.25	.35	-.12	.48

Note. N = 50,  $R^2 = .02$ ,  $\Delta R^2 = -.07$  (ps >.05)

*Summary of Simultaneous Regression Analysis for Variables Predicting ratings of Lazarus on the CERS*

Variables	B	SE B	$\beta$	P
AVS-R	.97	.39	.31*	.02
IDI	.03	.01	.35**	.01
CP	-.03	.01	-.41**	.002
IIP	-.34	.24	-.20	.15

Note. N = 50,  $R^2 = .39$ ,  $\Delta R^2 = .33$  (ps <.01), \* Sig. at p < .05, \*\* Sig. at p < .01

*Summary of Simultaneous Regression Analysis for Variables Predicting ratings of*

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*Persons on the CERS*

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Variables	B	SE B	$\beta$	P
AVS-R	.73	.55	.20	.19
IDI	.02	.02	.21	.19
CP	-.01	.01	-.08	.60
IIP	-.74	.33	-.36*	.03

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Note. N = 50,  $R^2 = .13$ ,  $\Delta R^2 = .06$  (ps > .05), \* Sig. at  $p < .05$

*Table 11. Summary of Simultaneous Regression Analysis for Variables Predicting ratings of Raskin on the WSCS*

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Variables	B	SE B	$\beta$	P
AVS-R	-.55	1.42	-.06	.70
IDI	0	.04	.02	.92
CP	.04	.04	.17	.27
IIP	-.50	.86	-.10	.56

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Note. N = 50,  $R^2 = .04$ ,  $\Delta R^2 = -.05$  (ps > .05)

*Summary of Simultaneous Regression Analysis for Variables Predicting ratings of Comas-Diaz on the WSCS*

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Variables	B	SE B	$\beta$	P
AVS-R	-.45	1.38	-.05	.75
IDI	.01	.04	.06	.71
CP	.01	.04	.07	.64
IIP	-.62	.84	-.13	.46

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Note.  $N = 50$ ,  $R^2 = .02$ ,  $\Delta R^2 = -.07$  ( $ps > .05$ )

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*Summary of Simultaneous Regression Analysis for Variables Predicting ratings of Lazarus on the WSCS*

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Variables	B	SE B	$\beta$	P
AVS-R	2.08	1.27	.23	.11
IDI	-.06	.03	.27	.07
CP	-.06	.03	-.25	.07
IIP	-1.18	.77	-.24	.13

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Note.  $N = 50$ ,  $R^2 = .20$ ,  $\Delta R^2 = .13$  ( $ps < .05$ )

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*Summary of Simultaneous Regression Analysis for Variables Predicting ratings of Persons on the WSCS*

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Variables	B	SE B	$\beta$	P
AVS-R	.57	1.42	.06	.69
IDI	.02	.04	.10	.56
CP	0	.04	-.01	.95
IIP	-1.06	.86	-.21	.22

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Note.  $N = 50$ ,  $R^2 = .04$ ,  $\Delta R^2 = -.05$  ( $ps > .05$ )

Participants' ratings of counselor credibility of Dr. Lazarus' session were significantly associated with participants' scores on the IDI, and preferences for action-oriented therapy. Thus, we can predict participants' perception of counselor credibility of Dr. Lazarus from their interpersonal dependency and preferences for action-oriented therapy. In other words, those who were more interpersonally dependent and preferred action-oriented therapy to insight-oriented therapy were more likely than their

counterparts to perceive Dr. Lazarus as more credible.

*Research Question 2. Does participants' willingness to receive psychotherapy increase after watching the videotaped sessions?*

A paired samples t-test was conducted to study whether attitudes toward seeking professional help increased after watching videotaped sessions. The result showed that there was no significant difference in attitudes toward seeking counseling between before and after watching videotaped sessions ( $t = -1.24, p = .22$ ), and the effect size was trivial ( $d = .10$ ). Hence, watching taped sessions did not influence ratings on attitudes toward seeking counseling.

In addition, two regression analyses was used to study whether participant variables including scores in the AVS, IDI, IIP and CPF and participants' evaluations of four sessions predicted attitude change. The first regression analysis used participant variables including the AVS, IDI, IIP, and CPF as predictors. The second regression analysis used participants' session evaluations as predictors. No variable was found to predict attitude change (all  $p > .05$ ). The results of the regression analyses are shown in Table 12 and 13.

*Table 12. Summary of Simultaneous Regression Analysis for Participant Variables Predicting Attitude change*

Variables	B	SE B	$\beta$	P
AVS-R	-1.64	1.94	-.13	.41
IDI	.04	.05	.12	.46
CP	-.01	.05	-.02	.90
IIP	-.93	1.18	-.13	.43

Note.  $N = 50$ ,  $R^2 = .05$ ,  $\Delta R^2 = -.04$  ( $ps > .05$ )

*Table 13. Summary of Simultaneous Regression Analysis for Session Evaluations  
Predicting Attitude Change*

Variables	B	SE B	$\beta$	P
V1 Depth	.35	.65	.14	.59
V1 Smooth	.88	.85	.20	.31
V1 CERS	-.56	1.03	-.16	.59
V1 WSCS	-.31	.40	-.22	.45
V2 Depth	-1.33	.91	-.46	.15
V2 Smooth	-.10	.67	-.03	.87
V2 CERS	1.59	1.25	.46	.21
V2 WSCS	.11	.54	.08	.84
V3 Depth	1.02	.80	.34	.21
V3 Smooth	-.39	.59	-.13	.52
V3 CERS	.44	1.30	.11	.74
V3 WSCS	-.14	.45	-.10	.77
V4 Depth	-.11	.77	-.04	.88
V4 Smooth	-.36	.96	-.11	.71
V4 CERS	.55	1.18	.16	.64
V4 WSCS	.37	.41	.27	.38

