EFFECTS OF A PSYCHOTHERAPY PRESENTATION ON ASIANS' THERAPY EXPECTATIONS AND HELP-SEEKING ATTITUDES

DISSERTATION

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By

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The effectiveness of an educational psychotherapy presentation on Asians' therapy expectations and help-seeking attitudes was investigated. Subjects were foreign-born Asian university students. Compared to a non-Asian American normative sample, the Asian group demonstrated significantly less accurate expectations about therapy and less positive attitudes about seeking help for psychological problems. A psychotherapy presentation was used to modify expectations and attitudes. It consisted of an audiotaped lecture on therapist and client roles and the types of problems discussed in therapy. It also included a written transcript of therapist-client dialogues for subjects to read. The experimental group, which received the presentation, was compared to placebo control and delayed-treatment control groups. The psychotherapy presentation did not modify Asians' expectations or attitudes more than the control groups. Instead, all three groups showed improvement at posttest. Because there is a clear need to assess further the therapy expectations and attitudes of Asians, future research was recommended.
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CHAPTER I

EFFECTS OF A PSYCHOTHERAPY PRESENTATION UPON ASIANS' THERAPY EXPECTATIONS AND HELP-SEEKING ATTITUDES

During the past 25 years, a growing interest in expectations about psychotherapy has emerged among clinical researchers. The focus of much research has been to evaluate the expectations held by individuals before they enter therapy. These expectations may be about the therapy process, the utility of therapy for particular problems, or the roles of the therapist and client. Although there are some individuals who hold fairly accurate ideas or beliefs about therapy, others have unclear or inaccurate expectations.

The accuracy of these expectations is important for several reasons. First, expectations may affect an individual's attitudes toward seeking professional help for psychological problems. If help-seeking attitudes are negative, psychotherapy may not be considered as an option when serious problems arise. Several early studies on student perceptions of university counseling services have suggested that individuals with relatively inaccurate expectations about counseling and its utility do not make use of available resources (King & Matteson, 1959;
Rust & Davie, 1961). Second, if pretherapy expectations are inaccurate, the person who has begun therapy may decide to terminate treatment prematurely when these expectations are disconfirmed (Overall & Aronson, 1963; Sasseen, 1976). It has become apparent that expectations about therapy need to be evaluated further, particularly in groups which tend to underutilize therapeutic resources and to terminate therapy prematurely.

Asians in America (both Asian Americans and foreign-born Asians) are one such group. They typically underutilize psychological resources (Kitano, 1969a; Sue & McKinney, 1975) and demonstrate a high rate of premature termination (Sue, 1977; Sue & McKinney, 1975). Many studies have revealed that Asians' attitudes are negative toward seeking professional help for psychological problems (Ho, 1976; Le, 1980; Uba, 1982). Fewer studies have evaluated Asians' expectations about therapy, including the process of therapy and the roles of therapist and client. There is a need to explore further their expectations about therapy and how these expectations relate to help-seeking attitudes.

Together with the growing interest in therapy expectations there has been an interest in developing methods that can help change inaccurate expectations. The literature on modifying pretherapy expectations has demonstrated the effectiveness of methods such as the
role induction interview (Hoehn-Saric, Frank, Imber, Nash, Stone, & Battle, 1964) and the therapy preparatory film (Strupp & Bloxom, 1973). A survey of the literature on improving inaccurate expectations of therapy yielded no studies dealing specifically with Asians or Asian Americans. The purpose of the present study was to evaluate the effectiveness of a psychotherapy presentation in improving the therapy expectations and help-seeking attitudes of Asians.

Review of the Literature

Attitudes toward psychological disturbance and mental health. To understand the attitudes of Asians toward seeking professional help for psychological problems, one must appreciate their attitudes concerning psychological disturbance and mental health. Traditional views of mental illness in Asian culture form the basis for more recent attitudes. Among the traditional views in Chinese culture are the moralistic, mystic, physiological, and genetic views. The moralistic perspective is that severe "misconduct" may be responsible for the development of mental illness (Lin & Lin, 1978). This misconduct involves either deviation from socially prescribed behavior or negligence in paying proper respect to one's ancestors. Mental illness is a form of punishment for these transgressions. According to the cosmic or mystic view, mental illness results when an individual incurs the wrath of the gods.
This anger on the part of the gods is a reaction to some intolerable act committed by the person in a previous life. A slightly different version held by traditional Buddhists is that mental illness is the manifestation of a "sin" which was committed generations ago by one's ancestor (Chien & Yamamoto, 1982). The physiological view has several variations, such as the imbalance of yin and yang (i.e., the two forces of nature that are typically balanced by each other) as the cause of psychological disturbance (Lin & Lin, 1978). If the delicate balance between yin and yang is disrupted by deficiencies or excesses in physiological functions, mental illness will result. For example, manic excitement is believed to involve imbalances and problems in diet, exercise, and/or climatic changes. It is referred to as "peach blossom insanity" because it supposedly occurs in the spring among the young. One manifestation is hypersexuality. The genetic view is that "bad blood," which is passed down from generation to generation, is the cause of emotional disturbance (Chien & Yamamoto, 1982). In this view, disturbance will not be evident in every family member, but only certain ones.

Although the traditional perspectives of mental illness presented are less commonly held today, several common attitudes and reactions toward psychological disturbance in the Asian community, which may prevent the use of mental health services when needed, have been
reported (Kinzie, Tran, Breckenridge, & Bloom, 1980; Kitano, 1969b). The reaction of fear has been reported in several Asian groups, including the Japanese (Kitano, 1969b) and the Vietnamese (Kinzie et al., 1980). Fear stems in part from lack of understanding of the disturbed individual and how to deal with him or her. In Japanese culture, it is generally believed that if an individual just tries hard enough then any obstacle can be overcome, no matter how difficult. The idea that a person may not have the resources to cope with obstacles such as interpersonal stress is contrary to this cultural belief. A person who reacts poorly to stress and begins to exhibit signs of emotional disturbance may be regarded with confusion and fear, because it is not understood why he or she cannot cope with the stress. Ridicule and rejection are sometimes directed toward the disturbed individual, usually by persons outside the family or close circle of friends. However, these reactions appear to be less common than fear or confusion.

Within the family, tolerant and even protective attitudes toward the individual with emotional problems are not uncommon (Kitano, 1970). Kitano was careful to mention that the use of the word "tolerant" is not entirely appropriate, because it implies an understanding of the behavior in question. The "tolerance" displayed by the family refers to a willingness to allow deviant behavior or ideas within
the confines of the family without taking any steps to get outside help for the person in question. The family perceives that they have no options in dealing with the individual except to cope with him or her themselves. Members of the community who are well-acquainted with the disturbed individual may react similarly (i.e., with tolerance and protection). They usually react this way toward a community member who demonstrates "eccentric" behavior but is considered "harmless" by the community. In the Japanese community such an individual may be labelled kichigai (insane), and be the object of much discussion, but would not be referred for professional help.

Kitano (1969b) provided an example of such an individual. She was an elderly Issei (first generation Japanese in America) woman who was known in the community for her eccentric behavior, including communicating with spirits and talking to animals. She was a widow who owned a small neighborhood grocery store. At times she would display extreme emotional behavior (e.g., when communicating with spirits). Although her extreme emotionality and absent-mindedness interfered with the smooth operation of the business, her employees remained loyal and protective of her, and customers continued to shop at the store. Gradually, the employees took over most of the duties of running the store, and merely handled her as they would a child. There was no thought of hospitalizing her or
seeking help from a community mental health agency, or any other source. Instead, her "odd" behavior was regarded with amusement, and she continued to be tolerated and protected by the Japanese community. Through this example, Kitano attempted to demonstrate the lack of a "mentally ill role" in Japanese society. This has both positive and negative consequences. On the positive side, such solutions as quick hospitalization usually do not occur as a response to deviant or even disruptive behavior. One negative consequence, however, is that appropriate resources (e.g., mental health clinics) may not be considered for someone who is in real need of such help.

Certain fundamental values that are prevalent across Asian cultures are tightly bound to attitudes and reactions to psychological disturbance. Ho (1976) described several of these values, including self-control, inconspicuousness, and avoidance of shame. Often a family's initial reaction toward an individual with psychological problems is to appeal to the person's sense of obligation to the family (Sue, 1981). The family member is not considered mentally disturbed or urged to seek outside professional help. Instead, the person is lectured on the need to restrain potentially disruptive emotions, and is warned against behaving conspicuously. He or she is expected to control urges to act independently (i.e., independent of the family's wishes) and is constantly reminded of the obligation
to uphold the family name by behaving appropriately (Tinloy, 1978). The shame and disgrace that deviant behavior would bring to the family is emphasized. If appeals to familial obligation do not work, the individual might be labelled "selfish" and "inconsiderate" by the family rather than psychologically disturbed (Sue, 1981). In a study by Kitano (1970) on conceptions of mental illness, it was found that Japanese families typically did not recognize the initial symptoms of mental illness in family members who were later hospitalized for their disorders. Instead, the family perceived the inappropriate and unusual behavior of the person as a form of malingering or as a lack of motivation. Whether families stress familial obligation, the need for greater motivation to cope with difficult problems, the avoidance of shame, or all three, deviant behavior is usually handled with a high level of tolerance in the family (Cheung, 1980). Although the individual may be lectured, cajoled, or disciplined for the behavior, he or she usually is not ostracized from the family or strongly urged to seek professional counseling or other forms of outside help. Only when a problem progresses to the point that the individual's behavior is out of control will the family seek help from a professional or professional agency.

Research comparing attitudes of Asians and non-Asians toward mental illness revealed significant differences between the groups. In one study (Sue, Wagner, Ja,
Margulis, & Lew, 1976), comparisons between Asian American and Caucasian American university students were made. Nunnally's (1961) 40-item questionnaire of attitudes toward mental illness was administered to the two groups. Differences on five of the 10 factors were found. Asian American students were more likely to believe that the mentally ill look and act different from "normal" people. They indicated agreement with the idea that will power forms the basis of personal adjustment, and that persons who remain mentally ill do not "try" hard enough to get well. The views that women are more prone to mental disorder, and that avoidance of "morbid" thoughts and keeping oneself busy enhance mental health were demonstrated by Asians on the questionnaire. Finally, they expressed the belief that mental disorders are brought on by organic factors such as diseases of the nervous system, and can be cured by "physical" means. In an earlier study, Arkoff, Thaver, and Elkind (1966) also used Nunnally's questionnaire to compare American students with Asian students (Chinese, Filipino, Japanese, and Thai) at the University of Hawaii. The greatest differences between the groups were found on the factors of will power and avoidance of morbid thoughts. Asian students expressed the belief that mental health could be enhanced through exercising will power, and that avoiding unpleasant thoughts and occupying oneself with pleasant ones leads to good psychological adjustment.
Cheung (1980) reported that Asian Americans tend to view mental health as the capacity to cope with problems and stresses in life. As in the findings from Nunnally's questionnaire, a strong self-will and the ability to utilize internal resources were seen as necessary to maintain psychological health.

**Attitudes toward seeking professional help.** Asians tend to contain personal and psychological problems within the family (Cheung, 1980; Le, 1980). Mental health professionals or agencies are not usually contacted, unless the problem becomes so severe that the family can no longer tolerate it or hide it from others. As mentioned previously, the family will attempt to control the deviant or distressed individual through cajoling, appeals to family obligation, or lectures on the need to maintain self-control. Many Asians believe that seeking help from mental health agencies would bring shame and disgrace to the family. Therefore, Asian families do not hold positive attitudes toward seeking outside help for a family member with emotional problems (Cheung, 1980; Ho, 1976; Le, 1980; Uba, 1982).

The shame that would result from the public admission of personal problems often prevents both the individual with the problem and the family from using mental health services. They believe that problems must not be exposed to outsiders, but must be contained and if possible
resolved within the family structure. Asians traditionally view mental health facilities as places for "crazy people" who have lost control over their lives (Chien & Yamamoto, 1982). Kitano (1970) studied the process of psychological disturbance and eventual hospitalization among Japanese in Los Angeles, Hawaii, Tokyo, and Okinawa. The role of the family is considered in his analysis. The first noticeable sign that something was wrong with a family member often was a disruption in work patterns. Either difficulties with co-workers, or the loss of a job signaled to the family that the person was developing severe problems. The behavior of the individual was typically described by the family as kichigai (insane), with very few of the family members using more professional and less disparaging terms such as seishinbyo (mental illness), noiroseh (neurosis), or seishinretsusho (schizophrenia) to describe the individual's condition.