Note.  $N = 50$ ,  $R^2 = .26$ ,  $\Delta R^2 = -.11$  ( $ps > .05$ )

Dependent Variable: Change in ASPPH-A (post- ASPPH-A – pre- ASPPH-A)

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Independent Variables: AVS, IDI, CPF, IIP, V1 Depth, V1 Smoothness, V1 CERS, V1 WSCS, V2 Depth, V2 Smoothness, V2 CERS, V2 WSCS, V3 Depth, V3 Smoothness, V3 CERS, V3 WSCS, V4 Depth, V4 Smoothness, V4 CERS, V4 WSCS

*Research Question 3. Is preference for action-oriented or insight-oriented therapy after watching the videotaped sessions related to preference on a self-report measure before watching the videotaped sessions?*

As mentioned above, the participants' preferences for the two sessions in each condition were significantly different from each other, thus this research question cannot be answered. Instead, I examined reasons for preference for each of four sessions.

*Research Question 4. What are the reasons of participants' preferences for a particular session to the other sessions?*

Participants' responses to this question were analyzed qualitatively. Three categories of reasons of preferences were developed from the data by my advisor and me. The three categories were (a) expertise/ competence, (b) techniques/ intervention/ skills, and (c) positive manner/ attitude/ facilitative condition/ nonspecifics-positive. In addition, three categories of reasons of dislike of a particular session were also developed from the data: (d) lack of expertise/ competence, (e) lack of techniques/ intervention/ skills, (f) negative manner/ attitude/ lack of facilitative condition/ nonspecifics-negative. Three graduate students in a counseling psychology program independently put the responses into the three categories. Agreement levels among three pairs of judges using the kappa statistic (Cohen, 1960; Tinsley & Weiss, 1975) were adequate (average  $K = .73$ ). The results of the categorization of reasons are shown in Table 14.

*Table 14. Reasons of Preferences for a Particular session to the Other Sessions*

	Raskin	Comas- Diaz	Lazarus	Persons
Number of Comments	42	42	44	42
% of Expertise/Competence	.05	.10	.09	.02
Techniques/Interventions/Skills	.10	.19	.48	.21
Positive Manner/Attitude/ Facilitative condition/ Nonspecifics-positive	.21	.36	.21	.33
Lack of Expertise/Competence	.10	.10	.02	.02
Lack of Techniques/ Interventions/ Skills	.36	.14	.02	.14
Negative Manner/Attitude/ Lack of Facilitative condition/ Nonspecifics-negative	.19	.12	.18	.26

The most frequent comments on Dr. Raskin's session were about lack of techniques, interventions, and skills (36%). An example of comments on Dr. Raskin's session was, "He didn't say much of anything except for what was obvious."

Comments on Dr. Comas-Diaz's session were mostly about positive manner/ attitude/ facilitative condition and nonspecific – positive (36%). An example of comments on Dr. Comas-Diaz's session was, "The counselor was very sincere and seemed very trustworthy."



The most common comments on Dr. Lazarus' session were about good technique, interventions, and skills (48%). More specifically, a number of participants reported that they liked the role-play in Dr. Lazarus' session. An example of comments on Dr. Lazarus' session was, "I liked the session because of the role playing."

The most common comments on Dr. Persons' session were about positive manner, attitude, facilitative conditions, and nonspecifics-positive (33%). An example of comments on Dr. Persons' session was, "I liked the session the best because the counselor seemed very friendly and had a sense of humor."

Hence, participants seemed to like Dr. Lazarus because of his techniques, and they liked Dr. Comas-Diaz and Dr. Persons for their positive manner. But, they did not like Dr. Raskin because he did not use many specific techniques.

In addition, male and female participants' comments were separately analyzed to examine whether male and female participants showed different patterns of reasons for their preferences. However, the number of male participants' responses was very small ( $N = 7$  to  $10$ ), so percentages did not seem to be meaningful. The analysis of female participants' responses showed the same pattern as in the analysis of all participants' responses.

## Chapter 6

### Discussion

#### *Preliminary Analyses*

When the means of the scores on the IDI, IIP, MHI-5, ASPPH-A, and CPF in this study were compared with those of general American samples, the participants in this study received higher scores on the IDI and IIP, and lower scores on the MHI-5 and ASPPH-A. Their scores on the CPF were not different from those of general American samples. Interpretation of the higher IDI and IIP scores should be made with caution because both were developed by American researchers based on European American cultures. The definition and appropriate level of interpersonal dependency in Asian culture might be different from those in American culture. In addition, problematic behaviors, thoughts, or feelings in relationship in the American culture might not be problematic in the East Asian culture.

The higher scores on the IDI and IIP indicate that East Asians and East Asian Americans might be more interpersonally dependent than the general American populations and tend to demonstrate behaviors, thoughts or feelings that are different from the general American populations. They might either seek more emotional reliance in relationships or rely on authorities' opinions in the decision making process than non-Asian Americans do. In addition, from an American point of view, behaviors, thoughts, and feelings of East Asian Americans could be seen as domineering, vindictive, cold, socially avoidant, nonassertive, exploitable, overly nurturant, and intrusive.

Participants in this study also received lower scores on the MHI-5 than the general American samples. Lower scores on the MHI-5 indicate a higher level of psychological distress. This result might mean that East Asians or East Asian Americans

might perceive their level of psychological distress as higher than general American samples do. It is possible that because of their status as a minority and the possibility that they are experiencing racism, Asian Americans may have more psychological distress and need mental health services more than European Americans (Atkinson, 2004; Leong et al., 1995).

The lower mean score on the ASPPH-A indicates that East Asians or East Asian Americans were less likely to seek psychological help. This result is congruent with findings in previous research. Atkinson (2004), Snowden, and Cheung (1990) found that Asian Americans have used psychological services less than would be expected, Asian Americans' rate of entrance into hospitals for mental health concerns has been lower than any other racial and ethnic group, and Asians tend to terminate therapy prematurely.

The mean score on the CPF of participants in this study was not significantly different from that of a general American college sample. Different from research findings that Asians are more likely to seek immediate resolution such as action-oriented counseling than general Americans (Sue & Zane, 1987; Kim, Li, & Liang, 2002; Atkinson, Maruyama, and Matsui, 1978; Atkinson & Matsushita, 1991), the participants were not different in preference for insight-oriented or action-oriented counseling from a general American sample. This result will be discussed more in depth in the following section.

### *Main Analyses*

*Hypothesis 1. Asian Americans will prefer action-oriented counseling to insight-oriented counseling.*

The mean score on the Counseling Preference Form indicates that East Asian or East Asian American participants had a slight overall preference for action-oriented

counseling, but there was no difference between the number of participants who preferred insight-oriented counseling or action-oriented counseling. These results were not different from those from the general American college samples in Goates and Hill (in prep.). Hence, contrary to the hypothesis that Asian Americans would prefer action-oriented counseling to insight-oriented counseling, a clear preference for action oriented counseling was not found in this study, and their preference for insight-oriented or action-oriented counseling was not different from those of a general American sample. Previous researchers found that working with Asian or Asian American clients, a counselor is likely to assume that a client has certain preferences in therapy because of stereotypes of Asians in therapy setting (Yeh, 2001). The result from the present study may caution against the counselors' stereotyping of Asians as preferring action as opposed to insight.

*Hypothesis 2. Asian Americans will regard action-oriented counseling as deeper than insight-oriented counseling.*

*Hypothesis 3. Asian Americans will regard action-oriented counseling as smoother than insight-oriented counseling.*

*Hypothesis 4. Asian Americans will regard a therapist in an action-oriented condition as more credible, expert, and attractive than a therapist in an insight-oriented condition.*

The four videotapes were analyzed separately because the two sessions in each condition received significantly different ratings. Hence, I will discuss the ratings on each session separately.

Dr. Lazarus' session was most highly rated and Dr. Persons' and Dr. Raskin's sessions received lowest ratings on the Depth, CERS, and WSCS. Perhaps, East Asian or East Asian American participants preferred "doing" in therapy to "talking about doing".

Dr. Lazarus' session used a role-play, which could be seen as a demonstration or rehearsal of behavioral change outside the session. On the other hand, Dr. Persons and Dr. Raskin focused on talking about problems. This could be related to Sue and Zane's (1987) suggestion that Asian Americans prefer immediate relief in symptoms. Since Dr. Lazarus' role-play could be more closely related to immediate relief in symptoms than techniques used by Dr. Persons and Dr. Raskin, the participants liked his session and were more willing to see him as a counselor.

*Research Question 1. Can we discriminate participants who prefer insight-oriented counseling from participants who prefer action-oriented counseling in terms of the Asian values, interpersonal pattern, interpersonal dependency, and emotional reliance in therapy?*

*Research Question 1-1. Can we predict participants' ratings of the four sessions on the Depth and Smoothness scales, the CERS, and the WSCS from Client Asian Values, Interpersonal Dependency, Interpersonal Problems, and Counseling Preference?*

Because of significant differences between the two sessions in each condition, ratings of each videotape were analyzed separately and Research Question 1 was changed to Research Question 1-1.

From the regression analyses, the ratings of Dr. Lazarus' credibility were found to be related to the participants' scores on the IDI and their preferences for action-oriented counseling. In other words, the more a participant tended to be interpersonally dependent and to prefer action-oriented counseling, the more a participant perceived Dr. Lazarus as credible. Dr. Lazarus' authoritarian stance might have appealed to those who were interpersonally dependent. An interpersonally dependent person might prefer a role-play in the session because it can provide more immediate help than talking about insight

or action and asking to do further work outside the session. It is interesting that the AVS-R was not a significant predictor ( $p > .01$ ) of the counselor credibility ratings of Dr. Lazarus.

*Research Question 2. Does participants' willingness to receive psychotherapy increase after watching the videotaped sessions?*

The participants' willingness to receive psychotherapy did not change after watching the videotaped sessions. This result is disappointing because it indicates that watching videotaped sessions did not help participants have more positive attitudes toward counseling. Watching sessions might be different from receiving actual therapies, and it could be draining to watch videotaped sessions because it is hard to become involved in sessions as an observer unless one actually receives therapies. The participants watched sessions they liked and sessions they did not like, which might also explain why the willingness did not change.

*Research Question 3. Is preference for action-oriented or insight-oriented therapy after watching the videotaped sessions related to preference on a self-report measure before watching the videotaped sessions?*

This research question could not be answered because of significant differences between the two sessions in each condition.

*Research Question 4. What are the reasons of participants' preferences for a particular session to the other sessions?*

Participants reported that they liked Dr. Lazarus because of his techniques, and they liked Dr. Comas-Diaz and Dr. Persons for their positive manner. But, they did not like Dr. Raskin because he did not use enough specific techniques.

In terms of techniques in sessions, East Asian or East Asian American

participants preferred a role-play to listening and attending, restatement and reflection of feelings, and information and direct guidance. A number of participants wrote that “I liked Dr. Lazarus’ session because of the role playing.” One participant wrote “Dr. Raskin didn’t say much of anything except for what was obvious.” The other participant wrote “Realizing the problem and discussing about it can relieve the pain in some way, but for me personally I want to be able to face the problem and find solution to solve it.” As mentioned above, this preference for a role-play to other techniques might be related to Asians’ preference for immediate resolution in therapy.