As time passed, the disruptive behavior lead to greater conflict in the family. Family members attempted to change the behavior of the patient through argument, discipline, appeals to shame, and cajoling, and spent much time and effort trying to deal with the problem. When these methods proved ineffective, and the patient began to turn against the family, sources of help outside of the family were sought. Friends and relatives were consulted most often in all four subcultures. Among the Japanese in Hawaii and Okinawa, psychiatrists were contacted more frequently than
in Los Angeles and Japan. In most cases, by the time outside help was sought, the individual's problem had progressed to the point that hospitalization was required. At this point, the family could no longer avoid the shame and disgrace which they believed would result from the hospitalization of the patient, but knew they had no other alternative.

Attitudes of suspicion and mistrust toward mental health agencies have been found among foreign- and American-born Asians (Cheung, 1980). These attitudes are often directed toward the non-Asian professionals who usually provide services at these facilities (Sue & Sue, 1972b). Some Asians expect that these professionals are not familiar with their cultural values and norms, and therefore will be insensitive to their needs. Lin & Lin (1978) reported that mental health professionals working with Chinese Canadian families inevitably met with great resistance. The professional's presence was viewed as an intrusion unless the family can be convinced of the value of treatment. Lin and Lin suggested that convincing the families of the potential benefits of treatment requires not only patience but also the ability to clearly communicate the rationale for the intervention techniques that will be used. It is also necessary to persuade the family of the competence of the mental health professional. Another factor related to these attitudes of suspicion
and mistrust may be the discrimination which Asians have encountered in American society (Sue & Morishima, 1982). This discrimination may lead them to become very guarded against exposing any weakness to individuals outside of their own racial or ethnic group. This guardedness and suspicion most likely extends to the therapy or counseling situation as well. Finally, the unfamiliarity of psychotherapy may be threatening to many Asian immigrants and Asian Americans. Suspicion about the nature of therapy is understandable in a culture that has traditionally used other means for dealing with personal problems.

In summary, it appears that Asians hold negative attitudes toward seeking psychological help for problems. Outside agencies are typically contacted as a last resort when severe problems develop. The attitudes are related to feelings of shame and disgrace about turning to external sources for help, and also to suspicion and mistrust of the mental health agencies and professionals employed at these agencies.

Expectations about counseling and therapy. When given a choice of counseling approaches, a directive and structured approach is often expected and preferred by Asians. Fukuhara (1973) reported that Japanese students preferred directive approaches to counseling rather than less structured, non-directive styles. On a counselor preference test, subjects were required to select the counselor styles
they most preferred from several choices. The Japanese students selected the probing and evaluative styles, which were directive in nature, rather than the interpretive, supportive, and understanding approaches. In another study (Nakama, 1980), Japanese Americans expected the counseling situation to be highly structured, and believed that the counselor would assume an active, directive, but supportive role. They also expected the counselor to determine the length of treatment. Similarly, Yiu (1979) found that Chinese American university students preferred structured, directive, and task-oriented therapy approaches over affective and reflective styles. In addition, the students made more self-disclosing statements in the structured, directive therapy sessions. In contrast, the control group of Caucasian students had a higher level of self-disclosure in non-directive therapy. Asian American students in another research study (Atkinson, Maruyama, & Matsui, 1978) rated counselors who used a rational, directive approach as more credible and approachable than non-directive counselors. When the counselor focused on reflecting and summarizing feelings, rather than asking for specific information, the credibility ratings decreased. Ho (1976) discussed effective social work with Asian Americans in the context of their cultural norms and beliefs. It was suggested that since Asian Americans have the expectation of a clear role definition for the social worker and client, and expect a
pragmatic approach to problem-solving, client resistance can be reduced by explicitly describing the agency's services and functions, as well as the type of assistance the client and his or her family can receive. It was further recommended that emphasis should be placed on short-term goals with concrete results, rather than long-term changes.

Other researchers have suggested that Asians expect not only a directive style, but also a strong, authoritative approach by the therapist. Chien and Yamamoto (1982) contended that since most Asians come from societies with a more vertical structure than that of the United States, they expect a therapist to behave in an authoritative manner. They also expect the therapist to have an immediate understanding of their situation, and to quickly provide symptomatic relief for whatever problems led them to seek therapy. Cheung (1980) maintained that the Asian client, whether foreign-born or American, expects the therapist to provide specific advice after the problem is revealed. The Asian client who is confronted with a mental health professional unaware of this basic expectation will most likely discontinue therapy after a short time.

Nonverbal cues are an important aspect of communication in Asian culture. Asians expect the therapist to be sensitive to the nonverbal messages they give, which may not completely parallel the verbal statements they make.
Toupin (1980) discussed a situation which sometimes occurs in therapy when the client is Asian and the therapist is a non-Asian unfamiliar with the cultural norms and values of the client. The client may feel and think one way, but discuss issues which he or she thinks the therapist would like to hear. Angry that the therapist seems to accept these discussions at surface value, and frustrated that the therapist does not respond to his or her nonverbal cues, the client may decide to terminate therapy abruptly.

Finally, Asians typically expect therapy to be relatively brief, with symptoms relieved in a short time (Chien & Yamamoto, 1982). This expectation is based on familiarity with the medical model, which emphasizes relief from symptoms in a brief period of time. One study found that long-term, insight-oriented therapy was not very effective with Chinese patients in a Los Angeles psychiatric hospital (Brown, Stein, Huang, & Harris, 1973). Sue et al. (1976) argued that Asian Americans are not unwilling to discuss problems and emotions openly, but do not expect or prefer to dwell on them and engage in deep analyses of thoughts and feelings, as often occurs in insight-oriented therapies.

**Effect of expectations on therapy utilization and termination.** Expectations about the process of therapy, the utility of therapy for particular problems, and the roles of therapist and client will effect the willingness of individuals to utilize psychological services. In an
early study comparing students who used and did not use counseling services, Rust and Davie (1961) reported that those who tended not to use these services doubted whether their problems were important enough to warrant counseling. These students had preconceived notions about which problems should be handled by themselves and which are serious enough for counseling. In another study on perceptions of counseling center services (King & Matteson, 1959), it was found that students were much more likely to take educational or vocational problems to the counseling center than social or personal problems. The authors suggested that since there is less stigma attached to discussing educational or vocational problems, students may be less hesitant to admit the need for help in these areas. In a study done at Southern Illinois University to explore the reasons why some students do not use university counseling services, it was found that subjects generally had only minimal information about the counseling center and the counseling process (Snyder, Hill, & Derksen, 1972). Although the subjects reported favorable attitudes toward counseling, they indicated that they would choose friends and close relatives before counseling for help with personal and social problems. In an investigation comparing the expectations of psychotherapy held by mental health professionals and laypersons, Kupst and Schulman (1979) found that laypersons were much more apt to believe that no one can
solve another person's problems. Moreover, they believed that a person with problems should try to resolve them alone. If another's advice should prove necessary, the laypersons perceived a spouse, parent, or close friend as more helpful for discussing personal problems than a psychiatrist, psychologist, or social worker. These findings suggest that the subjects would not ordinarily think to use therapy as a method for solving their problems except perhaps as a last resort.

In the foregoing studies with non-Asians, it is clear that reluctance to use therapy is different in degree and in origin from that of Asians. Yet the studies do establish that it is probably the expectations of Asians about therapy which are related to the low rate with which they utilize available therapy resources. Asian underutilization of psychological services is most likely related not only to the shame and disgrace they associate with seeking outside help for problems, but also to the lack of real need they expect for therapy in the first place. For example, related to the Japanese belief that if one tries hard enough, any obstacle can be overcome (Kaneshige, 1973) is the belief that individuals must utilize their own internal resources to deal with stress or frustration. Therapy would be pointless according to this view, since the individual is responsible for finding solutions to his or her own problems. Also, in those instances when Asians
might consider therapy for a problem, it may become eliminated as an option if it is expected that uncomfortable thoughts and feelings must be discussed and analyzed at length (Sue et al., 1976). Another expectation relating to underutilization is that, since the therapist is perceived as an expert and authority figure who must be obeyed, Asians believe that once therapy has begun, they have no choice but to follow the recommendations of the therapist, even if this seems distasteful.

In addition to the somewhat negative perceptions of certain aspects of therapy, many Asians probably do not have clear expectations regarding several other aspects at all. Lin and Lin (1978) contended that mental health and social welfare agencies were foreign to a large portion of the Chinese population in Canada. They tended to view such agencies with awe and even fear, and typically avoided using them. In attempting to explain why it is not easy for Indochinese refugees to accept a psychiatric referral, Kinzie et al. (1980) emphasized a cultural problem: The lack of a traditional counselor in Asian societies. "Traditional counselor" refers to someone who listens to and works with clients to find solutions for personal problems. The lack of a counselor or therapist role model may lead to inaccurate expectations about the therapist's role and style. This was supported by another study (Fukuhara, 1973) which suggested that Asian students
have a less clear understanding of counseling and its potential usefulness than non-Asian students.

Alternatively, it is possible that underutilization of psychological resources is due to a lesser need for therapy among Asians than to negative or unclear expectations about therapy. However, the hypothesis that Asians are better adjusted and experience less psychological distress than other groups has not received convincing support. Although they have a lower rate of highly visible problems such as juvenile delinquency (Kitano, 1967) and violent crime (Kitano, 1969a), they often express their stress in low acting-out symptoms such as psychosomatic problems (Chien & Yamamoto, 1982; Sue & Kirk, 1975; Sue & Sue, 1972a). Japanese and Chinese students receiving therapy at a university clinic exhibited more somatic symptoms than non-Asian clients (Sue & Sue, 1974). Besides somatic symptoms, Asians sometimes had negative and often disruptive feelings which also are not highly visible to those in their environment. Japanese-American male students in one university revealed greater feelings of loneliness and anxiety than non-Asian students (Sue & Kirk, 1973). Chinese-American students at the University of California at Berkeley reported greater feelings of uneasiness with themselves and others than non-Chinese students (Sue & Kirk, 1972). These studies suggest that psychological problems are not less prevalent among Asians, even though
they may be better hidden. Their use of available resources is not proportional to their need for therapy and counseling.

In addition to therapy utilization, premature termination of treatment is often related to the initial expectations held by the client. Overall and Aronson (1963) found that clients of low socioeconomic status who held inaccurate expectations about psychological treatment were less likely to return after an initial interview. These clients initially believed that the therapist would assume an active, medical role in therapy. Ratings by the clients after an initial interview on an expectation questionnaire indicated that the therapist was considerably less active and medically oriented than was originally expected. Another investigation (Sasseen, 1976) demonstrated that disconfirmation of clients' expectations was related to premature termination, which was defined as missing any of the first five therapy sessions and not returning for four consecutive sessions. The factor of disconfirmed therapy expectations was also related to dissatisfaction with the initial interview. Orne and Wender (1968) provided a profile of the type of client who has not had adequate socialization about what to expect in therapy, and who therefore holds inaccurate or poorly defined expectations about his role and the role of the therapist. This hypothetical client relies on the only model in his experience,
namely the medical model. He expects the psychiatrist to act like any other medical doctor, which is understandable, given a lack of experience with psychotherapy. Orne and Wender's scenario of the initial interview is the following. After briefly describing why he came to therapy, the client waits to be asked further questions by the psychiatrist. However, the psychiatrist makes little or no response and listens attentively as he waits for the client to say more. Both wait expectantly for the other to say something, and both become increasingly uncomfortable. The client doesn't understand why the psychiatrist isn't asking more questions and the psychiatrist wonders why the client isn't offering more information or talking more about what is troubling him. The client may terminate therapy prematurely as a result of this uncomfortable and confusing experience.

Among Asians and Asian Americans, premature termination occurs fairly frequently. Given the many reasons which ordinarily eliminate therapy as an acceptable option for dealing with problems, it is extremely unfortunate that among those Asians who do finally decide to enter therapy, a high percentage tend to terminate prematurely (Cheung, 1980; Sue, 1977; Toupin, 1980). Researchers have reported dropout rates as high as 52 percent for Asian patients (Sue & McKinney, 1975). The reasons for the high rate of treatment termination by Asian Americans were explored in one study (Sue, 1977). It was found that none of the
variables examined could adequately account for the dropout rate of over 50 percent. These variables included demographic differences, staff at intake, staff during therapy, and type of program and service. In the discussion, the author suggested that variables not investigated in the study, particularly the interpersonal relationship between therapist and client, could be important in understanding the high rate of dropout among Asians. A related explanation is that the Asian client's initial expectations about how the therapist and he or she would interact were not confirmed during therapy. Therefore, the client decided to terminate therapy.