It is interesting that comments about two male therapists were mostly related to the use of techniques, whereas the comments about the two female therapists were mostly about their positive manner and attitude. We can speculate that East Asian or East Asian Americans expect male therapists to use good techniques in therapy and female therapists to present positive manner and attitude. Another interesting finding was that although both of the two female therapists were perceived as presenting positive manners and attitudes, Dr. Comas-Diaz (who focused on insight) received higher ratings than Dr. Persons (who used cognitive behavioral techniques such as information and direct guidance). This might indicate that participants were more comfortable with a female therapist who focused on insight than with a female therapist who used cognitive behavioral techniques.

#### *Summary of the four tapes*

Perhaps a summary of the four videotaped sessions would help understand the results. In the first insight videotape, Dr. Raskin used a client-centered approach. The client talked about her childhood relationship with her parents and current relationship with her boyfriend. Dr. Raskin let the client explore and mostly used listening, attending,

and restatements. He used a number of “m-hm” throughout the session to convey his empathy. A number of participants reported that they did not like his techniques that seemed to be “doing nothing but obvious.” Dr. Raskin’s techniques were not considered as “gift giving” or facilitating immediate resolution in therapy (Sue & Zane, 1987), which perhaps explains low ratings of Dr. Raskin’s session.

In the second insight session, Dr. Comas-Diaz used an ethnocultural approach. In this approach, she encouraged the client to realize “self as an internal ethnocultural representation” and examined causes and results of the client’s ethnocultural position in society. In the session, the client discussed about her anger management issues and the therapist helped the client explore her childhood and discuss how the client’s family’s emphasis on achievement and her parents’ attitudes toward the client influenced the current issues. Although both Dr. Comas-Diaz and Dr. Raskin’s session could be regarded as insight-oriented counseling, Dr. Comas-Diaz took more action and said more than Dr. Raskin. Dr. Comas-Diaz directly commented on achievement issue in the client’s family and tried to relate how the client’s parents treated her to the client’s current issues. Since East Asian culture also emphasizes achievement and relationship between family members, the participants might have liked this session. The use of cultural issues in the session could also have allowed Dr. Comas-Diaz to be perceived as more multiculturally competent than the other three therapists, which could be another reason for the participants’ high ratings of this session.

Dr. Lazarus, in the first action-oriented session, used role-plays. The client’s issue was his relationship with his father. Dr. Lazarus suggested role-playing, first between the client today and the client as an eight-year old and then between the client and his father. Dr. Lazarus’ session was the most preferred by the participants and was



rated higher than the other sessions. A number of participants mentioned his good use of techniques as the reason for their preference for this session. As mentioned above, the preference for a role-play could be explained by Asian's preference for gift giving in therapy (Sue & Zane, 1987).

In the second action-oriented session, Dr. Persons used cognitive-behavioral interventions. The client presented concerns about anxiety related to social events at work. Dr. Persons asked the client about ways to reduce her anxiety and also provided some information and guidance on how to reduce her anxiety level. Interestingly, the participants' comments were mostly on Dr. Persons' positive manner and attitude instead of her techniques. Perhaps the participants had stereotypes about female therapists, expecting them to focus more on manner than on techniques.

### *Limitations*

One of the limitations of this study was that the original manipulation of two conditions (insight-oriented counseling and action-oriented counseling) did not work. The two sessions in the insight-oriented condition and the two sessions in the action-oriented condition differed significantly in most ratings, which prevented me from performing analyses based on two conditions. Hence, three hypotheses and one research question could not be answered and I had to derive new research questions according to the new four different conditions. The reason for the failure of the manipulation might have been that the participants differentiated the therapies based on other factors than insight- vs. action- orientedness. In other words, although insight- or action-orientedness could have been one of the influential factors for categorizing types of therapy, the participants might have perceived other factors (such as techniques) as more salient and important for

differentiating and evaluating the sessions.

In addition, the use of the specific videotapes might have been problematic. Because all the therapists in the videotapes developed by APA seemed competent and were professionally prominent, the videotapes were deemed adequate, rather than making new videotapes. However, since the videotapes were not specifically developed for this study, they were different in more than just insight- or action-orientedness. The clients in the sessions brought different issues, the numbers of words in the chosen segments of the sessions were different, and the competence of the therapists might have been different from one another although all of them were considered experts in specific types of therapies.

The other primary limitation was the nature of an analogue study. In this study, participants watched videotaped sessions instead of actually receiving real therapy. The setting of the study was artificial and contrived. Watching therapy sessions in laboratories may not resemble actual sessions; therefore, applying the study results to typical therapy settings should be done with caution.

Another limitation was participants in this study. Most participants in this study were in their twenties or thirties and were mostly college students or recent graduates of college. In other words, those who participated in this study were young adults who had more education than high school graduates. Thus, applying this results to East Asians who are not in their twenties or thirties and do not have higher education should be done with caution.

In addition, the participants comprised mostly females (12 male, 32 females, and 6 not answered) and more Koreans than other East Asian Americans (23 Korean, 13 Chinese, 11 Taiwanese, 2 Japanese, and 1 Taiwanese/Chinese). Thus, future studies need

to include a more balanced sample of female and male participants, and Chinese, Taiwanese, Korean, and Japanese participants.

In addition, since the participants were recruited in diverse ways, there might have been extraneous participant variables that have affected the results. I recruited the participants from Psyc 100 classes, upper level psychology classes, one Asian studies class, and organizations like Asian American students' associations and Korean Catholic church organizations. It is possible that those who took Psyc 100 class were different from those who took Asian studies classes. However, since the sample size in each way of recruiting was small, differences among recruiting could not be tested.

Another limitation was the small sample size. Recruiting participants in this study was more difficult than expected. The East Asian or East Asian American sample pool was small, and they were not interested in participating. Advertisements on the webpage of organizations or in classes were not effective. In addition, completing a number of measures and watching four videotaped sessions took longer than 90 minutes and was draining for participants, which made it hard to recruit participants by word of mouth.

Another limitation was that all measures were self-report. Thus, participants' answers to the measures could be distorted by their bias. For example, although participants did not mention therapist sex as one of reasons of their preference possibly because they did not want to be seen as sexist, their bias toward male and female therapists might have unconsciously or consciously affected their ratings of therapists.

In addition, the measures used for rating after watching the sessions – the Depth and Smoothness scale, the CERS, and the WSCS were developed for participants who received actual therapy sessions not for those who watched therapy sessions. Thus, the

participants' ratings in this study could not be compared to other studies using actual therapy. Furthermore, other measures completed before watching the sessions including AVS-R has not been used for the same population in this study, which made it difficult to compare the results to results in other studies using the same measures. Hence, it was difficult to test whether the samples in this study fell in the normal distribution of East Asian population or not.

Lastly, it was difficult to find a good measure to test acculturation level or level of participants' Asian values. It is difficult to measure how much a person is influenced by Asian culture because the influence can be subtle and might not be shown in psychological measures. Previous studies have shown mixed results in terms of the influence of levels of acculturation or Asian values on evaluations of session outcome or therapist credibility, which might have been partly due to problems in the acculturation measures. In this study, Asian values did not predict participants' ratings of the session. However, it was not clear whether that means participants' ratings were independent from Asian values, or the AVS-R could not detect Asian values that were more crucial for ratings of the sessions.

### *Implications*

Despite the limitations, this study has implications for research and practice.

*Implications for Research.* This study found that participant characteristics other than Asian values could predict preferences for types of therapy. Previous studies on Asian samples have studied effects of acculturation levels and Asian values on preferences, but researchers did not examine influences of other personality characteristics which could also explain preferences. In this study, participants' interpersonal dependency and preferences for action-oriented counseling in the pre-

session self-report measure predicted the counselor credibility rating of Dr. Lazarus. Thus, researchers should investigate the effects of dependency on preferences for types of therapy more.

In addition, this study found significant differences between the two sessions within conditions – insight-oriented and action-oriented condition. Previous studies on Asian American have usually manipulated different conditions using directiveness/nondirectiveness or insight- or action-orientedness (Atkinson, Maruyama, & Matsui, 1978; Atkinson & Matsushita, 1991; Kim, Li, & Liang, 2002; Yau, Sue, & Hayden, 1992). However, participants might have focused on other factors such as techniques and manner rather than directiveness or insight- or action- orientedness. This result suggests that researchers should examine what aspects of directive or non-directive counseling, insight-oriented or action-oriented counseling appeal to East Asian or East Asian American and study additional factors such as manner and techniques in therapy setting which are valued by East Asians or East Asian Americans.

In addition, it would be interesting to replicate this study using actual therapy sessions and asking East Asian or East Asian Americans' preferences based on their experiences in actual therapy sessions. For example, participants might receive both insight-oriented and action-oriented psychotherapy with two different therapists (therapist sex will be randomly assigned), rate session effectiveness and counselor credibility, and report which session they prefer and why.

Lastly, since all measures other than the AVS-R were developed based on European American culture, it is necessary to test cultural fairness of personality measures. Furthermore, personality measures need norms for East Asian or East Asian American population.

*Implications for Practice.* In the pre-session self-report inventory of preference for insight-oriented or action-oriented counseling (the CPF), East Asian or East Asian American participants were not different from the general American participants in Goates and Hill (in prep.). This result suggests that a therapist should not decide a client's preference only from his or her ethnicity.

In addition, participants' scores on the IDI and initial preference for action-oriented counseling in the self-report measure predicted ratings of counselor credibility of Dr. Lazarus better than scores on the AVS-R. Hence, therapists should caution against activation of stereotypes of Asians when working with Asians and make efforts to know more about individual clients' dependency and preference for insight- or action oriented therapy. In other words, therapists should tailor manner and techniques in therapy to individual clients' interpersonal style and preferences.

Appendix A  
Client Demographic Form

Age:

Gender:

Where do you or your family come from? (Please indicate the name of the country.)

\_\_\_\_\_

Generation Status:

1<sup>st</sup> generation \_\_\_\_\_2<sup>nd</sup> generation \_\_\_\_\_3<sup>rd</sup> generation \_\_\_\_\_4<sup>th</sup> generation \_\_\_\_\_

Highest Degree Completed:

Major:

Year in school (circle one):

Freshman

Sophomore

Junior

Senior

Other

\_\_\_\_\_

Have you ever been in therapy/counseling before? Yes / No

If yes, please describe (e.g. how long, group or individual, etc.)

How long have you been in USA?

\_\_\_\_\_ years

How do you perceive your English proficiency?

- 1 Native Speaker (I don't have any difficulty in speaking English at all.)
- 2
- 3
- 4
- 5
- 6
- 7 I cannot speak English at all.