Methods for changing therapy expectations. Expectations about therapy have been shown to influence individual willingness to utilize psychological services (King & Matteson, 1959; Kupst & Schulman, 1979; Rust & Davie, 1961). Certain groups, such as lower socioeconomic classes and certain minorities, often have expectations about therapy that are not accurate (Acosta, Yamamoto, & Evans, 1982). These expectations may lead them to underutilize mental health services. In addition, the importance of expectations in the client's decision to remain in or terminate therapy has been demonstrated in several studies (Cheung, 1980; Overall & Aronson, 1963; Sasseen, 1976).
A result of these findings on therapy expectations has been the development of methods for changing expectations before a client enters psychotherapy (Heitler, 1976; LaTorre, 1977; Sloane, Cristol, Pepernik, & Staples, 1970). Orne (1964) presented one of the first methods for modifying client expectations. He called this technique the "anticipatory socialization interview," and presented a detailed description of the method and its rationale in a later article (Orne & Wender, 1968). It was argued that a crucial variable determining the success or failure of psychotherapy is the extent to which the client understands the "rules of the game." Certain groups tend to have a considerable amount of knowledge about the process of therapy, its importance, and its potential effectiveness. In addition, they often hold specific expectations concerning the therapist's and client's role and behavior. Orne and Wender described these groups as having had a good deal of anticipatory socialization before entering psychotherapy. Generally, middle- to upper-class clients fall in this category. In contrast are many members of less economically privileged groups, as well as individuals of certain ethnic backgrounds, who do not possess the knowledge of therapy and the role expectations that would help them to receive maximum benefit from therapy. Since members of these groups may have no concrete idea of what to expect in therapy or may hold inaccurate beliefs, the method of
anticipatory socialization is particularly useful. It is a method of communicating to the client what he or she needs to know about therapy.

In this method, a pretherapy interview is conducted either by the therapist or by another trained individual. The interview has three major purposes: to provide the client with a rational basis for psychotherapy and its potential utility; to clarify the roles of both client and therapist; and to give a general outline of the course of therapy. Included in the general outline are discussions about those aspects of treatment which have lead previous clients to prematurely terminate. For example, the client is told that he or she may sometimes feel that significant progress is being made, and at other times see no progress at all. Resistance and transference reactions (both negative and positive) are discussed in terms that can be understood by people inexperienced with therapy. Orne and Wender were careful to stress that anticipatory socialization should not be seen as a prescription for future in-therapy behavior, but as a way to help improve the client's chances of receiving the maximum benefits from therapy.

Closely related to the anticipatory socialization method is the role induction interview developed at the Psychiatric Clinic of Johns Hopkins Hospital (Hochn-Saric et al., 1964). In addition to the essential components
included in the anticipatory socialization technique (i.e., a general exposition of psychotherapy, a description and explanation of therapist and client behavior to be expected, and a discussion of certain rather common occurrences during the course of therapy, such as resistance), a realistic time expectancy for improvement, namely four months, was introduced. A comparison of a role induction group with a control group receiving no pretherapy interview revealed several findings which support the technique, including better attendance for the role induction group. Subjects in this group were rated by their therapists as showing a more favorable outcome, being more socially effective by the end of therapy, and demonstrating more appropriate therapy behavior after the third session, although by the last session, the control group had become as appropriate in their behavior.

The role induction interview received further support in a study which evaluated its effectiveness in relation to therapist and client characteristics (Nash, Hoehn-Saric, Battle, Stone, Imber, & Frank, 1965). The variable of client attractiveness as related to the role induction condition was investigated. Those clients who had been rated as "unattractive" (i.e., a global judgment of suitability for therapy based on such factors as education, age, and the ability to relate to others) in the role induction group were especially helped by the role
induction method. These "unattractive" subjects in the role induction group were rated significantly higher on outcome and therapy behavior than "unattractive" controls. There was also an interaction between experience of the therapist and the experimental intervention. Therapists with greater experience were able to obtain the best results with clients who had received the role induction interview.

Another therapy preparation method is the preparatory film, which has the advantage of potential use with several clients simultaneously. Strupp and Bloxom (1973) developed a role induction film which specifically addressed concerns of lower-class clients. The film depicted interactions in a therapy group, and demonstrated how the group experience led the principal actor (an unemployed truck driver) to gain a greater understanding of his own contribution to his problems. To evaluate the effectiveness of the film, three groups were compared: an experimental group which viewed the preparatory film, another experimental group which received a role induction interview, and a control group which viewed a neutral film. The results demonstrated that role induction, either through the film or interview method, led to a favorable therapy experience. Both of the experimental conditions yielded more positive results than the neutral procedure. The role induction interview was more successful in communicating information about the
process of group therapy, while the role induction film was superior on other measures, including the client's ratings of global improvement and specific target symptom improvement. Rosenzweig (1974) utilized the Strupp and Bloxom (1973) film as part of a three-hour psychotherapy class. First, clients were shown the 33-minute film, followed by a short discussion on the film. Next, there was a discussion about therapy behavior and the process of therapy. Finally, the class instructors modeled appropriate group behavior and participants role-played them. The therapy preparation class failed to affect clients' expectations about the working aspects of therapy and in-therapy behavior. However, it did have a positive effect on clients' and therapists' verbal expression of satisfaction with therapy outcome. The effectiveness of a preparatory film was also evaluated by Goldstein (1976). During the intake process, one group viewed a preparatory film while the other did not. The preparatory film group exhibited a greater change toward more realistic therapy expectations than the unprepared group, and demonstrated expectations closer to those of the therapist.

Extending the individual role induction interview to a group situation, Yalom, Houts, Newel, & Rand (1967) devised a 25-minute group preparatory lecture. It was similar to the role induction interview by Hoehn-Saric et al. (1964), but with emphasis on group therapy.
The findings indicated that prepared clients engaged in discussions more appropriate for effective group therapy in subsequent group therapy sessions. In a study with adolescents referred for group therapy (Corder, Haizlip, Whiteside, & Vogel, 1980), a pretherapy training and orientation program proved effective in several ways. It was related to faster development of group cohesion, and appeared to reduce the amount of time spent in "pass-time" discussions. It also helped to increase expression of positive expectation of group treatment, and aided clients in how to give and receive verbal feedback.

Other methods to induce appropriate client role expectations have been reported, including a vicarious therapy pretraining technique (Truax, Wargo, Carkhuff, Kodman, & Moles, 1966). One of the goals of this technique was to help clients to engage in self-exploration. Clients receiving this induction method listened to a tape recording of portions of therapy interviews which illustrated "good" client verbal behavior. These therapy interviews focused on exploration of feelings and beliefs, and included examples of topics suitable for therapy. The clients who received the vicarious therapy pretraining showed significant increases in their self-concept and in experts' ratings of their self-concept. In a more extensive study, Truax, Wargo, and Volksdorf (1970) employed 20 outcome measures in evaluating the effects of vicarious therapy.
pretraining. Significant group differences in favor of the pretraining group were found on only two measures, leading the authors to conclude that vicarious therapy pretraining did not generally produce more favorable outcome.

In summary, several methods have been used to modify clients' expectations about therapy, and to prepare them for the therapy experience, either individual or group therapy. These methods include anticipatory socialization, a similar technique called the role induction interview, group preparatory techniques, the preparatory film, and vicarious therapy pretraining. Investigations employing these techniques for the most part have reported favorable results.

Statement of the Problem

The studies reviewed in this paper indicate that Asians and Asian Americans typically have negative attitudes about utilizing professional help for psychological problems. In part, these attitudes are related to the shame and disgrace that the individual and his or her family would feel if problems were revealed to someone outside the family structure. However, these feelings of shame and disgrace do not account entirely for the reluctance to use mental health services and for the premature termination of treatment which often occurs among Asians who do try therapy. The expectations which Asians have about therapy and the roles of therapist and
client are probably related to their negative attitudes about therapy, which in turn effect their willingness to use psychological services and to remain in therapy once it has begun. These expectations about therapy were found to be either inaccurate or unclear in studies done with Asians and Asian Americans (Arkoff et al., 1966; Chien & Yamamoto, 1982; Fukuhara, 1973).

One way to increase therapy utilization and to decrease premature termination of treatment is to provide Asians with accurate information about the therapy process and the roles of therapist and client. The problem of the present study was to investigate the effectiveness of an educational psychotherapy presentation in modifying the therapy expectations and help-seeking attitudes of Asians. Through this investigation, the utility of two assessment instruments designed specifically to evaluate the therapy beliefs and help-seeking attitudes of Asians was determined.

**Hypotheses**

**Hypothesis 1.** Asian students have significantly less positive attitudes about seeking psychological help for problems than non-Asian American students.

**Hypothesis 2.** Asian students have significantly less accurate expectations about psychotherapy than non-Asian American students.

**Hypothesis 3.** An instructional presentation on psychotherapy will significantly modify inaccurate therapy expectations in the direction of greater accuracy.
Hypothesis 4. If therapy expectations become more accurate, help-seeking attitudes will become more similar to those of non-Asian Americans.
CHAPTER II

Method

Subjects

The subjects in this study were foreign-born Asian student volunteers who had lived in the United States for ten years or less. The subjects were all from nations in East or Southeast Asia, and were undergraduate or graduate students attending universities in Boston and its surrounding suburbs. Subjects volunteered in answer to recruitment notices posted in university buildings, or classified advertisements placed in student newspapers (see Appendix A for a sample notice). Additional volunteers were recruited through subjects who had read the notices or classified advertisements. Volunteers were paid $15 each for their participation in the study. Students who majored in psychology were excluded from the study, because their background might provide more accurate therapy expectations and positive help-seeking attitudes, which may not have been representative of Asian students as a whole.

There were a total of 45 subjects, with 15 randomly assigned to each of three groups. Participants ranged in age from 18 to 32 years, with a mean age of 22.1 and median age of 23. The sample consisted of 17 males and 28 females.
Material

Therapy Expectation Scale. This expectation scale was developed by the present author and used in a previous study with non-Asian American subjects (Plotkin, 1983a). Standardization data were obtained from that population of university students. The internal reliability of the scale was relatively high ($r = .81$). The scale consists of 40 items with a forced choice format (Appendix B contains the entire scale). Agreement or disagreement with each item on the scale is indicated by circling yes or no. The scale contains items concerning expectations, beliefs, and ideas about psychotherapy. More accurate expectations about therapy are indicated as scores increase on the scale. In addition to the present author's judgment of which items indicate accurate expectations about therapy, 15 student clinicians in the clinical and counseling psychology doctoral programs at North Texas State University also rated the items for accuracy of expectation (Plotkin, 1983b). Their assessments were collected prior to the standardization study with American students. An agreement level of 80 percent was achieved on 32 of the 40 items. Of the remaining eight items, agreement levels of 73 percent for one, 67 percent for three, 60 percent for three, and 53 percent for one were obtained.

The scale is divided into two parts: the first section consists of statements representing expectations about the
client's role and behavior in therapy, and the second part about the therapist's role and behavior. Many of the items represent issues of particular relevance to Asians, such as perceived therapist authority and the willingness of clients to disagree with their therapist. These issues were compiled from a survey of the psychological literature on Asian Americans, foreign-born Asians, and Asians in their native countries, as well as from personal communication with Japanese citizens in Tokyo, Japan, and Chinese and Japanese international students studying here in the United States. The content of the items was judged to be sensitive to Asian cultural beliefs by three Asian student informants. Several items related to the therapist's behavior were adapted from Overall and Aronson's (1963) expectation questionnaire.

Help-Seeking Attitude Scale. The Help-Seeking Attitude Scale was devised by the present author, and was used previously in the same study as the Therapy Expectation Scale (Plotkin, 1983a). Normative data for the scale were obtained on the same sample of non-Asian American students tested on the expectation scale. The attitude scale's internal reliability of .87 indicates relatively high internal consistency. The correlation between the Help-Seeking Attitude and another standardized instrument of help-seeking attitudes (Attitudes Toward Seeking Professional Psychological Help Scale, developed by Fischer and Turner,
1970) was significant ($r = .49, p < .001$). A total of 40 items using a yes-no format, with yes indicating agreement and no indicating disagreement with an attitude statement, comprise this scale (see Appendix C). More positive attitudes toward seeking professional help for psychological problems are indicated as scores increase on the scale. As had been done with the expectation scale, 15 student clinicians rated the items in terms of whether they represented positive or negative attitudes about therapy (Plotkin, 1983b). This was done as a check on the present author's judgment of the items. A total of 39 out of 40 items were rated the same by 80 percent or more of the clinicians.