Appendix B  
The Asian Values Scale-Revised

Asian Values Scale – Revised (AVS-R)

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

1 = Strongly Disagree

2 = Disagree

3 = Agree

4 = Strongly Agree

- \_\_\_ 1. One should not deviate from familial and social norms.
- \_\_\_ 2. Children should not place their parents in retirement homes.
- \_\_\_ 3. One need not focus all energies on one's studies.
- \_\_\_ 4. One should be discouraged from talking about one's accomplishments.
- \_\_\_ 5. Younger persons should be able to confront their elders.
- \_\_\_ 6. When one receives a gift, one should reciprocate with a gift of equal or greater value.
- \_\_\_ 7. One need not achieve academically in order to make one's parents proud.
- \_\_\_ 8. One need not minimize or depreciate one's own achievements.
- \_\_\_ 9. One should consider the needs of others before considering one's own needs.
- \_\_\_ 10. Educational and career achievements need not be one's top priority.
- \_\_\_ 11. One should think about one's group before oneself.
- \_\_\_ 12. One should be able to question a person in an authority position.
- \_\_\_ 13. Modesty is an important quality for a person.
- \_\_\_ 14. One's achievements should be viewed as family's achievements.
- \_\_\_ 15. One should avoid bringing displeasure to one's ancestors.
- \_\_\_ 16. One should have sufficient inner resources to resolve emotional problems.
- \_\_\_ 17. The worst thing one can do is to bring disgrace to one's family reputation.
- \_\_\_ 18. One need not remain reserved and tranquil.
- \_\_\_ 19. One should be humble and modest.
- \_\_\_ 20. Family's reputation is not the primary social concern.
- \_\_\_ 21. One need not be able to resolve psychological problems on one's own.



- \_\_\_\_ 22. Occupational failure does not bring shame to the family.
- \_\_\_\_ 23. One need not follow the role expectations (gender, family hierarchy) of one's family.
- \_\_\_\_ 24. One should not make waves.
- \_\_\_\_ 25. One need not control one's expression of emotions.

Appendix C  
Inventory of Interpersonal Problems Short (IIP-S)

Instruction: Here is a list of problems that people report in relating to other people. Please read the list below, and for each item, consider whether that matter has been a problem for you with respect to any significant person in your life. Then, select the number that describe how distressing that problem has been, and write that number.

- | It is hard for me to:  | Not<br>at all | A little<br>bit | Moderately | Quite a bit | Extremely |
|--|---------------|-----------------|------------|-------------|-----------|
|  | 1             | 2               | 3          | 4           | 5         |
| 1. trust other people. _____   |               |                 |            |             |           |
| 2. say “no” to other people. _____   |               |                 |            |             |           |
| 3. join in on groups. _____  |               |                 |            |             |           |
| 4. keep things private from other people. _____                              |               |                 |            |             |           |
| 5. let other people know what I want. _____                                  |               |                 |            |             |           |
| 6. tell a person to stop bothering me. _____                                 |               |                 |            |             |           |
| 7. introduce myself to new people. _____                                     |               |                 |            |             |           |
| 8. confront people with problems that come up. _____                         |               |                 |            |             |           |
| 9. be assertive with another person. _____                                   |               |                 |            |             |           |
| 10. let other people know when I am angry. _____                             |               |                 |            |             |           |
| 11. make a long term commitment to another person. _____                     |               |                 |            |             |           |
| 12. be another person’s boss. _____  |               |                 |            |             |           |
| 13. be aggressive toward other people when the situation calls for it. _____ |               |                 |            |             |           |
| 14. socialize with other people. _____                                       |               |                 |            |             |           |
| 15. show affection to people. _____  |               |                 |            |             |           |
| 16. get along with people. _____   |               |                 |            |             |           |
| 17. understand another person’s point of view. _____                         |               |                 |            |             |           |
| 18. express my feelings to other people directly. _____                      |               |                 |            |             |           |
| 19. be firm when I need to be. _____   |               |                 |            |             |           |
| 20. experience a feeling of love for another person. _____                   |               |                 |            |             |           |
| 21. set limits on other people. _____  |               |                 |            |             |           |
| 22. be supportive of another person’s goals in life. _____                   |               |                 |            |             |           |
| 23. feel close to other people. _____  |               |                 |            |             |           |
| 24. really care about other people’s problems. _____                         |               |                 |            |             |           |
| 25. argue with another person. _____   |               |                 |            |             |           |

It is hard for me to:	Not at all	A little bit	Moderately	Quite a bit	Extremely
	1	2	3	4	5

26. spend time alone. \_\_\_\_\_
27. give a gift to another person. \_\_\_\_\_
28. let myself feel angry at somebody I like. \_\_\_\_\_
29. put somebody else's needs before my own. \_\_\_\_\_
30. stay out of other people's business. \_\_\_\_\_
31. take instructions from people who have authority over me. \_\_\_\_\_
32. feel good about another person's happiness. \_\_\_\_\_
33. ask other people to get together socially with me. \_\_\_\_\_
34. feel angry at other people. \_\_\_\_\_
35. open up and tell my feelings to another person. \_\_\_\_\_
36. forgive another person after I've been angry. \_\_\_\_\_
37. attend to my own welfare when somebody else is needy. \_\_\_\_\_
38. be assertive without worrying about hurting the other person's feelings. \_\_\_\_\_
39. be self-confident when I am with other people. \_\_\_\_\_

Part II. The following are things that you do too much.

Not at all	A little bit	Moderately	Quite a bit	Extremely
1	2	3	4	5

40. I fight with other people too much. \_\_\_\_\_
41. I feel too responsible for solving other people's problems. \_\_\_\_\_
42. I am too easily persuaded by other people. \_\_\_\_\_
43. I open up to people too much. \_\_\_\_\_
44. I am too independent. \_\_\_\_\_
45. I am too aggressive toward other people. \_\_\_\_\_
46. I try to please other people too much. \_\_\_\_\_
47. I clown around too much. \_\_\_\_\_
48. I want to be noticed too much. \_\_\_\_\_
49. I trust other people too much. \_\_\_\_\_
50. I try to control other people too much. \_\_\_\_\_

The following are things that you do too much.

- |  | Not<br>at all | A little<br>bit | Moderately | Quite a bit | Extremely |
|--|---------------|-----------------|------------|-------------|-----------|
|  | 1             | 2               | 3          | 4           | 5         |
- 
51. I put other people's needs before my own too much. \_\_\_\_\_
  52. I try to change other people too much. \_\_\_\_\_
  53. I am too gullible. \_\_\_\_\_
  54. I am overly generous to other people. \_\_\_\_\_
  55. I am too afraid of other people. \_\_\_\_\_
  56. I am too suspicious of other people. \_\_\_\_\_
  57. I manipulate other people too much to get what I want. \_\_\_\_\_
  58. I tell personal things to other people too much. \_\_\_\_\_
  59. I argue with other people too much. \_\_\_\_\_
  60. I keep other people at a distance too much. \_\_\_\_\_
  61. I let other people take advantage of me too much. \_\_\_\_\_
  62. I let other people take advantage of me too much. \_\_\_\_\_
  63. I am affected by another person's misery too much. \_\_\_\_\_
  64. I want to get revenge against other people too much. \_\_\_\_\_

## Appendix D

## The Five Item Mental Health Index

1. During the past month, how much of the time were you a happy person?
  1. All of the time
  2. Most of the time
  3. A good bit of the time
  4. Some of the time
  5. A little of the time
  6. None of the time
  
2. How much of the time, during the past month, have you felt calm and peaceful?
  1. All of the time
  2. Most of the time
  3. A good bit of the time
  4. Some of the time
  5. A little of the time
  6. None of the time
  
3. How much of the time, during the past month, have you been a very nervous person?
  1. All of the time
  2. Most of the time
  3. A good bit of the time
  4. Some of the time
  5. A little of the time
  6. None of the time
  
4. How much of the time, during the past month, have you felt downhearted and blue?
  1. All of the time
  2. Most of the time
  3. A good bit of the time
  4. Some of the time
  5. A little of the time
  6. None of the time

5. How much of the time, during the past month, did you feel so down in the dumps that nothing could cheer you up?

1. All of the time
2. Most of the time
3. A good bit of the time
4. Some of the time
5. A little of the time
6. None of the time

Appendix E  
Interpersonal Dependency Inventory (IDI)

Instruction: Please read each statement and decide whether or not it is characteristic of your attitudes, feelings, or behavior. Then, assign a rating to every statement, using the values given below;

not characteristic of me at all	somewhat characteristic of me	quite characteristic of me	very characteristic of me
1	2	3	4

1. I prefer to be by myself. \_\_\_\_\_
2. When I have a decision to make, I always ask. \_\_\_\_\_
3. I do my best work when I know it will be appreciated. \_\_\_\_\_
4. I can't stand being fussed over when I am sick. \_\_\_\_\_
5. I would rather be a follower than a leader. \_\_\_\_\_
6. I believe people could be a lot more for me if they wanted to. \_\_\_\_\_
7. As a child, pleasing my parents was very important to me. \_\_\_\_\_
8. I don't need other people to make me feel good. \_\_\_\_\_
9. Disapproval by someone I care about is very painful for me. \_\_\_\_\_
10. I feel confident of my ability to deal with most of the personal problems I am likely to meet in life.
11. I'm the only person I want to please. \_\_\_\_\_
12. The idea of losing a close friend is terrifying to me. \_\_\_\_\_
13. I am quick to agree with the opinions expressed by others. \_\_\_\_\_
14. I rely only on myself. \_\_\_\_\_
15. I would be completely lost if I didn't have someone special. \_\_\_\_\_
16. I get upset when someone discovers a mistake I've made. \_\_\_\_\_
17. It is hard for me to ask someone for a favor. \_\_\_\_\_
18. I hate it when people offer me sympathy. \_\_\_\_\_
19. I easily get discouraged when I don't get what I need from others. \_\_\_\_\_
20. In an argument, I give in easily. \_\_\_\_\_
21. I don't need much from people. \_\_\_\_\_
22. I must have one person who is very special to me. \_\_\_\_\_
23. When I go to a party, I expect that the other people will like me. \_\_\_\_\_
24. I feel better when I know someone else is in command. \_\_\_\_\_

not characteristic of me at all	somewhat characteristic of me	quite characteristic of me	very characteristic of me
1	2	3	4

25. When I am sick, I prefer that my friends leave me alone. \_\_\_\_\_
26. I'm never happier than when people say I've done a good job. \_\_\_\_\_
27. It is hard for me to make up my mind about a TV show or movie until I know what other people think. \_\_\_\_\_
28. I am willing to disregard other people's feelings in order to accomplish something that's important to me. \_\_\_\_\_
29. I need to have one person who puts me above all others. \_\_\_\_\_
30. In social situations I tend to be very self-conscious. \_\_\_\_\_
31. I don't need anyone. \_\_\_\_\_
32. I have a lot of trouble making decisions by myself. \_\_\_\_\_
33. I tend to imagine the worst if a loved one doesn't arrive when expected.  
\_\_\_\_\_
34. Even when things go wrong I can get along without asking for help from my friends. \_\_\_\_\_
35. I tend to expect too much from others. \_\_\_\_\_
36. I don't like to buy clothes by myself. \_\_\_\_\_
37. I tend to be a loner. \_\_\_\_\_
38. I feel that I never really get all that I need from people. \_\_\_\_\_
39. When I meet new people, I'm afraid that I won't do the right thing. \_\_\_\_\_
40. Even if most people turned against me, I could still go on if someone I love stood by me. \_\_\_\_\_
41. I would rather stay free of involvements with others than to risk disappointments. \_\_\_\_\_
42. What people think of me doesn't affect how I feel. \_\_\_\_\_
43. I think that most people don't realize how easily they can hurt me. \_\_\_\_\_
44. I am very confident about my own judgment. \_\_\_\_\_
45. I have always had a terrible fear that I will lose the love and support of people I desperately need. \_\_\_\_\_
46. I don't have what it takes to be a good leader. \_\_\_\_\_
47. I would feel helpless if deserted by someone I love. \_\_\_\_\_
48. What other people say doesn't bother me. \_\_\_\_\_