Like the Therapy Expectation Scale, items in the Help-Seeking Attitude Scale were based on findings from the literature on the attitudes of Asian Americans, foreign-born Asians, and Asians in their native countries, as well as information from conversations with Asian students in the United States and Japanese citizens in Tokyo. The contents of the items were also judged by Asian informants to be sensitive to the help-seeking attitudes of Asians. For example, the effectiveness of therapy for social problems and the possible stigmatization of persons who receive therapy are two issues reflected in the questionnaire.

**Adaptation of the Fundamental Interpersonal Relations Orientation - Behavior Scale.** A subset of items from the Firo-B scale (Schutz, 1967) was created for the study (see
Appendix D). These items relate to interpersonal style and social preference. This adapted scale was included with the questionnaires to increase the face validity of the placebo control treatment, which focused on social relationships. This scale was not scored or analyzed, but was included merely as a distraction instrument.

**Demographic Information Form.** The following information was obtained on the demographic form: age, sex, country of origin, educational status, number of previous psychology courses, major in school, and previous therapy experience (see Appendix E).

**Audiotape of psychotherapy lecture.** A 20-minute audio cassette tape about psychotherapy was created which contained a general description of psychotherapy, a summary of the various professional providers of therapy, and a description of facilities where therapy can be obtained. The general description of psychotherapy was partially based on material from Collier (1977) and Wortman and Loftus (1981). In addition, a discussion of the roles of therapist and client was included, as well as examples of problems that people discuss in therapy (see Appendix F for written transcript of psychotherapy lecture).

**Written dialogues of therapist-client discussions.** Written dialogues from the therapy orientation program "Tell It Like It Is" (Evans, Acosta, & Yamamoto, 1982) were used in the study (see Appendix G). The written transcript
is an adaptation of the original slide-cassette program, in which slides depicting therapists and clients are presented along with audiotaped dialogues between them. There are seven dialogues, each of which is preceded by an explanation of the main point of the dialogue (e.g., the client should discuss with the therapist even those problems that may be embarrassing).

**Audiotape of social relationships' lecture.** This lecture was adapted from material about social relationships in *The Psychology of Being Human*, an introductory psychology textbook (Rubin & McNeil, 1981). The lecture covered the following areas: social comparison, benefits derived from social relationships, and the effects of physical appearance and reputation on social perception. It also included a discussion of factors influencing feelings towards others.

**Written material on social relationships.** This material is a continuation of the lecture on social relationships and is also based on the material in the psychology text by Rubin and McNeil (1981). It covers the topics of love relationships and the termination of relationships.

**Design**

A pretest-posttest design with repeated measures was employed. Subjects were randomly assigned to one of three groups.
Experimental group. Subjects received the psychotherapy presentation consisting of an audiotaped lecture on psychotherapy and written transcripts of therapist-client dialogues.

Placebo control group. Subjects received the social relationships presentation. It consisted of a social relationships' lecture on audiotape and written material on this topic.

Delayed-treatment control condition. Subjects received the psychotherapy presentation after completing test measures on two occasions.

Procedure

After being randomly assigned to one of the three groups and giving their informed consent (see Appendix J for Informed Consent Form), subjects completed pretest measures. These measures were the Therapy Expectation Scale, the Help-Seeking Attitude Scale, the Adaptation of the Fundamental Interpersonal Relations Orientation - Behavior Scale, and the Demographic Information Form. Then, subjects in the experimental group were given the psychotherapy presentation, and subjects in the placebo control group received the social relationships' presentation. Approximately one week after receiving either the psychotherapy or social relationships' presentation, subjects returned for a short meeting to complete the post-test measures, which were the same as the pretest questionnaires. The delayed-treatment control group completed the questionnaires on two occasions, separated by one week,
before returning to receive the psychotherapy presentation. One week following the presentation, the subjects in this group were sent the questionnaires by mail and were required to complete them for the third and final time.

**Psychotherapy presentation.** Subjects in both the experimental and delayed-treatment control groups received the psychotherapy presentation. The experimental subjects first completed the pretest measures, then listened to an audiotape of an educational lecture on psychotherapy, and then read written transcripts of therapist-client dialogues. This initial meeting lasted about 50 minutes. The second meeting, scheduled about one week later, lasted only 15 minutes, and consisted only of completing the questionnaires again. The delayed-treatment control group received the same treatment as the experimental group, except that another 15 minute session for completing only the questionnaires was added prior to the two sessions described above.

The audiotaped lecture on psychotherapy was specially designed for people with little knowledge of therapy and possible language deficits. Its vocabulary and sentence construction were kept simple, and definitions of psychological terms (e.g., phobia) were provided in an easily understood form. This was intended as an aid to the foreign-born Asian volunteers.

The written transcript of the therapy orientation program "Tell It Like It Is" (Evans, Acosta, & Yamamoto,
1982) consisted of hypothetical therapist-client dialogues. Similar to the psychotherapy lecture, this orientation program was designed for individuals who have minimal knowledge of therapy. The objectives of the program are to help the client (a) understand the therapy process, (b) clearly express any problems or expectations about therapy to the therapist, (c) respond more openly and directly to the therapist, and (d) take a more active role in the therapy process.

Social relationships presentation. Subjects in the placebo control condition received the social relationships' presentation. During the initial meeting, which lasted about 45 minutes, subjects first completed pretest questionnaires, then listened to a taped lecture on social relationships, and finally read written material on social relationships. One week later, subjects returned to complete only the questionnaires again during a 15-minute session.

As with the psychotherapy lecture, the language in the social relationships' lecture was designed for ease of understanding. The topic of social relationships was chosen for the placebo control group because it is similar to the topic of psychotherapy in interest level.
CHAPTER III

Results

The sample of Asian subjects (N = 45) in this study was compared to a non-Asian normative group (N = 152 for the Therapy Expectation Scale; N = 151 for the Help-Seeking Attitude Scale) which was tested in a previous study (Plotkin, 1983a). Asian subjects at pretest scored significantly lower than non-Asian subjects on the two dependent measures, the Therapy Expectation Scale (t = 1.96, df = 195, p < .05) and the Help-Seeking Attitudes Scale (t = 3.59, df = 194, p < .001). The Asian group had significantly less accurate expectations of what occurs in therapy and less positive attitudes about seeking professional help for problems. Folded F tests performed on both the expectation and attitude scale data revealed that the Asian and non-Asian samples had equal variances (F' = 1.04 for the Therapy Expectation Scale; F' = 1.26 for the Help-Seeking Attitude Scale). Table 1 (see Appendix K) presents the means and standard deviations from the Asian and non-Asian groups on the Therapy Expectation Scale and the Help-Seeking Attitude Scale.

A one-way analysis of variance was used to analyze the pretest data obtained from the Asian experimental, placebo control, and delayed-treatment control groups (n = 15 for
each group). No significant intergroup differences were found at pretest among the groups on the Therapy Expectation Scale ($F = .29, df = 2/42$) or on the Help-Seeking Attitude Scale ($F = 1.76, df = 2/42$). This analysis shows that all three groups began the study with no significant differences in expectations and attitudes about therapy. The analysis of variance summary information for these two scales is shown in Tables 2 and 3 (see Appendix K).

The effect of treatment was analyzed with a two-way analysis of variance with repeated measures for each of the two dependent variables. On the Therapy Expectation Scale, a significant main effect for the repeated measures factor, time of testing, was found ($F = 31.93, df = 1/42, p < .001$). All three groups as a whole demonstrated improvement from pretest to posttest. No significant interaction between time of testing and type of treatment was found ($F = 2.19, df = 2/42, p = .12$). ANOVA summary information is presented in Table 4 (see Appendix K).

Although the interaction between time of testing and type of treatment was not statistically significant, an examination of the pretest and posttest means listed in Table 5 (Appendix K) reveals that the largest increase in mean scores occurred in the experimental group.

Similar to the results for the expectation scale, the two-way analysis of variance with repeated measures for the dependent variable of attitudes toward therapy yielded
no significant interaction effect for time of testing and treatment type \( (F = .57, df = 2/42, p = .57) \). Yet, again the difference between the pretest and posttest means in the experimental group was larger than that found in the placebo control and delayed-treatment control groups. It appears that even though the pretest-posttest difference in the experimental group is not statistically greater than the others, there seems to be a trend in the direction of significance. As with therapy expectations, a main effect for time of testing was significant for the attitude scale, with higher scores demonstrated on posttest in all three groups as a whole \( (F = 4.56, df = 1/42, p < .05) \). The pretest and posttest means for the attitude scale are presented in Table 6 (see Appendix K). The findings for the two-way ANOVA with repeated measures are summarized in Table 7 (see Appendix K).

To determine the relationship between therapy expectations and help-seeking attitudes, Pearson product-moment correlations between the two scales were computed. A significant correlation between scales was found in all pretest subjects \( (r = .75, p < .0001) \) and all posttest subjects \( (r = .72, p < .0001) \).

Individual three-way ANOVAs with repeated measures were done for each of the control variables, sex, age, length of stay in the United States, and number of previous psychology courses. No significant main effects were found for these variables. Only one two-way interaction effect
was found, and that was type of treatment by number of psychology courses taken ($F = 2.95, p < .05$). However, this interaction is difficult to interpret because the subjects in each group varied considerably as to their number of psychology courses (0 to 3), and because interactions involving control variables are not as meaningful as main effects.

Frequencies and percentages of inaccurate pretest and posttest responses for each of the 40 individual items on the Therapy Expectation Scale are listed in Table 8 (see Appendix K). Items labelled "C" deal with beliefs about the client's role and behavior, and those labelled "T" focus on the therapist's role and behavior. The expectation questionnaire with these items is shown in Appendix B.

Of particular interest are items which relate to the concept of confidentiality in psychotherapy. These items are T37 ("During psychotherapy, I think that the therapist will tell the client's family about his problems if it would be helpful") and T40 ("During psychotherapy, I think that the therapist will sometimes discuss the client's problems with people who know the client"). The Asian pretest group gave inaccurate responses 71 percent of the time for question T37, and 53 percent of the time for question T40. The Asian posttest group showed no improvement on these two questions, giving inaccurate responses 73 percent of the time for T37 and 53 percent
of the time for T40. In contrast, the non-Asian group gave only 50 percent inaccurate responses for item T37, and 21 percent for item T40.

Another important subgroup of items for Asian subjects deals with the perceived authority of the therapist. This subgroup consists of C2 ("During psychotherapy, I think that the client will work together with the therapist to find solutions to his problems"), C6 ("During psychotherapy, I think that the client will not discuss any issue that might make the therapist angry"), and T34 ("During psychotherapy, I think that the therapist will provide rules that the client must follow completely"). The Asian pretest group demonstrated inaccurate expectations only 20 percent of the time on these questions in combination. This is similar to the non-Asian group which gave inaccurate responses 22 percent of the time.

Several other items on the expectation scale reflected inaccurate expectations among a fairly high percentage of Asian subjects at pretest (>53%). The items relating to the client's role and behavior in therapy were: C9 ("I think that the client will not tell his spouse what was discussed in psychotherapy."), C14 ("During psychotherapy, I think that the client will usually feel uncomfortable answering the questions asked by the therapist."), C17 ("I think that the client will continue in psychotherapy even if he feels no immediate benefits from it."), and
C19 ("During psychotherapy, I think that the client will only talk about the problem which made him decide to begin therapy."). Items in which a relatively high percentage of inaccurate responses occurred relating to beliefs about the therapist were T37 and T40, as well as T24 ("During psychotherapy, I think that the therapist will make suggestions that will always be helpful."), T28 ("During psychotherapy, I think that the therapist will act like a personal friend of the client."), and T39 ("During psychotherapy, I think that the therapist will be able to understand the client's thoughts and feelings by looking at his facial expressions.").

Frequencies and percentages of negative attitudes for the Help-Seeking Attitude Scale are shown in Table 9 (see Appendix K). Data for non-Asian, pretest Asian, and post-test Asian subjects are listed. Only two items reflected negative attitudes for more than 50 percent of the Asian pretest group. These items, which are labelled "A" for attitude, were A3 ("A person should tell anyone he wants that he goes to a therapist.") and A20 ("People with mild to moderate problems don't need psychotherapy."). The non-Asian group gave negative responses only 29 percent of the time for A3 and 34 percent for A20.
CHAPTER IV

Discussion

The hypothesis that foreign-born Asians have significantly less accurate expectations about therapy than non-Asian Americans was supported by the data. The lower scores of the Asian group on the Therapy Expectation Scale at pretest suggest less accurate expectations about the therapist's and client's role and behavior in psychotherapy. One important example of these inaccurate beliefs involves the concept of confidentiality in therapy. When the two items concerning confidentiality are examined in the Asian pretest group and non-Asian group, Asians more frequently indicated a lack of understanding of this concept. They tended to believe that the therapist would divulge information revealed by a client to the client's family or to others familiar with the client. This belief certainly would be reasonable cause for anyone considering therapy to avoid it or to prematurely terminate. This belief may originate in Asians' lack of experience with therapy and lack of a counselor or therapist role model in traditional Asian society (Lin & Lin, 1978).

The hypothesis that Asians would have less positive attitudes than non-Asians toward seeking professional help for problems was also supported by the data. For example,
Asian subjects tended to believe that therapy is not appropriate for other than severe personal problems. They also believed that discretion must be exercised when persons reveal to others that they are in therapy. A positive relationship between therapy expectations and help-seeking attitudes was found. This is consistent with the findings from an earlier study with non-Asian subjects (Plotkin, 1983a). As predicted, more accurate expectations about psychotherapy are associated with more positive attitudes about using it. When a person has a clear understanding of the therapy process and the roles of therapist and client, it is probable that his or her attitude about utilizing therapy for psychological problems would be more positive than someone who has vague suspicions about what happens in therapy.

The psychotherapy presentation did not modify expectations or attitudes significantly more than either of the two placebo conditions. Instead, all three Asian groups as a whole showed significant improvement at posttest. Participation in the study, whether it consisted of exposure to an educational psychotherapy presentation, placebo presentation about social relationships, or merely completing the questionnaires on several occasions, led to higher scores on both the expectation and attitude scales. This general improvement in scores may be due to one of several reasons, including the participants' re-evaluation
and modification of their original responses in order to please the experimenter. It is possible that the payment of $15 for participation in the study may have contributed to the desire of subjects to give the experimenter what they expected she wanted. However, even if this were the case, the psychotherapy presentation should have brought about a greater increase in scores than the other two treatments, if it were more effective in improving expectations and attitudes. Alternatively, the general increase in scores may reflect a real modification of expectations and attitudes, but then the psychotherapy presentation appears to be no more effective than merely hearing a discussion about social relationships or completing questionnaires about therapy, the act of which may stimulate thinking about therapy.

There is, however, one aspect of the data which suggests that the psychotherapy presentation may be more effective than the other two treatments in modifying therapy expectations and help-seeking attitudes. That is the greater difference in means from pretest to posttest in the experimental group. For both therapy scales, the increase in mean scores for the experimental group was larger than either of the other two groups. Although this increase was not statistically significant, it suggests that future research which makes certain modifications may yield results in favor of the experimental treatment. For example, an
increase in the size of the sample may lead to significant differences between the psychotherapy group and the placebo conditions. In addition, a reduction in subject variability might increase the probability of detecting differences between groups. Subject variability might be reduced by using Asian subjects from one country, rather than several east Asian countries, as was done in the present study. A further reduction in error variance might occur if subjects were chosen more carefully with respect to their length of stay in the United States and number of previous psychology courses. Although these control variables (i.e., length of stay and number of psychology courses) did not show any significant main effects, the variance that did result might be lowered further if closer attention were paid to selection of subjects. For example, only Asians with zero or one psychology course who have lived in the United States less than five years might be included in the study.

In addition to possible problems resulting from subject variability, further limitations of the present study are the following. First, the East and Southeast Asian student volunteers in this study may not be representative of students in their native countries who have not come to the United States. It is possible that students living in Asia may have even less positive therapy attitudes and less accurate expectations about therapy than those who
have come to the United States to study. Therefore, caution must be used in generalizing the results of this study to other subgroups of Asians. Second, the paid volunteers in this study may have responded more favorably to the questionnaires than if they had not been paid. However, as was discussed previously, the experimental treatment should have lead to a greater increase in scores than the control treatments if it were more effective in modifying therapy expectations and attitudes. Third, the paper and pencil format of the questionnaires may have had an unintentional effect on the Asian subjects, namely leading them to behave as though they were taking an educational test on which high scores (i.e., positive attitudes and accurate expectations) are expected. The improvement in scores from pretest to posttest for the three groups may have occurred because of this perception of the questionnaires as educational tests.

One way to decrease the possibility that questionnaires will be viewed as tests may be to present questionnaire items orally rather than in written form.

The results of the present study have implications for future research on Asian expectations and attitudes toward therapy. First, the finding that foreign-born Asians do have significantly less accurate ideas than non-Asians about psychotherapy suggests the need for continued efforts to educate Asians about therapy and its potential usefulness for a wide range of problems. As several
researchers have found (Chien & Yamamoto, 1982; Sue & Kirk, 1973; Sue & Sue, 1972a), Asians and Asian Americans have as much need for therapy as other groups, but tend to underutilize available resources. There is a clear need to provide them with accurate information about psychotherapy and therapeutic services. Second, although the educational psychotherapy presentation did not differentially lead to improvement in expectations and attitudes (that is, all three groups showed significant improvement from pretest to posttest), it should be further evaluated in future research studies, using the modifications suggested previously. These include an increase in sample size and further reduction of subject variability. Third, evaluating the two parts of the educational psychotherapy presentation separately, namely the audiotaped lecture on psychotherapy and the transcripts of therapist-client dialogues from the therapy orientation program "Tell It Like It Is" (Evans, Acosta, & Yamamoto, 1982), would be useful in determining whether they are equally effective in modifying expectations. Fourth, the addition of a structured interview about therapy expectations and attitudes to the dependent measures presented either in written or oral form would allow Asian subjects to give their views about therapy in their own words, and would allow them to offer information not included in the questionnaires. Several subjects in the present study indicated surprise at the paper and pencil
format of the study, and expressed disappointment that they would not be given the opportunity to tell the interviewer about their perceptions of therapy. With the inclusion of such an interview, more detailed analysis of issues such as perceptions of confidentiality in therapy might produce valuable information for inclusion in the audiotaped psychotherapy lecture.
Appendix A

Recruitment Notice

ASIAN STUDENTS

Subjects needed for research project on attitudes and beliefs about psychotherapy. Subjects must have been born in an Asian country and have lived in the United States for less than ten years. Payment of $15 will be given for two sessions totalling one and one-half hours. If interested, please contact Rose Plotkin at 891-6663.
Appendix B

Therapy Expectation Scale

Instructions

The following statements represent beliefs and ideas about psychotherapy. Some of these statements use the terms "therapist" and "client." "Therapist" is used to mean "psychotherapist" or "psychologist"; the term "client" is used to indicate someone who receives psychotherapy (another word for "client" is "patient"). Please note that statements 1 to 19 involve beliefs about the client; statements 20 to 40 involve beliefs about the therapist.

Please circle "Yes" or "No" for each statement according to whether you agree or disagree with it. There are no right or wrong answers; just choose the answer that represents your honest thought or belief. Try to answer as quickly as possible. Do not spend too much time on any one statement. Please remember to complete each item.

During psychotherapy, I think that the client will...

1. talk to the therapist about his thoughts and feelings

   Yes  No

2. work together with the therapist to find solutions to his problems.

   Yes  No

3. never discuss thoughts or feelings which he is ashamed of.

   Yes  No

4. not state directly why he came to psychotherapy.

   Yes  No
5...ask the therapist very few questions. 
Yes  No

6...not discuss any issue that might make the therapist angry. 
Yes  No

7...tell the therapist his personal goals for psychotherapy. 
Yes  No

8...tell the therapist when he disagrees with the therapist's opinion. 
Yes  No

9...not tell his spouse what was discussed in psychotherapy. 
Yes  No

10...talk about problems even if they make him feel very uncomfortable. 
Yes  No

11...look directly at the therapist 
Yes  No

12...not tell the therapist if he is dissatisfied with psychotherapy. 
Yes  No

13...not talk about problems that he thinks are too small. 
Yes  No

14...usually feel uncomfortable answering the questions asked by the therapist. 
Yes  No

15...tell the therapist if he thinks that the therapist doesn't understand his situation. 
Yes  No

16...tell the therapist if he feels upset. 
Yes  No

17...continue in psychotherapy even if he feels no immediate benefits from it. 
Yes  No

18...try to hide his strong feelings. 
Yes  No

19...only talk about the problems which made him decide to begin psychotherapy. 
Yes  No
20. ask the client to take psychological tests only if the client has a severe mental illness. Yes No
21. not ask what makes the client afraid or nervous. Yes No
22. not ask about the client's private thoughts and feelings. Yes No
23. want the client to relax and feel free to discuss any aspect of his problem. Yes No
24. make suggestions that will always be helpful. Yes No
25. talk much more than the client during psychotherapy sessions. Yes No
26. discover the cause of the client's problem in the first session, even if the client does not know the cause at all. Yes No
27. ask the client many questions about his personal background. Yes No
28. act like a personal friend of the client. Yes No
29. refer the client to other professionals for problems which the therapist cannot solve. Yes No
30. choose the method of treatment that best suits his client's problem. Yes No
31. ask very few questions about the client's personal life. Yes No
32. not ask questions which might make the client feel uncomfortable. Yes No
33. be able to solve the client's problems without the client's input. Yes  No
34. provide rules that the client must follow completely. Yes  No
35. not necessarily prescribe drugs for the client's problem. Yes  No
36. probably not solve the client's problem in two or three sessions. Yes  No
37. tell the client's family about his problems if it would be helpful. Yes  No
38. ask the client just a few questions about the problem which caused him to come to psychotherapy. Yes  No
39. be able to understand the client's thoughts and feelings by looking at his facial expressions. Yes  No
40. sometimes discuss the client's problems with people who know the client. Yes  No
Appendix C

Help-Seeking Attitude Scale

Instructions

The following statements represent attitudes about psychotherapy. Some of these statements use the terms "therapist" and "client." "Therapist" is used to mean "psychotherapist" or "psychologist"; the term "client" is used to indicate someone who receives psychotherapy (another word for "client" is "patient").

Please circle "Yes" or "No" for each statement according to whether you agree or disagree with it. There are no right or wrong answers; just choose the answer that represents your honest opinion. Try to answer as quickly as possible. Do not spend too much time on any one statement. Please remember to complete each item.

1. Even if problems make a person feel quite upset, it is better to handle them by oneself than to go to psychotherapy. Yes No

2. A person cannot always solve his problems by himself, even if he has above-average intelligence. Yes No

3. A person should tell anyone he wants that he goes to a therapist. Yes No

4. It's OK for a person to tell people outside his family that he goes to psychotherapy. Yes No
Appendix C—continued

5. Male therapists are more helpful to male clients. Yes No
6. There is nothing embarrassing or shameful about going to psychotherapy. Yes No
7. Psychotherapy is not very useful for emotional problems (e.g., nervousness, depression, etc.). Yes No
8. Female therapists are more helpful to female clients. Yes No
9. A person should recommend psychotherapy to a friend who has psychological problems. Yes No
10. Most people will continue seeing a friend even if they discover that he is going to psychotherapy. Yes No
11. A person should not go to a therapist who is younger than himself. Yes No
12. Psychotherapy is not worth the time and effort involved. Yes No
13. Older therapists give better advice. Yes No
14. Psychotherapy is not very useful for dating or marriage problems. Yes No
15. Psychotherapy is useful since problems will not necessarily disappear as time passes. Yes No
16. If a person tries hard enough, he can deal with any problem by himself. Yes No
Appendix C—continued

17. The fact that a person goes to psychotherapy does not mean that his family has failed in some way. Yes No

18. A person who has never gone to psychotherapy is not necessarily healthier than someone who has. Yes No

19. Psychotherapy can be useful for family problems. Yes No

20. People with mild to moderate problems don't need psychotherapy. Yes No

21. Psychotherapy is not very useful for problems related to one's job. Yes No

22. People in any age group can be helped by psychotherapy. Yes No

23. Psychotherapy can be useful for sleep problems (e.g., difficulty in falling asleep, difficulty in staying asleep, etc.). Yes No

24. Psychotherapy can be useful for alcoholism. Yes No

25. Psychotherapy cannot help a person to become more self-confident. Yes No

26. Only people with severe mental illness should go to a therapist. Yes No

27. Anyone who needs psychotherapy is weak. Yes No

28. A friend almost always gives more helpful advice than a therapist. Yes No
Appendix C—continued

29. Most people who try psychotherapy will not be helped by it. Yes  No

30. It is wrong to lose respect for a person because he cannot deal with a problem by himself. Yes  No

31. Important responsibility should never be given to a person who has been hospitalized for past mental illness. Yes  No

32. Family members are not disappointed in a person who goes to psychotherapy. Yes  No

33. It is better not to talk about problems with a stranger such as a therapist. Yes  No

34. There are many positive effects of psychotherapy. Yes  No

35. Psychotherapy is not very useful for sexual problems. Yes  No

36. Psychotherapy is not very useful for problems in self-expression. Yes  No

37. A person should always ask for his family's advice regarding a psychological problem instead of going to a therapist. Yes  No

38. Psychotherapy is not very useful for school problems. Yes  No

39. A person does not develop a deeper understanding of himself or others through psychotherapy. Yes  No
40. Psychotherapy can be useful for problems with social relationships (e.g., loneliness, conflicts with friends, etc.).