Appendix F  
Client Preferences Form

## Client Preferences Measure

*Please circle your answer for each item.*

If I were going to a single session of counseling for stress, I would prefer my counselor:

Item	A	OR	B
1	Encourage me to challenge my beliefs		Help me think about changes I could make in my life
2	Help me become aware of contradictions in my thoughts		Help me identify useful resources (e.g. friends, parents, advisors, schools, clergy)
3	Help me become aware of contradictions in my thoughts		Discuss with me specific things I could do to make change happen
4	Help me gain a new perspective on my problem		Teach me specific skills to deal with my problems
5	Help me think about changes I could make in my life		Help me become aware of contradictions in my thoughts, feelings, and/or behaviors
6	Help me become aware of contradictions in my		Teach me specific skills to deal with my problems

	thoughts	
7	Help me identify useful resources (e.g. friends, parents, advisors, schools, clergy)	Encourage me to challenge my beliefs
8	Help me become aware of contradictions in my thoughts	Help me figure out how to solve a specific problem
9	Teach me specific skills to deal with my problems	Encourage me to challenge my beliefs

**A****OR****B**

10	Help me think about changes I could make in my life	Help me understand the reasons behind my thoughts
11	Encourage me to challenge my beliefs	Help me figure out how to solve a specific problem
12	Help me identify useful resources (e.g. friends, parents, advisors, schools, clergy)	Help me understand the reasons behind my thoughts

13	Discuss with me specific things I could do to make change happen	Encourage me to challenge my beliefs
14	Help me think about changes I could make in my life	Help me gain a new perspective on my problem
15	Help me understand the reasons behind my thoughts	Teach me specific skills to deal with my problems
16	Help me gain a new perspective on my problem	Help me identify useful resources (e.g. friends, parents, advisors, schools, clergy)
17	Help me figure out how to solve a specific problem	Help me understand the reasons behind my thoughts
18	Help me understand the reasons behind my thoughts	Discuss with me specific things I could do to make change happen
19	Help me gain a new perspective on my problem	Discuss with me specific things I could do to make change happen
20	Help me figure out how to solve a specific problem	Help me gain a new perspective on my problem





## Appendix I

## Counselor Effectiveness Rating Scale (CERS)

The purpose of this inventory is to measure your perceptions of the counselor by having you react to a number of concepts related to counseling. In completing this inventory, please make your judgments on the basis of what the concepts mean to you. For example, THE COUNSELOR'S EXPERTNESS may mean different things to different people but we want you to rate the counselor based on what expertness in counseling means to you. In recording your response, please keep the following important points in mind:

- a. Place your X's in the middle of the spaces, not on the boundaries.
- b. Be sure you check every scale even though you may feel that you have insufficient data on which to make a judgment - please do not omit any.
- c. Never put more than one X mark on a single scale.
- d. Notice that the good and bad scales are reversed every other time.

THE COUNSELOR'S EXPERTNESS		
Good	----- ----- ----- ----- ----- ----- -----	Bad
THE COUNSELOR'S FRIENDLINESS		
Bad	----- ----- ----- ----- ----- ----- -----	Good
THE COUNSELOR'S SINCERITY		
Good	----- ----- ----- ----- ----- ----- -----	Bad
THE COUNSELOR'S COMPETENCE		
Bad	----- ----- ----- ----- ----- ----- -----	Good
THE COUNSELOR'S SKILL		
Good	----- ----- ----- ----- ----- ----- -----	Bad
THE COUNSELOR'S RELIABILITY		
Bad	----- ----- ----- ----- ----- ----- -----	Good
THE COUNSELOR AS SOMEONE I AM WILLING TO SEE FOR COUNSELING IN THE FUTURE		
Good	----- ----- ----- ----- ----- ----- -----	Bad

## THE COUNSELOR'S APPROACHABILITY

Bad | \_\_\_\_\_ | Good

## THE COUNSELOR'S LIKABILITY

Good | \_\_\_\_\_ | Bad

## THE COUNSELOR'S TRUSTWORTHINESS

Bad | \_\_\_\_\_ | Good

## Appendix J

## Attitude toward Seeking Professional Psychological Help-Abbreviated Scale

- | Disagree | Partly Disagree | Partly Agree | Agree |
|----------|-----------------|--------------|-------|
| 1        | 2               | 3            | 4     |
- 
- \_\_\_\_\_ 1. If I believe I was having a mental breakdown, my first inclination would be to get professional attention.
- \_\_\_\_\_ 2. The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.
- \_\_\_\_\_ 3. If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy.
- \_\_\_\_\_ 4. There is something admirable in the attitude of a person who is willing to cope with his or her conflicts and fears without resorting to professional help.
- \_\_\_\_\_ 5. I would want to get psychological help if I were worried or upset for a long period of time.
- \_\_\_\_\_ 6. I might want to have psychological counseling in the future.
- \_\_\_\_\_ 7. A person with an emotional problem is not likely to solve it alone; he or she is likely to solve it with professional help.
- \_\_\_\_\_ 8. Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.
- \_\_\_\_\_ 9. A person should work out his or her own problems; getting psychological counseling would be a last resort.
- \_\_\_\_\_ 10. Personal and emotional troubles, like many things, tend to work out by themselves.



## Appendix K

## Post-session clients' preferences

Please rank the sessions which you just saw in order of your preference

(1; what you like best 4; what you like least)

1.  \_\_\_\_\_

2.  \_\_\_\_\_

3.  \_\_\_\_\_

4.  \_\_\_\_\_

Please explain why you rank four sessions in this order (briefly).

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