Yes  No
Appendix D

Adaptation of the Fundamental Interpersonal Relations Orientation - Behavior Scale (FIRO-B)

Instructions

The following statements represent ways you may interact with people. For each statement, decide which of the answers best applies to you. Place the number of the answer on the line to the right of the statement. Please be as honest as you can.

1  2  3
rarely  sometimes  often

1. I try to be with people.  1. ___
2. I let other people decide what to do.  2. ___
3. I join social groups.  3. ___
4. I try to have close relationships with people.  4. ___
5. I tend to join social organizations when I have an opportunity.  5. ___
6. I try to include other people in my plans.  6. ___
7. I let other people control my actions.  7. ___
8. I try to have people around me.  8. ___
9. I try to get close and personal with people.  9. ___
10. When people are doing things together I tend to join them.

11. I am easily led by people.

12. I try to avoid being alone.

13. I try to participate in group activities.

14. I try to be friendly to people.

15. I act cool and distant with people.

16. I like people to invite me to places.

17. I like people to act close and personal with me.

18. I try to strongly influence other people's actions.

19. I like people to invite me to join in their activities.

20. I try to take charge of things when I am with people.

21. I like people to include me in their activities.

22. I like people to act cool and distant toward me.

23. I try to have other people do things the way I want them done.

24. I like people to ask me to participate in their discussions.

25. I like people to act friendly toward me.
26. I like people to invite me to participate in their activities.

27. I like people to act distant toward me.
Appendix E

Demographic Information Form

Instructions
Please answer the following questions. For some questions, you will circle the appropriate response. For others, you will write in the answer.

1. Are you presently enrolled in school? Yes No

2. If enrolled, indicate year in school:
   Undergraduate: 1 2 3 4
   Graduate: 1 2 3 4

3. If not enrolled, indicate highest year completed:
   Undergraduate: 1 2 3 4
   Graduate: 1 2 3 4

4. Undergraduate major: ____________________________

5. Graduate major: ________________________________

6. Place of birth: _________________________________

7. If place of birth is not the United States, indicate the number of years you have lived in the United States: ______

8. Present citizenship: ______________________________

9. Native language: ________________________________

10. Age: ______

11. Sex: Male Female

12. Have you ever received psychological counseling or therapy? Yes No
13. If you answered "Yes" to the previous question, how many sessions did you have? ____________

Dates of therapy: _________ to __________

14. Marital status: Married  Not Married

15. If married, is your spouse presently enrolled in school? Yes  No
Appendix F

Transcript of Psychotherapy Audiotape

General Introduction

Today, I'd like to talk to you about psychotherapy, which is often just called "therapy." Possibly you know a lot about what therapy is, and what happens in therapy. Or maybe you have no clear understanding of therapy at all, especially if you have never tried therapy yourself, or don't know anyone who has tried it. Since I'd like to help you understand therapy better, I will explain what it is and give you examples of some common problems people try to solve when they go to a psychotherapist (that is, a person who gives therapy). Also, I will talk about how clients (that is, people who receive therapy) and their therapists actually work together in the therapy process to solve the client's problems.

I will introduce each of these topics with a question, and then I will give an answer that explains a bit about the topic. Later, you will be shown some written examples of what clients and therapists should say when they meet in therapy so that the therapist can help the client as much as possible. Now I will begin.
Lecture on Psychotherapy

What is psychotherapy? Psychotherapy is a type of treatment for many different psychological problems. These problems may be serious, such as drug or alcohol habits, hurting oneself or other people on purpose, or seeing and hearing things which do not exist. Or they may be mild problems, such as worrying too much about school, work, or family, or feeling sad and lonely most of the time. During therapy, the therapist tries to discover, through discussion, exactly what feelings, attitudes, and behavior create problems for the client. Then the therapist and client decide the best way to change those feelings, attitudes, and behavior. One of the general goals of therapy is to reduce the emotional pain which people believe they cannot control by themselves.

Therapy is different from discussing problems with a friend or relative. The difference is that the therapist is specially trained to help people solve their personal problems. Therapists have seen many clients with similar types of problems, and know many different ways to help clients solve their problems; friends or relatives don't have as much experience. Also, friends and relatives look at personal problems from their own point of view and, although they want to help, they may not be able to give advice that is effective for the client as an individual.
There are several types of therapy sessions. The therapist may meet with the client alone, which is called individual therapy, or with groups of clients who have similar problems, which is called group therapy. The therapist may meet with the client and his or her spouse together, which is known as couples therapy, or even with the client and his or her whole family, which is called family therapy. The therapist and client decide together which type of session will be most helpful. Therapy sessions are usually given once a week, and may be continued for a short or long period of time, according to the client's needs.

Who does therapy? Therapy is done by clinical psychologists, psychiatrists, and social workers. Clinical psychologists have either a Ph.D. or sometimes an M.A. degree in clinical psychology, and are trained to provide different types of psychotherapy, psychological testing, and research. A psychiatrist is a medical doctor who also gives treatment for psychological problems, but psychiatrists can write drug prescriptions for a client if necessary. Clinical psychologists can't do this because they are not medical doctors. Social workers have an M.A. degree in social work. Usually a social worker does family therapy, or may help the parents or spouse of a client who goes to a psychologist or psychiatrist for treatment.
All of these different types of therapists must meet special state regulations. They must either have a state license to practice psychotherapy themselves, or be supervised by a therapist who has already received a state license.

Where can a person get outpatient therapy? "Outpatient therapy" means therapy which does not require that a client must stay overnight or longer in a hospital for intensive treatment. Each therapy session lasts an hour or two, and then the client returns home. This type of therapy is useful for most personal problems which are not extremely serious. Outpatient therapy is available at psychotherapists' private offices, community mental health centers, university psychology clinics, and at outpatient hospital clinics. A family doctor can recommend some of these nearby, or people interested in therapy can look in the telephone book under "mental health," "psychologists," "psychiatrists," or "psychotherapists."

The staff of community mental health centers usually includes clinical psychologists, psychiatrists, and social workers. University clinic staff are usually graduate students supervised by clinical psychologists. Outpatient hospital clinics are staffed by psychiatrists, clinical psychologists, nurses, and social workers.

People who want outpatient therapy can phone these places and make an appointment. The fees that are charged
will be different from place to place, and in some cases
the fee will be based on the individual client's ability to
pay. A person with low income may pay as little as $5 per
session, particularly at government-supported community
mental health centers, university clinics, and outpatient
hospital clinics. Health insurance can often pay part of
the cost of psychotherapy.

Why do people want therapy? Generally people want
to try therapy when their personal problems become quite
painful, and seem very difficult to solve by themselves.
Some examples of problems that make people want therapy are
as follows.

1. Emotional problems: Depression, anxiety, and
phobias are common emotional problems. People who suffer
from depression often are not able to eat or sleep well, to
concentrate on their work or study, or to enjoy things that
were pleasant for them in the past. They feel sad and
empty inside most of the time. Anxiety means constant
worrying or nervousness which prevents clear thinking and
action. Anxious people usually try therapy when they find
they are not efficient in work or school. A phobia means a
strong fear of a specific object or situation. People who
have phobias are so terribly frightened by these objects or
situations that they avoid them regardless of any incon-
venience to themselves or others. For example, a salesman
who has a germ phobia might not be able to use a telephone,
because he fears he will become sick from germs on the mouthpiece.

2. Family conflicts: Conflicts between parents and their children, or between husbands and wives are a common reason for people to go to therapy. Arguments between a father and son concerning the son's career goals, group of friends, or grades in school are examples of parent-child conflict. Conflict concerning family finances is an example of husband-wife conflict.

3. Social problems: Many people want to try therapy because they are uncomfortable in groups. They feel nervous, shy and lonely at work or school and at parties and other social events. They also may not be able to keep friends.

4. Illness related to stress: Many people become ill with headaches, stomach pains, nausea, and muscular pains when they are very nervous. Sometimes illnesses related to stress can become dangerous, such as high blood pressure or stomach ulcers. Stress-related illness is called psychosomatic illness, and is a common reason that people go for psychotherapy.

5. Sexual or dating problems: Confused feelings about a boyfriend or girlfriend, fear of sexual inadequacy, or fear of sexual contact are also reasons that some people want to try therapy.
What will therapists do in therapy? People who go to see a therapist and discuss their problems will find that the therapist does the following things.

1. The therapist questions the client: The therapist needs to know exactly what upsets the client, and therefore must ask many questions about the client's thoughts, feelings, and relationships with friends and family. Sometimes the therapist may need to ask about private matters which the client does not usually talk about to anyone. This is because the therapist must have as much background information as possible to help the client properly.

2. The therapist explores the client's past: In addition to the client's present situation, the therapist may want to know about events from the client's past. This information will help the therapist to understand how the client's problems developed, and why these problems continue to upset the client at the present time. Also, the therapist must know how successful the client was in dealing with problems in the past.

3. The therapist gives psychological tests: The therapist may ask the client to take psychological tests, such as tests which show depression or anxiety. These tests, like the questioning of the client, will provide the therapist with more information to help the client. Some therapists always give tests to new clients, as a routine part of therapy. Others only give tests if their discussions
with the client do not provide enough background information. Other therapists don't give tests at all. Testing usually takes one or two sessions, and then the therapist tells the client the results later on.

4. The therapist assists and supports the client's own decision-making: Psychotherapy is a joint effort between the therapist and the client. The therapist, even if he or she is a psychiatrist, is not like a medical doctor who tells patients exactly what to do for an illness. Instead, the therapist and client try to discover the source of the client's problems together, using the above techniques, and then discuss possible solutions to the problems. If the client does not feel that a therapist's suggestion is useful, the therapist will try to provide another which is more acceptable. The therapist will not order the client to do things because that is not a therapist's role. He or she is not like a supervisor at work who orders an employee to carry out job assignments. The therapist also tries to show the client different ways of thinking about the world, so that the client can discover his or her own solutions in the future.

5. The therapist maintains confidentiality: Anything discussed in therapy sessions between the therapist and the client is considered strictly secret by the therapist. The therapist will not tell this information to anyone, not even friends or family of the client, unless the client gives specific permission to do so. Like medical doctors,
lawyers, and clergymen, psychotherapists must use this professional rule of behavior when treating clients. For example, if a mother calls her daughter's therapist and asks if her daughter's depression is improving, the therapist will not give her that information, and is not allowed to, unless the daughter gives her permission first. This is true regardless of whether the daughter has improved or not.

There is only one exception to this professional rule. That is when the therapist is supervised by another licensed therapist. In this case, both therapists may discuss what the client said in therapy with each other, but are not allowed to discuss it with anyone else.

What should clients do in therapy?

1. The client should participate actively: The client should describe his or her problems to the therapist in as much detail as possible, and give examples when appropriate. Anything that troubles the client should be discussed. Any issue that is important to the client should be discussed. Any of the client's thoughts and feelings about himself or herself and relationships with others should be discussed. Even if it does not seem directly related to the client's present problems, the client should tell the therapist anything he or she thinks the therapist should know.

2. The client should establish goals: The client should tell the therapist exactly what benefits he or she
expects to receive from therapy. This is often hard to do in the beginning. Some time may be necessary to decide what goal or goals would be possible for therapy. Some therapists suggest that their clients consider both long- and short-term goals. For example, a client who has marital problems might decide to spend more time each week in leisure activities with his or her spouse as a short-term goal, and then improve other aspects of their relationship as a long-term goal.

Several other points about the client's role and behavior will be explained in the written material that will be given to you soon.

_What else is important about therapy?_ Here are a few more things that are important to know about effective psychotherapy.

1. The therapist-client relationship: During therapy, the client may begin to feel very positive or negative toward the therapist. Or the client may feel very positive at one period in therapy and very negative at another. These feelings are not uncommon in therapy, and should be discussed with the therapist, even if it is painful to do so. Therapists are not surprised by these feelings and will not criticize a client because of them. Effective therapy is based on a free flow of information between the therapist and client; if positive or negative feelings reduce the flow of information then therapy will not be as effective.
2. Cultural differences between client and therapist:

If the client and the therapist have different cultural backgrounds, it may be difficult for the client to discuss personal problems. Sometimes the client may not be able to explain his or her point of view clearly. Or the client may feel that the therapist cannot possibly understand his or her problem, due to differences in culture or customs, even if the problem was explained clearly. In this case, it is important for the client to explain the cultural basis of poor communication to the therapist, so a free and accurate flow of information can be maintained. The therapist will try very hard to learn about the client's culture and customs, in order to understand and help solve the client's problems.

There are, of course, several other topics that can be discussed in the area of psychotherapy, but since our time is limited I must end the discussion here. Thank you for your attention.
Appendix G

Transcript of Therapist-Client Dialogues
from "Tell It Like It Is"

Narrator: The program you are going to read has seven ideas which can help you get more out of therapy. This program will present each idea and demonstrate people using that idea to help solve their problems of living and problems with feelings.

All people have some problems at various times in their lives, such as losing a job, or getting a divorce, which can cause stress, tension, or depression. Sometimes people feel physically sick even though doctors can find nothing wrong and say that their body is O.K.

Today, you will read about someone who has special experience in helping people with problems of living and problems with feelings. The person you will read about is called a therapist and the way you are helped is called therapy. Therapy involves talking about yourself, your problems, and your feelings so that, with the help of the therapist, you can feel better. Now, let's consider the first idea.
Try not to hide your problems. Your therapist won't know what you're thinking and feeling unless you "tell it like it is." Your therapist is only human, not a mind reader. So say how you feel, what you think your problems are, and what kind of help you want.

Therapist: It's hard for me to know what's troubling you. I wish you would tell me. You haven't told me exactly how you feel.

Client: Well (pause)...umm...(pause)...I came here because I feel awful. I want you to help me feel better.

Therapist: I'm glad you told me that. I do want to help. Could you tell me what you mean by awful?

Client: Well, I cry a lot, and I'm nervous and upset all the time. You see, well, my husband and I are not getting along. It's not the same anymore. We don't talk to each other.

Therapist: I can see why you are upset. That does help me. Could you tell me more about it?

Narrator: Remember, don't hide your problems. Your therapist can only help you if you say what is wrong and explain what your problems are.

Narrator: Our next idea is to be open, honest, and willing to express how you feel about anything,
even your therapist; for example...Don’t be afraid to disagree with your therapist. What you think and feel are very important to you and to your therapist.

Client: I know you're trying to help, but I'm not getting the help I want. You just seem to "uh-huh" all the time. I feel I'm not getting anywhere.

Therapist: Okay, thanks for telling me. Could you tell me what you expect from me?

Client: I think you should tell me what to do. I came here with a problem, and I want you to take care of it!

Therapist: Well, I want to help you but I can't make problems disappear. We have to work together to solve them. Now, let's see what we can do about your problems. Let's go over the main one again.

Client: Again?...Well, okay. My mother and I scream and yell at each other all the time. We just can’t seem to agree on anything anymore...

Narrator: Remember, it is very important that you be open and honest with your therapist, and don't be afraid to disagree with your therapist. Your therapist is trying to help you.
Another idea to consider is that, if you think your therapist is going to be treating you for too long a period of time, tell your therapist. Sometimes people expect to get better right away. Usually this doesn't happen. It may take a little more time to solve your problems than you had planned.

I've been here three times and haven't solved my problems yet. I usually don't see the doctors this many times.

I appreciate your telling me about it. But you know, some problems take a little more time than others. Were you expecting to have your problems solved by now?

Well, I think that after seeing you for three times, I should have solved a couple of my problems. You know, like why am I still feeling so depressed and why do I still feel like I'm getting nowhere in my job.

Remember, tell your therapist if you're not satisfied with the time it's taking to solve your problems.

A fourth idea is that, if you don't plan on coming back for your next appointment, whatever the reason is, say so.
Client: You know, I've been feeling a lot better for the last month. I don't think I need to come back to therapy anymore.

Therapist: I'm glad to hear that you're feeling better. Could you tell me more about how you feel?

Client: Well, I feel you've helped me understand myself. I think I can handle my problems better now.

Therapist: Well, you've made a lot of progress. I agree with you, I don't think you have to come back anymore. But, if you ever do have problems again, please call and let me know.

Narrator: Remember, no matter what the reason is, good or bad, tell your therapist if you don't plan on coming back for your next appointment.

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Narrator: Idea number five: If, for some reason, you're unhappy with your therapist, tell your therapist. You have a right to think and feel as you do.

Client: I don't like coming here, it's too hard. (On the verge of tears) I don't feel you're helping me that much...

Therapist: I'm sorry you feel that way. I can see it was hard for you to say that...(pause) Can you tell me more about how you feel?
Client: Well, since I've been vomiting here, I've been trying really hard, but I still feel nervous. I have trouble falling asleep, and I wake up too early. My stomach still burns. I should be well by now.

Therapist: I know you're still hurting. But I don't think meeting here five times is enough to change the pains you've developed over several years. I think you can benefit if we continue to discuss your problems just a few more times.

Narrator: Remember, tell your therapist if you're unhappy with your therapy. They can only help you if you say how you feel. Your therapist wants to help you.

Narrator: Talking about certain problems may make you feel awkward, or embarrassed. Our next idea is that you should talk about your problems, even though it may make you feel uncomfortable. Talking about them will probably help.

Therapist: I've noticed that you get really tense whenever you talk about sex.

Client: Yeah, well, I...(long silence...5 seconds) I just feel real embarrassed when I talk about sex, you know.
Therapist: Is it just with me, or anyone?

Client: Anyone, I guess. I think I have a problem. But I just can't tell you what's wrong. It's really hard to talk about, you know.

Therapist: I can see it's difficult for you. Is this a problem you'd like to work on? If it is, we have to talk about it.

Client: Well...I do want to solve my problem.

Narrator: Remember, even though talking about certain problems may make you feel embarrassed and uncomfortable, you should talk to your therapist about these problems so that your therapist can help you solve them.

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Narrator: Our last idea is that you can talk to your therapist about any problem you may be having. For example: work, money, sex, personal feelings, welfare, medical, family, school, or anything, whether you are seen by your therapist individually or in a group. No problem is too small to talk about. Sometimes even little things, if left unattended, can become major problems.

Client: I hate to bother you with this little problem, but I keep waking up early in the morning and just can't get back to sleep.
Therapist: Well, let's see. Your waking up might be important. Has anything in particular been troubling you this week?

Client: Well, I hadn't thought about it, but I have felt pretty low lately (tears...softly).

Therapist: It's good you brought this up. Let's try to figure out what's been making you feel low.

Narrator: Remember, no matter how small your problems may seem to you, they may be very important, so tell your therapist.

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Narrator: The seven ideas and examples you have just read about therapy were to help you tell it like it is. By using them, you will get more help and greater benefits from therapy, whether you see a therapist by yourself, or in a group. Now, let's briefly review the seven ideas.

One, don't hide your problems.

Two, be open, honest, and willing to express how you feel, even if it means disagreeing with your therapist.

Three, if you think your therapist is going to be treating you for too long a period of time, let your therapist know.
Four, if you don't plan on coming back for your next appointment, no matter what the reason is, tell your therapist.

Five, if you are happy, or unhappy, with your therapy, tell your therapist.

Six, even if you feel uncomfortable or embarrassed about certain problems, talk to your therapist about them.

Seven, feel free to talk about any problems you may have. No problem is too small.

Remember, these seven ideas are only examples of things which may help you in therapy. Therapists try to help you with your own special problems. It's what you think and feel that's important. So...tell it like it is.
Appendix H

Transcript of Social Relationships Audiotape

General Introduction

Today, I'd like to talk to you about social relationships. Your relationships with other people will be important to you throughout your life. From our earliest attachment to our parents to our later relationships with friends and lovers, social relationships are both rewarding and challenging. During this lecture, I will discuss several aspects of social relationships. First, I will discuss the need to form relationships with others. Then, I will talk about how we form impressions of other people. Finally, I will mention reasons why we like or dislike other people. After the lecture, you will be given a paper to read about love relationships and why relationships end. Now I will begin.

Lecture on Social Relationships

The first topic I will discuss is the need for social comparison. One of the main reasons that we seek the company of other people is to compare our feelings and ideas about important events with theirs. Many experiences in our lives would be confusing or even meaningless if we could not compare our own ideas with those of other people. If we did not compare ideas with other people, we would not know what situations are dangerous or safe, when to laugh
Appendix H—continued

or cry, or what our strengths and weaknesses are. Social comparison is clearly needed in order to understand the experiences we have.

The need for social comparison when we are afraid was shown by the psychologist, Stanley Schachter (cited in Rubin & McNeil, 1981) in an experiment with college women. Half of the women were told that they would be given painful electric shocks as part of the experiment. This group was called the high-fear group. The other women were told that they would be given very mild electric stimulation that would actually feel pleasant. This was the low-fear group. Then the experimenter told the women that they could either wait in a room by themselves or in a room together with other subjects until he needed them. Sixty percent of the high-fear group chose to wait with others, compared to only 33 percent of the low-fear group. The fearful women tended to seek the company of others, just like most people do during emergency situations.

Now, I'd like to discuss how we benefit from relationships. Not only do people need the company of other people in general, but they also need to form close, long-term relationships with specific people. The psychologist, Robert Weiss (cited in Rubin & McNeil, 1981) believes that people need to form two different types of social relationships: a close emotional attachment to one other person (for example, a spouse) and social ties to a group of
friends. Each type of relationship provides certain benefits. Close emotional attachment provides a sense of comfort and security, while social ties provide identification with a group. The adult need for close emotional attachment seems to develop from the infant's attachment to its parents. Social ties, usually to friends of the same age, are important in childhood and become more so in adolescence.

When people lack either close emotional attachment or a social group, the result will probably be loneliness. Robert Weiss (cited in Rubin & McNeil, 1981) believes there are two kinds of loneliness: the loneliness of emotional isolation and the loneliness of social isolation. The loneliness of emotional isolation results from the absence or loss of social ties. Both types of loneliness can be extremely unpleasant. A person who has either type of loneliness will probably feel sad and empty. Weiss has found that one type of social relationship does not decrease the loneliness caused by the absence or loss of the other type. For example, a person who has lost a lover may feel painfully lonely, even though he or she spends time with many friends. Similarly, a person who has a close emotional attachment to a lover may still feel great loneliness if he or she has no group of friends. Feeling lonely, therefore, is not the same thing as being alone.
Now, I'd like to talk about how we form impressions of other people. One important factor in the impressions we form is physical appearance. A person's height, weight, age, facial features, and color often affect the impressions we form about the person. The importance of physical appearance was studied in an experiment by Dion, Berscheid, and Walster (cited in Rubin & McNeil, 1981). They showed their subjects photographs of young men and women who had different degrees of physical attractiveness. The subjects were asked to give their impressions of the people in the photographs and to predict their future success. The subjects believed that the better-looking men and women were more sensitive, kind, interesting, and sociable than the less attractive ones. The subjects also believed that the better-looking people would probably be more successful in their careers, become good husbands or wives, and find happiness in their lives.

Other experiments had different results, but still showed that appearance affects our impressions of other people. Dermer and Thiel (cited in Rubin & McNeil, 1981) showed that beautiful people are often viewed as vain and self-centered. Krebs and Adinolfi (cited in Rubin & McNeil, 1981) showed that beautiful people are likely to be rejected by peers of their own sex, perhaps because of jealousy. In research done by John Bassili (cited in Rubin & McNeil, 1981), men and women who were physically attractive
were also thought to be exciting and interesting, but not especially kind, sensitive, or sincere.

Another important factor in forming impressions of other people is reputation. Students learn about a new professor by talking to former students of that professor. And before going out on a blind date, a person is usually given a good deal of information about his or her date by friends. In each case, reputation is likely to affect people's impression.

Harold Kelley (cited in Rubin & McNeil, 1981) did an experiment which showed that reputation clearly affects the way people are perceived. In this experiment, subjects were told that their class would be taught by a new instructor. They were asked to evaluate this new instructor at the end of the period. Before the instructor arrived, the students were given a brief description of him to read. Half of the students were told that the new instructor was a 26-year-old graduate student who was rather warm, hard-working critical, practical, and determined. The other half of the students received the same information with one difference: they were told that the instructor was cold rather than warm. After the instructor led the class in a 20-minute discussion, the students who were told that he was warm rated him as more considerate, sociable, good-natured, and humorous than did the students who were told that he was cold. In addition, 56 percent of the
students who were told that he was warm participated in the discussion, compared to only 32 percent of the subjects who were told that he was cold.

My next topic on social relationships will be liking others. Our likes and dislikes determine who we will spend our time with and who we will avoid. Psychologists have studied many factors which make us like particular people, and they have found that two important factors are distance and similarity. Think for a moment about distance and you will see that it is quite an important issue. If you were to live in California and I were to live in Michigan, it is not probable that we would become friends, or even get to know each other. The distance between any two people directly affects the probability that they will become friends. Preist and Sawyer (cited in Rubin & McNeil, 1981) studied a college dormitory and found that students tended to like the person next door more than the one who lived two doors away, and to like that person more than the one three doors away, and so on. In another study, Newcomb (cited in Rubin & McNeil, 1981) found that persons who were assigned to the same dormitory room became friends much more often than expected simply on the basis of their other characteristics.

As you may already have realized, nearness doesn't always lead to liking. Close and frequent contact can result in disliking as well. But researchers have found
that close and frequent contact leads to liking much more often than to disliking. This is because contact with people usually provides us certain social rewards, such as opportunities for joint activity or for comparison of personal experiences and reactions. Nearness seems to affect love and marriage in the same way. Studies by sociologists have shown that the closer a man and a woman live within a city, the more likely they are to marry one another (Katz & Hill, cited in Rubin and McNeil, 1981).

Now, let's consider the second factor in liking: similarity. Once an opportunity to meet others exists, similarity becomes an important part of liking or disliking later on. We usually make friends with people who are similar to us in many ways, such as age, occupational status, educational level, and political preferences. This was shown in an experiment by Laumann (cited in Rubin & McNeil, 1981). Similarity is also important in our choice of husbands and wives. Many studies have found that husbands and wives are similar in characteristics ranging from height to intelligence (Rubin, cited in Rubin & McNeil, 1981).

The most important similarities for liking are beliefs and attitudes. In an experiment at Bennington College, Theodore Newcomb (cited in Rubin & McNeil, 1981) discovered that many students changed their attitudes in order to be liked and accepted by their classmates. Newcomb (cited in Rubin & McNeil, 1981) also studied
friendships later on, at the University of Michigan. His experiment there showed that friendships among students were mostly due to similarities in attitudes and values. For example, one group of five friends in the liberal arts college all had liberal political views and strong intellectual and artistic interests. Another group of three war veterans in the college of engineering were all politically conservative, and had more practical interests than other students.

There are, of course, several other topics that can be discussed in the area of social relationships, but since our time is limited, I must end the discussion here. Thank you for your attention.
Appendix I

Written Material on Social Relationships

Loving Others

Although psychologists have been studying the area of liking for some time, they have only recently begun to study the more complex topic of love. Love means different things to different people. Some students who were interviewed by the psychologist Zick Rubin (1981) described love as follows: "Love is really ambiguous. I have a feeling for her; I don't know what to call it; it's a warm feeling, an appreciation of her, an understanding of her, a respect; if you want to call it love, sure" (p. 601). "Our love was pretty practical. It's just an overall very good feeling about a person, I think. I just wanted him to be there. Even if he was being really disgusting, I just liked being with him" (p. 601). "Love means that I'm not going to hide or hold things from her, that she is the person I'm going to be totally open with and I hope will be totally open with me" (p. 601).

Rubin tried to define and measure love. Based on the results of a questionnaire given to several hundred dating couples at the University of Michigan, Rubin developed a measure of love that he called the "love scale" (Rubin, 1981). On his scale, student subjects were asked to write how much they agreed or disagreed with several statements
about feelings toward a boyfriend or girlfriend. Rubin analyzed the students' responses, and found that for them, love consisted of three parts: attachment, caring and intimacy. Attachment means a person's need for the physical presence and emotional support of another person. Caring means feelings of concern and responsibility for another person. Intimacy means the desire for close communication with another person. Rubin believes love is an attitude held by one person toward another that includes all three of these.

In order to test the accuracy of the scale, he did an experiment in which boyfriends' and girlfriends' scores on the love scale were compared to the amount of time the couple spent staring into each other's eyes (Rubin, cited in Rubin & McNeil, 1981). Eye contact was considered to be a good behavioral measure of a couple's true feelings for each other, and if scores on the love scale were similar to the amount of eye contact the couple made, then the scale would be accurate. Couples were observed through a one-way mirror while they sat in a waiting room. Rubin found that "strong" lovers, who had above-average scores on the love scale, made much more eye contact than "weak" lovers, who had below-average scores on the scale.

Love and Sex

What is the effect of sex upon romantic relationships?

One view, suggested by Sigmund Freud (cited in Rubin &
McNeil, 1981), is that sex can reduce feelings of love. Freud believed that when couples have sex their love for each other may be reduced, because according to his theory, feelings of love occur only as a substitute for sex. Other theorists disagree, since they have observed that sex between two people often increases their love for each other.

For example, Dermer and Pyszczynski (cited in Rubin & McNeil, 1981) did an experiment to test the second idea, and found that sexual excitement increased male college students' love for their girlfriends. The male students were asked to read a detailed description of a college woman's sexual behavior and fantasies. After that, the students were asked to write their answers to the questions on Rubin's love scale. Their scores on the love scale increased. This showed that sexual excitement can increase feelings of attachment, caring, and intimacy, which Rubin believes are the components of love.

In reality, the connection between love and sex depends greatly on the sexual values of the people involved. Although many dating couples believe that their sexual relationship helps to strengthen their love, others believe that their love can be strong even without sex. Peplau, Rugin, and Hill (cited in Rubin & McNeil, 1981) found that sexual intercourse had no clear effect on the future of student couples' relationships. Couples who
had no intercourse were just as likely to stay together for the two-year period of the study as couples who had intercourse.

Leaving Others

According to television programs, movies, and magazines, if two people are well matched, they will fall deeply in love the first time they meet and stay together forever. But this ideal is not true in reality. Love rarely occurs at first sight and usually deepens only after time passes by. Love does not necessarily last forever. In many cases, love ends even after a long-term relationship or marriage, and this may result in a separation or divorce.

Why Do Relationships End? Relationships end for many reasons, ranging from simple boredom to differences in lifestyle. In their study of student couples, Rubin and his co-workers examined some of the factors that cause couples to separate (Hill, Rubin, & Peplau, cited in Rubin & McNeil, 1981). About half the couples they studied over a two-year period stayed together and the other half separated. The experimenters discovered that those who stayed together were more similar in age, intelligence, career plans, and physical attractiveness than those who separated. In addition, separated couples told the experimenters that differences in personal interests, backgrounds, sexual attitudes, and ideas about marriage
caused their separation. So it seems that when people are similar they are more easily attracted to each other and will stay together longer.

When Do Relationships End? Hill, Rubin, and Peplau (cited in Rubin & McNeil, 1981) found that student couples usually separated at specific times during the school year: in the months of May/June, September, and December/January. These are the times when semesters begin or end, or there is a vacation break. At these times, people are more likely to be away from each other or to meet new partners. In addition, if a person has already thought about ending his or her relationship, it may be easier to end the relationship at these times. For example, the person who wants to end the relationship may find it easier to say, "While we're apart we should try dating other people" rather than, "I've grown tired of you and I don't want to date you any more."

After Breaking Up. The ending of a love relationship often leads to unhappiness and pain. These feelings usually are more severe for the partner who did not want to separate, but they also affect the partner who wanted to separate, as well. In spite of the pain, however, the ending of love relationships can teach people valuable lessons. When people directly experience difficulties in a love relationship, they usually learn more about their own strengths, weaknesses, and needs. This knowledge can be of
value to them in future relationships. For example, after
the end of a relationship, a female student said, "I don't
regret having the experience at all. But after being in
the supportive role, I want a little support now. That's
the main thing I look for" (Hill, Rubin, & Peplau, cited
Appendix J

Informed Consent Form

I understand that I will be participating in a research study. This study is investigating expectations and attitudes about psychotherapy. I will be asked to attend either two or three sessions. If I am asked to attend two sessions, the first will include the completion of several questionnaires, listening to an audiotape, and reading written material. It will take about one hour and fifteen minutes. The second session will involve the completion of several questionnaires, and will take about fifteen minutes. If I am asked to attend three sessions, an additional fifteen-minute session for completing questionnaires will be included.

I understand that I will receive payment for participating in the study. If I would like to know the results of the study, they will be conveyed to me at the end of the project. I understand that there are no risks in this study.

The results of all questionnaires will be kept completely confidential. I understand that my name will not be used in any way. Instead, I will be assigned a code number, which will be used on the questionnaires. In this way, the identity of the person who completed the questionnaire will not be known.
Appendix J—continued

My participation in this study is completely voluntary and I may withdraw my consent and terminate my participation at any time. I will not lose any benefits or be penalized in any way if I decide to discontinue.

I have had the opportunity to discuss the study with Ms. Plotkin and my questions have been answered to my satisfaction. I have read and understand this consent form and agree to participate in the study.

Signature                  Rosette C. Plotkin, M.A.
                           Principal Investigator

Date
Appendix K

Statistical Analyses of Data: Mean Scale Scores, Standard Deviations, Analysis of Variance Summary Information, and Item Frequencies and Percentages
Table 1

Mean Attitude and Expectation Scale Scores and
Standard Deviations of Asians and Non-Asians

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<th>Non-Asian</th>
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<td></td>
</tr>
<tr>
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<td>SD</td>
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<td>Attitude</td>
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</tr>
<tr>
<td>SD</td>
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Note. The two scales represented in the table are the Therapy Expectation Scale and the Help-Seeking Attitude Scale.

Table 2

Analysis of Variance Summary of Asian Pretest Groups on Expectation Scale

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<tr>
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<th>MS</th>
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<td>Between</td>
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<td>18.53</td>
<td>9.27</td>
<td>.29</td>
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<tr>
<td>Within</td>
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<td>Total</td>
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<td>1342</td>
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Note. Asian pretest groups are experimental, placebo control, and delayed treatment control.
Table 3

Analysis of Variance Summary of Asian Pretest Groups on Attitude Scale

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<td>Within</td>
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<td>Total</td>
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</table>

Note. Asian pretest groups are experimental, placebo control, and delayed-treatment control.

Table 4

Summary of Two-Way Analysis of Variance with Repeated Measures on Expectation Scale

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<td>Type of treatment</td>
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<td>Error - between</td>
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<td>Within subjects</td>
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<td>184.90</td>
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<td>Type * Time</td>
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*p < .001.
Table 5
Means Scores on Expectation Scale at Pretest and Posttest

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<tr>
<td>Experimental</td>
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<tr>
<td>Placebo Control</td>
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<td>Delayed-Treatment Control</td>
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</tr>
<tr>
<td></td>
<td>Posttest</td>
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<tr>
<td>Experimental</td>
<td>31.87</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Placebo Control</td>
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<tr>
<td>Delayed-Treatment Control</td>
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<td></td>
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</table>

Note. Each group has 15 subjects.

Table 6
Mean Scores on Attitude Scale at Pretest and Posttest

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</thead>
<tbody>
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<td>Pretest</td>
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<tr>
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<tr>
<td>Placebo Control</td>
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<td>Posttest</td>
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<td>Experimental</td>
<td>30.93</td>
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<td>Placebo Control</td>
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<tr>
<td>Delayed-Treatment Control</td>
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Note. Each group has 15 subjects.
Table 7
Summary of Two-Way Analysis of Variance with Repeated Measures on Attitude Scale

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<th>F</th>
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<td>Error - between</td>
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<tr>
<td>Within subjects</td>
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*p < .05.
Table 8

Frequencies and Percentages of Inaccurate Responses to Expectation Scale Items

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<td>f %</td>
<td>f %</td>
</tr>
<tr>
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<td>3 7</td>
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</tr>
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<td>C3</td>
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<td>8 17</td>
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<td>C4</td>
<td>18 40</td>
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Note. The item percentages were based on 45 subjects for the Asian groups, and 157 to 160 subjects for the non-Asian
group. In the non-Asian group, subjects occasionally omitted an item, and therefore the total number of subjects for that item was adjusted accordingly.
Table 9

Frequencies and Percentages of Negative Responses to Attitude Scale Items

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References


Hoehn-Saric, R., Frank, J. D., Imber, S. D., Nash, E. H.,
preparation of patients for psychotherapy: I. Effects
on therapy behavior and outcome. *Journal of Psychiatric
Research, 2*, 267-281.

Kaneshige, E. (1973). Cultural factors in group counseling
and interaction. *Personnel and Guidance Journal, 51*, 400-
405.

of counseling center services. *Personnel and Guidance,
37*, 358-364.

Kinzie, J. D., Tran, K. A., Breckenridge, A., & Bloom,
J. D. (1980). An Indochinese refugee psychiatric
clinic: Culturally accepted treatment approaches.

Kitano, H. (1967). Japanese-American crime and delin-

of a subculture. Englewood Cliffs, New Jersey:
Prentice-Hall.

S. C. Plog & R. B. Edgerton (Eds.), *Changing perspectives

Journal of Social Psychology, 80*, 121-134.


